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Building a history with your patients

Art and spirit in healthcare

Using words to unravel the tangle of pain

Historytaking and Historymaking

The history of history taking

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editorial

Historytaking and Historymaking

"Words, Words, words," replied Hamlet. To use words is part of our God-like image. The fourth sentence in my Bible starts: *"And God said:...."* Who heard His words? Maybe the angelic host, or was it communication within the Trinity? By the word of the Lord the heavens were made (Psalm 33). The letter to the Hebrews tells us that the word of God is living and active.

You may recall the children's taunt "words will never hurt me." How wrong! James asserts that *"the tongue is a restless evil, full of deadly poison."* In the consulting room we are usually very circumspect. We are dealing with people who are made in the likeness of God. Psalm 139 declares: *"Before a word is on my tongue, O Lord, you know it altogether."* – and 141 prays: *"Set a guard, O Lord, over my mouth; keep watch over the door of my lips!"* The Apostle Paul, perhaps echoing the words of Zechariah: *"Speak the truth to one another; render... judgments that are true and make for peace,"* enjoined the Ephesian Christians: *"Speaking the truth in love we are to grow up in every way into Christ."* As we reflect upon the matters of communication discussed in this issue, may we ever keep in mind these fundamental Scriptural principles.

Scripture itself is a progressive revelation of God in history. The Living Word reveals Himself in a Person, but also in a narrative. And as our contributors observe for our patients, the history reveals the person. We discover it sometimes with wonder, but always with respect.

John Foley
Editor, Luke's Journal

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Luke's Journal

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Building a history with your patients

by Prof Geoff Mitchell

Geoff is a Professor of General Practice and Palliative Care at the University of Queensland. He is Head of the Medical School program at the Ipswich Campus.

I am continually humbled by the wonderful privilege I have as a general practitioner to walk the journey with my patients.

Our practice has a long history of hosting medical students. When a medical student observes you work, you become acutely aware of what you are doing. When introducing the student, I will often say that this patient and I have known each other for 10, 20, 30 years. I introduce them as friends. Depending on the person, there may be a joke shared between us, or a polite reference to their job, their family, the pet cat or their football team. I talk rain with farmers, the economy with builders, sleepless nights with mothers, and future dreams with school leavers. I have fun with the kids. And then I get on and talk medicine.

A GP's knowledge of a person builds with every visit. Each snippet of their life story contributes to a picture of the whole. A good doctor will actively seek this knowledge, by trying to bring in at least one personal comment or question into each consultation.

People collect an array of complex medical and social issues over many years. The management of medical complexity requires knowledge of each condition and how they interact. Then you draw on your knowledge of the person – their responses to adversity, their beliefs and support structures and so on in determining how best to resolve the problems. Foreknowledge of the patient and their circumstances make the process of coming to a diagnosis, and explaining the treatment plan highly efficient and effective.

Why is this important? Why even talk about it? Isn't this whole person knowledge a given in general practice?

"Foreknowledge of the patient and their circumstances make the process of coming to a diagnosis, and explaining the treatment plan highly efficient and effective."

The primary care sector was once a sector of small businesses, where the doctor was the practice owner. There is an inherent long-term commitment in this model to the practice and its community. While this model still exists, another model has arisen, where health and medical services are being delivered by corporate practices, sometimes even listed on the stock exchange. Corporate business modelling links general practice, pathology and radiology into one vertically integrated entity. The motive is profit and the means is turnover. Loyalty is to shareholders, and anything that gets in the way of "efficiency" and profitability is pushed aside. Patients see whoever is next available, and if they want to see the doctor of their choice they must wait, sometimes for hours.

The result – the breakdown of a process that has developed over at least a century. A new generation now fails to recognise that a GP can deliver far more than episodic care. A strong doctor-patient relationship is not valued because it has never been experienced. Often the people who need this sort of care the most are the least likely to receive it, because price drives such people to the cheapest alternative, and you get what you pay for.

As Christians we know that God loves us and cherishes a relationship with us. He knows our every need. He knew us before we were even born (Jer 1:5) And as for us – we have been blessed so that we can be a blessing to others. (Gen 12:2) We are God's hands and feet. His love for us drives us to love one another. Christians from all walks of life are called to live out this love and to be His servants.

"Agape" love desires the best for another person and strives to see that achieved. (Jn 21:18) This kind of love takes commitment and invests fully in the wellbeing of that person. The opposite of agape love is not hate – it's indifference. That patients can be seen as units of production and sources of Medicare revenue is the ultimate expression of medical indifference – a perversion and should be resisted at all cost.

My prayer for doctors at the beginning of their careers is that they understand the sacredness of the

task they have been called to. For those further into their professional lives, it is that they never lose sight of their calling. I pray that whatever field of medicine they end up in, they see the people they serve as children of God, and treat them with the utmost respect and care. If that field happens to be general practice, then be prepared for surprise by both the depth of the agape love you develop for your patients, and the affection you receive from them. The relationship that develops as the history between you builds will benefit them by enabling the highest quality of medicine. It benefits you as it allows a glimpse of God's love for his beloved children. ●

The history of history taking

by Dr Don Todman

MD FRACP FRCP

Don is a Brisbane neurologist.

Although medical practice in the 21st century is highly reliant on technology and diagnostic imaging, history taking from the patient is still paramount in reaching a diagnosis. A number of studies have indicated that diagnosis is reached on the medical history in over 90% of cases, physical examination and diagnostic testing are usually for corroborating the provisional diagnosis.

The way that doctors interview patients has evolved over time. Once considered just a fact gathering exercise, the medical interview now encompasses a process of building relationship between doctor and patient, establishing social history and a spiritual history and also providing patient education. Whilst the way that we interact with patients will continue to change, it is valuable to reflect on how the medical interview has transformed within the history of western medicine.

In the ancient world there were no records of medical interviews. Information about the doctor-patient relationship is gained by indirect methods from writers of the time and from texts such as the Hippocratic Corpus and the writings of Galen.

An insight into the doctor patient relationship is given by Plato in his play, *Laws* where one of his actors states "the visits of the free doctor are mostly concerned with treating the illnesses of free men; his method is to construct an empirical case history by consulting the invalid and his friends: in this way he himself learns something from the sick and at the same time he gives the individual patient all the instruction he can. He gives no prescription until he has somehow gained the invalid's consent." Whilst this passage gives only a glimpse of the doctor's craft, it suggests that doctors gathered information from their patients in some structured manner.

In the Hippocratic volume *EpidemicsVI* , the art of speaking to the patient is emphasised. A kind of persuasive rhetoric was used in communication. The author states, "arrangements for the sick person and enquiry about the disease; what is explained (by the patient), what kind of things, how it must be accepted; the reasoning." The focus was on interpreting the patient's responses to reach a conclusion. A physician, Herodicus of Leontini in Sicily, remarked to a colleague, "many a time I have gone with my brother or with other doctors to call on some sick person who refuses to take his medicine or allow the doctor to perform surgery or cauterisation on him. And when the doctor failed to persuade him, I succeeded by means of no other craft than oratory."

Although the Roman physician, Galen is best known for his emphasis on anatomy and physical diagnosis, his writings also portray his views on communication and rhetoric. He deliberately cultivated an authoritative bedside manner where patients were treated in public and recommendations for appropriate treatment given in front of onlookers. Although this suggests a very detached relationship with the patient, Galen also emphasised the importance of gaining the patient's confidence in order to make a diagnosis and treat the disease.

The modern history of history taking has developed since the 19th century with many changes and developments during the 20th century. There have been changes in the use of medical history as well as its content and processes. Clues about the doctor-patient interview have largely come from old medical records, as there were few published interviews until well into the 20th century. Abbreviated office notes of doctors from the 19th or early 20th century suggest that each visit was recorded to emphasise salient features for subsequent review.

"The early concepts of physician-centred social histories limited to smoking, alcohol and drug use have now developed into a richer interview that includes many aspects related to functional status, occupation, sexual history and religion."

The two parts of the medical history, namely the presenting complaint and the history of the presenting

illness began to appear from the mid 19th century. Details about the patient's occupation, smoking and drinking habits and family history also became standard from that time. Elements of a brief biography were recommended in the standard textbook by Richard Cabot *Case Teaching and Medicine* (1905). Cabot recommended expanding the degree of enquiry to include more detailed facts about the patient's background and social information as well as their physical complaint. Cabot's work could be considered as laying the groundwork for the social and psychological aspects of medical history, which were developed further in the 20th century.

The concept of developing a complete history that included family history and social history became standard. It included the presenting complaint, history of the present illness, past medical history, family and social history. These five items can be known as a complete history and standard methodologies were developed for patient notes and recording.

This methodology and notes were standard until the 1970s when Weed developed a new problem orientated format "S.O.A.P". In this method, patient's problems derived from history were separated as a subjective element from the objective components in the physical examination or tests. A diagnosis and treatment were designated assessments and plans. Whilst this problem orientated format was not necessarily directed at greater attention or understanding of the patient, it did help to refocus attention to the patient's problem.

From about the 1940s psychiatry and medicine became more closely associated in teaching hospitals. Psychiatrists brought with them more open-ended questioning and emphasis on psychological and social elements that began to influence practitioners in other fields of medicine. Psychiatrists also brought special expertise from wartime experience with soldiers who had suffered from post-traumatic stress, some of whom had had associated physical symptoms. History-taking moved from what was once a rote interrogation of patients to become a medical interview. The structure acknowledged that the doctor and patient were engaged in an interpersonal process.

The behavioural sciences have also influenced the evolution of the medical interview. Behavioural science researchers and teachers have been involved in universities and teaching hospitals in the decades that followed. Their emphasis was not only questioning for diagnosis, but also having regard and empathy with patients. This has influenced teaching in medical schools that has sought to develop effective interpersonal communication behaviours in the medical setting. Behavioural sciences have had a major influence on the way in which interpersonal skills, such as empathy, are taught to medical students. It is now commonplace for students to use role-play or simulated patient interviews to develop these skills. Such behaviours are often observed and videotaped and critiqued by students and instructors.

Social history now can be considered as a way to get to know a patient as a person and to enhance the therapeutic process. The early concepts of physician-centred social histories limited to smoking, alcohol and drug use have now developed into a richer interview that includes many aspects related to functional status, occupation, sexual history and religion.

Taking a spiritual history is also a field in which Christian doctors and others seek to discern in the interview factors that may contribute to wellbeing or illness. There has been a growing recognition that there is a link between spirituality and health and many doctors are now exploring ways in which spiritual history can be sensitively taken. Questions about belief, which are non-confrontational, have been suggested such as "do you have a faith which helps you (in a time like this), or do you have a personal faith, or what is important to you? Questions can relate to belief, practice and connection with a faith community.

There is no doubt that taking the medical history is central to the clinical method, but what constitutes a good medical history has changed over time. Whilst the interview process continues to evolve, there is a general recognition amongst physicians and educators that a more patient-centred approach can not only improve a patient's satisfaction, but also improve the relationship with the patients. This process is echoed in the quotation from Sir William Osler who said "the good physician treats the disease; the great physician treats the patient who has the disease." ●

Jesus the Word

by Dr Richard Hargreaves

Richard is a GP registrar in Toowomba.

CB Samuel recently taught me that the culture of the west is to define everything. To understand and communicate, things must be fully defined. At every high school debate we are taught the basic of first defining in order to defend a position.

The culture of the East is less rigid in that regard. And so when Jesus talked about the Kingdom of God, he never actually defined it for us. Have you noticed that? He hinted at it, and alluded to it. And most significantly, he used images to enable us to understand it. He kept saying the kingdom is like... A treasure hidden in a field, the kingdom is like the yeast mixed into bread. And we spend ages trying to define it to fit into our way of thinking – books – whole libraries in fact, if you were to pool everything dedicated to explaining and defining the Kingdom. Jesus never defined it.

A similar thing is done with Jesus himself – Jesus is the bread of life, the good shepherd, the gate. Rather than defining himself fully for us, he opens up doorways of understanding that draw us to the point he wants to take us to. Where a definition would leave us in no doubt as to who Jesus is in all technicalities, an image elicits a response. Instead of just categorising things, he invites participation through the *way* he reveals things to us. Image: I am the good shepherd, I know my sheep and my sheep know me. Response: Oh, a shepherd. One who cares for his flock, protects them at all cost. Am I part of his flock? Do I know Jesus as shepherd? – See what I mean....

The earliest image used of Jesus in John's gospel is to call him the *Word*. In the beginning was the Word and the Word was with God and the Word was God. The Word became flesh and made his dwelling among us.

If you're like me, you've wondered about this choice of image for Jesus. What does it tell us about him? In the Eastern mindset, what response does it invite?

"...when Jesus talked about the Kingdom of God, he never actually defined it for us. He hinted at it, and alluded to it. And most significantly, he used images to enable us to understand it."

At this point I've found falling back into my Western weakness of defining things helpful. Marshall Mcluhan has been quite useful. Hands up if you've heard the phrase "the medium is the message"? So Mcluhan was the philosopher who coined this phrase. He worked in communication theory. Theories about how people communicate.

Now Marshall Mcluhan said this about Jesus.

> *"In Jesus, there is no distance or separation between the medium and the message. It's the one case where we can say that the medium and the message are fully one and the same."*

This is the one thing that sets Jesus apart from all other teachers, sages, leaders, authors, you name it... He is the one case where the medium and the message are one and the same.

Now as I've spent more time reading on communication theory I've realised that Mcluhan is actually referring to something deeper than my initial interpretation of this medium and message catchphrase. In true Western style, he defines medium and message for us. In my own poverty of communication semantics, here's my summary – the medium, explained Mcluhan, is the extension of ourselves. Like a hammer is used as an extension of our arm. Or speech is the extension of our thought. That's the medium. An extension of our internal reality. The message, according to Mcluhan, is the change effected by this extension. So the message of a news report is not the actual story, but the change it makes in human affairs – for example the change the news stories produce in the public attitude towards crime. So Mcluhan is talking about Jesus being at one and the same time both the medium – the internal reality of God and the outward extension of God – and the message – the change made in human affairs through himself.

What Mcluhan has helpfully done for us is really to notice the implications of the image of Jesus as the Word. He

is both a being and a narrative. A person, and a love expressed; and that love has undeniably altered the course of human affairs. A medium and a message.

John 5 says the same thing.

> *"Everything you have seen me do is from the Father. For I do what I see the Father do."*

Jesus is the extension and the effect of the Father. And Hebrews 1:3 *The Word is the exact representation of his being* – the internal reality of God.

So all Mcluhan has really said, is that in the beginning was the Word, and the Word was with God, and the Word was God... And the Word became flesh. Maybe John's audience got there quicker than I did, but I needed Mcluhans help.

And so as we sit today in this writing elective, I want to encourage you to reflect on Jesus as the Word. An example that we follow, that we embrace, and whom we, in a sense, absorb into ourselves as we soak up the narrative of God's love expressed – as he alters our course of human affairs.

What does that mean for us when we communicate? Let me offer two thoughts to finish off.

1. **How separate is our medium – our writing in this case – from ourselves?** How much of an extension is it? When we write is it raw and true and honest?
2. **What is our message?** Not so much what is our content, but what is the change we are hoping to effect in our reader? And what change does it effect? If we don't like the change – maybe we need to re-examine our medium – and our own internal realities. Or maybe the changes we see are good, and we can know that Jesus' message has effected our message. ●

Art and spirit in healthcare

by Assoc Prof Lindsay Farrell

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St Luke is known for his writing the Gospel of Luke and the book of the Acts of the Apostles. Christian tradition also has St Luke involved in medical practice.

It is interesting to also note that early Christian tradition describes St Luke as an icon painter. This combination of author, artist and medical practitioner is an interesting combination of spirituality, creativity and science. The close sensitive observation and attention to the human person in the light of their being made in God's image is a necessary dimension to each. St Luke writes his Gospel about God's ultimate image bearer "icon", Christ. As a missionary doctor companion of St Paul, he may have heard Paul express this as Christ being "the image [eikon] of the invisible God", (Col 1.15). The Christian origins of art, spirituality and healthcare are expressed in the person and ministry of St Luke and can inform deep Christian reflection.

This short paper presents some historical and contemporary viewpoints on art and spirituality in healthcare drawn from Christian perspectives in healthcare settings. These viewpoints are drawn from some recent research conducted by the Australian Catholic University. The team of researchers included health-science researchers, theologians and arts researchers.

First we will look at art in five hospitals as case studies (including contemporary contexts). Second, the paper will discuss some concepts and approaches to art and spirituality in healthcare. Third, it will reflect on the importance of art and spirituality and the use of art in healthcare settings as a possible way of helping people engage with meaning making and spirituality.

The Foundling Hospital

Imagine a hospital founded and funded, not by governments or health corporations, but by artists. In Renaissance Florence of the 15th century, art and hospitals were integrated in a way that may seem foreign to our experience. The **Foundling Hospital** designed by Brunelleschi in 1419 was considered to be the model Renaissance building of classical proportion and form. The radical imagination of Brunelleschi took the medieval cloisters and

St Luke Drawing the Virgin, by Rogier van der Weyden, c. 1435-40, Museum of Fine Arts in Boston.

Ceramic roundel Andrea della Robbia. (Source: http://italianpotterymarks.freeforums.org/the-infant-wrapped-in-a-swaddling-cloth-t14.html)

opened them up to the civic space of the public square. The institution was amongst other things, school, orphanage, chapel, hospital and civic art gallery that had its raison d'etre in the care of the marginal disadvantaged orphaned children of Florence. The beautiful ceramic roundels made by Andrea della Robbia of children in swaddling (still a symbol of children's health care) remind us of the Christ figure, but, in the 15th century they reminded the Florentines that unwanted and abandoned children should be cared for *(pictured above)*. This art and health project was driven by spiritual, social and political motivation and was funded by the silk-merchants and goldsmiths.

The Isenheim Altar piece

The Isenheim Altar piece is one of the great spiritual images of western art. It was painted by Matthias Grunewald in early 16th-century for a hospital at **Colmar** which offered relief to those afflicted with the dread disease of Saint Anthony's fire *(pictured below)*. Commissioned by Antonite monks, the altarpiece was created between 1512 and 1516 for the chapel hospital where the monks ministered to patients suffering from this painful and often fatal disease. The altarpiece Grunewald created is a many-faceted collection of disturbing and uplifting images that unfold as the wings open to reveal a series of scenes. As in most Christian art, the Saviour plays a central role, appearing in a terrifying Crucifixion panel and a powerful Resurrection. In the work, the tortured Saint Sebastian and Saint Anthony are prominently featured. The figures seem meant to give hope and consolation to the ill, conveying the possible message that pain also can provide an opportunity to bring one close to God. The images of the plague sores on the Christ figure were the same as those on the patients who possibly helped make meaning of their living and dying though the art. As well, the herbs at the feet of the Saints were part of the medical aid given to the patients.

Contemporary Healthcare

In the succeeding centuries, art in healthcare has waxed and waned. In our contemporary healthcare setting art is again emerging as a vital component of care. For example, in the **Wesley Hospital Brisbane** an art curator attends to the major art collections, art exhibitions, art classes, and artists in residence and art education programs. The rationale

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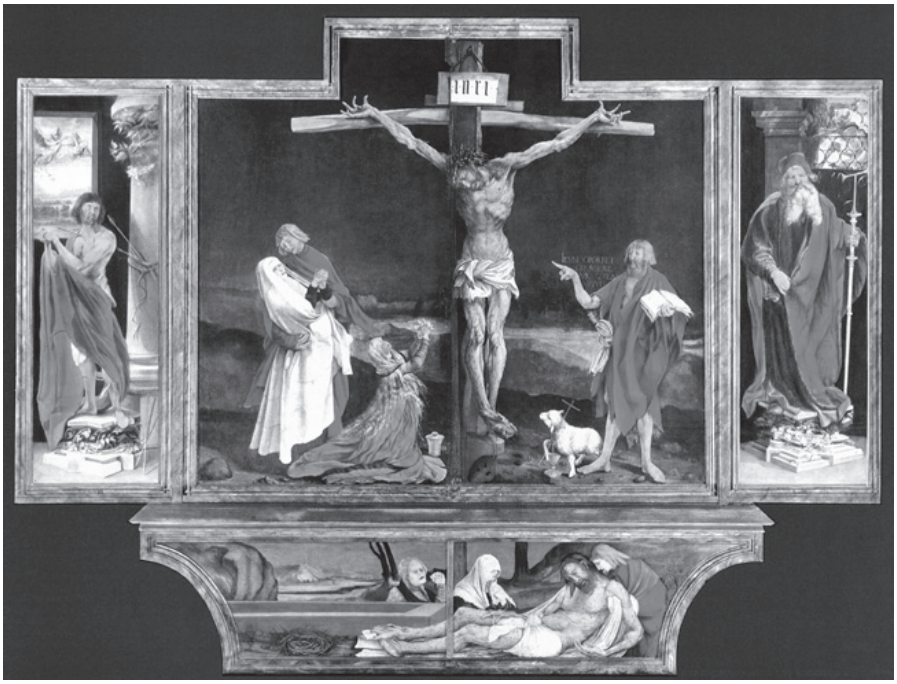


Isenheim Altarpiece, first view by Matthias Grunewald.
On display at the Unterlinden Museum at Colmar, Alsace, in France.

for this program is embedded in the Christian mission of the hospital in caring for the whole person. Art has the habit of asking us questions and setting us off in search of meaning. In some earlier research at the Wesley, it was often the artworks that were problematic and that challenged people (staff, patients and visitors) that were of the highest interest and where most significant engagement occurred. Artworks often remind us that we don't know all there is to know or can't know all there is to know.

Another place where we researched art and spirituality in hospitals was the **Mater Children's Hospital**. We were involved with the art project at different stages and completed a study looking to describe its effects on the hospital community. Over 7500 children from all parts of Queensland (birth – 18 years) participated in the project with over 5000 tiles throughout the hospital corridors.

Part of the 5000 tiles at Mater Hospital, Queensland.

A third hospital is **St Vincent's Holy Spirit Northside** in Brisbane, who ran an art in hospital project in partnership with the Queensland Art Gallery. We selected seven of the popular, permanently displayed art works from the QAG collection and made available multiple prints for display in the hospital wards for meaning-making in, through and about art.

Each patient, shortly after admission, was shown a set of post cards and not only selected the food menu for the day but also selected the art work for their own room. They got to live with the image through their time in the ward. For many people this was a significant time of learning. The art was, for most, a very important part of their making meaning of their life experience. At the end of their stay, staff presented each person leaving the hospital with a post card of their print and a personal positive message, encouraging them to visit the QAG as part of their recovery to wellness and see the original painting they had lived with during their hospital stay. Often patients preferred to talk about their painting rather than their illness. This project was simple and yet profound on many levels.

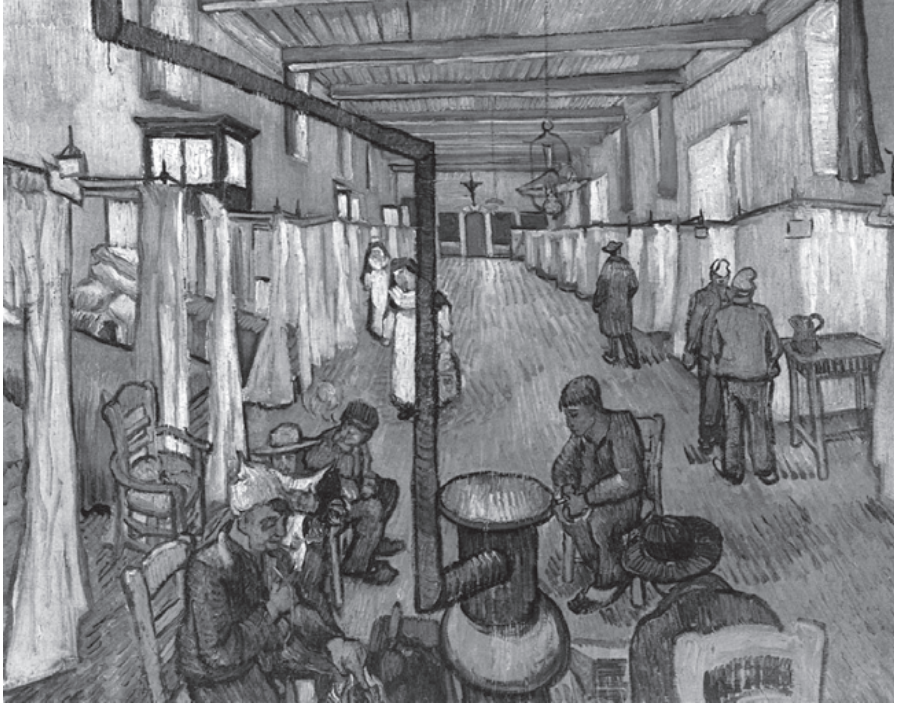
What we discovered...
Our studies in these very different hospitals were ethnographic and asked people what they experienced in, through and about art in each context. In our studies we found that patients, families and staff valued the variety and creativity that art brought to the hospital. They also valued art as a means of communication, as a means of expression of their feelings, as a way of engagement with others, as a way of enjoyment, as a means of cultural development and as a way of service to the community. In each hospital art proved to be a means of improving staff morale, a way of instilling feeling of wellness and a way of improving the atmosphere in the hospital. Art also made the hospital more like the outside world.

"...art proved to be a means of improving staff morale, a way of instilling feeling of wellness and a way of improving the atmosphere in the hospital. Art also made the hospital more like the outside world."

Two contemporary social theories informed our investigations. Often, social reality is defined in terms of "systems" (Habermas, 1987). German social theorist Habermas sets these in opposition to and removed from what he describes as "life world values". In hospitals many people are faced with deep questions of "meaning- making" and concerns for economic systems may be antithetical to particular "life world" values, myths and identity associated with that meaning-making.

Another Social theorist is Bourdieu (1993) who argued that the economic "systems" that dominate institutions intersect with meaning-making and the "life world values" of art. According to Bourdieu (1993), institutions are shaped by processes that are constructed as "cultural capital" where the "symbolic aspects of social life are inseparably intertwined with the material conditions of existence". He

argues that agents and institutions possess different forms of capital. Economic capital (skills, material wealth), cultural capital (knowledge, intellectual skills) and symbolic capital (one's sense of value) all interact. The issues of meaning-making through art in these health settings were of particular interest. Of particular interest was how art in these contexts informed the spiritual dimensions of existence.



*Vincent van Gogh's **Ward of Arles Hospital** (oil on canvas, 28-1/4x35-1/4 inches) is part of the Collection Oskar Reinhart 'Am Römerholz,' Winterthur.*

How does one define and measure spirituality?

Panikkar (2006) defined spirituality as an inward quest in contrast to a material quest… a way of handling the human condition. Second, Schneiders (2006) defined spirituality as the experience of consciously striving to integrate one's life in terms, not of isolation and self-absorption, but of self-transcendence toward the ultimate value one perceives. Third, Cousins (2000) talked about the inner dimensions of the person… the experience of one's ultimate reality. The connection between the spiritual quest and art is important.

Recent theological reflections by the French scholar Jean Luc Marion (2012) suggest that spirituality, art and meaning-making are fundamental human experiences. He suggests aesthetic approaches to the mystery of human experience and God. Marion uses the language of art to contrast an idol and an icon. He says that the idol returns our looking, while the icon windows our gaze to the mystery beyond. We see through the icon to the mystery of God. This has implication to the use of art in health contexts. Art in healthcare contexts can and does prompt a quest for meaning-making and spirituality.

In conclusion

Lastly this paper concludes with a story about art and spirituality in hospitals at Arles and St Remey in the 19th century. A very poor marginalised patient was admitted May 1889. This patient had an interest in art and was suffering from a range of physical and mental health illnesses. Staff decided to make room for art. They gifted him a place to sleep and another to paint. In the following months he painted a picture a day as he moved from his room to the garden and then to the surrounding country side. The artist patient was Vincent van Gogh a failed evangelical pastor come painter.

Henri Nouwen (2007) used Vincent's art to reflect deeply on spirituality. He said, in our highly technological and competitive world, it is hard to avoid completely the forces which fill up our inner and outer space and disconnect us from our innermost selves, our fellow human beings and our God.

*Vincent van Gogh's **The Entrance Hall of Saint-Paul Hospital.** (Public domain)*

It seems that health-care environments, even though highly technological and competitive, through including art can help people make connections with the spiritual dimensions of life. In the first century, the work of St Luke, the icon painter, author and medical doctor embody this project. The images from the Foundling Hospital in Florence made over 500 years ago are still a way of helping metaphor our healing endeavours. At the iconographic level (image/symbol) it is about a child with open arms waiting…inviting those who care about caring health environments to join in the task of working together as a community to set about our vocation of caring for the whole person. At the iconological (meaning-making) it reminds us also that the story of the vulnerable child is the story and mystery of the Christ in every person and the outsiders like Vincent and the nurse that moved a bed and made space for art… we still marvel at the mystery and gift of art. ●

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Speaking the truth in love

A History of CMDFA in Queensland

by Dr Anthony Herbert

and Dr Frank Garlick

Detailed biographies of the authors appears at the end of the article

It is now about 60 years since a Christian Medical Fellowship formed in Queensland. Other fellowships had formed and existed in other states of Australia before, or at a similar time to the Queensland group. We felt it would be helpful to document this history and speculate that an understanding of where we have come from will be of some assistance in determining what the future will hold in coming years.

People

A group of committed Christian doctors met together for fellowship and encouragement in the 1950s. The Christian Medical Fellowship emerged from this group. They weren't a ghetto group but were more like a Roman square of legionnaires ready for action. It was "un-named", perhaps an informal Christian Medical Fellowship, by the late 1950s in Queensland. Most had Evangelical Union backgrounds and attended Intervarsity Fellowship Conferences. Professionally, they were a disparate group bonded by a common loyalty to Jesus Christ. There were close links to the Evangelical Union and Graduate's Fellowship, with a commitment by these doctors to teaching and preaching at meetings of these groups.

"They" included the following senior doctors:

- **Lyn (LD) Walters** – Physician.
- **ERW Thomson** – Surgeon
- **Norm Chenoweth** – General Practitioner and Missionary
- **Gordon Wright** – Respiratory Physician and Allergist (Children and Adults)

LD Walters

LD was often referred to as "Pappy" as his favoured method of address was "Now just look here, Son". He obtained his undergraduate degree from Melbourne and his fellowship in internal medicine from Edinburgh. His association with the University of Queensland as an undergraduate teacher spanned three decades. He adopted a holistic and generous approach to his patients and was well regarded for his ability as a diagnostician and "trouble shooter'. He was also committed to connecting with the small number of overseas students who resided in Australia at the time (through the Colombo Plan) offering them hospitality and fellowship. His church background was Methodist.

Evan Thomson

Evan Thomson was one of the first graduates of the University of Queensland in 1942. He became a Fellow of the Royal College of Surgeons and was instrumental in the founding of the Wesley Hospital. He also served as President of the AMA – Queensland branch. Like, LD Walters, his contribution to the medical profession and his standard of practice and professionalism were widely respected. He contributed to both the Brethren and Uniting Churches in Brisbane. Like Pappy Walters, he also played a key role in undergraduate education, and for 20 years was the Clinical Lecturer in General Surgery at the Princess Alexandra Hospital.

He made the following insightful comment about medical education in a report which he led: "We have tried to stress the need for greater emphasis on the humanistic in Medicine but without risk of loss of the scientific". He challenged other Christian doctors to not place a distinction between the secular and sacred. At the International Congress of Christian Physicians in 1966 held at Oxford he said: "The Christian surgeon must synthesise his Christianity and science in the practice of scientific therapeutics. Though Christianity will not figure in a textbook of scientific therapeutics, the Christian must bring his Christianity into this sphere to the extent of making scientific therapeutics a Christian vocation. Christianity, then, has a place in scientific therapeutics and, indeed, it must pervade the whole of a Christian surgeon's practice. Philosophy and science may meet best in medicine and I believe the Christian doctor has more to offer than anyone else towards a true philosophy of medicine."

Evan was a founding member of the Christian Medical Fellowship in Australia in 1962 when the state fellowships combined as a national body. This was at a meeting held at Deaconess House in Sydney. Others who attended included Alf Steinbeck (NSW Chair), Jean Benjamin (NSW Secretary) and Murray Clarke. Don Kidd (SA) and doctors from WA were not present but were supportive of the meeting. Ron Winton, editor

of the Medical Journal of Australia from 1957–1977, became the first president of the national body.

Interestingly, Alf Steinbeck had worked in Brisbane for a short period as the second full-time academic in the Faculty of Medicine, University of Queensland. He returned to Sydney as an academic physician and Professor in 1961 where he had a tremendous impact at the University of New South Wales. Jean Benjamin had also been a resident at the Mater Mother's Hospital and also had good contacts with various doctors in Queensland and other states helping to build linkages between Queensland and the southern states in the formation of the national body.

"Professionally, they were a disparate group bonded by a common loyalty to Jesus Christ."

Norm Chenoweth
Norm also graduated from the University of Queensland. He studied at the Melbourne Bible Institute before working as a missionary in China with the China Inland Mission. He was in Shanghai when Chinese communists over-ran the country. It was at this time in 1949 that he married Joan. They were married by the China Inland Mission leadership in Shanghai while in a "house arrest" type situation and were also married at a Communist Registry House (so that their marriage would be recognised by the government). After leaving China, they were able to have a "traditional" wedding in Hong Kong.

Norm returned to Australia and established a general practice in Ascot, but his heart remained on the mission field. He still maintained a strong sense of calling to overseas mission. He (along with the CIM – later to become OMF) maintained a passion and vision for mission to East Asia.

He later returned to work in medical clinics at Manoram Christian Hospital in Thailand for a number of years.

There was some overlap here with Dr Peter Farrington, a dental member of CMDFA in Queensland. Joan assisted in an administrative capacity in the outpatient department.

Gordon Wright
Gordon, worked as a Respiratory Physician and Allergist, with a special interest in Paediatrics and Cystic Fibrosis. He undertook medical training during World War II and at this time was a member of the No 7 Field Ambulance – a Militia Unit composed essentially of medical students from the University of Queensland. Gordon was a deep thinker, and published early work on the house dust mite and its role in allergy as well as in the area of cystic fibrosis.

Appreciated and Respected
All four of these doctors were deeply committed to their faith and a secular-sacred divide was not apparent in how they practiced medicine. They were very professional in their approach to medicine, appreciated by their patients and respected by their colleagues. Undergraduate education, missionary work, research and a commitment to a diversity of protestant denominations set the foundations for the future of the fellowship both within Queensland and nationally.

A number of junior doctors at this time recall the support that these men were able to offer them, particularly at important transitions in their medical career (e.g. during undergraduate studies and at times of becoming a consultant). These "junior doctors" also played a key role in developing the fellowship and included:

- **David (Colin) Webster** – later Psychiatrist
- **Brian Smith** – later Obstetrician and Gynaecologist
- **Frank Garlick** – later Surgeon

This list isn't exhaustive. There were certainly others who played an integral role.

Professor John Rendle Short (JRS) and **Hughling Jackson** moved to Brisbane after establishing their medical careers and Christian faith in other parts of the world. In the mid 1960's, a student group, including **Beth and Peter Ravenscroft** met in John Rendle Short's office at the Royal Children's Hospital. Students were invited to come to CMF meetings for the first time. Rendle Short became a tower of strength for the fellowship in the 1970s.

Programs
Initially, they met as a group for the occasional speaker (on various topics including the Gospel), Bible study and prayer and the very occasional meeting in a hospital (e.g. showing a Billy Graham film). They found that in meeting together there was mutual encouragement, support and real inspiration.

The Queensland group knew of groups meeting in other states such as **Ron Winton** and **Paul White** in Sydney, and the Clarke brothers (**A Murray Clarke** and **J Eric Clarke**) from Melbourne. There was also the international influence of CMF (UK) and CMS (USA). **Douglas Johnson**

continued over page

was the CMF UK's first general secretary and a tangible support to groups meeting in Queensland and Australia.

Frank Garlick recalls Paul White's dictum as a constant challenge:

> *Frank – be aware – 80 % Christians fall by the way following graduation.*

So the group's primary bonding in those days of the 1950s was our (their) unifying loyalty to God and our friendships, which included inspiration and encouragement, fostered and nurtured in our meetings together.

But the influence and witness of the Christians who composed the group was unseen (invisible) and unquantifiable and for that reason significant. Ethical standards were assumed by the profession as a whole. Few people stepped outside the accepted norms. Little by little the need to spell them out, deal with issues, and espaliate them became apparent.

The word "integrity" sums up those Christians of the 1950s and "having done all to stand".

Somewhere in the early 1960s came to birth (in a formal sense) CMF Queensland.

During the chairmanship of **Peter Ravenscroft** (1987–1991), a mentorship programme for students was instigated. Students were linked to a graduate and they met for encouragement and a meal together. Peter Ravenscroft was elected National Chairman at the National Conference held at Twin Waters in 1991. For the first time since inception, the National Executive of CMDFA moved out of Sydney. During the Chairmanship of **Paul Mercer** (1995–1999), videos of meetings were created and sent to all members to try and service members living in regional, rural and remote areas. There are currently almost 100 members of CMDFA residing in Queensland.

Some benefits of having a national office began to emerge after its establishment in 2000. Examples related to a national strategy to student work and also conferences. **Dr Tash Yates** also had a significant contribution to the fellowship in Queensland (particularly amongst students and recent graduates) and ultimately became the CMDFA's first National Recent Graduate and Student Worker in 2004. Conferences also became important with major highlights in recent times including National Conferences held at Twin Waters on the Sunshine Coast in 1991 (where Dr Leon Morris led the Bible Studies), another National Conference at Mapleton, 2001. IMPACT conferences have been held at Mapleton (2001), Magnetic Island (2007) and Mt Tamborine (2011).

"Many Christian students still lose their faith at university and in the early years of working as a doctor."

Christian Dental Fellowship in Queensland

Dr Peter Farrington was greatly helped by fellowship and mentoring from Christian Dentists and the Christian Dental Fellowship while a student at Birmingham University. He went on to serve as a missionary at Manorom Christian Hospital with OMF from 1970 (the same hospital at which Norm Chenoweth had served).

In 1974, Peter was invited to speak at a CMF Queensland conference while on home assignment by **Dr John Morris**. John Morris worked as a Ear Nose and Throat Surgeon – having graduated from both the medicine and dental undergraduate course. Further linkages were established with the CDF group in NSW (through Michael Payne) and Victoria.

Around 1994, Dr Peter Farrington was invited by Dr John Morris, CMF National Secretary, to join CMF Australia National Committee to represent Dental interests, when the committee was based in Brisbane. At this time, it was difficult to interest Dentists in the mainly medically orientated CMF programs.

In 2000 and 2002, **Ross Dunn** and **John Yarad** had visited Bangladesh. As a result of their short term Dental Team visits. *Smiles for Life* Dental Health Project was established in association with HEED Bangladesh. This project was accepted by Healthserve Australia in 2003 as their first Dental Project

There was interest in *Smiles for Life* among Christian Dentists in Queensland and this gave impetus to the formation of a separate CDF group in Queensland in January 2003. The aim of CDF was to promote Dental Missions, mentor students and reach out to the profession. Membership is open to all members of the Dental Team.

The group now has regular meetings with the Dental Students at the University of Queensland Dental School and contact with the students at Griffith University Dental School, outreach meetings in the Dental School and an annual Dinner where up to 65 Dentists and spouses other dental professionals and students attend. Dental missions form a key component of the CDF Queensland ministry. The group continues to have links with CDF UK who include CDF Queensland in their Prayer Calendar. National conferences, particularly Impact conferences, are one tangible area where doctors, students and dentists can come

together for encouragement and inspiration.

Conclusion

In the history of the CMDFA in Queensland, from its early and informal beginnings we see a number of themes that are still relevant today. The need for Christian doctors and dentists to be united under Christ while at the same time engaging with the secular health system around them (within a diversity of roles and disciplines). Fellowship and prayer meetings (within the hospital or at doctor's / dentist's homes) remain integral to our mutual encouragement, support and serve as a source of inspiration. A Christian Dental Fellowship has been very active in Queensland and has runs independently (although collaboratively) with the medical fellowship.

The need for integrity and the challenge to keep a Christian distinctiveness was present both in the 1950s and remains today. This is perhaps even more challenging today with less "Biblical literacy" and less emphasis on absolute moral truths by the wider community. The challenge of engaging with ethical issues probably stands out, as Christian ethics separate from the secular ethic, as mentioned briefly in this paper. Groups such as the Australian Medical Association will no longer have the same perspectives on ethical issues, such as abortion and euthanasia.

There is a need to continue to encourage students and recent graduates (through conferences, mentoring, prayer and fellowship meetings) particularly as many Christian students still lose their faith at university and in the early years of working as a doctor. Finally, the variety of denominations and disciplines of medicine, surgery and dentistry represented continues and is a strength of the fellowship. In amongst this diversity, we find our unity in Christ. ●

Biography of Authors

Dr Anthony Herbert *– graduated from the University of Queensland in 1996. He is a paediatrician based in Brisbane who specialises in palliative medicine and pain management. He was national secretary of CMDFA from 2006– 011.*

Dr Frank Garlick *– graduated from the University of Queensland in 1951. In the early 1960s, Frank and his wife Val (also a medical graduate) went to the Christian Medical College and Hospital (CMCH), Vellore, in South India where Frank was in charge of one of the 3 surgical units. After 8 years, they felt a conviction to move and responded to an invitation to join the Union of Evangelical Students (UESI) where Frank became a staff-worker – among the many medical colleges (100 or more) in India. After a further 6 years, the organisation – Evangelical Medical Fellowship of India (EMFI) was born. Dr MC Mathew was a co-founder of this group with Frank. Frank and Val returned to Brisbane where Frank took on the job of Director, Emergency Department at the Royal Brisbane and Women's Hospital for 13 years. In 1989, Frank and Val were able / invited to return overseas, this time to Kathmandu (Nepal) as Medical Superintendant of Patan Hospital for 5 years.*

International Saline

by Dr Michael Burke,

MBBS FRACGP PhD.
Michael is an Australian
International Saline Trainer.

INTERNATIONAL SALINE is a training activity specifically for the healthcare setting. This one day training activity explores ways that healthcare professionals can with sensitivity, respect and permission (1 Peter 3:15) engage with others – patients and colleagues – in the workplace, in the important area of their faith beliefs, values and expectations.

International Saline can assist the Christian health professional better understand how the faith and/or values of a colleague or patient are important in identifying helpful responses to complex health problems. International Saline is one way of better integrating faith and practice. It sits well within the widely accepted framework of Evidence Based Practice (EBP). *See diagram below.*

"Evidence Based Practice (EBP) is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations, and values (Sackett D, 2002)."

Hassed (2008) of Monash University writes "Spirituality is an important determinant of physical, emotional and social health and may, in some circumstances, be a central aspect of the management of some conditions. Assessing spiritual and religious issues within the consultation is an important core skill that requires sensitivity, as well as religious and cultural tolerance".

The role of spirituality in medicine is gaining much greater attention and interest. Many new studies have indicated important relationships between religion and/or spirituality and health. In the domain of mental and social health, those who are **religious** and/or **spiritual** are reported to have the following:

- Reduced incidence of depression
- Quicker recovery from depression
- Recovery from major surgery with less depression
- Improved coping with disability, illness and stress
- Reduced substance abuse including alcohol and illicit drugs
- Facilitation of psychotherapy
- Improved palliative care outcomes
- Greater social support

And in the domain of **Physical health**, there is reported to be:

- Reduced all cause mortality and greater longevity
- Reduced incidence of heart disease and hypertension
- Improved recovery from cardiac surgery
- Reduced incidence of and longer survival with cancer
- Modification of physical risk factors with associated reductions in lifestyle related illnesses such as emphysema and cirrhosis

The International Saline in Australia story began in an International Saline presentation at the 2006 International Christian Medical and Dental Association (ICMDA) World Congress held in Sydney. The next step four years later was a 2010 International Saline Trainers workshop in Brisbane. At that meeting participants developed a vision to present International Saline to all CMDFA members. While this is not yet achieved, God has blessed this activity greatly.

International Saline teaches many skills in these areas of working with patients and understanding how their values and expectations can be mobilised to contribute to better health care. One foundation skill taught is how to take a spiritual history. See table below for a list of possible questions to ask when taking a spiritual history.

While engaging in this area may seem at times too difficult, neglecting religious and spiritual issues important to the patient is also unlikely to produce an optimal outcome. (Hassed, 2008)

Training Days

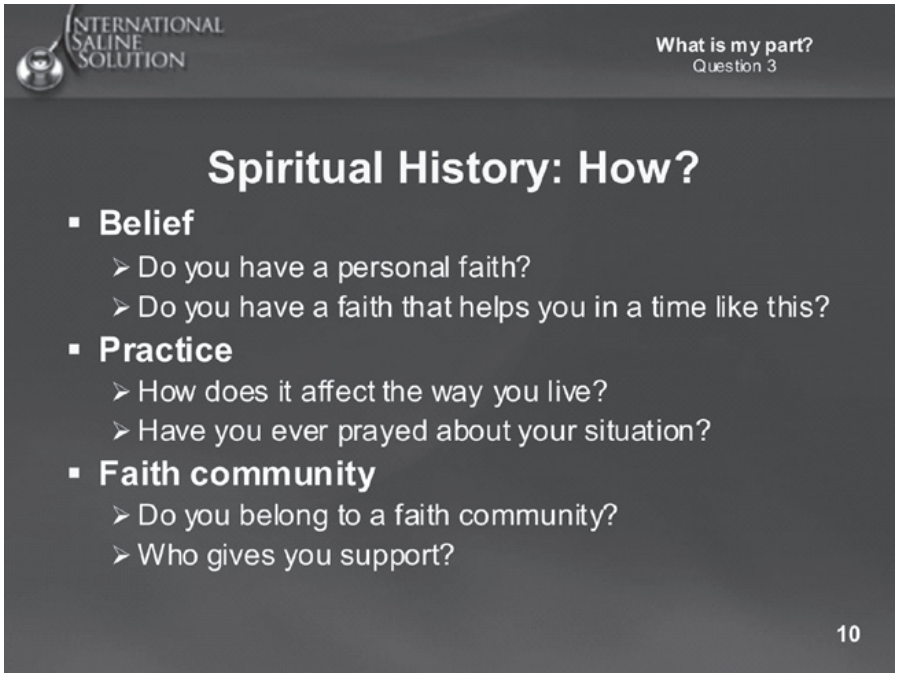
Over twenty International Saline training days have been facilitated around Australia, two hundred and ninety health workers and students have attended International Saline day training and five hundred and fifty, including the above two hundred and ninety, have attended International Saline presentations.

International Saline introductory sessions were also well supported at the IMPACT 2013 and 2013 CMDFA Graduate Conference. Excitingly new and capable trainers are emerging – Catherine Hollier (Newcastle, NSW), Jill Wyatt (Perth, WA), Jason Ong (Melbourne, Victoria), Carolyn Russell, John Hagidimitriou and Anthony Herbert (Brisbane, Queensland).

"International Saline can assist the Christian health professional better understand how the faith and/or values of a colleague or patient are important in identifying helpful responses to complex health problems."

In 2013, six Australian training events were held where one hundred and seventy people participated. These gatherings were in four states and included the major regional centres of Newcastle and Townsville.

We face the following challenges – to build and strengthen our team of trainers, to build linkages and champions in various committees and to review teaching materials to continually make them more relevant to our Australian setting. ●



Interested?

If you would like to participate in or organise an International Saline training day please contact the CMDFA office – office@cmdfa.org.au or mnjburke@bigpond.net.au

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My Wheelbarrow

by Mac Campbell

Mac is a Franciscan whose interests include the politics of the inter-testamental period, histories of jurisprudential philosophy, Chinese art history, and admiring his friends struggling with brain differences called mental illness.

I'm not saying Jesus invented the wheelbarrow. I haven't the faintest idea whether He had one. It's a try at metaphor.

Just as a wheelbarrow has three points of real contact with the floor, the ethical attitudes attributed to Jesus have 3 points of solid contact with reality useful in clinical practice. **Cosmopolitanism**, (or if you like, inclusion of the foreign) is the first leg. **Creative Irony** is the second leg. And the third point of contact with reality is **Conscience**. I'm going to call the brilliant creative combination of ideas attributed to Jesus, an ethical wheelbarrow. I'm going to claim that just as the wheelbarrow is now found pretty much everywhere, the ethical ideas in the words and actions of Jesus are historically unstoppable. I'll explain how each point of ethical contact is superbly realistic, and then I'll go on to claim that just as the genius of the wheelbarrow is a combination of pre-existent ideas, the genius of the ethics of Jesus is His creative combination of three pre-existent ethical values.

Practical, realistic. A brilliant Chinese idea, a brilliant combination of pre-existent ideas. You'd think the wheel had to be invented first. The brilliance of the wheelbarrow is a superb insight about balancing a load over one wheel. Of course, you say, the other realistic thing about a wheelbarrow is its two other points of contact with the floor when you put it down.

Being realistic is what matters about Jesus. What's so realistic about the ethical wheelbarrow I'm attributing to Jesus is it has three points of practical contact with the planet you and I are on.

The one point of ethical contact that never leaves the ground is the pre-existent idea of being open to including the other, including people who are deeply different. Long before Jesus, the Greeks called it cosmopolitanism. Whilst totally loyal to your own lingo, you are a citizen of the world; you include and welcome the foreigner and the weirdo. Solidly there in the Old Testament too. (eg. Isaiah 58), and other ethical texts of the period. So practical cosmopolitanism is the wheel always in touch with the ground. The world experienced by Jesus was certainly full of foreigners and strangers, just as we are now. His message? If you want your civilisation to flourish, suck it up, get practical. Treat 'em wholesomely.

"People who have never heard of Jesus benefit from servant leadership when it cuts its healing way into their helplessness, overthrowing their hopelessness."

The two legs of the wheelbarrow are creative irony and conscience. Both solidly in touch with the ground, with the way the world really is. Creative irony is my phrase for the highly imaginative approach we find in the records we have about Jesus' life. The realistic thing about them is their solid grounding in paradox.

It's just realistic to say that the world is full of paradox, of dialectic tensions, of contradictions, not just conflicts. Given that the world is full of paradox, an eye for it can open creative possibilities. For example the exciting paradox of servant leadership. This one single piece of creative genius attributed to Jesus is the best chance we've got to handle the greatest human problem short of the destruction of our own habitat. We all know the horrible downsides of hierarchies, the cruelties, the humiliations, the powerlessness with no comeback, the learned helplessness at the bottom. The trouble started long ago when people first lived in cities (like Ur). The first civilisations were enabled by specialisation and hierarchy just as ours is, and we are still paying the price. The irony of servant leadership cuts deep into the tissues of the social body. You might call it radical surgery where the patient is a civilisation. (The Kingdom of God…). So paradox is the thing to see, and creative irony (e.g. servant leadership) is the surgery. It's a paradoxical insight that the most effective leaders happen to be the most interested in listening, empathetically listening.

The pinnacles of the literatures of great civilisations sparkle with irony and paradox. I think those who are most realistic about the human condition face most squarely the contestation between interests and the contradictions between principles that bedevil us in virtue of the world's real paraconsistency. See Graham Priest or Richard Routley, et al. Swift's essay, *A Modest Proposal* echoes beautifully the challenge of Jesus to Pilate, which went roughly, if I remember rightly, something

like, "You don't really have any discretionary leeway in any of this, do you?" Normally translated "repentance," the *metanoia* He recommended is better translated as "beyond customary rationality." Ironic insight. Clinically practical. Realistic. Surgical.

Conscience, the other leg. Think of it in combination, think of it as informed. Plenty of responsibility for personal judgement in His Hebrew tradition already, but how do extant accounts of the life of Jesus show Him strengthening the idea? With the 20/20 of hindsight we can imagine His reasoning, thus: If the beginning of ethical thinking is empathy, and if empathy is imaginative insight into what it might be like to be someone else, and if imaginative insight of that kind is deeply personal, then personal judgement is required at the beginning of ethical thinking. Personal judgement is conscience, therefore conscience.

Not surprising, then, that the biographies of Jesus are full of examples of acts of personal responsibility for imaginative insight into the lives of others. Calling a distant God "Daddy." Ripping responsibility for forgiveness out of the hands of religious professionals (reported to have declared, "Yahweh has left the building!!" as He left the Temple Precinct for the last time. Making forgiveness everybody's, (Forgive us as we forgive them…).

You'll be thinking of examples if you've followed Jesus at all.

Since then, Paul and others immediately after left us with a rich record of practices of personal judgement. History has since been a cultural see-saw between how much choice the individual gets, and the importance of the group, the tribe, the family. Western clinicians unexposed to non-individualistic legal frameworks may be blissfully unknowing that most of the world's cultures require the presence of a close relative in the clinical contact. Informed consent to be legal, is countersigned by a next of kin. Patient confidentiality thus legally includes the whole family. This is not mere inherited tribal tradition. Some great literatures pre-date Christianity. Including highly theorised traditions of conscience in which clinical obligation is primarily to the family.

The expansion of markets has since generated civilisational change that conditions us to re-imagine ourselves in ways friendly to sales figures. We buy identity markers. This remaking of personal identity and its effects on conscience is happening now everywhere, in every culture.

So the take-home message about conscience is that although we have much to thank Jesus (and his followers) for, other thinkers such as Confucius have also had a big influence on how conscience actually works in the real world. And now the effects of world-wide market choice on identity and obligation and thus conscience are still developing.

The core civilisational values of Jesus (The Kingdom of God is like…) are historically unstoppable. The ethos of inclusion, the sheer practicality of creative irony in squarely facing the paradoxes and contradictions in the real world is also an unstoppable civilisational force. People who have never heard of Jesus benefit from servant leadership when it cuts its healing way into their helplessness, overthrowing their hopelessness. These two core civilisational values might have got off to a slow start historically as principles of civilisational governance, but now have serious cultural and institutional inertia.

By contrast the progress of Jesus' emphasis on personal judgement, combined though it has been by various versions of obligation in other great literatures, is traceable through centuries of Christian tradition. Although there have been dark times when conscience has been pretty much a matter of mindless compliance, the progress of personal judgement was never so alive as when it has combined with social inclusion (of foreigners and others whose rationalities are different) and creative insight / irony.

I think *metanoia*, (thinking beyond customary rationality) will win. I think conscience, creative irony, and inclusion, three ethical contact points with the real world that were so brilliantly combined in the Jesus of the texts, are now historically unstoppable. Plenty of opposition, sure, but they're winning because they generate immense human flourishing and prosperity. They *work*.

The ethical wheelbarrow. More realistic than any other way of generating the attitudes necessary for humans to flourish in cities. "The Kingdom of God is like a wheelbarrow." You can quote me. ●

Using words to unravel the tangle of pain

by Dr Frank New

Dr New has worked in the field of Pain Medicine since training as a Psychiatrist, with an appointment to the Professor Tess Cramond Multidisciplinary Pain Centre in 1984. The importance of understanding communications in this field was encouraged by work with the Pain Lang research group with Professors Jenny Strong and Roland Sussex.

Mrs Smith says, *"It hurts."*

Dr Caring thinks: *Thanks a lot. Now I have a job to do. I've got to work out what this means and how best to respond. It would obviously be good to work out a way of getting rid of Mrs Smith's pain, or at least reduce how much it is hurting her, and how much she is suffering.*

Already the challenges for the practitioner, patient, and family are mounting. Tension is rising.

"What do you mean I might not be able to get back to what I was doing before, to what I hoped and dreamed I could accomplish, to what I have been working hard to achieve, investing time, energy while putting off easier pleasures?"

Crash – reality looms.

Let's help them through this as best and gently as we can.

But part of me (Dr Caring) thinks *"I don't want to go there myself. It hurts me as well as Mrs Smith! Perhaps I could neatly step aside the issue."* There are numerous means to do this that come to mind.

- *It will pass*
- *It's not really that bad*
- *She is exaggerating*
- *She doesn't really have pain*
- *She doesn't have **real** pain*
- *It's her fault*
- *There is no solution*
- *I don't have a solution and it is not right to pass a problem like this onto a colleague*
- *It may be Syndrome XYZ – just possibly – (even though there is no evidence for this Syndrome). At least someone has proclaimed it, even though they don't have a good explanation for it.*
- *There has been research that showed that a group in (St Elsewhere's) has got good results with (ABC new treatment) so it might be worth trying even though no one else has found the same. After all Mrs Smith is in pain and this can't hurt her anymore. Could it? Is it worth the risk?*

Will she understand when I explain it? Can she possibly understand when her ability to think clearly is fuddled by her pain, lack of sleep, distress and desperation? Maybe I could sell her anything! That's a bit scary really, all this responsibility with her in such a vulnerable state.

How did I let myself in for this dilemma?

I didn't have to be available.

I didn't have to listen to her.

I didn't have to take her seriously.

I didn't have to accept that she has pain.

I didn't have to accept the job of helping her.

But

That's what I have done. It is part of being the professional Doctor. Not just acting the role but *being* one.

Something about acceptance and commitment to a role that I believe to be valuable, honourable, a worthwhile contribution to the people I see, to the community, while also providing for my own satisfaction and living. I can justify my place in this community.

So Mrs Smith has said that she is hurting. What now?

Do I believe her?

How can someone believe a person when they tell me they're in pain? They may be just wanting a sickie, or worse, drugs!

Yuck! This is horrible. I have to make a decision and I don't have any way of proving what they are telling me. I could ask them to tell a number out of 10, but I don't really know what that means. I don't know what to do with a number because people tell

me that numbers don't match the pathology I can find, they also vary. Do I treat on a number or not?

Actually when I ask them what ***they*** *mean by the number, most people don't know! They say it because I have asked them, and because other doctors have asked them the same, even though their husbands, children and friends don't ask them for a number. Mrs Smith doesn't ask her children for a number to see if they are cold, hungry, tired or angry or in pain.*

It is strangely comforting, as if being "technical", "expert" and "medical" is a good indicator of effectiveness, but it somehow doesn't give me any confidence about what to do next.

Better ask her what she means, and if she can explain what is happening in some other words. The best thing I can offer Mrs Smith is good medical practice. Maybe that is a good thing to have available. After all, we have one of the best medical standards in the world, which means we have got one of the best medical standards ever in the history of mankind. Yep that's worthwhile. And after all good Pain Medicine depends upon good medicine.

Taking a history! It seems like it will take ages. *She has so many complaints. But are they all urgent?* How can I tell her they're not? Wait a minute though, there has got to be a difference between things that are urgent and things that are important. Things that are important still need to be done, but it is reasonable, and perhaps actually better, to plan to do them at a time when they can be considered more carefully, not cutting corners and taking undue risks, to make it more likely of getting a good result rather than only a quick result. Prioritising and planning an overall approach to getting a good understanding, then developing a good way of managing her problems, is worth the investment of that extra time. This means asking her to make other appointments as well as today.

I could go through the checklist of questions. That would give me

information about the pain but it's not going to give me enough information about what it means to her. There seems to be no substitute for asking her questions, not suggesting the answers to her, to have her explain her problems in her own words. If she is very disorganised, she might need some prompting and a bit of structure, but the influences on her perception, thinking, emotions, and behaviours that come from things around her, past and present. It is a big ask for someone with no special training. Perhaps that's my role to guide her in this task, just a few prompts to help her elaborate here and there while she is describing her problems and her predicament.

"There seems to be no substitute for asking her questions, not suggesting the answers to her, to have her explain her problems in her own words."

I can't understand her pain, or her suffering, until I get her in a situation where she can explain these to me. I suppose that also means I have to be in a situation where I can listen, properly, to hear the messages between the lines, as well as the actual words she is using. After all Mrs Smith hasn't extensively trained to communicate effectively in a sophisticated medically-orientated manner. She doesn't know the science of pain, and the intimate links between the process that are occurring physically in her body, psychologically in her mind, nor

After she's run out of steam, got that off her chest, and told me what she regards as important, I can go back and check, to make up for the gaps with a "systemic interrogation", to find the information that she might not be aware of as relevant.

This "helping her settle", open questioning, and closed questioning make sense. It might seem to be time consuming, but having been a General Practitioner for the family for a fairly long time, I already know a lot

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of the information about Mrs Smith, her family, and her life experiences. I already know her medical details and the medication, and the information I get through this more detailed history can be very useful in helping her and her family in the future with their other problems. She might also have confidence that I can do that, knowing that I have this understanding, a good base to provide useful information relevant to them.

Fortunately we have good training and experience to conduct a good quality physical examination, including a pain-oriented examination. It might be very important to elicit specific features such as:

- Allodynia
- Hyperalgesia
- Hyperpathia
- Sensory loss
- Motor loss
- Sphincter impairment
- Abnormal autonomic features (change of colour, temperature, sweating, oedema, trophic changes)

Investigations. It is easy to start, but where do I stop. There's always another one I can do, but is it really going to make a difference? Will it help my management? I can't stand this uncertainty. It is hard to manage at times. Now hold on, that's why Mrs Smith has come to me. She doesn't know what is going on and she needs someone to guide her through this. If she's come to someone that can provide certainty, well that's a problem because most of the time, despite the best of modern medicine, I am not really able to do that. We often feel we can, but a closer examination of what we do reveals that a lot of the time, we are able to provide very well informed opinions, and useful opinions, but they're not certainty. After all, I can't even be certain of getting home tonight. No one can. That's the stuff of life that we need to be able to manage without absolute guarantees. It takes some confidence. I suppose if one's confidence has been knocked around that's going to be more difficult for them. Maybe that can be the problem, that Mrs Smith doesn't have the confidence to manage her pain because of something else that's happened to her. It's a bit premature to decide that, but we need to keep that in mind.

Referrals. Same again. Do I refer or don't I? I know I don't know everything. I know that many of my colleagues are able to provide a lot more knowledge, experience and wisdom from the benefits of their experience, but I know that they don't know everything either. I suppose it comes down to when that can be likely to progress the management, it might be a good idea.

How to handle this uncertainty? Maybe if I talk with Mrs Smith, and perhaps her family about the big decisions, put what I know and don't know in front of them, explain the advantages and disadvantages, and get them involved in the decision making. Of course I would need to know that she has a reasonable chance of understanding, and is likely to make reasonably sensible and responsible decisions. If that is not the case she will need someone else to make them for her, or at least provide stronger advice, and if there is no one else, I suppose that becomes my job. If she would agree with that, we're cooking. Sounds like the development of a therapeutic alliance.

If I am going to refer her to a Specialist, what's my job? Sometimes I never see them back, but it is useful to have those opinions. Mrs Smith keeps coming back to me. That's often helped by bringing all these opinions together. After all, as a General Practitioner I am likely to have a much better understanding of context, to help her prioritise the issues, taking into account her personal situation, and most importantly, to be around for the long term, to provide continuity. Something like being a Conductor, a Coach or a Team Manager.

What about her pain? What's the diagnosis?

"It is a big ask for someone with no special training... that's my role to guide her in this task"

We've got these diagnoses like Nociceptive Pain and Neuropathic Pain. But are they really diagnoses? They don't really tell me what is going on to cause this. Is there any point in using these terms?

Well perhaps there is because the treatments are different, particularly the importance of identifying a neuropathic pain for which the usual analgesics might not be as effective. The use of neuropathic agents such as the Gabapentinoids. Tricyclics might be more effective. But there is still the job to try and define the underlying physical pathology and provide good management for this.

This is now getting into the more 'medical' aspects of helping her manage her pain. After setting the scene with her, we are likely to progress better now, with a clearer direction to follow.

But it's a bit of a worry that Mrs Smith might not get better.

We'll do this first, review how she goes. Then later we may need to change course from focusing on (depending on?) a cure, to working out how to help her adjust her life to get good quality despite the pain.

That's another ballpark to consider later. Sounds an interesting challenge. ●

His Story is History and History is His Story

by Paul Barnett

This entry was posted in New Testament history and tagged *After Dawkins His Story will still be History, BC and AD* by Paul Barnett. Bookmark the permalink.

Tacitus the great historian of First Century Rome leaves us in no doubt about the main historical outlines of the New Testament. Tacitus, a leading politician and a provincial governor, reports that the 'Christians' took their name from a person called 'Christ' who was executed by Pontius Pilate in Judea in the era of Tiberius Caesar.

Tacitus expected the movement to die with its founder but instead it spread to Rome where, by the time of the great fire in AD 64, it had become 'immense'. Tacitus's history tell us (a) Jesus was known as 'Christ', (b) that he was therefore a genuine figure of history, (c) when and where he was executed, and (d) that in spite of his death as a disgraced felon within thirty years his movement spread from Palestine on the edge of the empire to its heart, Rome.

Tacitus's confirmation of the 'raw' facts about earliest Christianity is impressive. Not only was he a careful historian he was also bitterly critical of this new movement, which he calls a 'superstition' whose members were guilty of evil 'vices' and who, he said, 'hated the human race'. Tacitus, a proud Roman, despised these Christians who loved their Christ more than the empire. Tacitus's comments about Christian origins are all the more important since he is an independent witness, in fact, a hostile witness.

The word 'Christian' (*Christianos*) literally means 'a follower of Christ' and it was a word coined by outsiders, most likely public officials in Antioch in Syria. Only later did the Christians use the word for themselves. Also significant is the fact that the word 'Christ' originated as a title, 'the Christ' which is Greek for 'the Messiah' or 'Anointed King'. So the Christians were seen to be followers of *the* Christ. And it was this that brought them into headlong conflict with the Roman authorities. The Romans crucified Jesus as 'king of the Jews' and they persecuted his followers for saying there was 'another king', that Jesus, not the Roman Caesar, was the true king over the world.

Historical analysis demands that Jesus knew he was *the* Christ, the long awaited One anointed by God, the 'son of David' prophesied centuries before. Even during his three year ministry his disciples had become convinced that Jesus was 'the Christ'. The writers of the New Testament are certain that Jesus was the Christ. Where did that conviction come from except by the impact of Jesus upon them, as dramatically confirmed by his resurrection from the dead?

At the head of his letter to Christians in Rome Paul sets out this summary of God's gospel as:

> *"...concerning his Son, who descended from David according to the flesh who was designated Son of God in power according to the Spirit of holiness by his resurrection from the dead Jesus Christ our Lord." (Romans 1.3-4 RSV)*

From this pre-formed summary statement we learn three things.

First, the words '*his* Son' points to an intimate relationship between God and his own Son. This is consistent with Jesus' prayer to God as *Abba*, Father and to Jesus' reference to himself as 'the Son' and to God as 'the Father'.

Secondly, he was truly human having descended from the line of David. The RSV translation 'descended' does not bring out that Jesus 'has come' – comma – 'out of the seed of David'. This implies that Jesus 'came' from somewhere else, that is, from his eternal pre-existence in the presence of God and – historically speaking – came through the 'seed of David'.

Without mentioning it this is in line with the virginal conception of Jesus which Matthew and Luke independently attest in their genealogies, and which Paul confirms in his letter to the Galatians where he writes that Jesus was 'born of *a woman*' (i.e., independently of a man).

Thirdly, the historical person of Jesus was 'designated' as Son of God

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Dokta at large

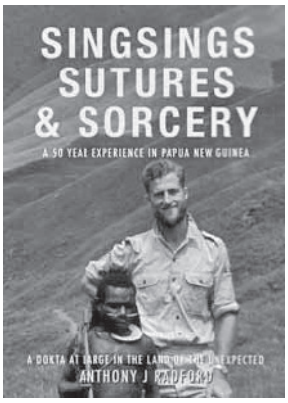
by Nick Johns-Wickberg

First published in the RACGP's Good Practice, July 2013.

For Dr Anthony Radford, visiting Papua New Guinea in 1959 was the start of an enduring connection with 'the land of the unexpected'.

Dr Anthony Radford.

Dr Anthony Radford has done a lot for Papua New Guinea (PNG). In perhaps the most difficult conditions a health professional could ever expect to see, he spent 10 years as a 'dokta at large', solely responsible for more than 50,000 patients at a time in one of the world's most under-developed areas. He performed specialist procedures far beyond what would be expected of most GPs, taught vital skills to a generation of local health workers – considered by many of his peers to be almost untrainable – and made significant improvements to PNG's public health system.



All of this is described in Radford's book – *Singsings, sutures & sorcery* – which has its origins in diary entries and letters dating back to 1959 and was published in late 2012. Radford recounts fascinating stories about life in the most linguistically diverse country in the world – a land where more than 800 distinct languages are spoken and the majority of people live in rural areas, many in communities whose way of life hasn't changed for hundreds of years. 'It was an extraordinary experience and we got on wonderfully well with the people,' Radford told *Good Practice*. 'We didn't live their lives with them, but we enjoyed and joined in what they were doing.' Among those cultural experiences were 'singsings', celebrations where villagers would dress up in traditional clothes for feasting, songs and dance.

'Some of the wonderful things that happened, I just wanted to get them down and record them, and in retrospect I'm sorry I didn't keep much more extensive diaries,' Radford added.

There are three parts to Radford's book. The first describes his 2-month student placement in 1959-60, the second his 10 years as a bush doctor from 1963-72 and the third his numerous consultancy trips over the following 40 years.

Perhaps Radford's most striking first impression of PNG was the 'casual racism' – a term he borrows from historian Hank Nelson – shown towards the local people. The prevailing attitude among the white people living there, Radford writes, was that the PNG nationals were savage, unintelligent and incapable of looking after themselves. With remarkable maturity for a then 22 year old, Radford saw the injustice and tried to set himself apart. Nevertheless, he readily acknowledges that some of those views rubbed off on him at first. Radford left the language of the diary extracts and letters published in Part I of *Singsings* unedited in order to illustrate this.

'If you look back on me – and there are a couple of instances I record in the book – I probably did become part of it,' he said. 'In those days we didn't think of ourselves as colonialists. I'm not sure that many people did. Certainly Europeans regarded themselves as better than the natives.'

'To me racism is about power. It's not about education per se, it's not about colour,' he added. 'What I've learnt over the years is that, if you happen to be white and you have the power

continued over page

of economy or control, then you tend to look down on other people, and that's racism.'

When Radford returned with his wife Robin and firstborn son Mark in 1963, he was contracted to work in PNG for 4 years. He stayed for 10. By the time they left, there were two additions to the family – David and Sarah – who had grown up to love village life in PNG. After spending an initial year in PNG's capital city, Port Moresby, the Radfords moved between villages across the country, including Kainantu in the Highlands and Saiho in the jungle. It was in these small villages that medicine was at its most challenging.

Radford made sure to get as much Australian training as possible to prepare himself for the workload. He focused on dermatology, obstetrics and anaesthetics in particular, knowing that he would be the only port of call in the smaller villages. However, it was impossible to bear the load alone, so Radford relied heavily on nurses and *dokta bois* – best translated from Pidgin as 'orderlies' – to help with the legwork.

'It was unmanageable and that's why we had *dokta bois*. And these people quite often had nowhere near reached the limit of their educational capacity,' Radford said. 'But back then, the only way we doctors could survive was to train other people to recognise and manage the common conditions. So in the outpatients department, which was like the casualty department in our hospitals here, we taught those people how to recognise and manage simple things from scabies and bronchitis to suturing lacerations or opening abscesses.'

'I developed a series of axioms of healthcare and one of them was: "Nobody should be prevented from doing anything they can readily be taught to do competently",' he added.

Needless to say, education was a huge part of Radford's role in PNG. He was responsible for teaching a wide range of health workers, many of whom had had very little formal education. There were frustrations; many students didn't understand their own capabilities and struggled to grasp the concept of being empathetic towards people from other villages.

"Nobody should be prevented from doing anything they can readily be taught to do competently."

'Normally in New Guinea society you do things because they're expected of you. You know culturally what to do in this situation, but to care for someone else from the other side of the island was not part of that,' he said. 'That used to infuriate me, their lack of empathy with sick patients or parents.'

Despite that, Radford managed to train many successful doctors and *dokta bois* throughout the decade. Equally important was teaching local people how to better take care of themselves. Radford summed up his approach to communicating Western health principles to the villagers in one sentence: 'As with communities in Australia, I found that one of the most difficult tasks was to find concepts from their existing culture on which to graft new ideas and effect change.'

'It takes a while to get people – a generation or two – to accept these changes, just like for us,' he said of his efforts to improve behaviours such as eating and hygiene. 'I remember talking to village people because community education is just as important as doctor education and communication. We know well that if doctors just raise the subject of smoking to patients, they are more likely to give it up. But how do you get across the concept of germ theory when they believe that all illness is caused by sorcery?'

Radford used drinking water as an example. A local river had been polluted by waste from an international company and villagers downstream had been getting sick because they kept drinking the water. Radford told the villagers that even if they couldn't see anything in the water, they could tell from the taste that something was wrong. It went against their traditional understanding of cause and effect – that illness and injury were caused in retaliation for something they had done – but the message got through and they found another water source.

Singsings is filled with tales of Radford's makeshift medical successes. Among the most poignant is his account of performing an emergency hysterectomy on a profusely bleeding woman. Radford had never done a hysterectomy before so he went 'by the book' – he was literally reading instructions from a book as he was operating. To raise the degree of difficulty from about 9.2 to an even 10.0, the power cut out halfway through surgery and when the generator was restarted, the operating theatre – protected only by fly-wire walls – was swarming with insects. Radford managed to get the insects out of the open wound, remove the uterus and eventually close the woman up after remedying a blood-clotting problem, but some of his medical supplies had mysteriously vanished in the chaos. They reappeared days later in a Port Moresby hospital when a staff member found two packs, half a dozen swabs and half a needle inside the woman! Thirty years later, on one of his return visits to PNG, Radford was re-introduced to the woman whose life he saved, still healthy and very happy to see him.

Radford's writing is as anthropological as it is medical. One of his favourite memories of PNG is the time his father-in-law – who had come to visit Robin and the family – joined him on a patrol. After befriending one of the elders and enjoying a meal by the campfire, Radford asked the villagers to share some stories from their local folklore. They told tales for hours, and when there was nothing more to tell they asked Radford's father-in-law to share some tales from his culture. At a loss, he decided to tell the first thing that came to mind; Rudyard Kipling's story of how the elephant got its trunk. According to the tale, the elephant's nose was nothing more than a stub, then a crocodile latched onto it and stretched it until it became the long trunk it is now. Despite never having seen an elephant, the people loved the story. Radford had a sneaking suspicion about what would become of the conversation.

'As we were going to bed, I said "I'll bet sometime in 30 or 40 years' time an anthropologist will come into this area and come out with a story that these people have about elephants."'

Sure enough, he was right. An anthropology student he met on one of his latest trips told Radford how surprised he was that isolated villagers in a country without elephants told this tale. Kipling had become part of their folklore!

The hard work and occasional hardships of life in PNG didn't just affect Radford. Robin sacrificed a comfortable life in Australia to be part of the adventure, something Radford believes she gets little credit for.

'I think it's in her character, but I think the wives have not received their due reward, Radford said. 'I would go to work and I'd be interacting with people and things, and she'd be left at home – particularly in the more isolated stations – with maybe only one or two other Europeans on the station whom you may or may not get along with. So she was starved for intellectual conversation.'

Her skills were far from wasted, though. Throughout the decade she acted as Radford's research assistant, eventually writing a thesis and publishing a book about foreigners living in the PNG Highlands.

After his decade in PNG, Radford worked in many other developing countries, sharing his experience and working to improve public health across the globe. The fundamentals apply in Australia, too; Radford played a key role influencing public health on the RACGP's SA Faculty board for many years. He sees himself, not as an Australian or a PNG national, but as an 'internationalist', a label he believes fits the whole family. None of them have forgotten PNG's role in their life, though; Mark still calls his younger siblings by the village names they were given as children.

So how does Radford measure his legacy in PNG? It's difficult to say; in some ways he believes the country has progressed since the '60s, in other ways it has gone backwards. His proudest achievement, he said, was establishing a medical training program that immersed student doctors in rural areas on 3-month placements and taught them vital skills they couldn't learn in a classroom. He has reservations about the long-term sustainability of the programs and systems he helped create, but there is no doubt that doctors like Radford have sowed seeds that will continue to help PNG in years to come.

He recalls a quote by Mother Teresa that sums it up perfectly: 'I alone cannot change the world, but I can cast a stone across the waters to create many ripples.' ●

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in power (that is, as 'Lord') by his *resurrection* from the dead and by his outpoured gift of the *Holy Spirit* at and subsequent to Pentecost.

Paul's brief statement is as historical as Tacitus's. Tacitus wrote historically about Christ from the viewpoint of an uninformed and hostile outsider. The 'external' facts that he gives agree exactly with those of Luke-Acts. But as an outsider he does not know the 'inside' story that Paul gives us at the beginning of Romans. Jesus 'came' from a pre-existent eternity; as a historical figure he was a descendant of the messianic line of David; God raised him from the dead as his 'powerful Son' (i.e., as 'Lord of all'); whereupon he poured out 'the Spirit of Holiness', which he continues to do.

Paul's summary statement, though accurate, is incomplete. Paul will expand upon it later in the letter to teach that God 'did not spare his own Son but gave him up for us all' (Romans 8:32). In other words, the Christ who existed before the creation of the universe, who came into our world in fulfilment of prophecy, who died on the Roman cross for our forgiveness, who was raised alive from the dead, who pours out his Spirit to those who commit to him in the One who rules history until his historic return. This Christ, whom Christians follow is the Lord of history.

By a happy quirk of language his 'story' is the true and eternal 'history'. Modern day enemies of Christ like Richard Dawkins attack this history, but it will still be true when his days are passed. Christians must continue to struggle for the BC and AD division of history since it represents His Story. ●

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What is the CMDFA?

Aims

- To provide a Fellowship in which members may share and discuss their experience as Christians in the professions of medicine and dentistry.
- To encourage Christian doctors and dentists to realise their potential, serving and honouring God in their professional practice.
- To present the claims of Christ to colleagues and others and to win their allegiance to Him.
- To provide a forum to discuss the application of the Christian faith to the problems of national and local life as they relate to medicine and dentistry.
- To foster active interest in mission.
- To strengthen and encourage Christian medical and dental students in their faith.
- To encourage members to play a full part in the activities of their local churches.
- To provide pastoral support when appropriate.

Origins

Its historical roots are in the Inter-Varsity Fellowship (IVF) and the Christian Medical Fellowship (CMF) that started in the UK. Along with similar groups being set up around the world after World War II, separate Australian state fellowships of doctors and dentists were established from 1949.

These groups combined as a national body in 1962 and the Christian Medical and Dental Fellowship of Australia (CMDFA) became officially incorporated in NSW in 1998. In 2000 the work became centralised with the establishment of a national office in Sydney to assist with growing administrative needs.

CMDFA is governed by state branch and national committees elected at annual general meetings of its financial members.

CMDFA is linked around the world with nearly 80 similar groups through the International Christian Medical and Dental Association (ICMDA) which includes Christian Medical and Dental Associations of the US.

Why join the CMDFA?

• Fellowship • Evangelism • Discussion • Mission • Student Work

CMDFA seeks to:

- Unite Christian doctors and dentists from all denominations and to help them present the life-giving Christian message of God's love, justice and mercy in a tangible way to a hurting world.
- Help students and graduates of medicine and dentistry to integrate their faith in Jesus Christ with their professional practice.

Membership is open to students and graduates, who want to follow Jesus Christ as Saviour and Lord. Associate Membership is also available to Christian graduates in related disciplines.

By Joining the Fellowship you can:

- Be motivated in mission for Jesus Christ.
- Be encouraged in your growth as a Christian Health professional.
- Be committed in serving God and your neighbours in the healing ministry.
- Learn from others in integrating your Christian faith and your professional life, drawing on the experience of older graduates as mentors and facilitators.
- Encourage and support other colleagues in fellowship and prayer.
- Share your resources with those in need through special ministries.
- Network with others to effectively bring God's love to patients, colleagues and daily contacts.
- Collectively make an impact for Christ in heath care.

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