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CMDFA
CHRISTIAN MEDICAL
& DENTAL FELLOWSHIP
of AUSTRALIA Inc

Volunteering

Bringing Spirituality into Clinical Practice

Planning to Start Health Services in a Developing Country?

Health, Poverty and Justice

Healthy Service: Preventing Burn Out

Medical Teaching as Ministry and Mission

Cross-Cultural Serving

Healthy Service

- Clinical encounters
- Population health initiatives
- Intentional care for the poor

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Vol 21 No 1	Apr 2016	Family Matters
Vol 21 No 2	Sept 2016	Life Before Birth
Vol 21 No 3	Dec 2016	Healthy Hope: *Luke's Journal* 1996-2016
Vol 22 No 1	Mar 2017	Mentoring: Passing on the Baton

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editorial

Dentistry and Medicine are often described as "service industries". The care and attention we provide patients attracts a "fee for service". Service is a core aspect of what we do.

This has always integrated easily into our Christian faith and outlook. After all, we follow Jesus who humbly leads the way, "the Son of Man came not to be served but to serve and give his life as a ransom for many," (Matthew 20:28). After washing the disciples' feet, Jesus spoke these words: "I have set an example that you should do as I have done for you. I tell you the truth, no servant is greater than his master," (John 15:15-16). It is of little wonder the apostle Paul describes Jesus as: "taking the very nature of a servant," (Philippians 2:7) and in the letter to the Christians in Rome, while reflecting on the gifts of the spirit, he challenges Christians, "If it is serving, let him/her serve," (Romans 12:7). The background of widespread slavery in the Greco-Roman world accentuates the power of the 'metaphor of service' for medicine and dentistry today.

Service then, is an unavoidable consequence of the transforming power of the gospel in our lives. Christian service compliments and sustains us in medical and dental practice.

This edition of *Luke's Journal* seeks to develop our theme in stories, reflections and biblical insights.

The scope for service is wide. Clinical encounters, population health initiatives, intentional care for the poor and marginalised through to administration and governance. The current Nobel lauriet for literature, Bob Dylan, alerts us to a growing problem. Quite simply he sings: "Babe, we don't care anymore." Medical and dental care is at a tipping point crisis. Managerialism, technique and the capitalisation of Hippocratic medicine are the sources of a "service sinkhole." Medicine and dentistry have never before been more technically excellent, yet many experience fragmented, isolated dehumanised service. I have a patient who I call "world famous" for calling for ambulance care from the ward of a major Brisbane private hospital. Four hours of "no service" was a line in the sand for her.

As Christians we seek to be Christ-like, to take up our cross daily and follow Jesus, who the gospel writers present as always willing to serve compassionately. The witness of service in the name of Jesus should be a light on a hill in our times. To reinforce the case for service, we can appeal to a growing evidence base for kindness and compassion as improving health outcomes, reducing health costs and restoring dignity to any health care journey.[1] There is an article on burnout in this edition to remind us that self-care and service are healthy companions.

Kind service that responds to whole person needs is under threat today. Now is the time, as never before to show we are Christians by our love. Now is the time for Healthy Service.

Paul Mercer, *Editor*

1. Youngson, R. (2014). Compassion in Times of Change. *GPET Convention*. Brisbane.

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Luke's Journal

Themes for Next Editions:

Living with or without Pain
– copy by 7 October 2017

Disabling Disability
– We're all in this together
– copy by 1 February 2018

Dignity and Right to Health Award 2016

of the ICMDA Leadership in Christian Health and Development Initiative

by Michael Burke

Michael is a Christian doctor passionately committed to the vitality of Christian ministry in addressing issues of justice and dignity for individuals and communities. He is a CMDFA Board member, a CMDFA Saline trainer and is executive officer of HealthServe Australia and coordinates the ICMDA Dignity and Right to Health Award.

The "Dignity and Right to Health Award" is an activity of the International Christian Medical and Dental Association Leadership in Christian Health and Development Initiative. The award provides an essential opportunity to recognise, support and publicise the most outstanding role models and champions acting to address health and development issues including the HIV global epidemic.

It is well positioned to continue as an important symbol for ensuring that voices from diverse communities and countries are acknowledged and championed. The Dignity and Right to Health Award aims to model, mobilise and encourage creative and sustainable ways that enhance the dignity and human rights of people, all made in the image of God, and communities living with a range of health and development challenges.

The award will be given to individuals and/or community based and national organisations for excellence, outstanding leadership and compassion in responding to various health challenges.

* * * * * * * * * * * *

Dr Anil Cherian

Dr Anil Cherian is the winner of the Dignity and Right to Health Award 2016 of the ICMDA Leadership in Christian Health and Development Initiative. Let me share with you the excellent story of Anil Cherian.

Criteria 1 – Leadership

Demonstrated visionary and innovative leadership

Dr Cherian is from the state of Kerala in South India and qualified in 1989 in the Christian medical college, Vellore.

After a junior doctor year he returned to Vellore and successfully trained as a paediatrician. This was followed by twenty years of service with the Emmanuel Hospital association, national organisation serving mission hospitals in India. He was the Director for Community Health and Development at the Emmanuel Hospital Association in India from 2007-2013. During his service he had also become very involved in community health. His wife Shalini, an obstetrician was not only supportive but a very able co-worker.

His involvement in the Sudan started in 2011 when he was invited by ICMDA to join a team of five given the task of how South Sudan could be helped in the development of their health services. They felt that teaching local staff would be the best contribution and the institute of health sciences was born. Dr Cherian was asked the following year 2012 to lead and develop this project. Anil and his wife moved to South Sudan at this time both feeling the call of God to serve in Sudan for 7 years.

The initial plan was to have the teaching institute in a town called Bor but the following year intense fighting occurred in Bor making it utterly impossible to have the teaching there.

The responsibility of an alternative venue for the institute of health sciences largely fell on Anil and the teaching commenced in Mengo hospital in Kampala, in neighbouring Uganda, in early 2014. (Mengo is an Anglican mission hospital on one of the hills of Kampala). CORDAID which is a Dutch NGO has also provided much of the funding.

There are seventy students in training. Most are high school graduates but

Midwives studying at the ICMDA NIHS. *Photo: www.thebiggive.org.uk*

around a fifth have some experience in community work, nursing or midwifery. There are three teaching streams – clinical medicine and public health, nursing and midwifery. Every attempt has been made to attract women students and at present a third are women. These will complete training in mid 2017.

A team of teachers has been formed – mostly full-time, but with some part-timers and volunteers.

It is obvious that Anil has made a huge contribution to the success of this venture though you would not get that information directly from him.

Criteria 2 – Target group: Marginalised / Hard to Reach Communities

Provision of health services for communities who have difficulties in accessing care due to ethnicity, caste, behaviour, and/or other reasons, or are hard to reach due to geographical difficulties, violence or conflicts.

In Sudan, talking about communities who have difficulties accessing health facilities is irrelevant since everything everywhere is in a mess and not likely to improve any time soon, especially now there is intense tribal warfare. This means that all the population are in dire need and every small contribution is of value. The Cherians are without doubt doing all they can.

Criteria 3 – Program outcomes

- Significant impact at local and wider level.
- Empowers others in integrated community responses.
- Facilitates church integration and participation in best practice models of care.
- Demonstrates excellence in full community involvement and empowerment of the target communities.
- Works, facilitates and advocates for gender equality in community participation and response to issues faced by the target communities.
- Links well with government and other agencies in a comprehensive approach to issues faced by the target communities.
- Models creative and compassionate responses that inspire many to similarly enhance the dignity and human rights of the target communities.

The hope is that these students when they graduate will return to Sudan to serve there. The training was set up in full co-operation with the government. The plan has been that some should work in clinical settings and some in mission hospitals and others in the community. Every effort will be made to fulfil this aspiration and indeed commitment but the situation in South Sudan is such that anything could happen.

Anil and Shalini will continue their commitment to the country when the training is completed.

Funding has been difficult and the best contribution has come from the CORDAID, A Dutch NGO. Anil has co-operated with other NGOs whenever appropriate and contribution to refugee (mostly internally displaced persons) work is being considered.

"[The Award is] an international award acknowledging the importance of the contributions of Christian doctors, dentists, nurses and other health workers..."

Criteria 4 – Personal Life

Exemplifies a life that does justice, loves kindness and walks humbly with God and assists individuals to be worshipers of the Living God

The story I have covered very superficially speaks for itself. Anil and Shalini have not just engaged in a project but have given themselves to the service of the people of South Sudan. This has continued the work they did in India but it has meant changing home and country to a most insecure situation. To enable this they left their two sons in India to complete their education. There is much to celebrate and learn from this extraordinary life. ●

Servanthood

by Barbara Deutschmann

Barbara has a background as a teacher in Australia and a health program trainer in India. She formerly worked with TEAR Australia, coordinating the fieldworker program and later the Indigenous support program. She enjoys reading in the area of public theology with a special interest in the issues relating to reconciliation and gender equality and helped to found the Melbourne chapter of Christians for Biblical Equality. She is currently doing a PhD looking at gender relationships in the book of Genesis. She worships with the Anglican parish of St Mark's in Spotswood.

Beautiful images come to mind when we think about servanthood: Mother Teresa serving the dying in Calcutta; the political leader pitching in to clean-up after a flood; parents sacrificially caring for dependent children; even the pastor washing the dishes in the kitchen after that church event. We think we know what servanthood means and from time to time, we even accomplish it. Few of us, however, really plumb the depths of the meaning of being a servant in Christian terms.

For me, it brings to mind a beautiful sculpture that stands in the grounds of Union Biblical Seminary in Pune, India. It is a nine-foot sculpture by Esther Augsburger depicting the idea of serving one another in love. The figures gaze at one another in love, reminding me that it takes as much grace to be served as to serve.

Serving the Earth

We first encounter the notion of servanthood in the Bible in a surprising place: Genesis 2:15. In this creation story, humans are placed

Esther Augsburger sculpture, Pune, India

in a garden with a vocation to care for the *adama*, the fertile soil. That vocation is expressed with two words, often translated as "to till and to keep", but neither Hebrew verb is horticultural in origin. The nuances are best captured in this translation: *"And the Lord God took the human and set him in the garden to work and serve it, to preserve and observe it."* Our first responsibility is to serve the earth, which has expectations of us. Ahead of any responsibility we have to other humans, is this fundamental positioning of ourselves as servants of the fertile soil that God gave humanity. We are servants of the soil, preserving the earth until He comes, whose earth it is.

Our first point of reflection must be here: how well are we serving and keeping the earth? This is not just care of the soil – although that is a great place to start. It bids us to ask about the broad parameters of our lives. The wellbeing of the physical earth, of the animal and human communities that live on it, are all part of the service of our primary vocation. Unless we have our eyes on the global scene, we are failing in our first task. The Sustainable Development Goals give us a guide to holding those in power to account.

For most of us, however, and indeed for much of our New Testament, the primary orientation is the idea of service to others and here we encounter a number of different stories and teachings that give a framework for the Christian life. Before we look at these, it is important that we not romanticise the notion of being a servant.

Before we put up our hand to enrol as a servant, let's really understand what it means. Being a servant is a position of powerlessness. No one who has ever been a household servant is unaware of this. What it means is doing the menial jobs that others will not. The Dalits, (formerly *Untouchables*) the casteless people of India, do the dirty jobs in that culture: they sweep roads, clean public toilets, collect and sort the rubbish. Without them, India's sanitation systems would grind to a halt. Less visible are the countless people who keep our own economy serviced through providing cheap labour in factories across Asia. For these people, being a servant means being without voice, having no means to change the rules of the game or even have a say in conditions of work. In other words, to be a servant is to encounter the exercise of raw power.

The New Testament Context

This was especially the case in the Greco-Roman world in which the New Testament took shape. Palestine was dominated by the Roman Empire whose rule brought oppression for the poor, including tax burdens on the peasant population. To make matters worse, Rome did this in

Jesus washes his disciple's feet. *Photo: www.freebibleimages.org*

collusion with Israel's leadership – both political and religious. In response, many grassroots resistance and reform movements sprang up and whose leaders were known as bandits, prophets or messiahs. These movements culminated in war with Rome in the late 60s and ended with the destruction of Jerusalem in 70 CE. Those who reached positions of power and wealth in the Empire became benefactors and patrons of others, dispensing protection, debt relief, and employment in exchange for allegiance. The Roman Emperor was chief patron in an elaborate scheme of interlocking dependencies and allegiances. At the very bottom of the scale were slaves.

There are a number of words that express the idea of servanthood in the NT but one of the most common is *doulos*, a word that often means slave. The Roman Empire was built on the back of slavery. Some estimate that one in five of the population of the Empire was a slave. Slaves (often conquered peoples) worked in households, mines, manufacturing facilities and big agricultural estates. According to contemporary historian Josephus, Roman warlords enslaved tens of thousands of Judeans and Galileans who then ended up in slave markets in Rome and elsewhere in the generations before, during, and after the life of Jesus, Paul, and their associates.

"Before we put up our hand to enrol as servant, let's really understand what it means. Being a servant is a position of powerlessness."

New Testament writers therefore wrote against the background of slavery, an institution so pervasive they did not think to question it. The book of Philemon is about a slave; in Acts 16 the key character is a slave-girl who appealed to Paul and Silas. Many of the parables are about the household *doulos* (the parable of the slave-manager, Luke 12:43-48; the parable of the banquet, Luke 14:16-24). Slavery was part of the air they breathed.

For Jesus, the *doulo*s became the main image of the incarnation. The book of Philippians contains an early hymn grafted by Paul into his letter on life in Christ: *"who . . .emptied himself, taking the form of a slave (doulos), being born in human likeness."* (Philippians 2:5-11). The exalted Jesus took the form of the lowest social being – a slave. This is not just about deportment, it was not just about acting humbly. Jesus became for all intents and purposes, a slave.

Jesus' use of this term in John 13:16, therefore, and his enactment of the role of a slave, must have been alarming to his hearers. Jesus washed feet in the middle of his last meal with the disciples and it was not just an exercise in good hygiene. Peter voiced the distress of others when he baulked at the idea of Jesus washing his feet. In Jesus hands, the washing became a picture of a deeper cleansing about to take place and as such, was a symbol of the impending crucifixion. In a recently subjected region like Judea and Galilee, crucifixion was a torturous execution reserved for the lowest – often for rebellious slaves. Jesus, the slave of all was about to undergo a violent death. Before he did, he wanted them to understand what was required of

continued over page

his followers. *"For I have set you an example, that you also should do as I have done to you…no slave is greater than his master".* (John 13:15)

Where are you in the story?
The fact is, most of us reading (as well the one writing) this article are people with considerable power and status. We are literate, well-educated, with professional skills that put us into positions of status and wealth in our society.

We think about servanthood as a kind of attitude that we can adopt as clothing that will somehow nullify the apparatus of power that most of us carry with us. We "put on" humility as an outer garment to cloak what lies beneath. There is scripture warrant for this: there is something in the idea that we "put on" Christ as clothing and that begins to shape the person within. Think of a graft of skin that gradually takes and heals what is underneath. This is a lovely process and not to be gainsaid. We are in fact re-shaped by the practices that we enact as we "put on" Christ.

But being a servant (read, *slave*) is a lot more challenging than our deportment as a Christian. It involves deliberately divesting ourselves of the apparatus of power and approaching our life and work from the position of slave. What might this mean? The New Testament has some interesting examples that deserve greater reflection. People with agency are pointed toward powerlessness. Nicodemus, a leader of the Jews, (John 3) was challenged to consider following Jesus through a return to the vulnerability of the new-born. People without status are consistently held up as models of a new way. Women, especially vulnerable, un-partnered women, are held up as models of faithful discipleship. The unnamed woman at the well, is the first in John's gospel to apprehend Jesus as messiah. She became a fruitful evangelist. When his disciples asked about greatness, Jesus placed a child before them and said: *"Truly, I tell you, unless you change and become like children, you will never enter the kingdom of heaven."* (Matthew 18:3)

Mother Teresa of Calcutta, India.

"Our servanthood must come from a deeper place than that of an enacted performance. It must come from a life transformed by an encounter with the crucified Christ."

Our servanthood must come from a deeper place than that of an enacted performance. It must come from a life transformed by an encounter with the crucified Christ.

Today's World
Of course, there are endless possibilities for self-deception. There are many ways that Christian servanthood can be corrupted. The annual church foot-washing ceremony can become an exercise in self-aggrandisement for leaders who rarely do other humble things. Politicians and prelates love photo-ops of themselves serving food or talking with the homeless. This is not service; this is self-promotion done under the pretence of doing something else. And we all know it.

Often the qualities of meekness, obedience and humility are taken on by women who become the unrecognised servants of everybody else. Their embodiment of these supreme Christian qualities however, does not often issue in opportunities for church leadership. Servanthood can become exploitation of those willing to do menial tasks, an aberration as common in the Christian home as in the church.

Those of us in positions of power may believe that the marginalised have little to say to us so we rarely hear from those who are refugees, the global poor, the sexual minorities. Part of our servanthood may be to open ourselves to these voices and begin to feel our hold on power tremble a little. Servanthood in many contexts will mean being prepared to usher the powerless into the centre of church and institutional life to hear what they have to say, to see what insight they can give into the life of service.

The best examples of service for God are often hard to see. They are rarely visible and do not draw attention to themselves. Look for them in people you know whose careers have not gone in straight paths toward lucrative, prestigious roles. Look for them in those who work with those at the bottom of the social pile. And look for them in places on earth where no one else wants to go. Slaves must go where they are bidden. ●

'God lives in PNG'

by Ben and Eleanor Reardon

Ben and Eleanor live in north-west Sydney. They serve at C3 Church Wahroonga campus. Ben works as a Resident at Gosford Hospital and has served the Oceania Region as the Junior Regional Representative for the past two years.

Our brothers Hermin and Erick with us in Port Moresby, PNG

Now a resident medical officer for NSW Health, I am serving as part of the International Christian Medical and Dental Association (ICMDA) team for Oceania. Together with ICMDA, and supported by HealthServe, my wife and I were able to visit our closest geographical neighbour, Papua New Guinea for ten days.

Our main goal in visiting was to support our close friends, Dr Erick Mange and Hermin Peamo, who are both based in Port Moresby. They were planning community health awareness talks in their home villages in the Southern Highlands, led by their on-campus Christian group. This was the second time they had organised such an event and had a group of twelve medical and pharmacy students. The community health awareness talks were all in the local language of *tok pisin* and included topics such as tuberculosis, HIV/AIDs, cardiovascular disease, type 2 diabetes, family planning, breast and cervical cancer, and the risks of smoking tobacco and chewing betel nut.

PNG is a small nation of 7 million, with a life expectancy of 62 years (and healthy life expectancy of 53 years). PNG suffers hugely from largely treatable diseases. PNG has a maternal mortality rate as high as 460 per 100,000 live births, and under-five mortality rate of 61 per 100,000.[1] Other leading causes of mortality in PNG include malaria, tuberculosis (TB) and multi-drug-resistant TBA and HIV/AIDs.[2] Although mortality rates for all of the above are declining, they are still well beyond that of Australia, New Zealand, or even that of Indonesia.[1] In 2000, it was estimated that there were only 5 physicians per 100,000 people, identifying it as one of 57 nations with a critical shortage of physician and healthcare workers.[3] Comparably, Australia has 286 physicians per 100,000 people. In one of the provinces of Ialibu we visited, there was no doctor employed by the local health service for 60,000 people.

Knowing these statistics before we left, we knew that there was tremendous need, and we had so little to offer in our short journey across Torres Strait. As we arrived in Port Moresby, we extended our hands to greet people, but were instead embraced by strangers like lost family. Instead of exchanging good-willed sentiments, we were invited over for meals as honoured guests. Instead of going to teach others about what we knew, we were taught so much. And instead of giving to others, they showered us with gifts. Throughout our time in Moresby and the highlands, we were honoured and so moved by the people and their generosity.

Papua New Guineans are beautiful people. Men and women are often seen holding hands with their same-sex friends and family, and almost always hug to greet each other. Mental illness (not associated with substance abuse) is not a large health burden in PNG. It is interesting to compare their strong community and family ties with our individualistic, and at times isolating, Western culture.

In the Southern Highlands people would often say to us, "God lives in PNG", as we were surrounded by a mountainous jungle, native banana trees and luscious gardens of tropical fruit. Both Elle and I have grown as a result of our trip. We were challenged to see beyond their cultural problems of tribal warfare and witchcraft to see that our enemy is not people, but the spiritual forces of evil (Ephesians 6:12). We were confronted to see the death of our own selfishness and to remove the log from our own eyes (Matthew 7:5). We were reminded almost constantly how much Jesus loves each of the people we met, all those we didn't meet, and that they matter in a value beyond measure (1 John 4:9-11).

Remember to pray for our brothers, Dr Erick Mange and Hermin Peamo, as they lead the medical students and junior doctor ministry within PNG. They have faced incredible trials throughout their studies, and are now to embark into a healthcare system that is severely under-funded, under-resourced and under-staffed. Pray that they would continue to be strong as ambassadors for Jesus, finding joy in their every interaction and resting in true peace that can only be found in Him. ●

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Volunteering

by John Whitehall

John graduated from Sydney University and trained as a paediatrician, then as a neonatologist, while maintaining an interest in overseas medicine and politics. To further his knowledge on philosophies, he undertook a BA in 'Social and Political Affairs'. He has been a member of Baptist churches since his youth.

Invited to write on volunteering has caused me philosophical pause. I wonder whether, in a thankfully long and varied career, I have ever 'volunteered' for services. Or did they seem so 'obligatory' that there was no question of consent? More to the point – was anything actually achieved? Almost all of the 'causes' I adopted have witnessed deterioration, rather than success. The only thing I can half-proclaim is the verse, "Thy service is sweeter than wine." Why half? Because I am no longer a drinker, and because, when I did imbibe socially, I always found wine sour, and never sweet. But I get the point.

I first volunteered in 1967 when I joined a refugee aid programme in South Vietnam one year after graduation. I knew nothing, and left with a sense of guilt that still persists. I was helpless and unhelpful, but gained a lasting conviction that 'ideas have consequences' and that 'as a man thinketh in his heart, so he is':

What was in the mind of the Vietcong cadre who detonated the bomb under the civilian bus that followed me and whose oily crater was still being filled in when I returned hours later?

I was to learn of the ideas of Marx and Lenin and the dangerous power of

utopian persuasion. I think that same persuasion can be discerned as an underlying idea in the present-day attempt by 'man to save mankind' through the ideology of sexual fluidity. It is man saying 'yes' to the three temptations Jesus rejected:

1. Man can live by bread alone – he is a material being unrelated to any Creator and, therefore, veterinary ethics are available for his salvation.

2. Man's saviours, alone but elected by history, have been high on a pinnacle and able to envision mankind's trajectory from imperfection to utopia.

3. Able to cast themselves off, men have demonstrated the conviction that they are more powerful than 'Nature', and should be recognised as such.

Why begin an article on volunteering with such philosophy? Because I believe the utopian concepts that underlie much of the suffering I have been involved with can be understood in the light of Jesus' experience. In a way, those concepts defined who He was, the nature of the creature He had come to seek and to save, and what means He would use. Much of the richness of any volunteering I have ever done has resided in perceiving something of the forces at work.

After Vietnam, I returned to Australia and learned a bit of useful medicine – some paediatrics and, more importantly, some anaesthetics – before volunteering to work in a mission and then a university hospital in southern Africa. Those were the days! How I loved being there! The drums and distant cooking fires at night. The mountains. The ability to contribute something (anaesthetics). The chance to learn (some surgery). The smell. The Bible studies at our house. The Fellowship with others. But, emerging through the joy of that clinical service was the ideology of utopia. I was reminded of the experiences of Vietnam when we were taking blood samples one night in order to explore the prevalence of the parasite that causes elephantiasis. We were driving on a narrow track through bush when we were stopped by soldiers who warned that 'terrorists' from across the border had been laying mines. Declared 'nationalists' at the time, the leadership later acknowledged the Leninist plan that would culminate in a classless society.

Some years later, after specialising in paediatrics in England and then Australia, I volunteered to help set up an aid programme in East Timor which was believed to be headed for turmoil. That was where I learned of despair. When I arrived in a fishing boat with magnate Kerry Packer, there were over 70 wounded lying in a filthy, abandoned hospital, slowly and painfully waiting to die. One of my first patients was a small boy with a gangrenous leg. It was light, but sounded heavy when it entered the bin.

Despair was 'writ large' when I took another team of volunteers, a year later, to Lebanon. There, I learned more of God by His apparent absence. Such cruelty. Such vanity. Such destruction. Such danger. After a month, one team member remarked 'we were no longer smiling' in each other's company. I learned that chronic fear is debilitating, and wondered at the martyred saints, past and present.

After Lebanon, I happened to listen to Elaine Nile on the radio as she condemned the child pornography that had invaded Australia. At that time, I was so ignorant I did not imagine that child pornography actually involved, and was not simply 'for', children. However, I supposed I ought to do something if it was as bad as she declared.

It was, indeed, that bad. This led to a great series of experiences with the Festival of Light as I 'volunteered' my paediatric point of view. I learned so much. One day, I attended a prayer meeting about the growth of pornography in the media. There were about twelve of us seated around a table and, as Paul described, none of us amounted to much in this world, but prayer was being uplifted to curb the power of the media. Downstairs was a centre that practiced primal birthing in which the 'patient' was encouraged to yell and scream in the attempt to resurrect and confront all the pain that had been experienced when being born. The shrieking reverberated through the windows and around the room and, looking around, I wondered if I were the only one hearing it, so concentrating were the saints. Then, a little old lady (doubtless younger than I am now), got up quietly, closed the window and returned to the devotions. The shrieking was muffled to an unthreatening murmur, leaving me wide-eyed at the revelation of what I considered a spiritual truth – the winds of hell not prevailing. I learned a great deal in my volunteering with the Festival of Light and I am very grateful for the opportunities of further observing various forces.

By this stage in the early 80's, a revolution was fomenting in the Philippines led by the Maoist Communist Party. It was barely reported in Australia, but evinced many of the concepts of Pol Pot in Cambodia – the need to obliterate so-called 'bourgeois' thinking by driving the population of Manila into the countryside, the need for executions.

Having gone out of my way to learn more of Marx and Lenin, I had developed a Christian critique by attending education sessions of Australian communist parties and taking on a BA in social and political theory. As a result, I could not deny the temptation to volunteer, and ended up spending months in the Philippines over the next few years – lecturing to growing audiences in universities, trade unions and churches with the help of defectors from the local Party.

It was an astonishing period of evangelism. The beliefs and practices of Marx and Lenin would be considered in light of their texts, as would the opposing concept of sin and salvation from the Bible. Presentations were in the form of lectures, "…Don't believe us, here are the references, look them up for yourselves…" but sometimes the effect was incredible. After one afternoon in a university (where executions had occurred and tension was palpable), the university chaplain continued on in Tagalog by way of closing the meeting. He asked for heads to be bowed in prayer. Then, throughout the crowded auditorium, hands began to be raised. When it was over, I asked what had been going on – of course, Ben had been inviting people to the Lord! Perhaps to give some idea of the tension, while Ben had been praying I had been rehearsing my escape route in the event of gunfire. Sadly, some of us bear Peter's streak!

Marx and Lenin and the attempt to force the Bible into its concepts, known as Liberation Theology, overwhelmed me and I volunteered to fight those ideas full time, leaving medicine for two difficult years. The problem was that I was too successful (joke!) – causing the Berlin wall to fall and international communism to fold within about a year of my taking them on! Thus, I had to return to medicine, though with the conviction that I owed it to all my patients to 'brush up'. I did this by enrolling as a registrar again, emerging almost three years later as a neonatologist.

Though somewhat chastened, volunteering was not forsaken as I offered to leave my job and house in Sydney to go to Townsville in order to try and resurrect its dying NICU. With the help of wonderful colleagues, the unit was persuaded to shed its shroud and allowed us fifteen great years of service.

When the Asian tsunami struck Sri Lanka, I was able to take extended leave and ended up teaching paediatrics to an organisation deemed to be 'terrorist' in its pursuit of independence. In the carnage that followed my time, countless thousands died, including at least 9 of my 32 students. It was, once again, based on the human intent to create a perfected society, this time by racial genocide in the name of Aryan descent and the lord Buddha. It was an ugly process. Did I achieve anything? The answer, with regard to medicine, must be 'No' – children treated medically were soon blown to bits by high explosives.

"I was exposed to the concepts and practices of ideologies, hatred, cruelty, suffering and disease and wondered how [God] could love this fallen world."

But my students had a graduation ceremony after our three months of teaching, and they invited me to address them, their parents and functionaries and leaders of the 'Liberation Tigers of Tamil Eelam'. Of course, I had to share the Good News or every cock would have crowed its head off between Jaffna and Jerusalem. There was such silence in the crowded auditorium as I spoke of the God of Peace and Love, that I was worried they were taking offence, especially being mostly Hindu and hardened by years of violence. The silence continued after I stopped and I had become a bit unnerved, when applause finally resounded for The Message they had heard. I was approached to deliver the 'very same' message at the dinner they were now going to organise on the very next night so they could hear it again. I drew some comfort from these extraordinary events when I learned of their bloody fate.

My final (so far?) volunteering was to

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Cross-Cultural Serving

People don't care how much you know, until they know how much you care!

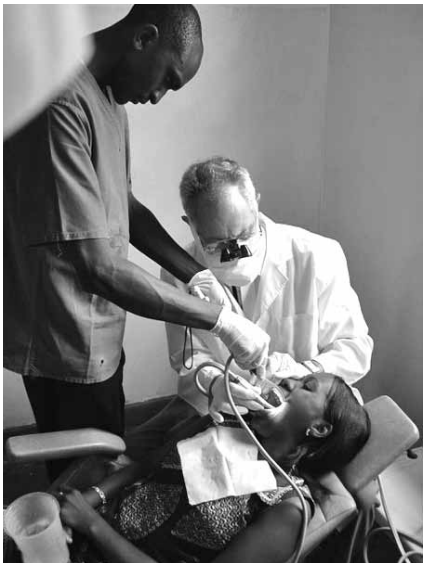
by John Yared

John is a general dentist, now retired from private practice but still working part-time at the University of Queensland. He has been married to Robyn for 40 years and has two adult sons and two grandsons. He plays tennis, touch football and golf, these days with more enthusiasm than skill.

My journey to the Democratic Republic of Congo (DRC) started figuratively, though not geographically, in Bangladesh. In 2000, Ross and Lorraine Dunn and I were invited to help a non-government organisation provide basic dental services to rural villages. From this initial trip to Bangladesh, there followed other short-term visits to the Philippines, back to Bangladesh and two trips to East Africa.

The work on these visits could be defined as "aid" rather than "development" since no training was done with local people, so services could not continue in our absence.

In 2006, a team comprised primarily from Gateway Baptist Church, was invited to the HEAL Africa hospital in Goma, DRC, to work there and help further the education of the staff. The founders of the hospital, Dr Jo Lusi (a Belgian-trained orthopedic surgeon) and his English wife, Lyn, realised the necessity of having medical personnel



from the west come to the DRC, as sending their doctors overseas for further training often resulted in an unwillingness to return when they had a taste of western lifestyle.

As there was no existing dental facility in the hospital, I performed some basic dental work with the help of my wife, Robyn, using a portable dental unit I brought from Australia. We were assigned a male nurse, Siva, as a translator and we found him to be organised and efficient, with the ability to think and plan ahead.

We approached the leadership of the hospital to seek their opinion as to whether they thought Siva would be a suitable candidate for further training in dentistry. They agreed and with the generosity of some Australian donors, Siva undertook a three-year course at the Makere University in the neighbouring country of Uganda. This qualified him as a "community dental officer", similar to a dental therapist in Australia. Another community dental officer, Lea, has also been employed at the hospital.

The dental clinic at the HEAL Africa hospital was started with a second-hand dental chair and unit from Queensland Health, which was transported in a shipping container. As is sometimes the case with donated goods, it was never fully functional, but the Congolese are used to adapting and making the best of what is available.

In 2015, we were fortunate to obtain a grant from a Brisbane philanthropic organisation which enabled the purchase of a new dental unit from Uganda. This has been operational since then and expanded the variety of treatment options.

The most common procedures performed in the clinic are extractions, removal of calculus (scaling) and some fillings. As is the case in other developing countries, there is a growing middle class, and it is hoped that their desire for more sophisticated treatment will then help subsidise the treatment of those too poor to pay anything at all.

Ongoing professional development is difficult in the Congolese environment since there is no local association of dentists. This is due, in part, to the culture of "knowledge is power" and hence, this knowledge is to be kept to one's self, not shared with others. Fellow professionals are therefore viewed as competitors, rather than colleagues.

Many lessons have been learned along the way, and are still being learned. We in the west have an inclination to want to "fix" things, and to achieve that aim as quickly and efficiently as possible. We need to realise that it is relationships and trust that are more important. As the old saying goes, "People don't care how much you know, until they know how much you care!"

Serving in a cross-cultural situation requires patience, since events often do not start or finish at the expected times. This gives rise to the expression: "Africans have time, Americans (and Australians) have watches". Flexibility, adaptability, a willingness to work in "less than ideal" circumstances, and cultural sensitivity are also beneficial.

"I have seen places that no tourists get to see, met incredible people and had experiences that have been enriching and life-changing."

The book *When Helping Hurts*[1] deals with a number of the issues encountered in cross-cultural mission. I would recommend it to anyone with an interest in this area of service.

The catalyst for my journey of service in developing countries was the realisation of the enormous blessing it is to have been born in a "first world" country like Australia, combined with the responsibility that comes to share our blessings with others less fortunate. As Jesus said in Luke 12:48 – "From everyone who has been given much, much will be demanded."

I have also found the words of Jesus when He said, "It is more blessed to give than to receive" [Acts 20:35] to be so true! I have seen places that no tourists get to see, met incredible people and had experiences that have been enriching and life-changing.

As I am in the twilight of my professional career, I am taking this opportunity to appeal for a general dentist who can take over my role as mentor to the dental practitioners in the HEAL Africa hospital in the DR Congo. This would involve a two to three week (largely self-funded) trip – preferably, but not necessarily, annually. You will be blessed as well as being a blessing to others. ●

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1. Corbett, S Fikkert, B *When Helping Hurts: How to Alleviate Poverty Without Hurting the Poor… And Yourself*, Moody Publishers 2009.

VOLUNTEERING – CONTINUED FROM PAGE 11

take on my current role at Western Sydney University as Professor of Paediatrics and Child Health, after many of my peers were retiring, and ranks had begun to thin from death and disease. It is work in progress.

This incomplete overview does not dwell on disappointments and hardships, of which there have been a few. It must read like an account of a pin-ball – bouncing here and there without hitting any jackpot on its way to the exit. I suppose I should be a bit embarrassed, as I withdraw from any suggestion my 'volunteering' might be a worthy template.

All I can say is that He promised Life and Life abundant, and that I have had. I can also say, "He lifted me from shades of night to plains of light. Oh praise His name, He lifted me."

From what was I lifted? From many things, including a routine medical practice in suburbia… though that is not quite fair because many suburban children were indeed sick and their families suffering. I was exposed to the concepts and practices of ideologies, hatred, cruelty, suffering and disease and wondered how He could love this fallen world. But I was also privileged to see something of that Love in His followers who were not ashamed or daunted, and believed in planting mustard seeds for His Kingdom. ●

Sara's Place

by Linda Smyth

I am a Christian married for 24 years, and we have two children. After our second child was born, I decided to go back to university and completed my law degree. I was in the field for a few years when we moved to Denmark. The time away created a break in my career and when we returned God had other plans for me. Every time I went for a job, I would get sick. So for almost three years I waited and in July 2014 I became the manager of the centre. This is a God appointment. I am not sure about retirement and will have to wait and see what is in store.

***Sara's Place* started as Pregnant Alternatives in 2012.**

We saw a great need for women to be supported during a crisis. Sara's Place provides much needed support, both emotional and practical, which fills a gap for women who are facing unplanned pregnancy in difficult circumstances. We also provide post-abortion support, which is difficult to access otherwise. Mental health care plans through a GP to a psychologist is the closest alternative provided, and this is often with a gap to pay. Sara's Place specifically caters for this particular kind of grief and loss and all services are offered at no cost to our clients, which is often crucial for women in need. Pregnancy can be a joyful time, but for some women it is not. We are the support system when women are facing pregnancy alone.

Our services are free to our clients as we rely on donations. We provide the following:

- Face to face consultation.
- Assistance with accommodation.
- Assistance with medical needs and expenses.
- Assistance and referral for legal issues.
- Provision of material goods for mother and baby.
- Post abortion consultation.

"Please take some time with every woman in this situation."

Our clients come from all areas of Sydney and metropolitan suburbs. We are available five days a week and often after hours for our clients.

The lack of support and assistance creates additional stress on these women whom we need to protect during this most vulnerable time.

Practical tips

I write the following as practical tips on what might be involved in a consultation when a woman presents unexpectedly pregnant:

- I want to encourage you, as the first responders, to be mindful that a woman may be facing this pregnancy alone. She might be in a domestic violence situation and/or she may be forced, or coerced, into an abortion. Often, people are telling her what to do, and what not to do, and do not ask her how she is feeling at that point in time.

- Please congratulate her. Many women have told me that no one has said 'Congratulations, you're pregnant!' No matter what her facial expression may be at the time, congratulate her.

- We have had some doctors giving our clients only two options. If the woman wants to keep the baby, she is given a blood test. If she does not want the child, a brochure for an abortion is provided. This is a somewhat simplistic outcome to what is a very complicated situation. Shocked people don't normally smile – they are processing the information. It may take a while before a smile is seen on a woman's face. This does not mean that they do not want the child.

- Please take some time with every woman in this situation. I know that

medical centres can get very busy, but you need to know that you may be the *only* person she speaks to about her pregnancy.

- If possible, perform an ultrasound so that she is able to hear the child's heartbeat. Often it feels unreal to a woman to find out that she is pregnant, especially if she does not have any symptoms of pregnancy. Hearing the heartbeat may enable her to fall in love with her child. It makes it more real.

- If a woman asks about abortion, please cover such topics as anxiety or depression.[1] Different research papers have said a variety of things on this topic.[2] Often stories are more helpful than statistics. If you have seen women after abortion and they haven't done well, perhaps alert other women to this fact if they are considering abortion.

- Have the woman do an STI test. Abortion clinics do not screen for this and only give antibiotics when the women leave after a termination. Please explain to them the dangers of spreading infection and future fertility complications.

- Sometimes it is helpful for the woman just to be able to hear herself think. Often people are talking at her, telling her what she should do, or telling her that she can just get on with her life, she doesn't need this right now. But no one is asking her about her own needs. Everyone is talking to her about choice, but if her only choice is an abortion, she is not getting a choice.

- The difficulty is that abortion can be seen as a quick fix – "you will go back to normal", "you won't feel anything", "life will be as it was before". This is not the case. Having an abortion does not make you un-pregnant. You are just no longer physically pregnant.

- The post-abortive women who come to our centre for help don't go back to normal. They do feel sad. They struggle and they are in pain. That is why it is so critical that when the woman is in your surgery you provide her with information and allow her to ask questions. Whether you do or don't have the time, please refer her to Sara's Place so that she knows there are people who will support her.

- If you see that there is something not quite right, please ask the woman for her complete reproductive history. Miscarriage and abortion may not appear on your file if she has not seen you about these issues. You can book an abortion online and there is no need for a referral. Is she sleeping, eating, working, studying as before? Does she have any nightmares? Is she drinking alcohol more than normal? Has she taken up smoking? Is she using recreational drugs, or has she been prescribed antidepressants?

"Let her know that there are people who can help, free of charge and who are there to walk with her. She is not alone."

- Coming to our centre and discussing post-abortion issues is easier for many women as they do not need to worry about our feelings. When women discuss this with family and friends, they have the additional burden of worrying about hurting them. One client advised that it was so helpful to talk to an unconnected third party as she didn't need to worry about how her abortion would make me feel, since we do not have a friendship. This is quite insightful and would be helpful for other women to know.

- Let her know that there are people who can help, free of charge and who are there to walk with her. She is not alone.

- Often clients wish that they had found our centre before they had an abortion. Therefore, we would encourage you to speak to your patients about our centre while they are still pregnant, since it is important for women to have as much information and resources as possible, in order to make the best decision for their health.

- If women go through with an abortion, they may not realise the distress of other situations that they may encounter. There are numerous triggers that may come their way, i.e. seeing a pregnant woman, a small child, their friends falling pregnant, the due date of the birth, and so on.

- Talk to her about her support networks. Often the shock of finding out that she is pregnant may lead her towards abortion because she feels that she doesn't have any support. Sometimes she thinks the male partner doesn't want the baby, but has not asked him. Some have not spoken to anyone or asked for help. It is important that she speak to as many friends and family members as she can. Many of our clients have been wrong. They *did* have support once they discussed their pregnancy with friends and family.

- Abortion is not discussed and this information is lacking. Women who have had an abortion generally don't discuss it with anyone. People don't really know what to do or say with women who have had an abortion. They can be very wary around them, and may watch what they say just in case they say the wrong thing. They may not talk to them at all. They may feel uncomfortable themselves.

- We encourage you to ask the woman if she has had previous abortions. Ask her how many weeks pregnant she was when she had her abortion. How did she do?

- Abortion has become a problem-solving tool – she might be trying to keep her boyfriend, partner, husband. But many couples don't survive abortion as it is always between them.[3] It is the elephant in the room and it takes up a lot of space.

- If a woman is trying to process and if people know, it can be awkward

continued over page

with others looking towards her, checking to see if she is alright. She may need to reflect to others regularly that today is either a good day or a bad day.

- Some women are strong and lay down the law and state they will not have the abortion. But even those that appear strong, you just never know. The testimony of my client below explains that she was considering abortion, yet when she came to see me, this was not the case. I did not feel that abortion was on her radar at all. I spoke with her many times and we spent hours having coffee. It just goes to show there is a lot that you may not know about a person. I was shocked when I read her testimony which she wrote for me and I read out on Rhema FM Central Coast.

"God doesn't give you more than you can handle. I am a firm believer in that.

Little did I know what exactly was in store for me. January 2015, I was celebrating the new year by returning to my adopted home with butterflies in my heart. I had found a place in the world and subsequently, a person. We met on my first go round in Australia and I was looking forward to what was in store for us.

Fast forward several weeks. When I returned, I was not expecting at any point to be pregnant, scared, and very much alone... but I was. Yes, I had family and friends close by, but the one person I thought I needed was not interested in being there with me, or for me. I found myself asking the question, do I, or don't I?

As every girl does, I went to some friends who, as I knew, would respect any decision I made regarding the pregnancy.

I called one clinic… no answer. Another... number not in service. And yet another – and again, no answer. I found myself thinking, "What are the odds?" At that point I said, "Well, God doesn't give you more than you can handle – I guess I can handle this." In a moment of doubt, I took to Google one more time. I found Sara's Place. I called and spoke to Linda, who made me feel like there was hope. Everything was arranged so I could see a doctor and make sure everything was going alright. I had many, many, many moments where I was in doubt... every time I had doubts as to whether I could be a single mum, my question was answered in one way or another.

First, not being able to find or get in touch with a clinic. Then finding Sara's place. Next, finding my due date was my best friend's birthday who had passed away several years earlier. Every day, I was given more hope... more faith in myself.

Fast forward to the present. I have a beautiful baby boy that I thank God for every day. No, being a single mum isn't easy. I am met with restless days and nights as I am working and taking care of bub. But ask me if it's worth it? Yes... a thousand times, yes. He is my joy.

I want to encourage you to encourage them. You can be a positive influence in their lives." ●

***Information about Sara's Place can be found at http://sarasplace.org.au/ Donations can be made through the website and are tax-deductible.**

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3. Inadequate Preabortion Counseling and Decision Conflict as Predictors of Subsequent Relationship Difficulties and Psychological Stress in Men and Women, Catherine T. Coyle, Priscilla K. Coleman, Vincent M. Rue, http://tmt.sagepub.com/content/16/1/16.abstract.

Also see the list of Crisis Pregnancy Centres around Australia on p39 of *Luke's Journal* "Life Before Birth", September 2016

REFLECTIONS ON HEALTHY SERVICE – FROM PAGE 17

I have many times been challenged to consider whether I am "being a Mary or a Martha". Although this challenge is well meaning, I actually think it is creating a false dichotomy. The truth is, it is possible to work hard all day and yet also keep our focus on Jesus. We don't have to **choose** between "being a Mary or a Martha" – Brother Lawrence's highly influential book, *The Practice of the Presence of God*, epitomises this. Colossians 3:23 exhorts us to keep Christ at the core of all we do – "Whatever you do, work at it with all your heart, as working for the Lord, not for human masters."

What we need to guard against is getting so caught up in the service that we forget Whom we are serving.

In ancient times, most religions taught that humans were created to serve the gods. They taught that the gods got tired of doing what needed to be done to keep the earth going, so they created humans as a race of servants (or even slaves) to do their bidding. The Jewish story of creation is in stark contrast to this: humans were created out of God's love, to be loved, and to be co-creators in the world – God's visible representation to the rest of creation. The original creation mandate does not describe us as servants. Quite to the contrary, we are given rulership and authority and blessing (Gen 1: 28-30). I have needed to wrestle with this, to guard against an almost default understanding whereby I view myself as a hard-working servant rather than the Biblical picture of a much-loved daughter.

The words that challenged me as a student have been a constant, gentle reminder throughout my life, helping me to focus on what I am truly called to as a Christian. Not the life of a servant, but that of a serving child of God, compelled by His love and empowered by His Spirit. ●

Reflections on Healthy Service

by Dr Natasha Yates

Tash has been a CMDFA member since her intern year, and has found the fellowship, education and support of CMDFA invaluable. She works part time as a GP and as an academic at Bond University on the Gold Coast. She is the mother of four energetic children and is married to David. They fellowship at Newlife Uniting Church.

Do you really love me?
*Do you **really** love me?*
I know that you will serve me,
*but do you **love** me?*

The above lines hit me like icy water on my face. It took a while to even register their power, and once I did, they literally changed my life. They were spoken at the ICMDA student world congress 1998, where I was attending as a medical student.

The student years are generally where we set our life trajectories. It is rare for people to make major changes in what they value and pursue once they have graduated. I was well aware of this when I was a student, and I had determined that I would value serving the Lord as pre-eminent. Thankfully, I had heard and responded to the gospel of Grace, and I knew that the only way my life made sense was for me to die to myself and live for Christ (Colossians 3:3-4). I was trying hard to live in total surrender and service to Jesus, which is why I was at that conference in the first place. That is why the rebuke in those words was such a humbling and unexpected shock. And like a hit of icy water, it took a while for my brain to register what it meant – in fact over the months and years since, I have reflected on these words again and again.

Do you really love me?
Jesus asked Peter this question in John 21:15-18, and I imagine Peter was just as offended by the words as I was. Jesus knows everything about us, including what we have sacrificed in order to follow him, so to be asked if we love him is to have our deepest motives questioned. However, the sobering truth is that we can spend our whole lives serving others, even serving God, and still not really love Him.

"A life lived primarily to serve, rather than primarily to love, is one that is destined to burn out."

An atheist friend at University challenged me about my supposed altruism: "Even if you work as a doctor for nothing, and give up everything to serve others, you are still getting some secondary gain. At the very least you are feeling good about your sacrifice. There is no such thing as a truly selfless act." He went on to talk about the importance of altruism for the survival of humanity as a whole, combatting my argument that Christian sacrifice flies against a traditional Darwinian "survival of the fittest" belief system.

I felt (and still feel) frustrated by perspectives that assume the non-existence of God, and therefore find other ways to explain Goodness. However I also see them as helpful – they strip away the 'Christian' gloss that we can paint over our deeds, and force us to see them for what they really are. For example, as I have faced career choices over the years, I have been tempted to choose the "more selfless" options because I am a Christian and that's what Christian service is supposed to look like. Right?

However a life lived in sacrificial service is not necessarily a life lived in love. In fact, a life lived primarily to serve, rather than primarily to love, is one that is destined to burn out.

One of the Bible stories that has always challenged me about service is found in Luke 10:38-42. Mary and Martha both loved Jesus, and this story is about Him visiting their home. Martha did what I would do in this situation: she rushed to prepare food and drink to serve their visitor (and maybe, if she really was like me, she also raced around putting away kids' toys and dirty cups and clothes strewn on the floor…!). I completely empathise with Martha, and feel that her asking Jesus to tell Mary to come and help her is a perfectly reasonable request. Jesus' reply seems unrealistic – how can he tell Martha that Mary has chosen 'the good portion'? Cups of tea don't get made by themselves! Mary's decision to just sit and listen to Jesus, apart from being culturally scandalous, seems downright lazy. If we all stopped serving and spent our time reading the Bible, praying, and fellowshipping, who would be left to do the work?

Martha is quite right in recognising that work is needed. However, the crucial issue here is not what each of them is DOING, it is where their FOCUS is. In verse 40, we are told Martha is distracted by all that needs to be done. Jesus then says to her: "You are worried and upset about many things, but few things are needed – or indeed only one." (NIV). He is not rebuking her acts of service, he is pointing out that her attention is divided. She is focusing on all the things she is doing, not on the Person she is doing them for.

continued on page 16

Have You been to India?

by James Wei

Dr James Wei is a country GP in Myrtleford, Victoria. Email: emailjameswei@gmail.com

Have you been to India?
If not, you will simply have to find the time.
There is no place like it on earth.
Trust me.

Have you heard of widows throwing themselves into fires after the death of their husbands? India is where this still happens, to this very day. Acid attacks and petrol burns are also all too commonplace in domestic disputes.

In fact, one of our Community Based Health Project (CBHP)[1] volunteers has burns over the left side of her face and body. Lifelong scars from her ex-husband. She is now free, and spends her time sharing her story of healing and redemption with other oppressed women.

Have you heard of babies being killed simply because of their gender? India is where this happens, to this very day.

In fact, in 2010, the very year CBHP commenced operations in the villages of Buldhana, rural India, one of our village health workers killed her own child by suffocating her with smoke under a straw basket. She now saves other female children destined to die from the moment of their birth.

Have you been to India?
If not, you will simply have to find the time.
There is no place like it on earth.
Trust me.

Have you heard of widows so desperate that they would consider prostituting themselves so that they could feed their own children? India is where this happens, to this very day.

In fact, in 2013, the year CBHP ran a sewing programme for village women, the village chief refused to let his widows leave their homes, saying that it is 'their culture, their custom'. Nevertheless, the persistence of our local team paid off. With some reluctance he allowed twenty of his widows to attend the sewing programme. Today, these widows have not only been able to feed their children, but also send them to school. Now they are able to hold their heads up high because they can shape their destiny. More importantly, this very village chief has since come up to Moses[2] to say "thank you for doing this for our widows".

Have you heard of entire communities of people destined to a life of oppression and poverty simply because of their last name?

You guessed it. India.

While this is the current destiny of many, it is being reversed, one family at a time. Moses Kharat and his family are testament to this. Because of the work of missionaries who pitched their tents under a tree in a village called Manubai one hundred years ago, the Kharat family is no longer defined as being 'untouchable'. They are now children of the Most High God.

Do you want to be part of something incredible?

Do you want to witness the transformation of entire communities?

Maya has taken initiative to set up sewing and beautician training classes in her very own home. She lives with her parents because of an abusive husband.

Come, join us in the CBHP story.

CBHP is not about foreign missionaries going into a resource-poor setting to make a difference. It is not even about low-cost clinics, mobile health teams and health workers. It is not about sewing classes, or schools.

Rather, it is about local people reaching their own communities. People who have proved their zeal, commitment, and sacrifice through decades of service to their own people. People

with a vision for change, with patience and foresight to invest in generations to see it come to pass. It is about foreign aliens recognising that they are powerless to change anything in another culture that speaks, thinks and behaves in a completely different way from them. It is about understanding that it takes three to five years simply to gain trust with communities, before one is able to have any influence in anything meaningful. It is about friendships that transcend culture, gender and demographics.

Do you want to know what it is like to journey in friendship with people who have made amazing sacrifices, of a magnitude that we can only begin to imagine?

What friendships do I speak of?

CBHP started not from a board room, nor a conference, but rather the Intensive Care Unit (ICU) of the Buldhana General Hospital. Varsha[3], an ICU nurse, would come across patients from every caste and creed. In time, these grateful patients would invite her back to their villages, and from there, a friendship is borne.

Varsha's brother, Moses, ceases his 'desert wanderings' and eventually finds his way back to his people

Eyes for the poor – Ram the optometry trainee who has provided low cost eyes (AUD 3 per pair) to over 200 people in his town and surrounding area in a 60km radius.

"More villages need to hear the good news, and experience freedom from the curse of their birth or gender."

in Buldhana, where he spent his childhood. That was 2010. A year later, I reconnected with Moses again in my final year of medicine after a two year hiatus. True to form, Moses, has plowed his life savings into starting CBHP – a Community Based Health Project, with Village Health Workers (VWHs) as the primary agent of change in their villages, supported by Mobile Health Teams (MHTs) and a low-cost clinic. He has some support from his family – even his mother, who cashes in her wedding gold to the tune of AUD 800 to sustain some of the community projects.

I asked Moses how long the operation could be sustained on his savings alone. He replied, "six months". His plan when the money dries up was to head to Assam in North India and work for several months for a well-resourced mission hospital which would pay him the equivalent of AUD 1,000 a month. When he had saved up enough, he would then return to Buldhana to start all over again.

This was how CBHP Australia was born – to support the work of a local doctor and his family, and to enable them to multiply their impact across as many villages in the district of Buldhana as possible.

Although significant milestones have been achieved in the seven-year history of CBHP, we are only getting started! More villages need to hear the good news, and experience freedom from the curse of their birth or gender. They need to hear that they are loved, and have a future that has been uniquely designed by their Creator.

Would you like to be our friend? ●

I met Moses for the first time in Jamkhed, rural India at the internationally recognised training centre in community health (CRHP Jamkhed – http://jamkhed.org

Although our friendship has spanned over seven years, this is only the second photo we have had together! This was taken at the VHW training centre in Buldhana, which doubles up as a guesthouse.

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1 The Community Based Health Project https://www.cbhp.org.au/
2 Dr Moses Kharat is the founding director of CBHP India
3 Varsha Rayarum is the co-founder of CBHP India and younger sister of Moses

Bringing Spirituality into Clinical Practice

by Peter Ravenscroft

Peter Ravenscroft AM, MD, FRACP,FFPMANZCA,FAChPM is Professor of Palliative Care at the University of Newcastle. His main role now is teaching medical students in the palliative care programme. He is a former Chairman of CMDFA (Qld), of CMDFA (Australia) and of the International Christian Medical & Dental Association.

For the Christian health practitioner, "spirituality" usually means "Christian spirituality", but in this article, I want to focus on generic spirituality as a domain equivalent to the physical, social and psychological parameters of illness.

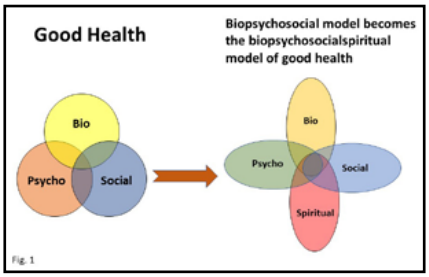
This article relates to those with chronic illness or terminal illness, who do not have a co-existing psychological illness. I am not suggesting that other presentations do not have spiritual issues, I believe they do. Many of the principles mentioned in this article would apply to those cases.

Spirituality is a generic term that covers many concepts outside biopsychosocial parameters. Although spiritual issues have been considered by health practitioners since ancient times, in modern times they were highlighted by Cecily Saunders, who started the modern hospice movement. She included spirituality as a component of "total care" that she aimed to provide to those in a hospice setting.[1] Viktor Frankl, after his experience of suffering during World War II, wrote, "man is even ready to suffer, on the condition, to be sure, that his suffering has a meaning".[2] That is an affirmation that spiritual values are critical to our wellbeing.

A study of our patients in Mercy Hospice, in Newcastle, revealed that about 30% of those patients being admitted to a hospice acknowledged that emotional suffering, not physical suffering, was the major reason for their admission.[3] The status of spiritual care has been recently reviewed by Kelly and Morrison[4] and positive outcomes for quality of life have been shown using spiritual support for patients with advanced cancer.[5]

Definition

I support a model of health care which includes spirituality. (Figure 1, below).



There are numerous definitions of spirituality. I have chosen two:

Allan Kellehear[6] defines spirituality as three groups of needs:

- **Situational needs**, including needs for purpose, hope, meaning, affirmation, mutuality, connectedness and social presence;
- **Moral and biographical needs**, including need for peace and reconciliation, reunion with others, prayer, moral and social analysis, forgiveness and closure;
- **Religious needs**, including need for religious reconciliation, divine forgiveness and support, religious rites/sacraments, visits by clergy, religious literature, discussion about God, eschatology, or eternal life and hope.

An individual's needs may spread across these groups. We also need to consider and manage those who are not religious by considering their needs as well. Those who are not religious often have a spirituality that is not focused on a supernatural being or doctrine, but they share many of the situational and moral issues listed above.

A second definition focuses on relationships as key to spirituality. The definition can be expressed thus:

Spirituality consists of relationships:

- to self (self-worth, dignity, meaning and purpose, guilt and shame),
- to significant others (love for family and friends, loneliness, reconciliation, gratitude, being remembered),
- with the community (status, dignity),
- with places and things (that represent precious values or give special pleasure),
- with transcendence or what is beyond this physical life (faith in God, anger towards or perceived abandonment by God, being remembered and leaving memorials).

When we consider these definitions, we can see that most people, if not all, have elements of spirituality in their lives, even though they might deny calling it, "spirituality".

If it seems that the patient does not like the label, "spiritual", I think it is better for the clinician not to use "spiritual" in conversations with the patient, but note the distress in whichever category it enters the conversation.

Spiritual distress

Spiritual distress is the distress that comes from unresolved spiritual issues. It is sometimes not recognised by the patient or the clinician as a specific area of stress. Patients may deny its presence if the word, "spiritual" is used, at least initially. The symptoms of spiritual distress (Table 1) may seem like those resulting from psychological issues, but most patients we care for do not have psychological pathology, but are reacting to the stress that is a normal part of dying. I think it is a mistake to use psychoactive drugs in spiritually distressed patients (at least initially), unless there are strong reasons to do so.

Table 1 – Typical questions suggesting spiritual distress

- Why is this happening to me?
- Why are my beliefs being challenged?
- What hope do I have?
- What will happen after death?
- Am I being punished?
- What is my value or self-worth?
- How can I transcend this suffering?

What do I do when a patient asks me, "What are your spiritual beliefs?"

Medical students have told me that one of their major concerns when talking about spirituality to patients is that of the patient asking them, "Do you believe there is a God?" How do we answer? My advice is to consider this situation very carefully.

In my experience, a patient who is terminally ill is generally unlikely to ask a recent graduate what they believe in, whereas it is more likely if the health professional is a more mature and empathetic person who has a good relationship with the patient. If a patient asks early in the relationship, it is more likely to come from their spiritual distress than genuine curiosity. A good question to ask yourself is, "Do I know this patient really well or not?" Explore with the patient why they are asking these questions of you. Most of the time they are rhetorical questions arising from their own distress, or coming from a need for deeper communication. Be sure that you are answering the patient's questions and not putting forward your own views of spirituality in the first instance.

Christian, or other religious witnessing, is often done out of concern for the patient's spiritual well-being, or out of responsibility to spread the gospel. Junior staff and students are generally not in a good position to do this, whereas a GP or specialist who knows the patient well may be. We need to remember that attempts at evangelisation when the patient is near death are complicated by the beliefs of family members or other staff. Also, the patient may listen to you, not out of interest in your spirituality, but out of respect, or to maintain your attention at a time of crisis.

It is a good rule for the health professional to respond to the patient's enquiries about spirituality and not lead the conversation. The advantage of having taken a spiritual history is that it may give a clue as to where the spiritual distress may lie. Ethics involved in the doctor-patient relationship suggest we should not use the power differential

continued over page

in the relationship between the practitioner and the patient to influence the patient at a time when they are vulnerable. If the distress is coming from religious concerns, e.g. are they being punished by God, it is important that a representative of the person's religion be involved.

Medical students often ask me about how they should engage with spiritually distressed patients when their time is limited by heavy commitments. I suggest that they listen empathetically to the patient for as long as possible, then explain to the patient that they will bring it to the notice of the team or talk to the practitioner in charge. Some issues run very deep and consultants may need to assist the patient.

The process of dealing with spirituality in practice

Start with a Spiritual History

Whether you are working in a solo practice or as part of a team, it is important to document spirituality as part of the history. This allows us not to have to ask the same questions repeatedly and allows your colleagues to refer to your notes as care for the patient continues. There are several formats you can use. I use the HOPE questionnaire[7], but other approaches are available in Puchalski and Ferrell's excellent book on spirituality:[8]

H Sources of **h**ope, strength, comfort, meaning, peace, love and connection e.g. How do I gain hope and comfort during my illness?

O The role of **o**rganised religion for the patient e.g. Does public worship have a place in your or your family's way of life?

P **P**ersonal spirituality and practices e.g. Are spiritual beliefs or practices part of your personal life?

E **E**ffects on medical care and end-of-life decisions e.g. Would your personal beliefs affect your health care choices at times of major threat to your life or at the end of life?

I have found it best to use these types of questions at the beginning of the consultation as part of the general health assessment together with the other questions on health status. Spiritual distress often becomes more evident as the disease progresses or as the patient comes to know the practitioner better over time.

"Empathetic listening and interacting is a skill that every student and trainee should aim to develop."

Develop a way of introducing spirituality into conversations

In other situations, the health care professional may want to lead into spiritual issues by introducing the topic like this,

> *We are aware that many people in your situation have spiritual or religious beliefs that influence their understanding of their illness and their preferred management. It would be helpful if you would tell me about any beliefs or practices that you may have, that we might keep in mind as we plan your care.*

If the patient responds affirmatively, follow up questions can be used to elicit further information. If the patient responds negatively, move on to the next topic, but bear in mind they may want to approach the topic later.[9]

The challenge of bad news

Considering how people react to bad news, such as a terminal diagnosis, is helpful in thinking about how to make meaningful responses. (Fig 2, below)

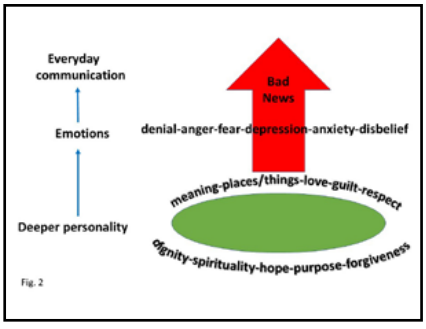


Fig. 2

Normally, everyday communication does not challenge our deeper values or emotions.

Emotions are a reaction to inner turmoil. The turmoil may be expressed directly (I am angry or anxious about the future) or indirectly (the care is poor, the food is dreadful, the bed is uncomfortable). Explore these emotions; they may be signs of a deeper disturbance.

Bad news, and reflection on it, is often the trigger for deep personal disturbance. Troubling thoughts about hope, meaning, guilt, or relationships with family members occurring during a review of life may break through as emotions or intrude into conversations of everyday life. Empathetic listening and assessment skills will allow a clinician to detect emotions expressed or unexpressed during the conversation. Empathetic listening and interacting is a skill that every student and trainee should aim to develop. It needs a lot of practice to be good at it, but is worth the effort.

Acknowledging these emotions and deeper issues is the first step in assisting the patient to process them. Expect that it will take some time and several conversations for the patient to understand the different relationships, expectations and changes in body image that life with a terminal illness can bring. I think that many patients, given the time and help they need, do a pretty good job of dealing with their changed circumstances and their forthcoming death. Family have an important role in this and bringing the family members together, helping them share the issues, can be pivotal in assisting the patient.

At the bedside or in the clinic

Review how the patient is progressing before you begin a clinical conversation with them. Information from the team meeting is particularly relevant where the allied health professions and nursing staff provide different aspects of the patient's progress.

I have found the concept of the "distance" between the clinician and the

patient very useful. I advise students and others to estimate the distance between them and the patient. Characteristically, a "long distance" is when the clinician stands at the foot of the bed, consults the chart, sets the agenda and leads the conversation focused on the medical condition and makes for the door at the earliest opportunity. A "short distance" is when the clinician first sits down by the patient, starts by asking open-ended questions and listens empathetically to the patient's story. This demeanour indicates that the clinician is interested in the patient as a person and will give them the time that they need to tell their story. Patients intuitively know the differences in these approaches. If the clinician indicates that their priorities lie elsewhere, patients will seldom inform them of their spiritual distress.

If the patient cannot express their distress

Some patients are unable to express their spiritual distress, either because they cannot find the words or are too sick. This is the time when just being with the patient, particularly if they are alone, is so important. Arrange to do this yourself or arrange for a staff member or family member to be there. If you talk about the patient always remember they may be able to hear you even though they cannot reply. Being with a patient at this phase of their life can help not only the patient, but also help the practitioner to appreciate the mystery of the final days of life. I have found that many doctors have not had this experience. They have missed a lot.

"Being with a patient at this phase of their life can help not only the patient, but also help the practitioner to appreciate the mystery of the final days of life."

Some suggestions if a practitioner or student wants to implement the process of spiritual care

1. Inform yourself well about the patient's progress before you see each patient and include items of spirituality.

2. Assess the "distance" you are from the patient during the interview. Make adjustments according to the patient's needs.

3. Open yourself to connectedness with the patient. If the context is appropriate, admit you too are a spiritual person and that you share some of their concerns. Remember Carl Rogers said that an improvement in outcomes depended on three attributes of the therapist, genuineness, accurate empathy and unconditional positive regard for the person.[10]

4. Familiarise yourself with the "Hope" questions or ones like them, so that you can introduce them seamlessly during the routine questions at the beginning of the consultation or into the conversation as it proceeds.

5. If spiritual issues become evident and you do not have the time to deal with these issues, tell the patient when you will be back to talk to them again or what your plan is to help deal with their concerns.

6. Remember that being present, listening to their story and acknowledging their distress can go a long way to helping people to process their distress.

Conclusion

For some Christians, this process outlined above may seem indirect, but having a methodology for all patients will help you get to know the spiritual issues for all your patients. If you are genuinely interested in the patient and empathetic to their spiritual distress, it is amazing what opportunities become available to share your spirituality within the ethics of the doctor-patient relationship. ●

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About Health, Poverty and Justice... in DR Congo

by Neil Wetzig

Neil is a General Surgeon and Emeritus Senior Surgeon, Princess Alexandra Hospital, Brisbane. Since 2006 he has led multi-disciplinary medical teams to the HEAL Africa Hospital (HAH) in Goma, DR Congo. He now lives and works up to 6 months per year in Congo with his wife, Gwen. HAH has appointed him Consultant and Advisor of Surgical Training Programs. He remains a member of the RACS Global Health Committee, an RACS Examiner and Permanent Council Member of the G4 Alliance for Surgery, Obstetrics, Trauma and Anaesthesia Care. He is a long-term member of CMDFA and Gateway Baptist Church, Brisbane.

"When we operate on someone we are operating on the image of God because we are all made in the image of God"... **As a surgeon, that phrase stunned me when I first heard it spoken on a cold July morning in Brisbane in 2002.**

I was attending a breakfast to hear a Congolese orthopaedic surgeon, Dr Jo Lusi, speak about his hospital in Goma, eastern Democratic Republic of Congo. I did not want to attend that breakfast because I was busy and had a particularly heavy week in my Brisbane general surgical practice, but God urged my wife, Gwen, and me to be there. Little did I know then, that I would be living in Goma and working in a 'volunteer' capacity as a surgeon at what is now known as HEAL Africa Hospital (HAH) for at least half of each year. I can assuredly say that this has only occurred because God heard Jo Lusi's faith and cries for help to train Congolese doctors and I happened to be part of God's plan.

The challenge that Dr Jo issued at that initial breakfast was that he wanted to train young doctors to serve the vast war-torn country of DR Congo, but if they travelled out of the country to receive training they often did not return. *"Would anyone come and help train them?"* was the other thing I heard that morning.

After I conducted an initial 'scoping visit' in 2003, the first multi-disciplinary medical team, mostly from Brisbane, visited HAH in 2006 and teams have continued to teach and train on an annual basis. Our ethos has been to only take those who have skills to train in areas of medicine that are deemed necessary by HAH. The journey we embarked on has been led by God – and has resulted in:

1. the establishment of a not-for-profit charity, 'AusHEAL'
2. support from the medical industry with gifts in kind
3. holding an annual fundraising dinner which has resulted in the provision of much needed funds to:
   a. purchase equipment for HAH, and
   b. provide scholarships to train or support at least 5 additional specialists,
4. supporting over 50 team members visiting HAH.

We have also had great support from our home church, Gateway Baptist Church, Mackenzie, in Brisbane.

But why Congo and why HEAL Africa?

Apart from the invitation from Dr Jo Lusi, when I researched Congo I found that the UN rates countries by the 'Human Development Index'. This index takes into account health, living standards and education. Congo was poorly rated – in 2015 DRC was rated 186 of 187 countries (Australia was number 2). War and continued political unrest created great needs.

"...when there is nothing and no-one else to depend on, one realises that God loves his people, He stands against injustice and He wants to use His people to do something about the many injustices in this world."

A core of Christians inspired by Jo and his British wife, Lyn, who held an unswerving faith, cried out to God for help to deal with the many injustices in DRC. Jo and Lyn set about providing what they simply called 'holistic care' – to not only deal with the many medical issues they encountered, but also with the social and spiritual issues that were rampant in this largely animistic country. While it may not be regarded as 'unreached', it had largely been deserted by missionary activities due to the insecurity. It was in great need of help, development and discipleship.

Dr Neil Wetzig instructing trainees.

DRC still has the world's highest incidence of 'sexual violence used as a weapon of war' and even in this past year (2016) there were 393 victim presentations to HAH alone. Dr Jo Lusi, in his role as a Senator in the interim DRC Government, was instrumental in having rape outlawed and the dignity of women and children recognised in the Congolese Constitution in 2006.

The hospital now has 197 beds, 14 specialists, 13 other doctors (many of whom are training), 82 nurses, 14 paramedical staff and 15 in administration. 42% of staff are female. Consultations at the hospital rose from 22,576 in 2015 to 27,443 in 2016 – though there were an additional 17,244 consultations for preventative measures such as HIV follow-up and nutritional care. 5,102 operations were performed by HEAL Africa staff in Goma in 2016 and 1,828 pregnancies delivered with no cases of maternal mortality for patients treated within HAH. The hospital now conducts outreach surgery through DRC and 719 cases were performed in 2015 rising to 825 in 2016: 28% for orthopaedic procedures, 53% for gynaecology (mostly fistula and prolapse repairs) and 18% for general surgery, many being for cleft lip and/or palate repair.

The community development projects conducted by HAH include supporting women who are victims of sexual violence, microfinancing and importantly the 'Nehemiah Committees' established in villages - drawing together community members to advise on recovery of whole communities from war and other turmoil. These Nehemiah committees are exceptional.

This was part of the realisation Gwen and I went through to come to the point of me finishing my surgical practice in Brisbane in early 2015 to spend more time teaching, training and offering consultant support at HAH. Once we took that step however God opened up a series of meetings and networking opportunities that have led to the development of a training programme in basic, essential and emergency surgery at HAH in conjunction with the College of Surgeons of East Central and Southern Africa (COSECSA). The aim is to train Congolese doctors in-country at HAH, thereby meeting the original challenge from Dr Jo in Brisbane on that first morning in 2002. This also runs alongside a realisation by the international surgical community to deal with the huge unmet surgical needs in low and middle income countries.

It is astounding to realise that in 2017, it is estimated that 5 billion of the over-7 billion people on this planet do not have access to safe and affordable surgical, anaesthetic and obstetric care when needed. Despite the poorest 30% of the world's population living in Sub-Saharan Africa (SSA) and India, only 3.5% of the world's surgery is conducted in those areas, with only 12% of the world's surgical workforce active in those areas. These are issues of injustice. And God is concerned about injustice!

"...in 2017, it is estimated that 5 billion of the over-7 billion people on this planet do not have access to safe and affordable surgical, anaesthetic and obstetric care when needed."

While these statistics are remarkable, even more so is the faith shown by key HEAL Africa staff. In particular, Dr Jo persevered despite severe adversity, including the death of his beloved Lyn from a malignancy in 2012. At HAH it is a regular event to see key people put their faith in God. They know that He hears their cries and that He will sometimes do the miraculous, but sometimes use ordinary people to meet their many and varied great needs. I believe we in Australia (and the developed world in general) have become far too self-sufficient and sometimes do not see the need for God. But when there is nothing and no-one else to depend on, one realises that God loves his people, He stands against injustice and He wants to use His people to do something about the many injustices in this world.

On a side-note: Recently, in April 2017, I had the opportunity to travel to Kampala, Uganda, to conduct Basic Surgical Skills Training and a Trauma Course at the ICMDA Institute of Health Sciences (Jonglei). I spent a week with 18 South Sudanese who are being trained for three years as Clinical Officers. If they pass their exams, in August they will return to their

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war-torn and famine-ravaged country. South Sudan has now become one of the epicentres of poverty in SSA. There I found young men and women (many of whom have been raised in Internally Displaced Persons camps and have seen large numbers of their family members killed) keen to learn medical skills and provide medical assistance to their country. As I talked with them I found that the issues are not dissimilar to DR Congo. Drs Anil and Shalini Cherian have given up lucrative positions in India to be called to lead this training programme. Despite limited and dwindling funding support, they persevere with this training which is effective, as evident by the questions their trainees asked. I believe this programme too is God's response to the huge unmet surgical needs in SSA.

Returning to Congo, we are constantly challenged and inspired by the resilience of the Congolese people. At HAH we regularly see people praising God despite adversity. We also know that while we can perform surgery and literally be God's hands – it is God, after all, who provides the healing. Equally, we also regularly see patients recover from surgery with few, if any, side effects. This is astounding when the potential for complications or side-effects is high. At HAH, each operation commences, not only with the WHO Safe Surgery 'Time Out', but also with prayer. And oftentimes God answers that prayer.

"We also regularly see patients recover from surgery with few, if any, side effects. This is astounding when the potential for complications or side-effects is high. At HAH, each operation commences... with prayer."

We and our teams do much preparation regarding Congolese culture and we are still learning about that. We want to be good witnesses for God but in a culturally sensitive way.

The local culture, as in many parts of the developing world, would see a patient preferring to see a 'traditional healer'. That healer may provide some sort of remedy or potion which is professed to be healing in nature, but often results in terrible consequences or at the very least late presentations for medical care. Much of that traditional healing (though certainly not all) is founded in evil spirits, with satanic origins common in animistic societies. The provision of good quality, conventional medical care, in the name of Jesus, goes a long way toward providing an effective witness and countering some of the traditional beliefs. Even HAH staff are sometimes pressurised by family to attend the traditional healer before going to the hospital.

The older I become, the more convinced I am that God wants us to spend time with Him in personal relationship and hear His heart for the poor. If we accept that Jesus Christ died for us and His spirit is in us, we can step out in confidence that He is with us and in us – whether called to work and teach in Africa, or to maintain our medical practices in Australia.

Gwen and I are constantly reminded to live out our 'life together verse'... *'Trust in the Lord with all your heart. Lean not on your own understanding... In all your ways acknowledge Him... and He shall direct your paths.'* (Prov 3:5-6) ●

AusHEAL

If you would like to know more about AusHEAL or the Congo Project, proceed to the link below or contact Neil Wetzig at neilwetzig@ausheal.org

Website: www.ausheal.org.au

The Intermed Family: a 'healthy' venture in training for Christian health professionals

A recently completed, but yet to be published, research project conducted by a post-graduate medical student at Flinders University in South Australia, assessed the impact of the Intermed international health and development short-course in preparing health professionals for cross cultural health and development work.[1]

The study noted the need to ensure future health professionals develop the necessary competencies for an increasingly globalised health-scape.

Over 20 years ago Professor Anthony Radford developed and established the Intermed summer school, building on the success of a medical student elective in international health and development. Since that time, over 1000 health professionals from all continents, except the Antarctic, have participated in some form of this course, with over 300 having completed the Intermed summer school held at Tabor College of Higher Education, Adelaide, South Australia.

The course is unique in Australasia, and possibly in the world, in combining principles and practices of community development, public health and clinical care, based on a biblical understanding of health and development and Christian values, and delivered during a summer intensive by a team of highly qualified and experienced presenters, most of whom follow Christ.

The research was conducted through an online survey of health professionals who had done the Intermed program in recent years, followed by telephone interviews with a sub-set of the respondents. The results were remarkable, with high proportions of the students agreeing that the course:

- developed knowledge of health care in less-resourced communities;
- facilitated critical reflection on personal and professional challenges;
- improved communication and problem-solving skills; and
- contributed to the ability to manage a range of health issues in these less-resourced settings.

Almost all the respondents agreed that the course provided practical preparation for cross-cultural health and development work.

Tabor College of Higher Education

Once this research has been published, we can share more details of the survey responses and interviews with *Luke's Journal* readers.

Over a period of some years, and negotiating at least two significant bureaucratic changes in higher education requirements, the core elements of the Intermed program gained full tertiary accreditation in 2014 as core subjects in a Graduate Certificate and Graduate Diploma in International Health and Development offered in partnership between Intermed and Tabor College of Higher Education. Students can now enrol to do the program for audit (as many have in the past) or for credit towards these qualifications. This move towards offering the option of a fully accredited program was in response to global pressures, where health professionals working for Christian organisations in an increasing number of less-resourced contexts were being required to have higher-level qualifications to gain visas and approval for their work.

The current core course consists of an online Foundations subject which can be done over one semester, followed by the two-week intensive in January with a focus on public health and clinical care. Completion of an existing Tabor subject on Poverty and Community Development (online or on campus) will gain those doing the course for credit the Graduate Certificate. Website links for more details on the course are provided below.

While the original Intermed program and the Tabor International Health and Development program follow good adult education principles and practices in having sound learning outcomes, there are other outcomes which we feel are even more valuable. The experience of being together, students from a rich variety of health professional backgrounds and cross-cultural experiences, and lecturers who have lived-out their faith in many diverse, and often adverse, circumstances, has provided a wonderful opportunity for fellowship and personal spiritual growth. Many friendships formed during this "intense" intensive remain strong, many years after the educational experience. The networking among students and staff has opened doors of opportunity for medical mission.

We like to refer to the Intermed "family" – those who have done the program as participants, those who have presented during the summer school, those who have offered accommodation for interstate and international participants, and others who support the program in many ways. There will be some reading this article who are part of this family, as *Luke's Journal* and the Christian Medical and Dental Fellowship of Australia have been strong supporters of the program since its inception. Our prayer is that others reading this article might sense God's call on their lives to expand and enhance their knowledge and skills in cross-cultural ministry by joining the Intermed family. ●

More information: Tabor College of Higher Education: http://tabor.edu.au/home/study-with-us/postgraduate-studies, Intermed: www.intermed.org.au

Reference:

1. The research was conducted by Angus Miller, with primary supervision from Dr Sneha Kirubakaran and additional supervision from Professor Anthony Radford and Dr Douglas Shaw. The research is being prepared for publication in an appropriate journal.

Providing Healing and Training in Rwanda

by Tim Walker

Tim Walker has just moved back to Australia with his wife Catherine and 3 primary age children. He has spent six years working as a missionary doctor in Butare, Rwanda, with CMS Australia. He grew up in Melbourne and did most of his postgraduate training in Geelong – starting out in internal medicine and then specialising in gastroenterology. Prior to working overseas with CMS, he spent a year studying tropical medicine with James Cook University in Townsville, a year studying theology at Reformed Theological College in Geelong, and six months doing cross-cultural mission training at St Andrew's Hall in Melbourne.

Our first year living in Rwanda was one of the most overwhelming times of my life.

We had two small infants, were living in one room in an African guesthouse, and were trying to study language half-time, whilst I worked clinically at the university hospital in Butare. We had no idea how to navigate society, shop or the politics of government and hospital bureaucracies, and few local expatriates to draw on for advice. Both my wife and I were thoroughly exhausted by 3pm every day – a seemingly endless wave of fatigue and stress threatened to overwhelm us.

I vividly remember standing at the end of many patient beds, lost in thought – trying to work out what was wrong with this person, how I might be able to prove the diagnosis, how the under-resourced health system might help them if my diagnosis was right, and then whether the patient would be able to afford the treatment. I felt totally out of my depth, and as if all my knowledge and skills were useless in the face of so many unknowns.

Even so, we knew that God had called us to work in Rwanda. If there's one thing the Bible teaches us time and again, it's that He's prepared to use flawed and imperfect people as tools for His work in the world. Our reliance on Him in those early months was very clear and, in some ways, very liberating. My experience has been that I'm much better at relying on God when it's clear to me that I can't manage things in my own strength. Probably I just need to get better at realising how often that is!

Over time, my cultural, linguistic and medical competence grew and I began to look for where I could contribute in the hospital setting. God had clearly called us to Rwanda some seven years earlier, and had laid on my heart to be involved in the establishment of postgraduate training pathways for physicians there. In 2005, there had been no such postgraduate training available, meaning that new graduates were always looking for training opportunities outside the country. By 2011, there were twelve postgraduates in training (four at our hospital) and about twenty medical specialists working across the country, serving a population of eleven million.
I started in a small way – running weekly teaching tutorials for medical students and postgraduates attached to the department, and refining the morning handover into a more education-focussed meeting.

"Providing medical care to suffering people in Africa [is like] swimming in the Pacific Ocean: you'd better know your own limits, because there is no way you will reach the other side."

This lack of specialists meant that a key challenge throughout our time in Rwanda was trying to balance the never-ending need for patient care against time spent planning and delivering training to create a well-trained future workforce. Allocating my limited supply of energy between these was a constant challenge. I often liken providing medical care to suffering people in Africa to swimming in the Pacific Ocean: you'd better know your own limits, because there is no way you will reach the other side. Knowing when to turn around and head for shore is a key part of surviving such a context.

A second key issue was to work out why God had me here. When faced with so much premature death (our wards had an average age of about 35 years and a 15-20% mortality rate), what could I provide as a Christian

doctor that was distinctive? In thinking this through, I found the passages from Isaiah that speak about God's kingdom (eg Isaiah 35:5-6, 61: 1-3), inaugurated in Jesus (Luke 4:16-21), very helpful. When we, as Christians, provide healing and comfort to God's world, we witness to Christ's kingdom that is present, yet incomplete until His return. Although we cannot heal all ills or end suffering and death, our expressed love can be prophetic of God's kingdom and point to the world's need for Jesus. From this viewpoint, Christian healthcare is not utilitarian: it is our loving care of the people who are the most marginalised and helpless, and for whom we can do the least, that is likely to be the most prophetic of God's kingdom. Our weakness points to the need for His saving strength.

Dr Tim Walker in Rwanda: "We, as Christians, provide healing and comfort to God's world."

Amazingly, during our second year in Rwanda, major United States donors agreed to divert $100 million of funding into Rwandan medical education efforts.[1] Suddenly there were many willing and experienced teachers available to Rwanda, and the political desire to rapidly increase the numbers of doctors and specialists in training. The following year, I was approached by my Rwandan colleagues in the University of Rwanda to become the Academic Head of Internal Medicine, responsible for all undergraduate and postgraduate training in internal medicine for the country. This was a massive task for a 35 year-old Australian with limited academic experience. Once again, the learning curve was steep, but God graciously provided wise and supportive local colleagues who kept me from wandering too far astray.

This latter season in Rwanda was a very fruitful one – the number of medical students in training doubled and the postgraduates in training increased five-fold. Restructuring the department, designing curricula, opening new training sites and revamping our assessment processes consumed much of my time and energy. Although the temptation was to continue in this role indefinitely, my growing health troubles and the toll taken on our family by this busyness were God's way of encouraging me to think about transitioning to train a local Head of Department, with my role based more around providing support and advice to him. After handing over the role to him in late 2015, we moved back to Australia in mid-2016.

Looking back now upon our years in Rwanda, I am struck by a few things:

Firstly, that God's vision for Christian medical education in Rwanda, and what part I could play in it, was far bigger than my own. He knew when we should arrive there and what preparation our family needed, even as Catherine and I chafed against the apparent delays and roadblocks in getting our mission started. None of our training time proved to be wasted, and His timing for our arrival was perfect.

Secondly, and not unrelatedly, I am struck by my own pride and arrogance in the face of the maker of the universe.

> *Of course*, God knows best.
>
> *Of course*, I had (and have) no idea what I was doing.
>
> *Of course*, I need to rely on His strength and not my own.

And yet, my human mind wants to flatter itself that it can fit the world inside it, comprehend it and control it. My human heart wants to claim some of the reflected glory from God's work for itself. Travelling and working cross-culturally is, in many ways, a profoundly humbling experience – yet this has not been enough to put to death my sinful pride and self-reliance. If, as CS Lewis says, "It is Pride which has been the chief cause of misery in every nation and every family since the world began,"[2] perhaps this is not surprising. However, I do think it is instructive. Maybe I am projecting my sins onto others, but I believe that the greatest battle we have as highly-trained, socially respected medical professionals is to be faithful to the Gospel against our own pride. Hospitals, both here and in other places, tend to be places of hierarchy and preening self-importance. As Christians, we need to swim against this tide.

Finally, work in Africa has convicted me of my tendency to value task over relationship. Most Rwandans are far less productivity-focussed than most Australians, and I learnt so much about my own blind spots from watching their consistent prioritisation of relationships. Jesus summed up the law as, "Love God, and love your neighbour," (Matthew 22:36-40,

continued page 32.

Service and Recognition: The Yotkom Project

by Dr Andrew Wright

Andrew studied a Graduate Diploma in Theology at Brisbane School of Theology in the mid-90s to become more grounded in his faith. His wife Anne also audited subjects at the college. Andrew and Anne have been instrumental in establishing medical/dental support services and training at Kitgum in North Uganda.

Yotkom medical team with Dr Andrew Wright.

In 2001 Dr Andrew Wright and his wife Anne went on a short term medical mission to Africa and encountered the community of Kitgum, Northern Uganda.

Over the last 16 years they have had the privilege of being part of this community and helping to address the needs of the poor and sick through health service provision. Ultimately this led to the formation of a project called **Yotkom Uganda** in 2008.

Yotkom seeks to partner together to improve access and excellence in Primary Health care in Northern Uganda. The organisation is focused on building relationships, resources and self-reliance.

Andrew and Anne describe themselves as part time, self-funded, cross-cultural medical mission workers who spend up to six months per year working alongside 30 Ugandan health workers and support staff at the Yotkom Medical Centre. This centre sees approximately 300 patients per week and provides a range of diagnostic and therapeutic services.

On January 26th 2017 the Brisbane couple were surprised and humbled to receive the honour of becoming Members of the Order of Australia (AM):

"for service given to the health and wellbeing of the Acholi people of Northern Uganda."

Service and Recognition

In this article we look back and reflect on the issues of Service and Recognition as they relate to our Christian calling and mission in Uganda.

Where we find ourselves now has been an evolving process over years and has involved much preparation and prayer. Going to Uganda helped us find a place where we could participate with God in bringing healing and hope to a group of people in need.

We have gradually overcome some of our fears, taken bigger faith steps and seen God answer sometimes audacious prayers and confirm His faithfulness to our acts of obedience. We have increasingly learnt the importance of working in the context of community.

Our Yotkom project also started out very small and nebulous but has now in the last two years undergone a growth spurt.

Much of our work in Uganda has been done quietly in the background on a small scale but now we find ourselves in a season where the work is coming out into the light and we recently received recognition in the shape of an Australia Day Honours Award (AM). This took us by surprise and we asked ourselves, what is the best way of handling this?

The "Kingdom of God" principle seems to be one of undertaking activities in secrecy, or doing our work as far as possible out of the spot light.

This was Jesus' advice to his disciples:

"Watch out! Don't do your good deeds publicly, to be admired by

others, for you will lose the reward from your Father in heaven. Matthew 6:1 (NLT)

Motivation for service is a response to the love and grace of God shown to us, so, public acclaim is not necessary. Rather we seek that final personal affirmation of Jesus:

"well done good and faithful servant" (Matthew 25:21)

We have no expectation of recognition or reward in this life because our treasures are being stored up in heaven. The one we seek to please in secret, is our Father – to bring Him pleasure by offering ourselves to Him completely. We also desire that our God-given talents be used wisely.

It is our prayer that the Holy Spirit within us will produce love and compassion for others (especially the poor) and motivate or impel us to action in order to meet their needs.

Also, the model of leadership we see in Jesus is one of humility whereby we use our gifting, power, position and authority for the benefit of others and not ourselves.

We are thankful and realise that with the blessing of resources comes responsibility and an expectation from God that we will be diligent and be good stewards.

The surprise and delight of being awarded an order of Australia compelled us to think about how we should respond to the inevitable public attention it would draw to our work.

We decided first and foremost, that this was a God-given opportunity.

Five key aspects

Firstly this is an opportunity to give God praise for miraculous acts, answered prayers and fulfilled promises.

The success of the work is a reflection of who is behind it. Others potentially see beyond us to the character and beauty of God and His power.

In the same way, let your light shine before others, that they may see your good deeds and glorify your Father in heaven. Matthew 5:16 (NIV)

Construction on the Yotkom Medical Centre.

Witnessing the truth that God can do over and above, more than we could ever ask or imagine, has built our faith and also bolstered the faith of others who partner with us or are watching us.

"The Church can also be seen in a positive light for its part in action to address social injustice, heal the sick and help the poor in our world."

It also reassures us to know He can work with broken vessels.

But we have this treasure in jars of clay to show that this all-surpassing power is from God and not from us. 2 Corinthians 4:7 (NIV)

Secondly, recognition is an opportunity to shine a bright light on the Church and the Yotkom team. The public honour given to us, is actually a shared one.

The impact on life and health of the Acholi people comes as a result of a community of believers, partners , supporters and donors, participating together and giving sacrificially. We would like them all to be encouraged and affirmed by this formal recognition.

The Church can also be seen in a positive light for its part in action to address social injustice, heal the sick and help the poor in our world.

Our church in Brisbane, Gateway Baptist has certainly played a vital part in our ministry. Blessings have come through our home group, pastors, prayer teams and through generous, sacrificial, personal and corporate financial giving.

We also share the celebration and recognition with our African team leaders and workers. Thirty people (doctors, nurses, chaplains and administrative staff) work in difficult conditions to create a place of hope and healing for their suffering community.

We also recognise and give thanks for the fact that Australians are kind and generous and are making a difference in the world through projects like ours.

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All these groups of people have encouraged us and given us the spiritual physical and financial resources we needed to achieve our vision. We want them all to be part of this celebration.

Thirdly, recognition for acts of service done in secret can give us a boost. God can use these times to build up our confidence and give us renewed capacity to go on the long haul.

Lots of events conspire to discourage, so when we are encouraged by worldly recognition we should gain energy, build passion and be confident to trust God more, take bigger faith steps, claim His promises and dream bigger. This event has given us confidence that we are moving forward on the right track.

Words of affirmation from others have the capacity to turbocharge us.

Fourthly, this is an opportunity to learn appropriate ways to accept praise and kind words and thank others for their encouragement. We must find ways of responding without becoming embarrassed, self-conscious or succumbing to words of self-depreciation. We should not deny that something significant has been achieved and that our God-given talents and our willingness to obey and persevere have been important ingredients in achieving success. It is a time to receive something from others.

Lastly, but most especially, we have found that personal public honour and recognition presents a significant opportunity for us to advocate on behalf of the poor community we serve – to develop to a greater level our roles as ambassadors. It has opened doors to speak and share at venues otherwise closed to us. It may widen our support base and will provide legitimacy to our cause. The rigorous process undertaken to successfully receive these awards gives us a higher level of credibility and accountability in the public arena.

The word of God urges us to take this opportunity to speak out.

"Speak up for those who cannot speak for themselves; ensure justice for those being crushed."
Proverbs 31:8 (NLT):

There is a time for everything under the sun. We will endeavor to make use of this time of public awareness and make the most of all these opportunities. We recognise this time in the light will pass and we will continue to be involved in ongoing secret service in Uganda.

"Personal public honour and recognition presents a significant opportunity for us to advocate on behalf of the poor community we serve."

The source of our power and passion will be Jesus and it is Him we seek to continue to serve.

The challenge for us is to continue to take obedient faith steps and trust, persevere, endure and never give up. We want to keep pursuing God, being filled with the Holy Spirit, grow in spiritual disciplines and finish well. ●

Providing Healing and Training in Rwanda challenge – from page 29

paraphrase), yet in subtle ways, my desire for productivity can get in the way of my commitment to loving others. Ultimately, the value of my time in Rwanda can be measured in terms of the people I met, meals spent together, words spoken in love and a deeper desire for God, rather than in terms of hospital and university productivity metrics, programs and systems created. If our witness is to a loving God who dwelt on Earth amongst us, our love for others and for Him needs to be central to our being. In an increasingly busy and disconnected Western world, this is a huge challenge to us all. ●

References:
1. Binagwaho A, Kyamanywa P, Farmer PE et al. The Human Resources for Health program in Rwanda – a new partnership. *New England Journal of Medicine*. 2013 Nov 21; 369(21):2054-9.
2. C.S. Lewis, *Mere Christianity* (New York: Simon & Schuster Touchstone edition, 1996), 109, 111.

Tim Walker with a group of postgraduate medical students.

Healthy Service

From One on One to One to Many

by John Hagidimitriou

Dr John Hagidimitriou is a current board member of CMDFA and works as an assistant surgeon in Brisbane. He has served across various other non-profit boards. He has a background in medicine and has qualifications across Business and Finance together with being a Graduate Member of the Australian Institute of Company Directors.

Service is one of the words that comes to mind when thinking about what we do in our careers as a Christian Doctor or Christian Dentist.

Who are we serving though?

- Our patients – by ensuring we provide healthcare to the best of our ability and to the highest level quality.
- Our practice or work environment – health care is no longer something that's seen as a profession practiced by a solo practitioner, but rather one that we work together with colleagues and staff to provide. However, in undertaking multi-practitioner care, we also serve those we work with.
- Our communities – whether this is the local community or city, or larger geographical areas.
- Or is it those in faraway places that we may never meet - yet can impact with the work we do, the words we say or by being involved in roles that may not provide direct care to them, but can impact their lives as a one-off event or in an ongoing way.

For me it's been a mix of all four, but for the purposes of this article I'm going to focus on the final two.

My professional journey has taken me from working across hospitals as a junior doctor, to community-based general practice in various towns and cities, later studying an MBA and gaining other business and finance qualifications and now back in the hospital system working as an assistant surgeon. I have also spent time assessing projects that will provide healthcare or other services via an overseas projects subcommittee of an aid organisation. For the last couple of years I have sat in a voluntary capacity across several boards.

This role of sitting on boards provides the opportunity to provide direction and strategy for an organisation – the governance role. Usually, there would be separation of this role from administration, which is implementing what has been decided by the board. However, in smaller organisations, the board is not only responsible for oversight, but also provides input into how decisions are to be implemented, (administration). This means that in smaller organisations (such as CMDFA) there is the opportunity to be more intimately involved in some of the management-type decisions.

For those who wish to join boards it is an interesting calling.

I'm currently in my second term on the National Board of the Christian Medical and Dental Fellowship of Australia. Although a small organisation in terms of financial resources, it has massive influence. Firstly, we connect with large numbers of students and graduates. Then there are thousands of people that each of the members will interact with – both clinically and in other capacities over the course of their careers. There is also the unique opportunity that Christian healthcare professionals have in understanding many ethical issues that others in our society may not appreciate, and so may not be able to be involved in or speak into. Over the years there have been various issues that come up – abortion, euthanasia, and recently changes to marriage and gender identity.

There are also other less widely known areas:

1. Artificial Intelligence – with advancing technology and significant progress in artificial intelligence and as robots become more common and are found in many homes, at what point (if any) should they be granted the rights of personhood?
2. Resource Allocation – such as when intensive care beds are limited in the setting of major epidemics (eg. Zika Virus and Guillain Barre Syndrome complications) which leads to massive demand. How do we determine who gets the ICU bed and who does not, therefore dying without this resource?

At what point do we have the push from hospital administrators that it's more cost-effective to use euthanasia as a means of cost-saving rather than treating or palliating someone (consider Canada – where this is being discussed in the literature)? Where is the concept – first do no harm?

Although not all of us can be an expert at each of the issues, it is crucial that we speak into these situations. Although we are all busy in many areas of our lives, it is vital that we move beyond thinking of just ourselves and our own situation, and move our thinking outwards. After all, we have a responsibility to "speak up for those that cannot speak for themselves" (Proverbs 31:8-9) and "defend the rights of the unborn" Oftentimes, we think we are doing so much in all the various areas of our life. Yet, in most situations we interact one-on-one, or one-with-a-few. However, in terms of impact, perhaps we should be considering how to put ourselves into situations where we can impact many.

When looking for positions where we can influence people, how do we stay

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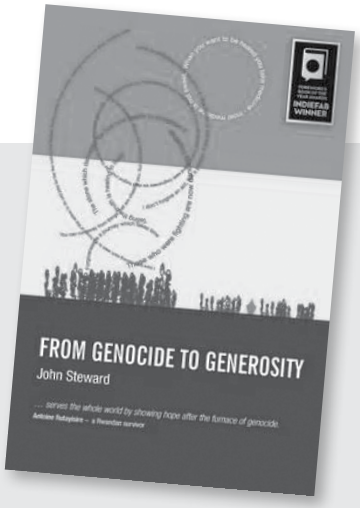
Forgiveness and Reconciliation in Rwanda

by John Steward

Towards the end of the Second World War my father stood outside his tent at the Army Hospital 16 miles from Port Moresby (Papua New Guinea) and reflected on his reading from Matthew 25.

John Steward. Photo: Lyndon Miechelsen



As a medical orderly he had stood in the mud and supported medical teams feverishly, working through the wounded and tending the dying in the evening darkness. As he looked up to the stars he found his heart moved to make a promise: if this ends and I return home safely, I would like to train as a doctor and go to one of these war-ravaged countries and help in their recovery.

Before many months dad was repatriated to Australia with malaria, malaise and mild depression. He was given treatment and discharged in early 1945 with a recommendation that he study medicine. I was born on the morning of his first year Physics exam.

Dad completed his MBBS and after a year of gaining experience, took his family of four children to East Java (Indonesia) where he became a civil servant and was responsible for the health care of a million people.

Those three years on Java as a boy were the best time of my life, where every afternoon dressed only in shorts I would run around the village, with all the other boys. There I saw my parents care of body, soul and spirit. There I saw faith integrated with everyday life and survival. I trembled at the demons and thrived on the reality of Christian testimony, faith, hope and love, in practice.

Years later I returned to Java as an adult, and also spent time working in Cambodia and Rwanda. Altogether I have lived overseas for 16 years of my life – in agriculture, community development, biblical reflection, mission and peacebuilding. Only now, as I write this, do I realise that dad gave far more than he bargained for when he promised God he would return something good in service as recompense for the destruction of war.

Twenty years ago, in Rwanda, I began to see individuals make great progress in improving relationships and so I wrote a book about these stories of hope and healing. Since publication in 2015, it's been inspiring to meet people who have been challenged by reading the book *From Genocide to Generosity* (Langham UK). They shared with me how their relationships with family members and business partners have begun to change and heal.

Today my life's work is about using these stories in *From Genocide to Generosity* with as many as possible, so people everywhere can find peace in their lives through the healing of relationships. This is work that complements the medical side of human health. In fact, healing of inner pain through traumatic events and restoring of relationships through repentance, confession and apology are leading to better health in some Rwandans. This is in contrast to the depression, sadness, mental stress, marriage breakdown and interpersonal friction which comes about through suppressed emotions and unwillingness to forgive.

On another occasion I will explain some of the details of how we worked to see amazing changes in some Rwandans. Right now I have a specific focus – raising funds to create a free, on-line study guide to help readers find personal value and possible change from the stories in the book. This will be for a general audience.

In June I began writing the scripts for each study; we began filming in July and the study guide should be available by early 2018. It's an exciting time. As of 9 June 30, 2017 we completed 40 days of crowd funding and received almost $5,500. We are $1,000 short of what we need over the next few months, for the videoing and trialling.

At time of printing full crowd-funding goal has been reached.
www.2live4give.org
FB: https://www.facebook.com/Genocide2Generosity/
Twitter: @FmGen2Gen ●

up-to-date in terms of what is going on in the world? For me, it is about communication and the need to be informed. I make sure to cover various perspectives when I learn about current events by using Google News. As a news aggregator, it offers news from a wide range of publications across multiple countries and has the advantage of being able to present a particular news event from multiple perspectives. I also attend various non-medical conferences and read widely beyond just medical journals.

Even more important is the need to stay connected with other Christians, especially our colleagues, through various CMDFA events – both local and national. When we can't connect with our colleagues via events we can connect with them over the internet, via Facebook, LinkedIn and Twitter.

One thing I've found useful has been to read the Twitter Feed of CMF Nederland @CMF_NL . As you may be aware the Netherlands is where euthanasia has been legalised. However, there has been a push to move beyond just making it available for the terminally ill. To be informed of what is going on I suggest you follow them.

Having read this article, I encourage you to consider carefully whether you may be called to serve in leadership roles in the future. Although you may initially be unsure as to whether you should or shouldn't take on these roles, seek out older colleagues, perhaps a mentor, have conversations and accept their advice, especially if they say to you, "Go for it – you will serve well." ●

Seeking Volunteer Editors

Luke's Journal is seeking committed Christians to help:

- Editing Christian medical articles for our 3-4 monthly publication
- Expanding the journal to a web-based platform

Contact Catherine Hollier at:
LukesJournalCMDFA@gmail.com

Healthy Service: Preventing Burn Out

by Peter Janetzki

Peter is a psychotherapist and educator and is the principal of a counselling practice in Wellington Point Queensland. He has been a sessional lecturer for more than 20 years in the School of Social Sciences at Christian Heritage College, Brisbane and hosted Talking Life, a life issues talk back radio program on Brisbane's 96five for sixteen and half years.

Over the past two and a half decades I have sat with numerous professionals from our health care sector, as well as people helpers, and those in ministry.

Time and time again they are sitting in front of me because of a life crisis that has tipped them into adrenal fatigue and burn out. And all of them are not only committed to their job, but also see it as a calling in which they make a difference to the lives of others. I know for certain that many of them have told others to take care of themselves and yet as Cummins et al (2007) says, "Like doctors, however, counsellors often are remiss in taking their own advice about wellness." It is certainly easier for us as professional helpers to dish out recommendations and advice that we do not put into practice ourselves. In the words of Julius Sumner Miller, "Why is this so?"

Mental Wellness?

Before I attempt to give some answers to this question let me take a few steps backwards.

A couple of years ago I had the privilege to attend a two day seminar with Dan Siegel, clinical professor of psychiatry

at the UCLA School of Medicine and Executive Director of the Mindsight Institute. Right at the start of his presentation Dan asked us to define what Mental Wellness was. It was obvious that of the couple of hundred of us attending that we didn't have a clear and succinct definition. Dan Siegel then went on to talk about how those of us working in the mental health field are really good at defining mental un-wellness and terrible at defining mental wellness.

So what does mental wellness look like? After listening to Dan Siegel for those two days and pondering his thoughts as well as the thoughts of many others since. I believe mental wellness is that space in our lives where we experience a sense of balance and harmony. The space in which the ebbs and flows of life are integrated into our being and we function really well in all aspects of our lives. The picture that I have is of the huge Morton Bay Fig trees at Wellington Point, near where I live. These massive trees are solidly anchored into the ground and even though they get blown around by the storms of life they don't fall over, and when some branches and leaves are knocked off and the cold of winter blows, spring provides the opportunity for new growth.

This space of wellness, according to Siegel, is wedged between the two extremes of un-wellness; rigidity and chaos. When we start to experience our lives becoming out of control it results in a sense of chaos in which we lose stability. And/or alternatively some of us bunker down into rigidity to regain a sense of control at the expense of our flexibility. Hitting the sweet spot of mental wellness and maintaining it is a constant process and begins with understanding what I need to do daily, weekly, quarterly and yearly to keep myself deeply rooted into solid ground.

A Story of Mental Un-wellness

One of my favourite stories of mental un-wellness starts in 1 Kings 18:1-40 with the prophet Elijah taking on 450 prophets of Baal and 400 prophets of Asherah on Mt Carmel. As the story goes Elijah took on these false prophets in a duel and they lost. Imagine the scene, Elijah is ready to go with his sacrifice to the living God and to prove his point he drenches it with water three times. Then he prays, "Lord prove yourself today" and boom God lights up the sacrifice with fire and all the water on the ground as well as the sacrifice are absorbed by the flames!

The people were convinced that the living God of Abraham, Isaac and Israel was indeed the true God so they killed the 850 false prophets. Imagine the impact of this event! And yet at this amazing point of Elijah's service in

which he witnessed the spectacular intervention of God, he spirals into exhaustion and depression (check out 1 Kings 19:1-5). I find it interesting that all it took to flip Elijah out of the sweet spot of wellness was the complaints and threats of one person, Jezebel, which resulted in him sitting under a tree contemplating suicide. In my own life and in the lives of those who I have sat with in the counselling room who are not traveling well, who have been faithful servants, sometimes all it has taken to push them over the edge is one person who has complained or made some kind of threat. The finish of the story is just beautiful as God responded to Elijah in gentleness, care and support.

"Healthy service, is based upon healthy stewardship which is founded on a healthy Christ-centred identity."

Unlike Elijah we have a growing body of research on personal and professional wellness that we can draw on. For example *Lifestyle and Mental Health,* an article that I recommend you read, is a meta-analysis of the research into lifestyle factors for mental wellness by Roger Walsh of Irvine College of Medicine at the University of California. Walsh (2011) identifies eight lifestyle factors which are critical to our mental wellbeing; Exercise, Nutrition and Diet, Nature, Relationships, Recreation and Enjoyable Activities, Relaxation and Stress Management, Religious and Spiritual Involvement, and Contribution and Service. And yet in spite of all the research many of us in the helping professions don't take our own advice.

"Why Is This So?"

Back to my earlier question, "Why is this so?" For me it is all about our foundations, the tree roots that anchor us and give stability to our life and work. This foundation is all about our identity, how we have constructed our view of ourselves and our purpose. In this fast paced rapidly changing world of ours the vast majority of people have unconsciously constructed their identity utilising other validated sources. The two big ones are work performance and how those I am in a relationship with view me. In short I define myself as 'who I am is what I do'. This in itself is a significant trap as it leads to having to do what I do because that is me! The 70s band the Skyhooks were right 'Ego is not a dirty word' however our ego can become a dirty trap. And knowing this trap can allow me to avoid its snare.

The Place of Personal and Professional Reflection

I recently read two of Jeffery Kottler's books *On Being a Master Therapist: Practicing What You Preach* (2014) written with Jon Carlson and *The Therapist in the Real World: What You Never Learn in Graduate School (But Really Need to Know)* (2015). What struck me was the need for me to continue to spend time in personal and professional reflection if I'm going to be really good in my field as well as running life for the long haul. I have also come to the realisation that the best way for me to prevent being ensnared into a performance mentality is spending time with myself (and a selected few) reflecting on who I am as opposed to what I do. By coming to a deep sense of who I am and knowing that I am fearfully and wonderfully made and that I have an intrinsic value means that it is easier to let go of some of the things that I do (even things that I like) so that I can live and maintain a more balanced life. I am also coming to a greater understanding that stewardship involves all of me, not just my finances, and just like budgeting my money I also need to budget my time. Therefore this requires me to clarify what I am going to say 'no' to so that I can say 'yes' to the best and most important things in my life.

A Page Out of Jesus' Book

I love reading the gospels as I see Jesus as a person who practiced what he preached, He is my ultimate example of healthy service in the face of constant demands for his time and attention. Needy people were a constant, right from the very beginning of his ministry life. In Mark chapter 1 (v29) we find the story of Jesus leaving the synagogue and going to the home of Simon and Andrew. When they get there Simon's mother-in-law is sick so Jesus heals her. Consequently all the people from the nearby town bring ALL the sick and demon-possessed for Jesus to heal. Now this is a big deal! The whole town was there. Just imagine that you had the capacity to heal people like Jesus did. Walk into ward 1A and tell them all to get up and they do. It would be big news! Front page story.

Let's pause here and jump towards the end of Jesus' life in John 17 (v4) where in His high Priestly prayer Jesus says, "I have brought you glory on earth **by finishing the work you gave me to do**". This begs the question what was the work of Jesus? The work that he finished?

Now let's go back to Mark 1 (v34) it says that Jesus healed many but not all and he cast out many demons but not all. The story goes on that early the next morning Jesus got up, found a solitary place to reflect and pray. However all those who had not been healed were waiting for Jesus, the news reporters were there, but no Jesus. So his mates went looking for him and when they found him (v37) "they exclaimed: "Everyone is looking for you!" and Jesus replied 'No!' "Let us go somewhere else – to the nearby villages – so I can preach there also. That is why I have come."

Now think about this for a moment and let's put unhealthy ego into the picture. Peter and the boys just say, "OK, Jesus. No way!" I can imagine them debating with him as it is their chance to be the front page story of the Jerusalem Newspaper. Yet Jesus with clarity and certainty knows who he is and what he is really called to do even in the face of needy people.

As health professionals you could explain the fragility of our human bodies far better than I could. However, what I do know is that healthy service, is based upon healthy stewardship which is founded on a healthy Christ-centred identity. ●

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A Journey in Health Service

by Peter Deutschmann

Peter Deutschmann, a surgeon and public health physician, lives in Melbourne and continues to work part time in Alice Springs.

It would be nice to be able to say that my professional life has followed a grand plan; neat, logical, measured. In reality it has been the opposite, encompassing high drama, boring rhythms, exotic travel and suburban domesticity.

The patterns have only been discernible in retrospect. Only now can I see places where I came to junctions where decisions were to be made. These are where I drew on the resources of faith and Christian community to discern ways forward, and the wisdom and support of a marriage partner.

I love being a doctor. It's what I had always wanted to do, long before I really understood what it would involve. It has proved to be rich in content and even richer in meaning.

I recently read a book subtitled 'the story of a country doctor' that describes Dr John Sassall, the subject of the book, as *'a fortunate man, his work occupies and fulfils him, he lives amongst the patients he treats and the line between his life and his work is happily blurred.'* There have been times in my life when this would have been an apt description of myself. The decade spent living and working as a doctor and surgeon in a township in the foothills of the Indian Himalaya, with more than a touch of the exotic, is one such period that had a lot in common with the book's sentiment.

My story began in Sunshine, an industrial suburb in Melbourne's west, where as a schoolboy I decided I would be a doctor. I'm still uncertain where that came from. There were no doctors in my family; in fact, neither parent had been to university. Perhaps it was the faith I placed in doctors during two serious childhood illnesses. Needless to say, in a naïve sort of way, I was determined.

In my final year of medical school I became a Christian. There had been no dramatic conversion experience, merely a growing confidence in the truth of the gospel in the context a church community in inner city Melbourne. In the years that followed I was exposed to Christian mission and developed a determination to use my developing skills in settings where those skills were needed. Thus began an active exploration that led to a decision to train as a surgeon. The advice of the day was that if one was to live and work where there were very few other doctors then it was best to be procedurally skilled, so I completed my FRACS specialisation.

We applied to Interserve, an international interdenominational mission agency, liking its dual commitment to 'word' and 'deed'.

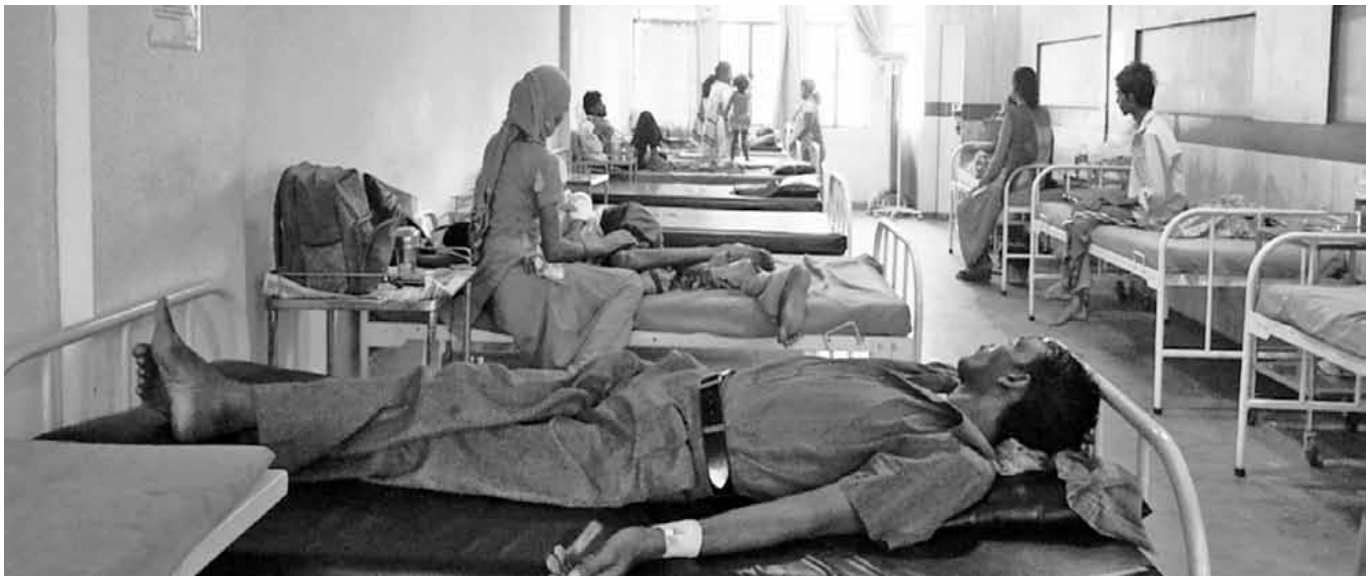
We were seconded to the Emmanuel Hospital Association (EHA) in the early 1980s. At the time, EHA was a new Indian interdenominational organisation created by traditional foreign mission agencies that had the foresight to pass on their vision and hospitals to Indian Christian leaders in the 1970s. EHA continues to work in remote parts of north India among some of the country's poorest people.

I was placed at Landour Community Hospital (LCH) in Mussoorie, about 400 km north of Delhi. LCH had long provided healthcare for the middle class of the town, but was struggling financially. EHA was the hospital's rescue plan. As an Interserve-supported surgeon, the hospital did not need to pay for my services and a surgeon was seen as potential means of increasing clientele and income. This conflicted with EHA's pro-poor emphasis and desire to reach out to villages in the district. It would prove to be a difficult transition but within a couple of years village folk increasingly accessed the hospital for their health needs.

I'd spent years learning how to do an operation. I now had to learn when not to do one. Disease was often well progressed at the time of presentation to hospital. TB and other debilitating diseases were endemic and the women and children malnourished. This, together with very rudimentary anaesthetic and (post-operative) nursing care meant that although an operation 'went well' the patient often did not.

"An... important and enduring adaptation was the discovery that instead of learning to do everything myself, I could teach the very capable men and women found among those that undertook the more mundane tasks as ward and theatre assistants."

Early in my time in India it was necessary to learn skills outside my 'scope of practice' such as how to perform forceps deliveries, initiate and maintain epidural anaesthesia, and care for the critically ill in a rudimentary high dependency unit. An early, more important and enduring adaptation was the discovery that instead of



the EHA Project (SHALOM). *Photo: www.globaldevelopmentgroup.org*

learning to do everything myself, I could teach the very capable men and women found among those that undertook the more mundane tasks as ward and theatre assistants. Whilst they lacked the schooling opportunities that most of us take for granted, many demonstrated an ability to learn well and quickly. Prem was one such person. Already a peri-operative assistant at the time when our nurse anaesthetist tragically died, Prem had shown the aptitude to take the next step. Within a year he was performing general and regional anaesthesia with confidence and skill. Called to an emergency on any given night I knew all would go as well as it possibly could if Prem was by my side.

Among the many challenges in those early years was that of maintaining permission to remain and work in India. In the early 1980s no visa was required for Commonwealth citizens to enter India but following the assassination of the Prime Minister, Indira Gandhi, in 1984, this freedom was withdrawn. Those of us already in the country were instructed to leave and re-apply for an entry visa. A growing anti-Christian sentiment at the time meant the likelihood of being granted a visa to re-enter was unlikely. Many left. We stayed on pending an appeal based on the provision of an essential service, for there was no other surgeon for the population of a quarter million people in the catchment of the hospital. This struggle continued for more than a year until we complied with a final Quit India order.

Two years later we found ourselves back in India with new visas following the success of another appeal from the community. To say this was a small miracle is an understatement.

It was very much a homecoming for all members of the family. The children were as delighted as their parents. I returned where I left off, with one foot in the hospital and one in an expanding community based primary health program.

In the meantime, a revolution was occurring in approaches to healthcare and India was at the forefront of that movement. Primary Health Care (PHC) was seen as the vehicle to deliver health care and illness prevention to all, not just those that found their way to a hospital. In most parts of the world at the time, hospitals and those that worked in them, were far removed from those with the greatest need.

The late Drs Raj and Mabelle Arole were at the forefront of the PHC movement in India. The Comprehensive Rural Health Project at Jamkhed in rural Maharashtra demonstrated what could be achieved if local women (selected by members of their village, trained by Dr Arole and other doctors and nurses) were given opportunity to promote health and prevent endemic disease – principally among those in greatest need, the women and children of their villages.

Dr Raj Arole, the chairman of EHA for those two decades, helped open the doors of the sixteen EHA hospitals, such that by the end of his tenure the hospitals had been joined by thirty rural and urban PHC projects. I too came under the spell of the potential for PHC to address the otherwise appalling daily presentations of late stage, and often fatal disease, mostly afflicting women and children, and mostly totally preventable. TB in its many guises, meningitis, tetanus, gas gangrene, pertussis and other vaccine-preventable diseases, typhoid small bowel perforations and amoebic dysentery were prevalent, not to mention obstetric disasters, a consequence of limited or non-existent ante-natal care.

Visits to villages in our catchment area and consultations with the village elders led to permission to begin village-based clinics and the selection for training of village health workers (VHWs). Once trained the VHWs set up the precursors of immunisation and antenatal programs. Not unlike the training of a peri-operative technician to give anaesthetics in the hospital, the principle that the least qualified but most capable person be chosen to undertake training as the village based health worker proved a huge success. This resultant PHC program endures to this day, more than thirty years later, supported by TEAR Australia.

It was during this time that I realised that if the PHC program was to develop to its full potential I too needed to learn more. After exploring what was

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available I embarked on a Flinders University masters degree in PHC, one of the first distance education courses offered by Australian universities in the early 1990s. This enabled me to study whilst working, putting into practice what I was learning.

After the completion of these studies and more than ten years in Mussoorie we moved to Delhi, to take up a joint leadership role with Interserve. I continued to work half time with EHA in a consultant role. One of the early consultancies in 1994 took me with a team drawn from leading Indian Christian healthcare and development agencies to Manipur state, in northeast India. The AIDS epidemic that would in a short time devastate this region of India was emerging alongside an entrenched major problem of intravenous drug use along the heroin trafficking routes from neighbouring Burma.

This led to the establishment of an interdenominational state-wide response to the dual epidemic of IDU and HIV in Manipur. This response was the first of its kind in India. This work captured the desire of the local community to enable its youth to find equilibrium, peace and wellness. It became appropriately known as the SHALOM Project. This project, with support from Australian partners AusAID and the Burnet Institute, provided a link when it became time to return to Melbourne.

A part-time role at the Burnet Institute to support the EHA Project (SHALOM) proved to be the bridge that enabled me to live and work in Australia whilst at the same time find meaning and continuity of involvement with partner agencies in India, and subsequently other Asian settings, around the themes and priorities of PHC and HIV/AIDS prevention.

At the Burnet Institute I found myself surrounded by colleagues who, like me, had worked in international settings and for varying reasons found themselves back in Australia. My primarily secular colleagues were initially a little wary of a returned 'missionary' in their midst but while they didn't share my Christian convictions they did share my passion to address the issues of inequality and inequity that abounded in many resource poor countries of Asia. We were a multidisciplinary group made up of public health physicians, infectious disease and vaccine specialists, paediatricians, sociologists plus a pharmacist and surgeon (me) that brought together an experience of working in many underdeveloped countries of our region. It was coincident with the expansion of the Australian government's international development assistance program in Asia and Africa. Opportunities to assist AusAID in this endeavour provided meaningful work that matched our passion. Whilst the discipline of international (public) health was in its infancy in Australia, to our surprise and delight we were the 'go to' group in Australia. A rapidly growing engagement in health program design and evaluation and public health education and research also led to opportunities to partner with universities that sought to engage in this new field. For me personally, this led to leading Australian government sponsored missions to design and implement health programs addressing women's and children's health through a PHC approach in Papua New Guinea and HIV prevention in the context of IDU in north east India, as well as designing and delivering inaugural international health subjects in the Monash University Master of Public Health.

"A new field was opened up, namely that of the strengthening of health systems in economically poor countries as a means of extending care to the poorest."

My six years at the Burnet Institute proved to be a preparation and foundation for the next decade, spent at the University of Melbourne. In 2001, I was invited to lead the university's Australian International Health Institute. From a modest start, a program evolved over the next ten years by which time seventy people from multiple disciplines were engaged in education, research and the practice of international health. As a group, we pioneered engagement in neglected or new fields of international health, namely adolescent health, mental health and disability. In time a new field was opened up, namely that of the strengthening of health systems in economically poor countries as a means of extending care to the poorest.

At the same time as employment at the Burnet Institute and subsequently the University of Melbourne afforded continuity with organisations (principally EHA and affiliates) in India and more widely in Asia, I also continued an active association with Interserve. I became a member of the Board of Interserve Australia. This association of seven years, five of which were as its chairman, was followed by a similar period as chairman of the Board of Interserve International. This was a great privilege for whilst it was a considerable commitment of time and travel it provided an opportunity to work with outstanding colleagues from around the globe and help review and then revise the governance of an interdenominational international mission agency and subsequently shape the future of the organisation.

After more than ten years, a name change to the Nossal Institute for Global Health and the successful recruitment of a well-credentialed medical researcher to lead the institute into the next decade, gave me the opportunity to move on. I'd been considering this for more than a year, during which time it was clear that Barbara's responsibility to develop the Indigenous program of TEAR Australia would be better served from a base in northern Australia. An emerging desire to return to clinical practice needed to be tested. With the permission of

the College of Surgeons and support of colleagues at Royal Darwin I spent three months of discernment and peer review at the hospital. Learning from young registrars while at the same time teaching and guiding from my past experience was a unique blend and experience. It proved successful.

Knowing when to move on and how to leave is not an easy thing. It helps if one's motives are clear and understood. I've been fortunate in that each step for me has been a link between what is or will soon be past and that which is new. Continuity and a strong sense of purpose go a long way. In hindsight there are patterns and common threads. Whilst my activities at various stages of professional life might appear disparate, there has been a strong consistent expression of Christian faith and social justice, and a constant geographical expression, for although back in Australia these past twenty years I have been able to mobilise resources to support many Indian agencies working to alleviate poor health.

The circle completed. Some fifteen years after an initial exposure to central Australia, I find myself back in the NT at Alice Springs Hospital having returned to my earlier vocation of a general surgeon five years ago. Unlike the general surgeon who 35 years earlier set off to India with no understanding of PHC let alone the social and economic determinants of health, I now have an opportunity to practice clinical surgery but this time through the lens of a population health perspective and approach. Needless to say the challenges in modern day central Australia are far greater than those I discovered thirty years earlier in rural India.

Perhaps the biggest challenge of all is that which I embarked on this year. I am now part-time surgeon at Alice Springs Hospital and exploring yet another transition, this time one to less than full time employment. The transition is greatly assisted by two young granddaughters. And by participating on active engagement in my local Church and on the Board of a Christian development agency working in Afghanistan... ●

SOME RECIPES WITH BIBLICAL FOODS

BEAN SPROUT CHUTNEY

When a pulse or bean is sprouted it becomes lighter to digest.

Ingredients:

2 cups of sprouted beans (MUNG preferred)
1 medium sized onion
½ teaspoon of crushed ginger/garlic
½ teaspoon of mustard seeds
1 tablespoon tamarind extract
½ teaspoon mixed spices
¼ teaspoon tumeric
½ teaspoon olive oil
Salt to taste
¼ cup of mixed fresh green herbs
1 green chilli

Method:

Heat the oil in a pan, temper with mustard seeds, ginger and garlic then add the onion. When the onion is soft add all the other ingredients and reduce heat before adding the bean sprouts. Taste and adjust seasoning. Add tamarind and simmer all for 5 minutes until the beans are cooked and soft. Serve hot with chopped green chilli for garnish.

HERBED and GRILLED FISH

Ingredients:

1 medium-sized perch/bream
1 tablespoon of mixed fresh herbs (thyme, basil, dill)
2 pods of crushed garlic
Juice of ½ lime
Salt to taste

Method:

Rub the fish with all the lime juice, herbs and spices. Leave to marinate for 30 mins. Place fish on a grill and cook for 10mins. With a flat spatula turn fish over and cook for another 5 minutes.

MODIFIED KADHI

Ingredients:

½ cup of low fat curd (yoghurt)
2 tablespoons yellow bean/pea flour
2 and ½ cups of water
1 inch ginger, chopped
¼ cup chopped coriander leaves
2 green chillies, slit in strips
1 inch of cinnamon stick
5 cloves
½ teaspoon mustard seeds
½ teaspoon fenugreek seeds
Salt to taste

Method:

Combine the curds and bean/pea powder and whip to a creamy consistency. Add the water gradually, avoid forming lumps. Then add the finely chopped ginger and salt to taste. Put over a low flame, stir as it simmers to avoid clumping. Slit the green chillies, chop the coriander and put them to the side. Dry roast the mustard seeds, cumin seeds, cinnamon, cloves, fenugreek seeds. Add the slit green chillies. If it dries up and starts to burn add a few drops of water. Put this mixture into the curd and bean/pea mix. Serve hot with unleavened bread.

Georgie Hoddle

The Real Gap

by Dr Lara Wieland

Lara Wieland has spent 21 years mainly working in Indigenous, Rural and Remote Health. She has been spending more time recently teaching medical students and registrars and also helps run a charity focused on the Indigenous community of Kowanyama which has been running since 2004. (www.otk.org.au) Lara and her husband also have kids from Kowanyama board with them to help them further their education in conjunction with their families.

Back in 2006 I wrote an article for *Luke's Journal* in the Fire In The Belly section entitled Issues in Aboriginal Health. That is the same year that the Close the Gap Campaign was formed "to achieve health and life expectation equality for Australia's Aboriginal and Torres Strait Islander peoples."

It is now 2017. There are a lot of things that have changed since then, but sadly in many ways not much has changed at all.

The preamble to the release of the 2017 Close the Gap report says

"The poorer health of Australia's Aboriginal and Torres Strait Islander peoples when compared to the non-Indigenous population is no secret – and something can be done about it."

"The campaign's goal is to close the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians within a generation. The campaign is built on evidence that shows that significant improvements in the health status of Aboriginal and Torres Strait Islander peoples can be achieved within short time frames."

So… something can be done, AND in short timeframes?

So it is interesting to note that the 2017 report goes on to say this…

"After 10 years, and despite closing the gap being a national bipartisan priority, it is clear that Australian governments at all levels are, in key respects, failing Australia's First Peoples.
….Much remains to be done and, as we move into the next phase of the Closing the Gap framework, enhanced program and funding support will be required."

Clearly the Close the Gap campaign is not achieving the outcomes they hoped for.

As someone who has worked for many years in a remote Indigenous community and in other areas of Indigenous Health this does not surprise me. At a time when governments were claiming to be "Closing the Gap" I saw basic frontline services cut to the neediest people in the country – numbers of doctors, nurses and Indigenous healthworkers providing basic, essential and cost-effective primary health care, cut to well below population benchmarks and needs. And these cuts seemed to disproportionately affect the most disadvantaged communities. I guess the squeaky wheel really does get the grease.

However is it just about more funding? I don't believe so because at the same time I have seen in recent years, more money than ever being poured into the areas where I work. But the health services descended into a deadly chaos almost inversely proportional to the huge amounts of money flowing in.

The money was being spent on more and more siloed programs and multiple organisations through multiple contracts. It became more and more about money and propping up organisations and contracts. Essential healthcare based on compassionate care provided by committed healthcare providers was completely undermined by the new ways of funding. Little wonder that things have gone from bad to worse.

All I have seen grow is organisation's buildings and bureaucracies (both government and non-government) and a steady succession of disengaged healthcare providers, not sure if they will stay beyond the six month contract which is all the organisation can offer them.

"At a time when governments were claiming to be 'Closing the Gap' I saw basic frontline services cut to the neediest people in the country…"

"…enhanced program and funding support will be required." It is more than that. Yes many areas will need an increase in funding if we are to be serious about closing the gap. But maybe we need to get back to solid basics when it comes to healthcare – like Comprehensive Primary Healthcare delivered by engaged, committed long-term staff who build relationships. And the rest will come through true capacity-building through relationships that cannot be manufactured by government programs and changed lives that can only come through Christ.

We can get so caught up in bizarre ways of looking at "Indigenous problems" that we forget that Indigenous people

are people. Not some alien entity but people who like any people group have a mix of damaged and hurt people, dysfunctional people, functional, capable people, amazing heroes and people with many strengths. And yes they have been hurt by some horrific history but they are also not alone in that.

So why can't we do what we should do with any group of people? Stand alongside those who are damaged and hurt and help them to rebuild their lives; encourage the dysfunctional people to also rebuild their lives and capabilities but do not enable their dysfunction; build up, facilitate and utilise the people who are the amazing capable people already doing great things in their communities.

A small group of health professionals advising a taskforce on Indigenous health raised the idea of capacity building families in remote communities utilising organisations such as Save the Children who were already doing similar work – working with families who were struggling, to help them learn how to parent and raise strong, resilient children for the next generation. This never gained traction as it was seen by some as too paternalistic.

"Empty slogans and funded campaigns rarely change lives."

So bureaucrats managing Indigenous lives and making specific programs for Indigenous people is less paternalistic? I know that some cynically refer to the 'Aboriginal industry'. This industry relies on the 'need' for Aboriginal-specific programmes to address the problems, that, should they ever be resolved, would negate the need for this industry. I don't know if I am that cynical yet but sometimes I do shake my head at some of the things that go on. For example, significant health funding going to a program that was designed by bureaucrats based in Brisbane to encourage grandmothers in the Far North of Australia to sing traditional lullabies to the babies. They of course 'consulted' with grandmas who provided all the information and material free of charge, so that the program project officers could be paid large sums of money to devise the program that would then go and tell the grandmas how to do what they'd just told the bureaucrats all about…
I kid you not!

And the numerous campaigns and T-shirts and drink bottles urging young Indigenous people to be Black, Deadly and Proud or similar multiple versions of such slogans. But after years of working with Indigenous youth my husband and I have realised that no one has ever told them what they are to be 'proud' of. I think the message is to be proud of being black and not be ashamed of that. Which on the face of it seems good – but what does it really mean and how does that change a young person's life? Again, I go back to our similarities and not our differences. I try to teach the youth that we can have a character that we can be proud of – like our honesty, our integrity, our determination and so on. This then gives them something to truly be proud of that they see actually works in the real world and has real meaning. And the connection is that being black is never to be a barrier to being any of those things or having those characters. And yes then they can be Black, Deadly and Proud. Empty slogans and funded campaigns rarely change lives.

As Christians we are called to stand up

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for the poor and needy but even more compellingly Jesus tells us we will be judged on the final day on what we did for the "least of these". (Matt 21:35-46)

So why aren't there hordes of Christians working in disadvantaged communities both black and white – standing alongside damaged people, encouraging and building up those who are being strong in those communities and helping them as they battle for a better future? Why is it that it is often my non-Christian colleagues who are working with the homeless, the alcoholics, the drug addicts, the mentally ill, the hurt and broken of our society – the "least of these"?

As Christians we can work to build a new generation of resilient people changed by the love of Christ who can lead their communities back to wholeness. There are many ways to do this and it is not only us health professionals who can do this. It could be going to work as a professional with these groups, giving some time to mentor someone, fellowshipping with Christians working in these areas or Indigenous fellowships and building each other up. Giving one's time to help teach literacy or budgeting, get involved in youth groups or parenting classes, playgroups, things that can help lift people out of their dysfunction and hurt, and help them to build

the character and capabilities for a better future. The disadvantaged communities of this country should be awash with believers serving. There are many Aboriginal Christians who are out there struggling and working in difficult circumstances and sometimes just need the encouragement of a 'brother' or 'sister' or someone to walk beside them.

"That gospel requires action outside the four walls of the church on a Sunday."

And if it is not possible to get physically involved then our generous wages that we've been blessed with can help support those who do.

I know of a teacher who has devoted her entire life to working in the remote lands between the NT and WA teaching Aboriginal children and adults English and adult literacy and translating the Bible into their languages and ministering to the people there. She is one of the most dedicated missionaries I know working in remote and difficult circumstances yet she struggles to gain support. As someone who also runs an Indigenous ministry[1] I know how hard it can be to have churches even want to hear about what you do but will get involved in multiple overseas missions in places like Cambodia which yes are needy but there are also mission organisations tripping over each other there.[2]

I will finish with the words of an Aboriginal Christian minister named Brooke "….It's about each and every Australian Christian stepping outside the four walls of the church to journey with us as Aboriginal and Torres Strait Islander peoples. If Australian Christians read the same gospel as I do as an Aboriginal person, they read of a gospel of truth, love and justice. That gospel requires action outside the four walls of the church on a Sunday." ●

References:
1. www.otk.org.au
2. The author has had some involvement in ministry in Cambodia.

Book Review – John Flynn by Ivan Rudolph – from p45

John Flynn's work in establishing the Royal Flying Doctor Service (RFDS), including cutting it's Presbyterian roots so as to be more accessible as a government-subsidised national service, gave birth to many other services:

- An Old Timers Camp at Alice Springs – an outback nursing home.
- The Bush Mother's Hostel to house and equip first-time mums around delivery.
- The "School of the Air" now in Canada as well as Australia.
- "Warrawee", a seaside camp for outback children.
- By 1985, 20 developing countries were using Traeger's pedal transceivers, benefitting Africa and Asia with their simplicity, ruggedness and low cost.
- Standardised medical kits for all outback radio operators to diagnose and treat over the radio.
- The RFDS spreads its "mantle of safety" over nine-tenths of Australia, operating out of thirteen bases with 40 flying doctors and 50 nurses. Each year they treat 150,000 patients for free, day and night, evacuating around 14,000 of them to hospitals.
- The RFDS provides primary (as well as emergency) care, including dentists, opticians, physios, vets, social workers, OTs and pharmacists.
- Flynn's patrol padres still operate as Frontier Services, including an aerial patrol padre.

For anyone excited by scenes of the outback and a vision for how to serve Christ in a myriad of practical ways, this book is a wonderful inspiration. It is fitting that Australia has commemorated John Flynn on the back of the twenty-dollar note. ●

BOOK REVIEW

John Flynn

by Ivan Rudolph

The Royal Flying Doctor Service

by Catherine Hollier

Review written by Dr Catherine Hollier, a part-time GP in Newcastle, with a love of 4WDing in outback Australia.

I visited Alice Springs and had been to the Royal Flying Doctors base there – wandering through the Visitor Centre, exploring the model air ambulance, the first pedal radios, messages sent in Morse, and considering whether I could locum there some time. I never found time to read the book on John Flynn, who paved the way for this service. However, *Luke's Journal* beckoned for a book review, so I sat down to read...

To my surprise, Flynn was not a doctor. I always imagined that a flying doctor service would have been the brainchild of a doctor. Not so. Flynn was a man with a heart for the people of inland Australia. At the time of his first forays into the Australian countryside, he was not even ordained. He could not afford the fees for theological collage, so he worked as a home missionary (similar to our ministry training schemes of today) for the Presbyterian church. He knew some first aid, was a keen photographer, and had the gift of being able to come alongside anyone for a yarn. He used these skills as a drawcard for gathering people – giving talks about basic first aid, using 'magic lantern' shows to illustrate anecdotes, and offering 'first aid for the soul' to those who wished to attend a simple church service.

Whilst completing theological college, Flynn ached to do something for the pioneers who were suffering from loneliness and isolation. He set up the "Mailbag League" as a pen-pal service that combined distribution of books with that of the local mail. Then he commenced "The Bushman's Companion" as a small practical handbook for Outbackers to carry about with them in their swags or saddlebags. This little volume with a durable linen cover he published at his own expense to give away for free. It was packed with helpful advice – first aid, how to make a will and keep an account, a calendar, advertising the Mailbag League, a few relevant Bible verses, prayers, favourite hymns and a simple funeral service – a sad necessity for the hard life of the bush.

As Flynn started work in his first outpost at Beltana, SA, he experienced first-hand the vast harshness of the land and the incredible distances to be traversed. When consulting with Jeannie Gunn of *We of the Never Never* fame, she advised 3 arms to minister to the needs of the Inland:

1. Medical missionary work.
2. Connecting people together socially.
3. The good old gospel – straight spiritual work. "Men in the bush are like men everywhere, they need God."

The remainder of the book traverses Flynn's action-filled life – his patrol padres roving around vast parishes on camels, and later by motor car; his desperation to get people connected so that they could call for help when needed; his work with Alf Traeger to invent a functioning cheap pedal radio – small and simple enough for every pioneer town or homestead; his fortuitous alliance with the Queensland and Northern Territory Air Service, later to become QANTAS as the first air ambulances; and his enormous reliance and trust on God as he advocated for funds and resources through the Great Depression and World War II.

The Australian Inland Mission (AIM) was to be built on the twin pillars of "love" and "faith". He wrote:

> *We will need a very large measure of love. That sacred word is used with hesitation, but no other is adequate. Strong love alone can bridge the long distances: strong love alone can prove effective where men meet but once or twice a year... strong love alone can suffice, because everything not strong must be rejected by pioneers.*
>
> *We will need strong faith, for faith is tested where platitudes cease to echo, and where with relentless regularity Nature assumes her harshest mood...*
>
> *The movement is founded on the fact that there is One who takes a personal interest in the lives of all men.*

continued page 44

CMDFA Vision and Servant Leadership

by Hannah Watts

Hannah is currently in her third year studying a Doctor of Medicine at the University of Western Australia. Over the past year she has been greatly encouraged by conferences like VISION and IMPACT, which seek to unify and grow Christian medical and dental students across Australia.

Earlier this year I had the privilege of attending VISION, a conference aimed at training existing and upcoming leaders within CMDFA. In 2017 it was held at CYC Burleigh Heads on the sunny Gold Coast.

The conference ran in late January and stretched from a Friday evening to Sunday afternoon. The conference was embedded with biblically grounded talks regarding leadership, as well as opportunities to grow skills in areas such as evangelism, mentoring, discipleship, leading bible studies and exploring worldviews in medicine. All the while we were given the chance to network with other student leaders and develop friendships that would continue well into the future.

I am thankful to those who help make VISION happen each year because God used this conference to shake me back into a state of passionate service for SMA (Shadrach, Meshach and Abednego), the Christian Medical and Dental student group in WA. You see, although I had been keen to serve SMA in my early years as a student, my motivation to do so had very much declined towards the end of 2016. I live an hour out of Perth city and after five years travelling back and forth, my enthusiasm to partake in club events was puttering out. Besides, I had my local church that I was serving and growing in. Surely that was enough? Well, since going to VISION I have had a lot of time to reflect on this. What is the purpose of parachurch groups for Christian medical and dental students? What role do I have to play as a leader in my own student group? Let me share with you how VISION shaped my current state of thinking.

State and Campus Time

State and campus time was an opportunity for us to discuss challenges to our student ministries and to plan for the year ahead. It's amazing how such a small part of the conference had such a big impact on me. At the end of 2016 I had been approached by one of the committee members to take on the position of SMA's mentor coordinator. I hesitated but said yes in the end, not because

What is the purpose of parachurch groups for Christian medical and dental students?

I had a burning desire for the role, but because I felt there was a need and someone had to step up. My mindset had been to help out because a role needed to be filled and I could fill it. I wasn't thinking about the bigger picture. I wasn't thinking about what purpose this leadership role was serving or even why it was important that SMA continued. Well, state and campus time changed that.

I felt particularly challenged by one of the mentors who really emphasised the need for a clear purpose and definitive goals for the group. What is the group trying to achieve? How is it different from our local Churches? I've since come to the conclusion that fellowship amongst Christian medical and dental students is important for a couple of reasons. One of which is to spur one another on in our walk with Christ as we journey through the healthcare system. The world of medicine is full of temptations and traps. I began to feel the full weight of this when I started my clinical years. It can be really hard to run the Christian race when you are surrounded by people whose main aim in life is not to follow Christ, but to follow after worldly desires. As such, we ought to *"encourage one another and build each other up"* (1 Thessalonians 5:11) being wary of the fact that *"wide is the gate and broad is the road that leads to destruction and many enter it"* (Matthew 7:13).

The fellowship we share as students now fosters friendships that will continue on into our working lives. These relationships encompass a mutual understanding of the hardships and challenges to our faith we will inevitably face in our area of work, and provide accountability to one another when they arise.

Solid Biblical Teaching

Another edifying element of VISION was the opportunity to hear talks encouraging servant leadership. Dr Joel Wight, CMDFA recent graduate worker, led us through the book of Jude and Dr Jacki Dunning, CMDFA student staff worker, talked on the topic of pride.

From these talks I gathered two main messages. Firstly, as leaders we must not discredit the gospel through the way we live. Jude condemned false teachers who maligned the way

Group photo, CMDFA Vision 2017.

through their lifestyle and lack of godliness. Therefore, as leaders we must be sure to yield good fruit in keeping with being followers of Christ. We ought to know the word of God revealed to us through the Bible and live this out faithfully, not living as false shepherds. Jude also implores us to contend for God's people, not false teachers. Therefore in our student groups we should be seeking out the lost, leading them to Christ, not quarrelling with those around us who are strongly opposed to the gospel.

Secondly, we must be wary of pride. Planning and strategising ways in which our student groups may grow is all good and well but when we start to depend only on ourselves and our efforts, instead of God, we forget that *"neither the one who plants nor the one who waters is anything, but only God, who makes things grow"* (1 Corinthians 3:7). I am certainly guilty of falling into this trap of self-sufficiency. To guard against this it can be helpful to ask the question, "when was the last time I devoted this ministry to God in prayer?" For if our ministry is not being dedicated to God, pride is sure to be lurking nearby. Moreover, if we are taking on leadership roles to look good or please others then we really need to revaluate our motivations because at the end of the day *"He [Christ] must become greater; I must become less"* (John 3:30).

"When was the last time I devoted this ministry to God in prayer?

Praise, Prayer and People

As a younger student I was built up and encouraged by SMA events organised by older students before me who believed that Christian fellowship with medical and dental peers was important. Now that I find myself on the other side of the coin in a position of leadership, I can appreciate not only the effort involved but also the disappointments and challenges that can arise. Nevertheless I have been encouraged to plough on and feel invigorated to serve in this way.

So I praise God for the way He works through conferences like VISION to grow and challenge His people, and I pray that He will continue to sustain our student groups so that we may continue to be transformed in Christ and in doing so, transform healthcare. ●

INSTRUCTIONS FOR CONTRIBUTORS

Members of CMDFA are invited to submit articles or letters to the editors for publication in **Luke's Journal**. Articles may or may not be on the advertised theme. Writers may wish to discuss their potential contribution with the editors or their state editorial representative before submitting.

Articles, letters, book reviews and lengthy news items should be submitted (preferably in electronic form) to the **editors** with a covering letter requesting their consideration for publication. Photos supplied should be high resolution JPEGs.

Advertisements and short news items should be submitted directly to the **sub-editor**. See page 2 for contact details.

Medical Teaching as Ministry and Mission – PRiME

by Owen Lewis

Owen Lewis is a general practitioner in Port Pirie, South Australia, who has previously served as a missionary in Nepal, as national secretary of CMDFA, as board member of HealthServe Australia (HAS) and continues to coordinate PRiME Australia activities of HSA.

What is Partnerships in International Medical Education (PRiME)?

Partnerships in International Medical Education (PRiME) Australia is affiliated with PRIME International, a Christian organisation of volunteer tutors assisting with medical education programs for healthcare workers.

Medical teaching is all about relationships and influence, with Jesus as our role model and teacher. As his disciples, we follow his example. We often talk about the privilege of serving patients. Let's talk about the privilege of serving students, trainees, fellow learners and teachers in medical education.

At home and away

PRiME Australia is at home and away. At home, we run tutor workshops to develop our education skills. These are applicable in the local situation but also prepare us for overseas teaching opportunities. Medical education, whether under the PRiME banner or not, can be ministry and mission if we consciously see it that way. PRiME Australia is involved in teaching activities in countries such as India and Papua New Guinea. These teaching trips overseas are a big part of PRiME's history and current activity. Both at home and away, Jesus challenges us to serve him for his glory.

Equipping teachers

The aim of PRiME is that educators engage with trainees at a deeper level, so as to challenge values and to open their view of health care to include, physical, mental, social and spiritual aspects. We develop our education skills and experiences within community, medical school, postgraduate and continuing professional development opportunities.

As students, we are exposed to many teachers in medical school. Some influence us a great deal – not just with their content or even their skill in imparting knowledge, but we recall them as the person who delivered the teaching. Our own calling as teachers is part of the Hippocratic tradition of our profession. PRiME equips teachers to share in ways to reach the student as a person. This is a vulnerable but enriching situation.

As clinicians, we teach patients all the time and may have a student sitting in on the consultation sometimes. Some of us also teach or facilitate medical education frequently, but others may not feel very adequate in a classroom situation. We may be comfortable conducting one-to-one teaching, but find groups stressful. There is a performance aspect in which we find ourselves exposed – we may worry about getting the latest "facts" right, forgetting that the technical detail is not necessarily the most important thing.

PRiME has an annual weekend tutor training event that rotates between the capital cities. After initial sessions about PRiME and its approach, we learn educational techniques and practice them within workshops. At every stage, we have opportunities to reflect and discuss what happened, what went well, and what can be improved. The vulnerability of the attendees allows us to be vulnerable ourselves as we prepare and present.

The PRiME approach to medical education

Modern medicine where science and art are divided is a child of the enlightenment. The rational emphasis excludes spiritual and faith matters in most medical curricula. PRiME counterbalances the prevailing biomedical model with a whole-person approach – lest the product of such a curriculum, "the doctor", performs in a blinkered and incomplete way.

As an example, PRiME slides picture an ordinary man with a heart attack, exploring all the issues from his point of view, including social and spiritual dimensions. PRiME is unashamedly Christian but addresses faith matters

"Medical teaching is all about relationships and influence, with Jesus as our role model and teacher."

in ways that are inclusive of people of different faith backgrounds. This is easier for people with cultural backgrounds that are actively religious, but may be new or uncomfortable for people with a secular, atheistic background. For the latter there is another PRiME slide series that explores the history of medicine and contributions of religion, including but not exclusively limited to Christian influences.

A passion for whole-person teaching

It began with gifted, visionary communicator and networker Dr John Geater. I first met John Geater in Nepal some years ago. Mary and I had established a department of family medicine in a peripheral teaching hospital in Dharan. As well as looking after the Emergency and undergraduate teaching, we were training GPs. The program was a 3-year residency with rotation through many departments and weekly classes in our home department.

John made contact and proposed to come to teach our residents. We arranged a joint program for a week involving psychiatric residents as well as our own. John has the gift of the gab and is passionate in sharing his message of whole-person teaching and whole person medicine. He soon had us all re-examining the basis of our medical knowledge and practice, bringing history of health care with Jesus' model of caring up front. In our group were Hindus, Buddhists and Moslims, but no Christians apart from ourselves. To our delight, the trainees were most responsive to discussion about the meaning of life and the spiritual dimension in their own and patient's lives. That was in about 2003.

The start of PRiME Australia

Then in 2006 John came to the ICMDA International Congress held in Sydney. He presented the same ideas and shared about the organisation he had established in the UK – Partnerships in International Medical Education (PRiME). He and others had been making trips to former Soviet countries teaching and encouraging doctors and medical students. He had built on his experience and connections in the RCGP and involved respected teachers in other disciplines. A strong message was the need to redeem medical teaching by broadening from the secular, technical and physical to include much greater emphasis on the person in their social, mental and spiritual context.

Following John's Sydney visit, CMDFA invited him back for a meeting in Brisbane 2008. PRiME Australia was then developed as a project of HealthServe Australia to provide its administrative base. We formed a small subcommittee, myself as coordinator, Carolyn Russell as trainer of trainers, and Michael Burke to keep us moving ahead. We began the annual training for PRiME tutors. The course is useful for all of us involved in CME group activities in Australia but is particularly aimed at upskilling us for teaching trips overseas. Carolyn Russell has been our main trainer. She has been involved in many PRiME UK meetings and trips and has a wealth of experience as a medical educator. Sharon Darlington joined the team and has been leading more recently – she is a full time medical educator at Queensland University with a very creative flare.

Partnering in India with CMC Vellore

Our overseas trips have included many to India. We have been helping as additional faculty in GP training, arranged by Christian Medical College (CMC) Vellore (*See extract below*). What was previously a two-year graduate diploma program by distance has developed into the MMed Family Medicine with an intake of 300 each year.

Course work is done by traditional paper as well as online methods using an excellent set of books and ever-expanding digital resources, all developed by CMC-V faculty. A requirement of the course is attendance at 3 contact programs. These are held in 10 centres around India that are mission hospitals and other secondary level hospitals. Classes are held for 10 days, including skill sessions, ward, outpatient and OT visits. The centres are connected by video link in the later afternoon for discussions.

The job of visiting GP faculty has been to prepare and present the materials provided, and increasingly, to encourage faculty in development in their teaching. These are alumni of the program who have come back

continued over page

An extract from Dr Nancy Nicholas' (a recently-retired GP from Melbourne currently locuming in country Victoria) sharing in a PRiME newsletter about her experiences as a first-time observer on a recent Chennai trip –

…clinical skills were taught by watching a DVD, then practising the skill with some input by us, and repeating the routine before two of their peers. At the end of the course there was a test of a skill – not marked, but a training process for their later examinations. I found it surprising that many of the students were unfamiliar with the use of an auriscope – used so commonly in my clinical practice.

I think it would be quite difficult running the course alone, as there are liaising things to fit in somewhere – e.g. arranging with the local contact person about visits to the wards, arranging a change of venue when the room we started in was obviously far too small for 25 students, getting photocopying done etc. I don't know how Owen managed previously on his own.

During the first week, I was saying " if I come again" and in the second week it was "when I come again". I hope to be able to help out again next year. I recently came across a quote from Betty Friedan:

"Ageing is not lost youth but a new stage of opportunity and strength."

I certainly feel that God has given me the strength and the opportunity to do this work for him at a stage in life when many of my contemporaries have retired. I feel very blessed to have had this experience.

as teachers. An important role of the visiting faculty has been to be a model of the experienced family doctor, sharing values we hold dear. In the daily schedule we start with a moment of reflection, a thought for the day. These can be a faith flag and lead to deeper conversations in class or afterwards.

Since 2009 PRiME Australia tutors have made about three teaching trips per year to Vellore, Angamali, Chennai, Bangalore, Hyderabad, Kolkutta, Herbertpur, Assam. PRiME UK has also sent many faculty to assist. A distinctive feature of PRiME's involvement in India is that we are assisting in the local program. While we may be influential, the program is primarily led by the Distance Education Unit of CMC-Vellore.

"Under the PRiME Australia banner, we have made other trips to PNG, Philippines, Indonesia, and China."

The advantage is that it is a true partnership in which we are serving and not having to worry about administration, logistics and the curriculum content. It means we can turn up and teach using rich resources and spend time relating to the trainees and other faculty. The need for extra faculty from the outside continues as India has few GP teachers at senior levels. CMC-V wants to maintain the Christian ethos of the training so is always looking for Christians who can serve in this way.

Other overseas teaching trips

Under the PRiME Australia banner, we have made other trips to PNG, Philippines, Indonesia, and China. While the Indian pattern has been individuals co-teaching with local faculty in the local course, in other places we have sent teaching teams at the invitation of our overseas partners, bringing in a program from the outside. The PRiME presentations in the CD resources may be used as the main contribution to the education event. Clinical topics may be offered depending on the expertise of the visitors, who are not only GPs but represent various specialities. Many

Les White writes about fostering whole-person care in PNG, and rebuilding pastoral and spiritual care at Port Moresby General Hospital –

As advocates for whole-person medicine, Ken Shakespeare and I have been fostering government hospital buy-in to pastoral and spiritual care for the past five years. Church people have always been visiting and 'encouraging' their sick members in hospital, but the more overt approaches of 'preaching' and 'casting out demons' has often brought conflict between them and hospital staff, and between denominations.

It is quite counter cultural in much of Melanesian society for friends to delve deep into feelings, let alone have a hospital-based stranger prompt discussion on grief, loss, feelings and stakeholders. Sadly, many of those trained in the nine locations to date have reportedly not volunteered for on-going rostered time on the wards of healthcare institutions, preferring to visit when convenient, rather than being a regular part of the team. The Melanesian concept of reciprocity also spoke to being remunerated in some way for time spent doing pastoral care.

The most recent training was a breakthrough on the tail of Divine intervention. Port Moresby General Hospital (PMGH) is the largest in the country with 1200 beds, 2,300 staff and 80-85% occupancy. There are around 700 nurses plus around 100-150 doctors. It is the main referral and teaching hospital – TB in its various forms is rampant with one in five admissions being positive; each month, around 40-50 unwed teen mums give birth; more than 100 unclaimed bodies reportedly go to mass graves.

Hospital systems are improving but often in disarray; there's an on-going shortage of medicines and consumables and crippling budget cuts. The two operating theatres reportedly have many cancellations due to 'no shows' by key stakeholders. Chaplaincy had been in disarray for more than a year. Prior to this, there were reportedly in excess of 11,000 pastoral care engagements annually, which is over 200 per week. Both the former CEO and the new CEO were in favour of a chaplaincy approach, which settled patients' fears and contributed to their healing.

In this somewhat debilitating context, we managed to contact the Quality Assurance Manager who had taken it upon herself to try again to get hospital Pastoral Care/ chaplaincy commissioned. Considerable pro bono consultancy was provided for two months prior to the June visit, and the churches were again approached to have people trained for volunteer chaplaincy roles. The hospital training room was made available but there was no budget. Nevertheless, a 30-page workbook was made available for sixteen attendees. The fledgling department would be under the Director of Nursing for the first six months and three senior nursing officers completed the four-day intensive training.

Steps have been taken to have this pilot program highlighted during the annual PNG Medical Society Symposium in the hope that many of the other 25 provincial hospitals and Provincial Health Authorities will follow suit. On each occasion books on grief and emotional and spiritual healing have been left with trained chaplains. With many of the rural trainings a variety of resources such as torches and solar phone charges were used as aids for teaching. These items were publically given to those who wrote how they would follow pastoral care principles in using the resources.

of these trips have been introductory, building relationships.

A particularly fruitful link has been that developed with ChickenDocs (named as China is shaped like a rooster on the world map) and local Chinese GP teachers. There have been some influential Christian doctors there who are developing GP teaching. Through them, Michael Burke and teams have made short trips to Hainan. As a result, groups of Chinese doctors have come to Australia on short educational trips. In 2016, they participated in the PRiME annual tutor training.

Building pastoral and spiritual care in PNG

A lasting contribution in PNG has been the work of Les White and Ken Shakespeare in running trainings in chaplaincy under the PRiME banner, filling a great need in urban and rural hospitals. Social work is another discipline that hardly exists in PNG, so chaplains may find themselves addressing domestic violence, drug issues and tribal conflict as well as spiritual concerns. The project has now trained more than 360 chaplains in PNG.

This is also a good example of how PRiME is more than just doctors, but potentially includes the entire health team. In our tutor training we have had nurses and physios and look forward to further broadening of our scope.

Training clinical officers in South Sudan

I have shifted my regular commitment from teaching in India to going to Uganda to teach South Sudanese clinical officer trainees for a month each year. The government of South Sudan asked the ICMDA to establish a medical school and the state of Jonglei was chosen. Teaching of clinical officers, nurses and midwives began in 2014 in Bor but due to the outbreak of war, the students were evacuated to Kampala in Uganda where Mengo Hospital has hosted the program since the beginning of 2015. In May 2016 I made a brief trip and offered to come for a month a year to teach. Most recently, I was in Kampala for 4 weeks in February 2017 teaching at the ICMDA National Health Sciences Institute Jonglei.

"Do consider yourself as a potential teacher of South Sudanese health workers..."

Conclusion

PRiME depends on the energies of its members. As membership is a rather loose idea I find the task of coordination has its ups and downs. There are opportunities not taken up because of lack of energy or insufficient networking. The reality is that developing relationships to enable successful teaching trips is a long process. We need more people engaging in the overseas relating (email, skype and scoping trips) as well as others ready to settle into a routine of periodic trips, such as 2 weeks per year.

There is a wonderful opportunity to build partnership and friendships with the PRIME people of HealthServe Australia and our valued partners. More tutors are needed! We ask people to attend a PRiME training before onsite work. ●

For more information, please contact Owen Lewis at prime@healthserve.org.au

Owen Lewis reports on a 2017 trip to teach South Sudanese Clinical Officers in Uganda –

I found it very easy to manage in Kampala, staying close to the hospital in comfortable accommodation. The trips on the back of a " boda boda" (motor bike) taxi were the riskiest thing I undertook. I did have some potential trouble at the airport because I had forgotten my Yellow Fever vaccination record, but they were satisfied with the photo of it my wife had sent by social media.

Yes, there is internet and thus a wealth of resources to tap for the preparation of classes. The second year clinical officers were going through a disease-structured curriculum. The third year officers, soon to graduate, were far ahead and teaching was based on clinical scenarios. Within a few months they may be in remote rural settings with a minimum of facilities and supervision. So it was a challenge to teach a balance of what is possible and desirable alongside the likely reality they will face. Of course, an internship program for them in the first year out would be far better. Anil is doing his best to negotiate such possibilities.

The students come from all over South Sudan from communities that are Christian but among whom there has been intertribal fighting for generations. We had some deeper discussions about resource allocation and about individual adaptive responses to tragedy and catastrophic illness. They have all been through a lot personally and face an uncertain future, so a faith perspective is very relevant both for themselves and in their dealings with the sick and injured. Alongside the deep and personal, a public health perspective is also an essential part of the course. As well as direct clinical roles, some will work with government and NGOs in public health work.

While I was there we had the luxury of two visiting faculty, including Dr Rosemary Croft from the UK. Once we left, the resident teaching staff (Dr Anil and Dr Shalini) were again coping with a very full teaching load. This limits Dr Anils' capacity to explore future possibilities for the Insitute. Very likely there will be a move to another location this year. It might be close to one of the huge South Sudanese refugee camps near the border. More visiting faculty is needed, and there is particular need for a midwifery teacher, long or short term.
Do consider yourself as a potential teacher of South Sudanese health workers!

Planning to Start Health Services in a Developing Country?

Tips from the HealthServe arm of CMDFA - Muko Project, Uganda

by David Outridge

David is a GP in Newcastle NSW with a special interest in alcohol and other drug addictions. He is working in association with an Anglican non-government organisation assisting people with substance use problems. He is married to Loraine, a registered nurse, with whom he works closely. They are involved in the Grainery Church which has had a longstanding association with a region in SW Uganda near Kabale. They have two adult children and feel that mission work retirement is potentially a good fit.

Partnering with churches in developing countries to develop health services is challenging, and requires the input of specialised advisers and good communication, preferably in person. HealthServe is well placed to facilitate such partnerships and offers a means to raise tax-deductible donations.

Muko Clinic is a rural health clinic in south-western Uganda, serving a population of 20,000. In late 2016, it was running as an outpatient facility with minor maternal and inpatient numbers. However, it needed completion of the in-patient building, to allow it to serve more mothers wishing to give birth in the presence of skilled attendants. The clinic had its own transport vehicle for emergencies, but needed more drivers trained. Purchase of equipment and some support for staffing and training was needed to ensure a safe transition from a level II (designed for a population of 5,000) to a level III facility (designed for a population of 20,000). The project was nearing completion from the aspect of capital works, but other constraints within the original funding body had prevented completion.

Muko Project

The idyllic hilly landscapes of south-western Uganda, called by some 'the Switzerland of Africa' because of its cool climate and deep lakes, belie the suffering behind the scenes. Of the sources of these sufferings, not the least are the high rates of maternal and child mortality.

Although Uganda is better off than some if its neighbours (possibly due to relative political stability since the overthrow of Idi Amin), as a whole, sub-Saharan Africa is lagging behind the rest of the developing world in achieving the Millennium Development Goals (MDGs). Uganda still suffers from severe poverty and marked underfunding and understaffing of health services, especially in rural areas. Only a quarter of health costs are paid for by the Government of Uganda, the remainder being picked up by Non-Government entities (34%) and Out-Of-Pocket (OOP) payments by patients' families (41%).

Reductions in child mortality and Maternal Mortality Rate (MMR) have been two of the MDGs which guided the development of the Muko Clinic project. The availability of skilled birthing attendants is part of the answer, as is availability of transport, facilities and skills to deal with complications. Supporting the benefit of the latter is the fact that Bangladesh has only a third of the rate of skilled birthing attendance compared to Uganda, yet has a much lower MMR, thought to be due to more readily available back-up services.

Muko is a rural parish in a mountainous area which at the time the project commenced, was connected by road to a general hospital two hours away by road (plus some hours stretcher-carry to Muko itself). There was no clinic apart from a cottage set up by the local church to provide first aid and support in procuring transport. Lack of a skilled birth attendant resulted in many deaths and emergency transport to the hospital was difficult to achieve (many times on the back of a motorbike whilst in labour)!

A Newcastle church ('The Grainery') has had a longstanding relationship with Muko after a chance meeting at a conference in Kampala between a member and the parish priest. In 2008, a clinic was planned, and money

was raised to build a Health Centre Level II in line with the documented 'population of 3,183'. Money was factored in for an ambulance vehicle and staff support, but the latter did not eventuate. Lessons were learned – in particular, the difficulty of doing a project 'site unseen'. It turned out that the population was more like 20,000 and therefore the local committee went ahead to build the sort of building they knew they needed – a Health centre level III (including wards for mothers, adults and children). Communication and coordination can be difficult in a different time zone, especially where language barriers exist, and so when a fair bit of money was on hand, it became the 'green light' to keep on building: Lesson 2 – drip feed the money as needed.

Nevertheless, a large, functional outpatient building with two delivery rooms, a two bed ward, lab room, pharmacy room, etc. plus staff houses resulted – PLUS a 'lock-up stage' large ward building and delivery suite. The unfinished building has been used to store potatoes and collect rainwater from its roof until now. Despite the diversion of funds to an unplanned goal, no money was wasted, and a huge amount of building was achieved for the money spent due to in-kind donations.

Stage 2 in 2013 was to raise more funds and purchase the ambulance and some equipment, so in 2014, three of us from the Grainery visited Uganda to buy the vehicle and equipment. Just as well, as the Toyota Troop-carrier that we envisaged was as rare as hen's teeth in Uganda. The alternative vehicle (as seen fit by the priest and his driver) was a family sedan. Thinking of the effect on the upholstery of litres of blood and liquor, we insisted on a long wheelbase diesel 4WD pick-up with a canopy, and side-seats, so we could easily and safely carry a stretcher. This took some time and organisation, which undoubtedly would not have happened if we hadn't been there in person.

We were able to meet with health officials in Uganda and the development committee in Muko to build a better picture of the needs of the clinic and future plans for the ward and delivery-suite building. We also equipped seven local villages with new stretchers and solar lanterns for transport to the clinic.

Muko clinic outpatient building.tif

Stage 3 was the one at which HealthServe was approached to assist in funding: the completion of the ward and improved birthing facilities. The existing birthing rooms (in the outpatient block) were not very private, which deterred some women from using them. The new rooms are more spacious and have en-suites attached.

"Rigor in project planning and outcome monitoring is an aspect which is also essential for success..."

Having seen the clinic in 2014, we noticed that the road passing by the front door was beautiful smooth asphalt, part of the new Trans-African Highway (Mombasa to Lagos route). Along with potential economic benefits and a quicker drive to the general hospital in Kabale, the highway will provide a high throughput of fast-moving vehicles, possibly more contact with new social ills and greater potential for HIV transmission. The health needs of the area and the role of the clinic are evidently changing, and the wards will be coming on line at just the right time for an expanding role for the clinic.

Funding was channelled through HealthServe from the beginning of the project to complete the electrical fitout and transition the clinic into its expanded size, increase staffing and equipment, and possibly up-skilling existing staff. Following a mid-project inspection by HealthServe, they also became involved in fundraising during the latter stages of the project. The Grainery was looking to draw a line under its involvement with the Muko Clinic in view of the distance and the specialised work involved in developing such health facilities, which necessitates close working relationships and site visits to appraise the situation at intervals.

HealthServe benefit

The benefits of having an organisation like HealthServe are many: it provides a means for Australian Christian healthworkers (often with existing partnerships in developing countries) to develop projects through the expertise, support, and connections provided through HealthServe.

The tax-deductability status increases giving potential for many donors and places the project in the same league as other major charities in terms of attracting larger donations.

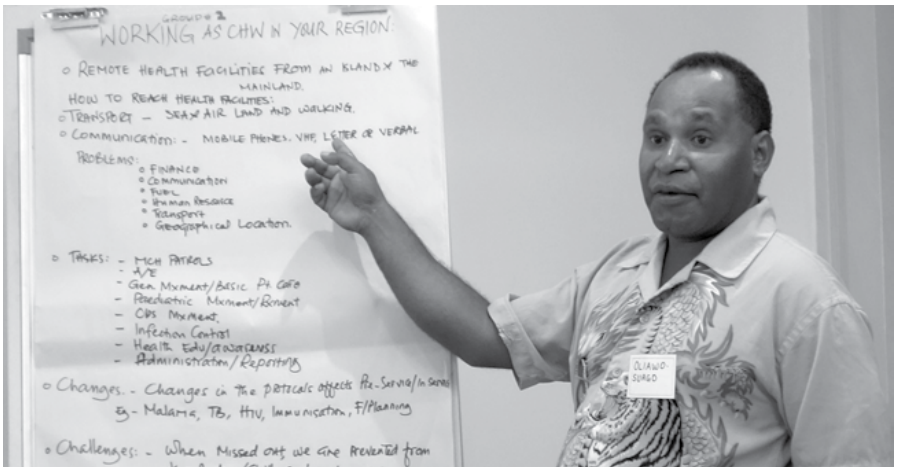
Rigor in project planning and outcome monitoring is an aspect which is also essential for success and is now an integral part of partnership with HealthServe.

HealthServe has certainly been essential to the success of the Muko Clinic Project, and it is a boon for those who wish to develop a health project within an existing mission relationship. ●

The Health Care Manual Project – Rural PNG

by John Oakley

John is a general practitioner and has worked in the remote Rumginae and Tabubil Hospitals in Western Province Papua New Guina for 16 years.



After leaving High School, Oliawa (pictured right) trained for 2 years as a Community Health Worker (CHW) at Rumginae in PNG. He was then posted to a remote Aid Post where he was the only health worker for a population of a thousand people living in villages scattered in the rainforest. The nearest hospital was four days walk away.

One morning a lady was brought to him in labour and when he examined her he realised the baby was breech. He was not trained to do a breech delivery and had no means to refer her to hospital. So he used the instructions from the late Clifford Smith's *Health Care Manual* to safely deliver a live baby.

Of a population of 7 million, over 80% of people live in rural areas, and the majority of women are unable to access health care for supervised deliveries. At 733 maternal deaths per 100,000 live births, PNG has the highest maternal mortality in the Pacific and one of the highest in the world. Neonatal and child mortality are also very high. In rural areas there is only one doctor for every 80,000 people, so for those who can access a health worker it is most likely to be a CHW. Almost all of the CHWs are trained by the Churches, and the majority of CHWs who serve the rural population work for the Churches. This is a key frontline Christian service and witness. Throughout PNG these workers depend on the Health Care Manual to guide them.

The 800 page *Health Care Manual* gives these CHWs the information they need to prevent and treat all the common health problems in PNG. But it is 21 years out-of-date and out-of-print.

Cliff Smith started a project to engage writers in PNG to do a collaborative major revision. However, sadly he was called home before he could see the fruit of his labour. During his final illness Cliff asked me to take over his role as Commissioning Editor.

The Project was initiated by Health Serve Australia, and is now run by the Baptist Union of PNG. We have engaged 18 doctors and other health professionals in PNG to work on this update. We are guided by AusVoc Educational Publishing, a Queensland company with extensive experience in publishing health materials in the Pacific.

We are deep into the process of commissioning and editing chapters, which are then being reviewed by our Technical Review Panel experts in Port Moresby. It is a massive task, but we believe that with the Lord's help it can be completed before the end of 2018. The project aims to deliver a copy of the new

Health Care Manual to every practicing CHW, and provide adequate supplies for the Training Schools so they can give a copy to every student to use during their training and then take with them into the field.

CHWs around PNG have told us how the old book has empowered them to provide health care in their remote communities and how they are longing for the new edition. The previous edition has been instrumental in saving countless lives and it is our prayer that the new Health Care Manual will have the same impact. The new edition will be in two volumes and include much more information on TB, HIV, maternal and child health, lifestyle diseases and particularly disease prevention. We have a vision to promote not just good health care but healthy communities.

Oliawa now enthusiastically trains the next generation of CHWs at Rumginae and shares with them his love for Jesus and his passion to serve the rural communities. His goal is to send more CHWs out with both the Gospel and an up-to-date Health Care Manual. Our goal is to enable this to happen. I want to thank Health Serve Australia and the members of CMDFA who support this project. ●

HealthServe Australia's website on the project: www.healthserve.org.au/png-health-care-manual-3rd-edition-feasibility-project.html

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Hayley Thomas

I wanted to spend dedicated time studying God's word, growing to know him more, and building a foundation for whatever he has for me in the future. During my year at SMBC, I enjoyed consistently hearing God's word taught faithfully, and having dedicated time to delve into it in study. This was complemented by the blessing of building relationships with staff and students – seeing the Christian life modelled and walking alongside others. I also benefited from the chance to reflect on the relevance of theology to a specific area of medicine, as I completed a research project in medical ethics. My time at SMBC has equipped me with knowledge to think more systematically about the Bible and theology, has broadened my exposure to mission, and has challenged me to grow in my own Christian walk.

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