CHRISTIAN MEDICAL & DENTAL FELLOWSHIP of AUSTRALIA Inc.

LUKE's journal

of Christian Medicine & Dentistry
Vol. 18 No. 2 August 2013

Conscience or the Collective

Conscience in Medicine

The Professional Morality of Medicine

Christian Conscience in Healthcare

Conscientious Objection – a Respected Right?

contacts

Published by the
Christian Medical and Dental Fellowship of Australia Inc.
ABN 95 084 292 464
Please submit all contributions to:

THE EDITORS:
Dr John Foley
14 Carunta St, Wattle Park SA 5066
Ph: 08 8332 5789
Email: djfoley@ozemail.com.au
Dr Paul Mercer
Ph: 07 3348 9940
Email: silkymedical@ozemail.com.au

Subscription and change of address details to the National Office listed below.

SUB-EDITOR:
Sue Furby
3/44 Birdwood Road, Carina Heights Qld 4152
Mobile: 0403 822 006
Email: suefurby@hotmail.com

CMDFA

Members of Council of Reference

CHAIRMAN:
Dr Judy Fitzmaurice
38A Stevens Street, Pennant Hills NSW 2120
Ph/Fax: 02 9980 5860 Mobile: 0434 967 678
Email: judyfitz@securenym.net
Or: fitzbitz25@hotmail.com

NATIONAL OFFICE:
Unit 35A / 9 Hoyle Avenue
Castle Hill NSW 2154
Ph: 02 9804 8890 Fax: 02 9804 8644
Email: office@cmdfa.org.au

BUSINESS MANAGER:
David Brown
Contact through the National Office

NATIONAL SECRETARY:
Teem Wing Yip
Email: office@cmdfa.org.au

NATIONAL TREASURER:
Dr Richard Allan (PHD Economics)
Email: office@cmdfa.org.au

ReGS (Recent Graduates & Students)
Dr Joanne Ma
Email: joannejjma@gmail.com

BRANCH SECRETARIES

NSW and ACT:
Richard Wong
Email: nsw@cmdfa.org.au

QUEENSLAND:
Vincent Lee
Email: qld@cmdfa.org.au

SOUTH AUSTRALIA (and NT):
Chrissy Lai
Email: Lai0051@hotmail.com

WESTERN AUSTRALIA:
Moses Lee
Email: Office@cmdfa.org.au

VICTORIA (and TAS):
David Tsang
Email: victoria@cmdfa.org.au

About the Journal

This Journal is published four times a year by the **Christian Medical and Dental Fellowship of Australia Inc. (CMDFA)**. The views expressed in the articles are those of the authors and not necessarily those of the CMDFA. Articles are reviewed by the editors and members of the editorial committee. Additional copies for passing on to interested colleagues can be obtained from the national office or Branch Secretaries.

Subscription of ***Luke's Journal*** is given to members of CMDFA. It is also offered to libraries and hospitals at the price of $55 per year including postage within Australia. Enquiries and notice of change or address should be directed to the national office.

About CMDFA

Membership of CMDFA is open to graduates and students of medicine and dentistry. Information about activities of CMDFA can be obtained from the website at **www.cmdfa.org.au** or from Branch Secretaries. Further information and application details are available through the national office.

Graphic design by Ivan Smith, Lilydale, Vic.
Printed by Amazon Printing, Warrnambool, Vic.

Back Issues

Back issues are available for the following Journals:

Vol 16 No 2	**Aug 2011**	**What it is to be Human**
Vol 16 No 3	**Dec 2011**	**Ethics Grand Rounds**
Vol 17 No 1	**Apr 2012**	**Suffering**
Vol 17 No 2	**Sept 2012**	**Parallel Careers after Medicine**
Vol 17 No 3	**Dec 2012**	**Administrative Affairs**
Vol 18 No 1	**April 2013**	**Complementary Medicine/ Dentistry**

These back issues are free for financial members of the CMDFA. The cost is $5 for friends of CMDFA or non-financial members (including postage). Please write to the national office making cheques payable to CMDFA Inc.

Other issues may be obtained from your Branch Secretary or from the national office.

editorial

Conscience in Medicine

No doubt we all have the experience of a guilty conscience. Christians also have the experience of God's forgiveness of the wrongdoing that produced the guilt, leaving us with a heartened awareness not only of our naturally sinful nature, but of gratitude for the grace of God. Modern society has brought to the fore matters – especially the debates about abortion IVF and euthanasia – that require us to know how to act according to our conscience. Mahatma Gandhi observed that "in matters of conscience, the law of the majority has no place."

But beyond these obvious and major sources of conflict and difficulty, there are many aspects of professional life that require a sensitive conscience. Have I been fully open and truthful? Have I given value for money whether it be for a fee or a salary? Have I sought my own comfort or convenience above that of my patient? Is my judgement clouded by self-interest? Have I taken responsibility above my level of competence? And others. We would all hope that such questions never raise their heads. But probably we have all been tempted in one of more such ways, and dare I say it, may not have recognised it at the time.

Most Biblical references to conscience come from the Apostle Paul. Before the Roman governor Felix he boldly claimed "I always take pains to have a clear conscience toward both God and man." To the church at Corinth he wrote about those with a weak conscience – perhaps he regarded them as overscrupulous and having not entered into the freedom that is found in Christ. But they were to be treated with Christian grace and forbearance. And to the Roman church he could write: "My conscience bears me witness in the Holy Spirit." God is the only one whose judgement of our actions is important. Oswald Chambers develops this principle well: "Whenever the conviction of God's Spirit comes there is the softening of the whole nature to obey; but if the obedience is not instant there will come a metallic hardening and a corrupting of the guidance of God."

As we wrestle with issues of conscience, and sometimes the issues are not immediately clear, as examples in this edition of the *Journal* demonstrate – or if we are plagued by a sense of guilt, we can seek the guidance of God. As we claim his promises, and he makes his way clear, we can go on with that peace that he alone can give, even in our current context of competing interests and values.

John Foley
Editor, Lukes Journal

Contents

Theme

Other Articles

LUKE's journal

Theme for next editions:

"Historytaking and Historymaking"
— copy by end of September 2013

"International Health & Mission"
— copy by mid October 2013

"Shining as Lights"
— copy by February 2014

Conscience or the

C*onscience is the natural law written on all human hearts, which individuals perceive more or less clearly and act on more or less faithfully. *Conscience is a perception, however clouded, of transcendent reality – a feeble resonance in our own minds of the justice and goodness of the Mind of God – and therefore as much a part of the rationality of the Universe as the mathematical beauty that so excites agnostic scientists from Einstein to Paul Davies. Conscience is not a social construct to be refashioned according to political fad.

It was after the fascist fad of the Nazi era, with its brutalising of conscience in the medical profession in particular, that a distraught world searched its soul and reaffirmed fundamental right and wrong; first in the Nuremberg code and then in the Universal Declaration of Hunan Rights (UDHR, 1948).

The preamble to the UDHR stresses the historical context:

> "Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people; Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law…"[1]

The noble affirmation of fundamental human rights followed, heavily influenced by Christian philosophers. Conscience had been required to rebel against the monstrous tyranny of the Nazi era; now the insights of a just conscience were to be enshrined in law "for all time".

Top priority in the UDHR is given to freedom of conscience, as being central to the dignity of a rational creature. The opening Article states:

> "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."

Article 18 reinforces the fact that reason and conscience are linked; rational reflection on right and wrong is the essence of conscience, and both are central to religious attempts at right living:

> "Everyone has the right to freedom of thought, conscience and religion".

The point is that conscience is not merely a scruple of religious minds that a secular world can indulge or dismiss as it sees fit. Intelligent conscience is the guide to right relationships for all peoples at all times. Take another look at the appendix to C S Lewis's book, *The Abolition of Man* to recall the similarities of moral judgement across widely differing cultures. Importantly, the Universal Declaration drew on the philosophical tradition of natural law; it enunciated inalienable freedoms that are ours by virtue of being rational creatures, not by fiat of any political power. One of the drafters of the Declaration was Charles Malik, head of UNESCO, and he stressed that these rights were recognised as inherent to human nature, not subject to the spirit of the age:

> It is not an accident that the very first substantive word in the text is the word "recognition":

Collective

by **David van Gend**
David is a GP in Toowoomba;
www.davidvangend.com
vangend@macmed.com.au

> "Whereas recognition of the inherent dignity and of the equal and inalienable rights, etc." Now you can "recognise" only what must have been already there, and what is already there cannot, in the present context, be anything but what nature has placed there… Dignity and rights are natural to our being and are not the generous grant of some external power.

Here is an assertion of immutable natural law – consistent with the Christian tradition – against trends to redefine right and wrong according to the interest of the dominant collective. For just a little while after the war the conscience of the world was wise; now the soulless collectivism that brutalised medical conscience three generations ago is brutalising it again.

Julian Savulescu, Uheiro Professor of Practical Ethics at Oxford, formerly of Melbourne, made the collectivist case in the BMJ in 2006:

> A doctor's conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law… If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors.[2]

Savulescu specifies that doctors who will not provide abortion should "be punished through removal of licence to practice". Crucial to his argument is that, "when society has already decided that a service is legal," then it is not for doctors to "compromise the delivery of services."

When Savulescu's article was discussed in 2006 in *Australian Doctor,* I was given as an example of the sort of doctor who, in his view, "should either get out of the specialty or the profession altogether".[3] By contrast, Melbourne ethicist Nicholas Tonti-Fillipini stated: "The claim that a doctor ought not to follow his or her conscience but is obliged to offer whatever medical services are lawful is totalitarian."

Consider the current example of the Christian GP, Mark Hobart, caught up in Victoria's abortion laws – brutal laws that carry "the hallmarks of totalitarianism" according to Frank Brennan, former

>>>

Chair of our National Human Rights Consultation Committee.[4]

Under Victoria's laws, abortion is permitted – with no medical justification required – up to 24 weeks of pregnancy. Any reason or none is sufficient for the killing of a baby even older than those in our hospital nurseries. A doctor must cooperate with such requests, or at least refer the client to a doctor whom he knows will have no conscientious objection to such requests.

And so, on April 28th we read in the press:

> A MELBOURNE doctor who refused to refer a couple for an abortion because they wanted only a boy has admitted he could face tough sanctions… The couple had asked Dr Hobart to refer them to an abortion clinic after discovering at 19 weeks they were having a girl when they wanted a boy.
>
> By refusing to provide a referral for a patient on moral grounds or refer the matter to another doctor, Dr Hobart admits he has broken the law and could face suspension, conditions on his ability to practice or even be deregistered. "I've got a conscientious objection to abortion, I've refused to refer in this case a woman for abortion and it appears that I have broken the rules," he said.
>
> Medical Practitioners Board spokeswoman Nicole Newton said doctors were bound by the law and a professional code of conduct.[5]

"Conscience is a non-negotiable element in the integrity of any person who would be a doctor."

Are the authorities siding with the Savulescu principle: that if a medical procedure is legal, even if gravely immoral, a doctor must comply or be punished? If so, the political brute force of law is once again crushing the conscientious right of a doctor to refuse to do what he considers wrong.

Consider other scenarios where law can conflict with conscience and leave Christian doctors uninsurable and unable to practice.

- If euthanasia became lawful, where does that leave a doctor who thinks it is wrong, and contrary to the role of a doctor, to participate in the intentional ending of a patient's life?
- If same-sex marriage and assisted reproduction becomes lawful, where does that leave a doctor who refuses to grant a lesbian couple's request for anonymous donor insemination, on the grounds that it is wrong to conceive a child in the full intention of depriving that child of a father?

My concern is that these scenarios will be so daunting to young, bright Christian students that they will choose some other profession rather than put themselves through such stressful ethical conflicts. It is for our generation to show them, by example and by clear ethical argument, that one can stare down this soft-totalitarian intimidation.

Of course, not all matters of conscience are matters of life and death for which we have to man the barricades; some are not true cases of "conscientious objection" at all and only debase the currency. For instance, a doctor in Queensland refuses to provide childhood immunisation on grounds of "conscientious objection". That is a misuse of the term. The question of the risks and benefits of vaccination is purely technical. GPs are bound to respect the authority of the public health experts on such questions. If they refuse to offer vaccinations, that may be on grounds of dubious "clinical objection" but not on moral grounds of conscience.

That is why a recent paper in a Christian journal of bioethics on "Objective Reasons for Conscientious Objection in Health Care" differentiates between spurious objection based on idiosyncratic whim and that based on foundational values and principles:

> Recognising a general right to conscientious objection based on individual liberty, and thus a subjective right, could have negative consequences. Conscientious objection in health care settings should be fully protected however, when the objection is based on principles that are fundamental to the medical profession and the legal system.[6]

One such fundamental principle, eloquently stated by the House of Lords Select Committee on Medical Ethics in 1994, is "the prohibition of intentional killing, which is the cornerstone of law and social relationships". This 1994 enquiry concerned euthanasia, but the principle is an equally objective reason for conscientious rebellion against Victoria's abortion law.

If we as doctors are obliged by law to do what is wrong, we must refuse. Conscience is a non-negotiable element in the integrity of any person who would be a doctor. Crush the conscience of a doctor and you will end up with a diminished and disintegrated person as your confidant and healer.

References

1 Universal Declaration of Human Rights (1948) http://www.un.org/en/documents/udhr/index.shtml

2 Savulescu J, Conscientious objection in medicine, BMJ Vol 332, Feb 2006 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360408/

3 Kron J, Do doctors have a right to refuse to provide treatments on moral grounds? *Australian Doctor*, 9/5/06 http://www.australiandoctor.com.au/articles/a1/0c03f1a1.asp

4 Brennan F, Totalitarian abortion law requires conscientious disobedience, *Eureka St*, 24/9/08, http://www.eurekastreet.com.au/article.aspx?aeid=9155

5 Herald Sun, "Melbourne doctor's abortion stance may be punished", April 28th 2013 http://www.heraldsun.com.au/news/victoria/melbourne-doctors-abortion-stance-may-be-punished/story-e6frf7kx-1226631128438

6 Meaney J, Casini M, Spagnolo AG, Objective Reasons for Conscientious Objection in Health Care; The National Catholic Bioethics Quarterly Volume 12, Number 4 / Winter 2012 http://ncbcenter.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,4,9;journal,1,48;linkingpublicationresults,1:119988,1

All in a **Days Work!!**

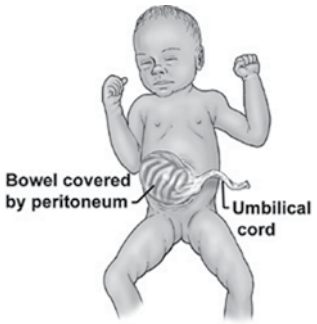
by **Dr Joseph Thomas**

These are real life situations provided by Dr Thomas who works as a Maternal Fetal Medicine Specialist in Queensland. The cases were discussed as part of the Ethics workshop in Melbourne at the National Graduates Conference June 2013.

CASE SCENARIO 1

How will my daughter have a belly button ring?

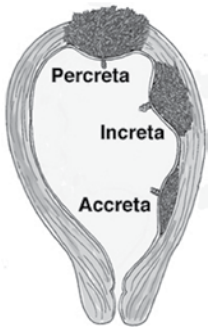
I was following up this young lady initially seen at 14 weeks with a diagnosis of an omphalocoel, a defect of the anterior abdominal wall. We performed an amniocentesis to rule out chromosomal abnormalities and counselled her adequately about the good outcome in these instances after repair of the anterior abdominal wall after the baby is born, by Maternal Fetal Medicine specialist and Paediatric Surgeons. She elected to continue the pregnancy.



At the 20 weeks antenatal visit she asked me a question about the belly button and if a belly button ring would be possible when this fetus (now known to be a girl) grows up. She was counselled about the reasonably good outcomes possible with repair and fashioning of what could represent a belly button. I got the surgeons involved in counselling her again. Nothing could make the mother change her mind about proceeding with termination.

FOOD FOR THOUGHT... What else could I have done?

CASE SCENARIO 2



I saw this lady, a multigravida at 20 weeks, with bilateral renal agenesis and anhydramnios (Potters Syndrome). In addition she had placenta praevia and accreta as she had 2 previous LSCS. She was at risk for serious maternal morbidity and mortality. In addition the baby had a poor prognosis at birth and most babies with Potters Syndrome die soon after birth.

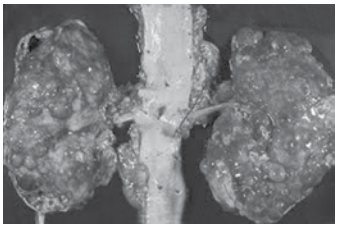
She was advised to have an elective preterm delivery of the baby and a planned caesarean hysterectomy since baby wouldn't anyway survive but refused. She also refused to have any blood or blood products since she had a religious belief against the use of blood and blood products. She presented to the emergency department with profuse vaginal bleeding and was rushed to theatre at 2 am ~ 34 weeks gestational age. She underwent an emergency caesarean hysterectomy. She nearly lost all of her blood volume and was shifted to intensive care on life support. She was true to her conscience (almost) to the end.

FOOD FOR THOUGHT... Was she right in what she did?

CASE SCENARIO 3

I had a referral sent in by a GP requesting us for a tertiary opinion and taking over the care of complex ultrasound findings. This was beyond the GP's competence and he told the woman that the hospital would continue her care from then on. We scanned her and arrived at the conclusion that the fetus had bilateral multicystic dysplastic kidneys – a kidney abnormality where the urine does not drain into the bladder and the fetus develops anhydramnios, hypoplastic lungs and is not able to breathe once delivered. In addition the anhydramnios causes severe musculo-skeletal deformities and facial dysmorphism. The woman was understandably distraught and we had several sessions of consultation offering her perinatal palliative care as one of the options.

However the woman decided to discontinue the pregnancy as the thought of giving birth to a baby who would die soon after was unbearable for her. I mentioned that I would send her back to her GP (as we do not provide a termination service) who would then refer her to another hospital. This was adding insult to injury as far as she was concerned and she did not want to go back to the GP who had referred her to us for care. In tears she requested me to make some arrangements for her so that she is not running from pillar to post.



FOOD FOR THOUGHT... What should I do?

The **Professional**

When we consider the role of conscience in medicine, it is not surprising that it seems to be under attack given the trend in secular bioethics towards elevation of respect for patient autonomy as the overriding principle.

One of the disturbing features of modern medicine is the loss of any sense of the doctor as a moral agent, making significant moral choices, either as a member of a profession with distinct values and standards, or as an individual with his or her own moral commitments. Priority is given to the values of the patient over those of the doctor. Medicine has adopted the language of the market, so that patients are now seen as consumers and doctors as service providers. Further, some believe that "there is nothing in the training of a doctor which makes him (sic) specially or uniquely competent to make a medical-moral decision of great weight."[1] So what has become of the idea of medicine as a profession of certain distinctively medical commitments, and of medical education as a process whereby students are trained to understand their role-specific ethical obligations as well as medical science and skills?

Medical ethics may be understood in two quite different ways. Either it is an exercise in the application of general or broad based ethical theory (ies) to the particular issues which arise in medicine, and which relies on a moral authority "external" to medicine; or clinical medicine may be understood to generate its own "internal" morality: a complex of professional role-generated norms and commitments which arise from the nature of medicine itself with particular and characteristic goals. So, doctors might have particular reasons (in addition to the general reasons that exist) for believing that for example, it is wrong for doctors to kill their patients, or breach their confidences, or have sexual relationships with them.

What is the basis for a distinctive professional morality of medicine?

Aristotelian virtue ethics provides a robust framework for role-based and professional ethics, since professions tend to have clear, specific and widely recognised goals. It is teleological (goal based), in that virtues are character traits required for human flourishing in general, which is the goal or end of human life, or for the achievement of the goals of particular professions, such as medicine, education or law. These goals shape the internal morality of the profession in question.

There are two ways in which it may be argued that such an internal morality exists. The first is to point out contemporary and historical evidence for doctors having distinctive moral norms and standards. The second is to argue philosophically for the coherence of such an internal morality.

Contemporary evidence for distinctive medical moral norms

One example comes from examining doctors' attitudes to killing and 'letting die'. Contrary to the dominant view in bioethics that there is no moral significance in the distinction between these, statements of medical associations worldwide oppose medical involvement in euthanasia and physician-assisted suicide, but approve the withholding or withdrawal of medical treatment, under appropriate circumstances. Both the American and British Medical Associations explicitly draw on the concept of medicine having distinctive goals and doctors having a particular role, when they describe both euthanasia and physician-assisted suicide as "fundamentally incompatible with the physician's role as healer"[2] and "in tension with the fundamental role of doctors."[3]

Historical evidence for distinctive medical moral norms: The Hippocratic Tradition

The most important historical evidence for an internal morality of medicine is found in the Hippocratic tradition, as exemplified by the *Hippocratic Oath*. However some scholars cast doubt on this, suggesting instead that it simply reflects the views of a particular, minority group of Pythagorean physicians.[4]

Two clauses in the *Oath* relate to physician-assisted suicide and abortion:

> *Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.*
>
> *Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art.*[5]

Despite the fact that the view that the *Oath* is a Pythagorean manifesto is accepted today by few scholars of ancient medical history, the idea that the *Oath* is discredited as an expression of ancient medical ethics has played an influential role in the public and medical debates about both abortion and euthanasia. Jack Kevorkian (sometimes called "Dr. Death") confidently claimed that euthanasia and assisted suicide were widely practiced in ancient Greece in accordance with the "true Hippocratic tradition."[6] Such a view was also cited in both the Supreme Court's opinion in Roe v Wade and by Michigan appellate-court judge Andrew Kaufman in his "Opinion and Order Concerning

by **Denise Cooper-Clarke**
Denise is a medical ethicist and researcher with ethos (Zadok Centre for Christianity and Society)

Morality of Medicine

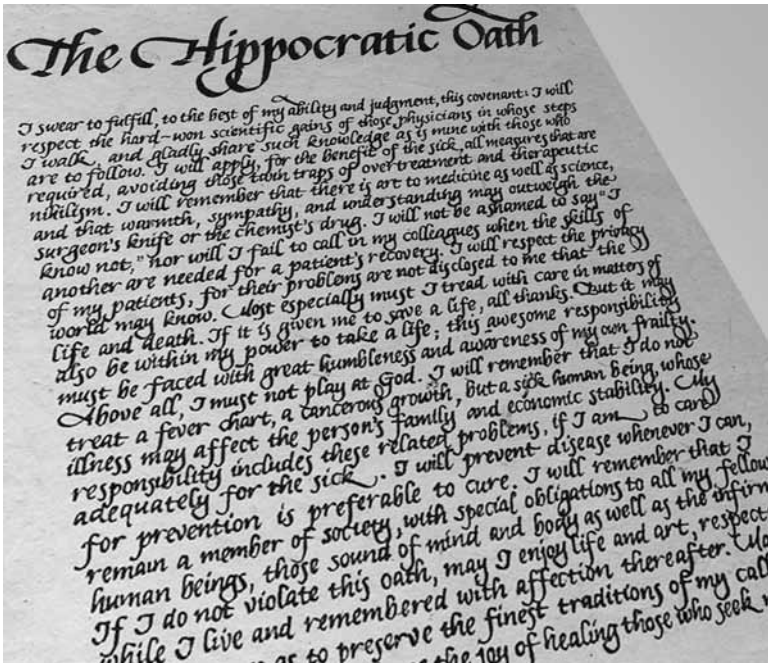
the Constitutionality of the Michigan Statute Proscribing Assisted Suicide", in order to discredit the *Oath* as "the expression of an absolute standard of medical conduct."[7] But these views are not supported by more recent scholarship.[8]

Nor is there a great deal of evidence that in ancient times doctors were involved in abortion and/or assisted suicide. Ancient abortive remedies were both unreliable and dangerous, and on those grounds alone doctors would have reason to avoid them. It seems in any case, abortive remedies were usually provided by midwives, though there was some evidence of medical involvement. Similarly, suicide was relatively common in the ancient world, but medical involvement cannot be simply assumed in a practice which by no means always or even often required it. Despite the claim that "the intervention of physicians in rational suicide was common practice, particularly if motivated by reasons of health,"[9] there is no example of an illness-related request for physician-assisted suicide, and only three examples of varying degrees of physician assistance in patient suicide.*

It is therefore problematic to conclude that the *Oath* was regarded as irrelevant or esoteric in ancient times. The fact that some physicians did not act according to the *Oath* is exactly what we would expect. No formal education, qualifications, or state regulation of physicians existed, and the Hippocratic *Law* notes that "Many are physicians by repute, very few are such in reality."[10] Some "physicians" may have simply been poison sellers.

And whether or not the *Oath* was observed by or agreed to by the majority of ancient physicians, it might still have reflected a genuinely medical morality. The most plausible basis for the moral standards of the *Oath* is the nature of medicine as an art/craft (*techne*). The use of this term in the *Oath* is characteristic of the Hippocratic writings. The writer/s of the *Oath* tried to draw out the moral significance inherent in the craft itself. The prohibitions of the *Oath* were based on the standards of a craft, the *telos* of which is to benefit the sick. This puts limits on the use to which medical skills can be applied, in that they cannot be used for alien ends (such as the destruction of human life). "It is not that to do these things would be to fail to be a good Pythagorean, but rather to fail to be a good medical practitioner."[11]

Thus, a review of the evidence and debate about the Hippocratic tradition suggest that it may reasonably still be regarded as an ancient expression of the internal morality of medicine.


The Hippocratic Oath

I swear to fulfil, to the best of my ability and judgment, this covenant: I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow. I will apply, for the benefit of the sick, all measures that are required, avoiding those twin traps of over-treatment and therapeutic nihilism. I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery. I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God. I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick. I will prevent disease whenever I can, for prevention is preferable to cure. I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm. If I do not violate this oath, may I enjoy life and art, respect while I live and remembered with affection thereafter. May I

Philosophical argument about an internal morality of medicine

The internal morality of medicine refers to the body of moral norms binding on doctors by virtue of their membership in the profession, derived from the special features of the doctor-patient relationship.[12] A significant influence on the development of the concept of an internal morality of professions was Alasdair MacIntyre's *After Virtue*, in which he introduced the concept of a practice (of which medicine is cited as an example). According to MacIntyre, being involved in a practice such as medicine involves accepting particular standards of excellence and obedience to (particular) rules, and the acquisition of certain virtues, which are required in order to achieve the internal goods (sometimes also called the goals or ends) of that practice.

MacIntyre distinguishes the internal goods of a practice from those external goods which may be attained incidentally by engaging in the practice, such as prestige or wealth. Goods are internal "because they can only be identified and recognised by the experience of participating in the practice in question. Those who lack the relevant experience are incompetent thereby as judges of internal goods."[13] This implies not only that medicine has an internal morality, but also that medical practitioners are in a privileged position when it comes to specifying what the internal goods of medicine are.

>>

* These examples are: the death of Seneca by poison given to him by his physician (Tacitus, XV, LXIV ; the physician Hermogenes who is said to have shown his patient Hadrian the point on his chest where stabbing would ensure swift and painless death (Cassius Dio), and the death of Lucan, who was condemned by Nero , but given "free choice of the manner of his death" ,"allowed a physician to open the veins in his arm" (Suetonius). There is also reference to Thrasyas of Mantineia as the discoverer of a drug derived from hemlock, poppy and other herbs which would induce a painless death, and for which there was no antidote" (Theophrastus, IX, XVI, 8).

On the other hand in the (fictional) *Golden Ass,* a physician states that he did not give poison when requested because "he did not believe it proper for his calling to be instrumental in bringing death to anybody, and because he had been taught that medicine had been invented not for the destruction of man but for his welfare" . Another, historical example of refusal to supply a lethal drug is the physician who, rather than give poison to the emperor Hadrian who wishes to commit suicide, prefers to suicide himself, as reported in *Historia Augusta*, Hadrian, XXIV. This example is particularly telling in that it involves not a general objection to suicide, but only, it seems, objection to medical involvement in a patient's suicide.

The Goals of Medicine Project, established in 1992 by The Hastings Center concluded that, "one source of the universality in medicine is our common human nature," which entails the universal experiences of illness, suffering, pain, and ageing.[14] However the expression of these values and goals may be different in different cultures.

It is useful to distinguish between the internal norms of medicine (derived from its universal features) and external norms, such as always informing patients of their diagnosis, respecting individual patient autonomy, or the just allocation of resources, which are to a certain extent relative to the particular culture in which medicine is practiced, and may indeed sometimes conflict with its internal norms.[15]

So, it is reasonable to think that at least part of medical morality is derived from its internal norms. The next question to consider then, is what the goals of medicine are.

The Hippocratic work, *The Art* defines the goals of medicine as "to do away with the sufferings of the sick, to lessen the violence of their diseases, and to refuse to treat those who are overmastered by their diseases, realising that in such cases medicine is powerless."[16] The traditional goals of medicine are generally construed as the promotion of health, and healing, which include saving life, restoring health, and enabling patients to cope with disability and death when cure is not possible. The aphorism "To cure sometimes, to relieve often, to comfort always" is frequently cited.**

In 1991 Eric Cassell proposed that the primary goal of medicine should be expressed in terms of the relief of suffering.[17] In the following year, the Hastings Center Goals of Medicine Project was commenced, as a result of the perceived need to re-examine the traditional goals of medicine in light of the enormous changes in the practice and potentialities of medicine in the Modern era.[18] After seven years of international collaboration, the Project specified four goals of medicine: 1) the prevention of disease and injury and the promotion and maintenance of health; 2) the relief of pain and suffering caused by maladies; 3) the care and cure of those with a malady, and the care of those who cannot be cured; and 4) the avoidance of premature death and the pursuit of a peaceful death.[19]

Not everyone would agree with these goals. And the participants in the Goals of Medicine Project (drawn from fields including medicine, law, philosophy, theology, health policy and administration) were in disagreement as to whether euthanasia or physician-assisted suicide would be compatible with the goals they proposed.

The corollary of medicine having specific goals is that it also has limits. Hippocratic physicians understood the task of medicine as working with or assisting nature to restore the "natural state of health". This also entailed setting boundaries to avoid the error of excessive confidence.[20] As we have noted, the Hippocratics refused "to treat those who are overmastered by their diseases, realising that in such cases medicine is powerless."[21]

** This aphorism is usually attributed to Dr. Edward Trudeau (1182-1915), founder of a tuberculosis sanatorium, although it actually derives from a 15th Century French folk saying.

Conclusion

A review of the historical and philosophical arguments about an internal morality of clinical medicine suggests that, while not uncontentious, the idea that medical morality is generated at least in part from internal norms which are derived from the goals and limits of medicine is both powerful and plausible.

However, moral practices such as medicine do not exist in isolation from broader social traditions. To a large extent in Australian society the Judeo-Christian tradition has given way to liberal individualism. It is a moot point whether the moral vacuum at the heart of liberalism can sustain the 'traditional' norms of medicine, such as respect for human life, or whether it will instead be filled by the law and market forces. The view of a doctor as a value neutral service provider is in fact the product of a particular values system (or 'tradition' if it may be called that): liberal individualism. But even as an expression of liberalism this view fails because it results in the patient effectively imposing his or her moral view on the doctor: the patient determines whether a particular act is right or wrong, and yet it is the doctor who is the agent, the one who acts. Practising medicine is an activity fraught with moral significance. Doctors, like all mature human beings, make moral judgments for which they have responsibility and are therefore moral agents. To require doctors to act against their conscience fails to recognise the moral significance of medicine itself as a moral practice, as well as the significance of the broader moral traditions which inform doctors' decisions. LJ

References

1 Kennedy, I.(1991) What is a medical decision? In *Treat me Right: Essays in Medical Law and Ethics*. Oxford, Clarendon Press, p.25.
2 American Medical Association. (1994). Euthanasia. Retrieved June 9, 2003, from http://www.ama-assn.org/ama/pub/printcat/8458.html
3 British Medical Association. (2000). End of life decisions- views of the BMA. Retrieved January January 27, 2004, from http://bma,org.ok/ap.nsf/Content/End+of+life+decisions+%2D+June+2000
4 Edelstein, L. (1943). *The Hippocratic Oath: Text, Translation and Interpretation*. Baltimore: Johns Hopkins University Press and Carrick, P. (1985). *Medical Ethics in Antiquity: Philosophical perspectives on Abortion and Euthanasia* (Vol.18). Dordrecht: D. Reidel.
5 Hippocrates. The Oath in W.H.S. Jones (Ed.) (1923). *Hippocrates with an English Translation* (Vol.1, pp. 299-301). London and Cambridge, Massachusetts: William Heinemann Ltd and Harvard University Press, p.299.
6 Kevorkian, J. (1998). A Fail-Safe Model for Justifiable Medically Assisted Suicide. In M. Uhlman (Ed.), *Last Rights: Assisted Suicide and Euthanasia Debated* (pp.263-295). Washington and Grand Rapids, Michigan: Ethics and Public Policy Center, Washington and William B. Eerdmans Publishing Company, p. 273.
7 1993 WL 603212 (Mich. Cir. Ct), p.10.
8 Larson, E.J. and Amundsen, D.W. (1998). *A Different Death: Euthanasia and the Christian Tradition*. Downer's Grove, Illinois: Inter Varsity Press; Risse, G. (2003). Reconstructing History Medical History, 47 (1), 108-112, p. 110.
9 Gourevitch, D. (1969). Suicide among the Sick in Classical Antiquity. *Bulletin of the History of Medicine, 43*, 501-518, p. 509.
10 Hippocrates. Law. In W.H. Jones (Ed.) (1923) *Hippocrates with an English Translation* (Vol.2, pp. 263-265). London and Cambridge, Massachusetts: William Heinemann Ltd and Harvard University Press.
11 Hauerwas. S. (1986). *Suffering presence: Theological reflections on Medicine, the mentally Handicapped and the Church*. Notre Dame, Indiana: University of Notre Dame Press. p.8.
12 Ladd, J. (1983). The internal morality of medicine: An essential dimension of the physician-patient relationship. In E. Shelp (Ed.), *The clinical encounter: The moral fabric of the physician-patient relationship* (pp. 209-231). Dordrecht: D. Reidel, p.209.
13 MacIntyre. A. (1984). *After Virtue* (Second ed.) Notre Dame: University of Notre Dame Press, pp. 188-189.
14 Allert, G., Blasszauer, B. Boyd, K., Callahan, D., Gillon, R., Glasa, J. et al (1996). Medicine and Society. *The Hastings Center Report, 26* (6), S6-S8, p, S6.
15 Ladd, The internal morality of medicine.
16 Hippocrates. The Art. In W.H.S. Jones (Ed.) (1977). *Hippocrates with an English Translation* (pp. 191-217). London and Cambridge, Massachusetts: William Heinemann Ltd and Harvard University Press, p.193.
17 Cassell, E. (1991). Recognizing suffering. *The Hastings Center Report*, 21 (3), 24-31.
18 Callahan, D. (1999). Remembering the goals of medicine. *Journal of Evaluation in Clinical Practice*, 5 (2), 103-106.
19 Allert, G., Blasszauer, B. Boyd, K., Callahan, D., Gillon, R., Glasa, J. et al (1996). Specifying the Goals of Medicine. *The Hastings Center Report*, *26* (6), S9-S14.
20 Jecker, N. S.(1991). Knowing when to stop: the limits of medicine. *The Hastings Center Report, 21* (3), 5-9.
21 Hippocrates, The Art, p.193.

Changing a **Medical Practice** from bulk-billing to non bulk-billing

Since its inception, Medicare refunds have not kept pace with inflation. However, the costs involved in running a Medical Practice have continued to rise, more in line with inflation. This has meant a continual eroding of medical incomes in bulk-billing practices. Why should a high quality service result in a declining income?

In the last two years, wages in the general community have risen greater than inflation, adding to the costs of running a business. The anticipated rises in compulsory superannuation will ensure this continues. No other service industry has those receiving the service making no contribution – so why should medicine? Patients who contribute towards their medical care are more likely to be appreciative, and failure to ask for that contribution effectively devalues the service, not only in the minds of the patient but also in that of the doctor.

There are three steps in ceasing to bulk bill all, or most patients:

1. **Inform all patients by letter, in advance of the proposed changes.**
   A draft letter is attached. It is best to mail it out to all patients affected by the increases in the fees a couple of months ahead and, while that involves considerable postage, it is quickly recouped with the fee rises. Alternatively, patients could be handed a letter when they attend, and the changes to them would then apply in all subsequent visits. This is much more difficult from an administration viewpoint, and I would not recommend it. It is not helpful for fee rises to apply to patients at different times, and it is very messy when multiple members of a family attend at different times. Reception staff will have much more difficulty in adapting to the changes if this latter approach is taken.
2. **Classify patients to indicate fee levels for each family.**
   Patients are classified according to their means – with a number of categories, say A, B, C and D. For example, "A" patients pay $25 over the Medicare refund, "B" $15, "C" $10, and "D" remain bulk billed. The classification may change over time, with changes in the family circumstances. It is most important that the classification is made in as objective a way as possible, and certainly not at the time of the appointment. Our natural empathy with our patients makes this more difficult then. And the actual billing needs to be at arms length to the doctor.

   You may choose to involve the reception staff in this classification. They may well be aware of individual patient's situations. Often patients tell reception staff what they did on holidays, of their new house or car etc. while the doctor assumed they are hard up.

   The actual level of these fees could be determined by consulting one of your medical friends as to what they do. You may well be surprised as to how high the fees are, and how little reaction the patients have to such fees.

   There is some anxiety as to whether patients will leave the practice if it ceases to bulk bill. In my experience few do leave, and remember that, if one third departed, you would still earn more money than now!

   If the system is a manual one, each individual or family file has the classification listed on the front page, so that reception staff know what to charge. If accounts are generated by computer, then there are four fee schedules, and the computer is programmed to choose the appropriate level of fees automatically. Some practice software packages allow a discount level to be programmed in, and then the discount is printed on the invoice. That is an ideal, and continually reminds the patient of your generosity.
3. **Approach Medicare to install the necessary hardware, and provide staff training, to enable the practice to claim on behalf of the patient for a Medicare refund, so that the patients are minimally inconvenienced by the changes.**
   This may involve an additional phone line but it is well worth doing. Patients need to notify Medicare of their banking details – you can issue the forms at the time of the appointment or enclose them with your letter – and their refund is deposited in their account (I think) 3-5 days after the visit. The additional administration for reception staff is very minimal. Increasingly, Medical Practices provide this service.

Draft Letter to Patients – dated and on letterhead

Dear Patient,

I am writing to inform you that, from date a couple of months ahead, the Practice Name will no longer be able to bulk bill all patients for their medical care.

Over the years the increases in Medicare refunds have not kept pace with inflation. However, the costs of running a medical practice have continued to rise more quickly. For this reason we will now require you to make a small contribution towards your own medical care.

All patients will be required to pay their account in full at the end of each appointment. No accounts will be sent. We will, however, be able to make a Medicare claim on your behalf so as to save you time and effort. It does require you to notify Medicare of your banking details, and a form to be sent to Medicare is enclosed with this letter. Normally, Medicare refunds will be deposited into your account so many days, whatever Medicare says, after your appointment.

It is certainly not our intention that anyone experience hardship as a result of these changes. If this applies to you, then please speak to the doctor when you next come for an appointment.

Regards,

Either the principal's name/signature or list all the doctors in the practice.

Conscience, Anaba

We live in a highly bureaucratically regulated society which gives, in practice, little room for the exercise of conscience. That is, legal structures and tightly defined procedural norms largely take matters of conscience out of the hands of the law-abiding and professionally regulated individuals.

Whilst there are obvious benefits in the collective regulation of individual choice and action, there are also serious costs associated with over-regulation and rampant litigation. The central cost is that a strict conformism to always follow proscribed procedures and legally mandated guidelines can clash terribly with the moral, religious and simply human requirements of conscience. For if a rigid and morally blind procedural conformism becomes entrenched in the legal and professional structures of our way of life, this deadens people to the voice of conscience, and this will have disastrous effects on the moral fibre of society. For example, in *Modernity and the Holocaust* the sociologist Zygmunt Bauman describes the manner in which Nazi Germany illustrates the way modern bureaucratic rationality actively tends towards silencing the voice of individual conscience and criminalising humane and moral action. Indeed, Bauman persuasively argues that the perceived morality of unswervingly following correctly authorised legal and procedural directives was a primary component in the moral horror of the Holocaust.

"...how to uphold conscience in an environment that increasingly removes conscience from the actions of individuals, and which increasingly defines 'ethics' as legal and procedural regulation, is one that Christian health care professionals cannot ignore."

Clearly – and there are many Australian examples that could be drawn on here – legal and procedural proscriptions are not necessarily moral. Clearly, laws and professional regulations always reflect the cultural values, beliefs and vested interests of the prevailing status quo in any given society. Clearly, also, Jesus was a procedural non-conformist who was condemned to death by an authorised legal process which upheld the vested interests of the dominant political forces of his larger community.

This does not mean, of course, that the rule of law is inherently bad, or that procedural regulation is intrinsically morally blind. To the contrary, we should thank God for law and procedural regulation. However, there is a necessary tension between morally virtuous individuals and the structures and systems that should support moral virtue within a society. For structures and procedures are no replacement for personal moral virtue, and the capacity to make intelligent and contextually specific moral judgements is – so Aristotle argues – a necessary condition for the aspiration towards a good society. Further, the prophetic critique of power and human authority by revealed truth is always needed in every society in order to guard against the natural fallen tendency of moral atrophy to coalesce with authority, wealth and power. As Walter Brueggemann points out, this courageous and marginal prophetic imagination is in the DNA of the Christian faith.

Aristotle's vision is one where morally mature individuals are able to judge when conformism is and is not morally required, and the moral society is one where larger political norms support moral citizens being courageous enough to challenge and resist merely prescribed guidelines and to challenge and even disobey laws were needs be. Historically, the combination of a Christian appreciation of the striking non-conformism of Christ and the martyrs coupled with an Aristotelian understanding of political morality has profoundly shaped the West's understanding of what the rule of law should entail, and what type of free and responsible moral actors mature citizens should be. Yet today, such an outlook is becoming increasingly incomprehensible.

The rise of consumerism as a way of life has culturally eclipsed more religiously and metaphysically framed notions of moral reality. Increasingly the normative structures of our larger society assume moral irrealism where whatever the bureaucratic and legal consensus is, that – for here and now – is definitionally ethical. Here morality is entirely socially constructed and the very notion of transcendent moral truth is displaced by the entirely material, tangible, 'bottom-line' realism of the market. Here values are private belief preferences and have no connection to public facts or social and political action. Here law and regulation are not subject to any higher moral truth but generate their own normative force. This normative force arises, so we seem to presume, simply as a result of the procedural negotiation of different vested interests as hammered out by lobby groups and parliament. The result of this procedure is a workable collective understanding of appropriate self-interest which defines normative validity. Increasingly, in this cultural context, the conscience-driven non-conformist will not be understood as anything other than unethical and inexcusably liable.

by **Dr Paul Tyson**
Paul is an Honorary Fellow,
School of Philosophy,
Australian Catholic University

ptists & Medicine

The Christian cannot accept that there is no transcendent moral reality which both can and often does clash with our legal and regulatory norms. Thus the question of how to uphold conscience in an environment that increasingly removes conscience from the actions of individuals, and which increasingly defines 'ethics' as legal and procedural regulation, is one that Christian health care professionals cannot ignore.

The Anabaptist tradition has some interesting things to say in relation to following one's Christian conscience in an environment which is totally unresponsive to foundational Christian truths. The Anabaptists are radical non-conformists who believe that the Sermon on the Mount must be followed. Jesus did not resist evil with force, Jesus broke the cycle of vengeance and retribution with forgiveness and by being a scapegoat Himself, Jesus practiced a counter-imperial politics of peace. Being the king of this sort of kingdom got Jesus crucified. In the 16th century, seeking to follow Jesus without recourse to sectarian violence likewise produced a great host of martyrs among the Anabaptists. Between 1535 and 1546 at least 30,000 Anabaptists were killed by Protestant and Catholic-aligned civil authorities in Holland and Friesland alone. Today, the Mennonite, Amish and other Anabaptist communities are together known as the historic peace churches and they still practice non-conformism regarding violence and the way of peace. The Anabaptists have discovered that if you are really serious about affirming life and refusing violence, then you become aware of how deeply entrenched death and violence are to our way of life. We will finish this short article off by quickly looking at one area where an Anabaptist understanding of the non-violent and life-affirming way of Jesus readily comes (ironically) into conflict with the prevailing legal and procedural norms of Australian medical practice. That area is "genetic counselling".

For legal purposes the unborn child is considered the medical property of the mother so if the mother wants to perform the medical procedure of aborting her unborn child, that is not a moral or religious issue in the eyes of the law, but simply a medical procedural issue which the mother – like a consumer of any legally available service – elects to have. It goes without saying that the Anabaptist refusal of violence, particularly towards the vulnerable, puts them in radical opposition to abortion. However, here I want to explore how medicalised commodification and legally sanctioned violence within an amoral consumer culture ties doctors into a system which must be problematic to Christian conscience in the broadly pastoral context of medical care. For any child that is born with a genetic abnormality will mean that the parents will be automatically offered "genetic counselling". Should they become pregnant again, the ubiquitous pre-natal screening process will inevitably be available to look for defects and if abnormalities are discovered abortion will be offered.

"Genetic counselling" is not a process in which the counsellor has theological and philosophical expertise regarding the life and death issues around whether abortion is a moral and humane act or not. Essentially this process is one where parents who have never considered abortion before are 'softened up' to the idea, because it is legally available to them and because it is 'rational' to consider this option carefully given that the dominant morality of our broader culture is utilitarian (here calculations concerning the amount of pleasure versus the amount of pain are the only real moral concerns). So "genetic counselling" is actually a morally tendentious activity where a powerful state-funded, legally supported and professionally authoritative persuasion apparatus comes into play that actively seeks to normalise abortion and that assumes the unborn child is a mere commodity to be terminated at will. Further, this apparatus swings into play precisely when parents are often very emotionally vulnerable and perplexed. In this context, if a Christian GP does not adequately inform parents about what they are in for, and does not provide them genuine access to alternative moral and philosophical resources in the evaluation of their choices, the GP's silence is part of the system which is rigged in favour of the violent, amoral commodification of human life.

> ***"...the Anabaptist simply expects to get into trouble with the law by following Jesus. And perhaps it takes that sort of courage to perform any serious exertion of conscience in our day and age."***

Abortion is legal and the progressive advocates of the right to choose have the power of the law on their side. A GP will risk radically offending the assumed morality of progressive utilitarianism, and will risk serious litigation should offense be taken. It is certainly safer for the GP to have a hands off 'your choice' approach to this situation. But here is where the Anabaptists are a pebble in our shoe. For the Anabaptist simply expects to get into trouble with the law by following Jesus. And perhaps it takes that sort of courage to perform any serious exertion of conscience in our day and age. Further, and most frighteningly, once you start thinking about it, it is striking how broadly compliant we Christians are with the amoral anti-Christian norms and procedures of our times. Is there any active Christian conscience left in us?

Conscientious Obje

On 23rd October 2008, the Victorian Abortion Reform Law Act came into operation. Irrespective of one's personal view on abortion, the law is especially noteworthy for section 8 (1), which states:

Abortion Law Reform Act 2008 – SECT 8

Obligations of registered health practitioner who has conscientious objection

8. Obligations of registered health practitioner who has conscientious objection

(1) If a woman requests a registered health practitioner to advise on a proposed abortion, or to perform, direct, authorise or supervise an abortion for that woman, and the practitioner has a conscientious objection to abortion, the practitioner must –

(a) inform the woman that the practitioner has a conscientious objection to abortion; and

(b) refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion.

The terms of reference from the Victorian Government put to the Victorian Law Reform Commission in 2008 required the Commission to devise legislative options to decriminalise abortion with regard to current clinical practice, current legal principles, community standards, laws in other Australian jurisdictions and the government's desire to modernise and clarify the law.[1] However, the introduction of a clause to constrain the consciences of health professionals in the area of abortion went beyond any such conventions. Human rights lawyers have condemned the constraining of the consciences of health professionals noting that: (i) there was no comparable legislation in other Australian jurisdictions (or for that matter UK and NZ) and (ii) it contravened well-recognised standards of the fundamental right to conscientious objection.[2] Further, there was no clinical practice precedent for this. For example, it was a common practice for junior doctors (and even nursing staff) who did not want to assist during theatre operating lists that included abortions, to inform hospital administration. My discussions with colleagues have indicated that such requests were always honoured and no doctor was censured for not wanting to take part in an abortion. Certainly, there was no obligation placed on the doctor to find another doctor to take his or her place or in any way facilitate or participate in the abortion to which he or she had a conscientious objection.

"A law compelling health professionals to contravene their consciences, places doctors under duress in the work place

Opposition to the conscientious objection clause from AMA (Vic branch) was detailed in a letter to then Premier John Brumby on 1 September 2008. Dr Doug Travis stated that the clause:

> *…infringes the rights of doctors with a conscientious objection by inserting an active compulsion for a doctor to refer to another doctor who they know does not have a conscientious objection. Respect for a conscientious objection is a fundamental principle in our democratic country, and doctors expect that their rights in this regard will be respected, as for any other citizen.*

AMA Victoria re-iterated its strong opposition to the law in its current form in 2012, stating: "Doctors should be free to express their conscientious objection by informing their patient of their position and exercise that conscientious objection by declining to provide the advice, treatment or procedure to which they object."[3]

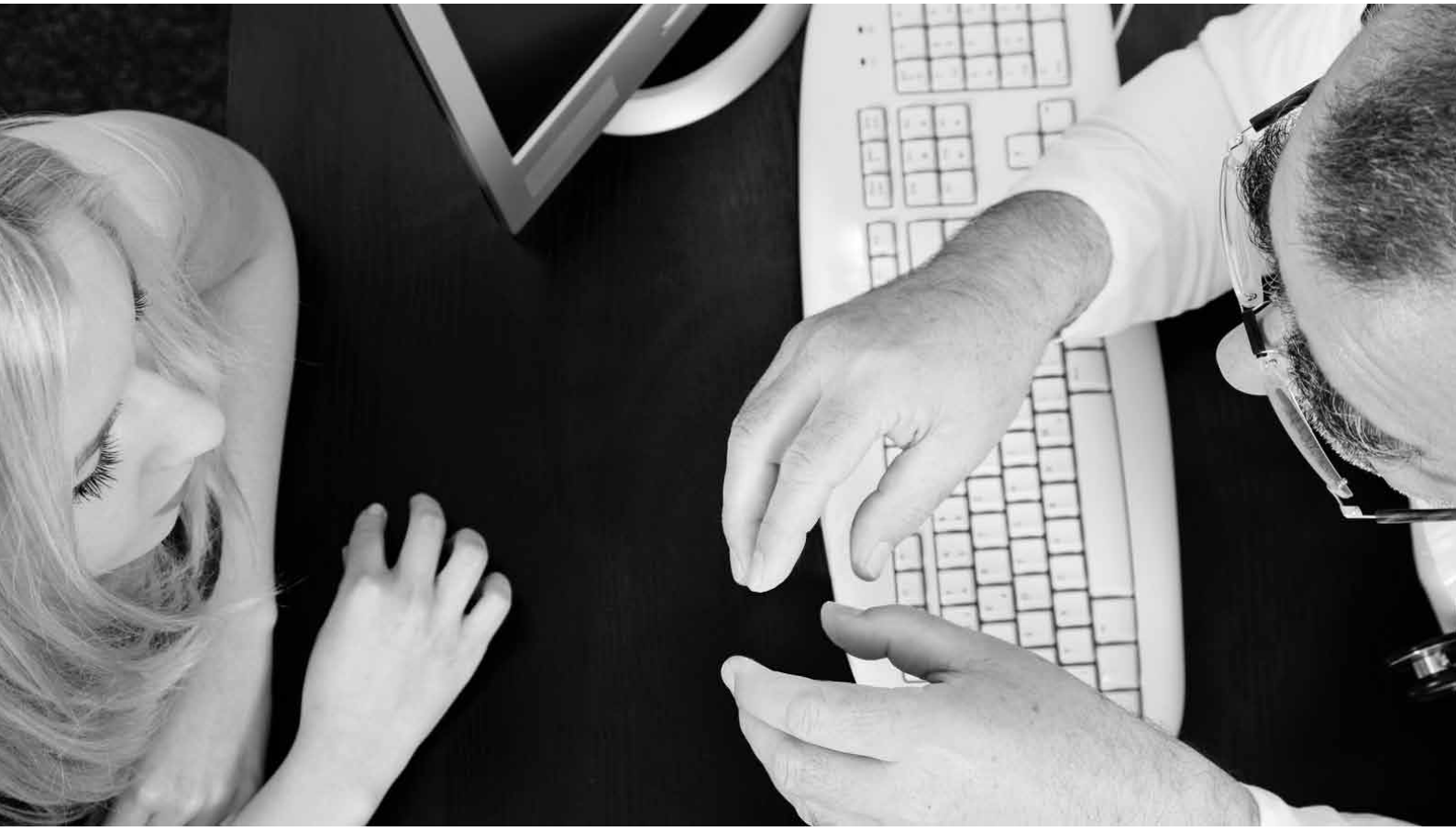
A law compelling health professionals to contravene their consciences, places doctors under duress in the work place, instilling anxiety that at any time a woman might walk into their surgery requesting a procedure that will place the practitioner in the invidious position of choosing between his or her conscience and the law. Such duress does not benefit the doctor or the patient; further it does nothing to advance the agenda of pro-choice advocates. Recently, Jill Stark of *The Age* published a lament from Beth Wilson addressing this very issue. It read: "We worked very hard to pass a sensible abortion reform act … but what we've seen is a reduction in the services available".[4]

A person's conscience is often about how he or she views the world and his or her place in the world. It is the essence of self and of awareness. As Descartes said: "I think, therefore I am!" Should the government be involved in changing how a person thinks? That would fundamentally change who he or she is, and their opinion of themselves.

Recent articles about a case of gender selection abortion underscore what a travesty this law is. Dr Mark Hobart was approached by a woman in the 19th week of her pregnancy requesting an abortion as she'd just discovered that the

by **Ivan Stratov**

ction – a Respected Right?



unborn child was a girl.[5] Gender selection abortion is roundly condemned by the public[6] and professional medical bodies such as the National Association of Specialist Obstetricians and Gynaecologists (NASOG)[7] and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[8] Even the Fertility Control Clinic has stated that it doesn't provide abortions on the basis of gender.[5] Yet the law would say that Dr Hobart is in the wrong for refusing to provide a referral!

What inspired pro-abortion advocates to incorporate such a clause into the abortion legislation? In the decade (or even more) prior to the 2008 legislation, I am not aware of any situation in Victoria where a woman seeking an abortion could not procure one. Yet the law stands, benefiting neither doctors nor women, nor the community at large. Furthermore, the lower house of the Tasmanian parliament has now passed an abortion reform bill that goes even further than the Victorian Bill, by also compelling counsellors with conscientious objections to refer to other counsellors, and by extending the obligations to include consultations relating to "pregnancy advice options" rather than just abortion.[9] Where will it end? LJ

References

1. http://www.lawreform.vic.gov.au/journal-articles/abortion-decriminalisation
2. http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&ved=0CEUQFjAD&url=http%3A%2F%2Fwww.doctorsconscience.org%2Fpdfs%2FDOCMediaRelease.pdf&ei=c9N8UbyZEcTPiAe9ooGQCg&usg=AFQjCNEgmHtrmwxIIIk0-yQHwaES13DCiA&bvm=bv.45645796,d.aGc
3. AMA Victoria Policy Unit Memorandum, 18 June 2012.
4. *The Age*, March 24, 2013
5. http://www.news.com.au/breaking-news/couple-abort-girl-because-they-wanted-a-boy/story-e6frfkp9-1226630789932
6. "Boy or girl? Australians think we shouldn't choose" http://newsroom.melbourne.edu/news/n-436
7. https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=1470c3b8-68fd-491c-81be-6c418be00236
8. https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=0e4bd2e3-4a2d-4f61-8f33-b261d780141f
9. Tasmanian Reproductive Health (access to terminations) Bill 2013

"In the decade (or even more) prior to the 2008 legislation, I am not aware of any situation in Victoria where a woman seeking an abortion could not procure one. Yet the law stands, benefiting neither doctors nor women, nor the community at large."

Glimpses of **Conscie**

Eyal Press is a journalist who in February 2013 released a book entitled* Beautiful Souls*.[1] In the prologue he makes this observation, "It is never easy to say no, particularly in extreme situations, but it is always possible, and so it is necessary to try to understand how and why ordinary women and men sometimes make what is difficult but possible real." (p10)

Conscience is often about making choices which go against the grain, which question the status quo. Press's book is an excellent account of conscience in the modern context. As an investigative journalist, he explores four stories of people he calls "beautiful souls" to describe many of the components of conscience. I want to share something of the stories told and the principles the author draws out about conscience. I want also to consider the 'why a conscience' question and identify where the biblical story can take us in this regard. I hope to link this material back to the clinical context – **Can exercising conscience have a positive ethical impact for medical and dental care?**

"Do we practice with a strong sense of our competence and skill or should we accept the broader wisdom of 'evidence-based care' and fall into line?"

The third story in Eyal Press's book is about a Jewish soldier who chose to disobey orders to kill innocent Palestinians. Avner Wishnitzer became a founding member of Combatants for Peace, a group of Israeli and Palestinian ex-fighters who put down their guns to promote reconciliation and dialogue. This chapter is titled *The Rules of Conscience.* (p85) In it, the writer introduces us to Henry Thoreau who in 1849 published an article *Resistance to Civil Government.* Thoreau refused to pay taxes, rejected slavery and promoted liberty for all. He said "under government which imprisons any unjustly, the true place for a just man is also in prison." (p86) Thoreau was primarily concerned with being a "good man" rather than a "good citizen." The world of medicine/dentistry often places us in this sort of dilemma. Do we practice with a strong sense of our competence and skill or should we accept the broader wisdom of "evidence-based care" and fall into line? Press asks good questions here: "How do we judge someone who claims to act according to what he thinks is "right?" What if we don't agree with his principles? What is to stop the principled defiance of a "good man" from being emulated so producing a dangerous fanatic? (p87)

Avner Wishnitzer was a highly trained and motivated soldier. His older sister was a filmmaker and invited him to lecture about the harassment of Palestinian farmers by militant Jewish settlers. Inevitably with the help of the army, these farmers were driven off their land and reduced to poverty. Avner decided to see first-hand and went with an aid party to help these Palestinians. The harassment at army road check points, the settler self-righteousness and the dispirited resignation of the Palestinians all made Avner ashamed and led him to act in conscience. As a soldier he knew there were times when obeying orders meant harassing or even killing innocent people. He made a choice for peace.

Avner was aware of his Jewish heritage. He knew from the Nuremberg trials that every soldier has the right of moral choice. Indeed Press recruits Adam Smith to his argument to suggest he would have proposed "assessing the ability or inability of those saying no to stretch their moral imaginations by putting themselves in the shoes of people who were suffering and extending sympathy to them."(p122)

This is indeed the place we are at as Medical/Dental professionals. We are called to exercise conscience in the context of hearing the story of suffering in our patients. A clear example in my own experience was to feel very unprofessional about my refusal on moral grounds to provide ongoing medical care for a "prostitute." At a subsequent opportunity I decided to allow grace rather than personal preference guide me. The short story is that this person left the "oldest profession" to re-establish normal family life. My professional rating was much higher in this later context.

Press quotes Susan Sontag, who observes "we are all conscripts in one sense or another" and goes on: "appeal to the existence of a higher law that authorises us to defy the laws of the state can be used to justify criminal transgression as well as the noblest struggle for justice. It is the content of the resistance that determines its merit, its moral necessity."

I find this an interesting position. Conscience is more than taking a stand on Christian principles or the Old Testament law. The actions of conscience need to be linked to 'virtue' in terms of outcome. So taking a stand against abortion which leads to killing an abortion practitioner cannot be construed as an act of conscience. Many 'softer' clinical challenges face us each day. A temporary filling for a decayed tooth will not resolve the long term issues of dentition and good nutritional health. Smoking in the

by **Dr Paul Mercer**
Paul is a GP at Manly, Brisbane and a co-editor of Luke's Journal.

nce In Clinical Care

Inset picture: Bassam Aramin and Avner Wishnitzer received the 2010 Goldberg IIE Prize for their role as co-founders of Combatants for Peace, an organization established in 2005 by Palestinians and Israelis who had played active roles as combatants and then committed themselves instead to non-violent activism.

context of vascular disease poses similar problems especially in low SES individuals.

Press makes the point that "for much of western history, the voice of conscience was simply assumed to be the voice of God."(p108) Our practical experience of conscience tells us that while in some respects conscience is a God given gift to us it intersects with our life course and the moral development we have encountered. Our professional roles provide clinical encounters which also indicate that generic factors, psychological experiences especially early childhood and culture all impact on the way conscience is experienced and develops. We are also aware that repetitive behaviours such as gambling, pornography and video game violence can blunt or harden conscience in some people.

Avner reflected on his life course change with Press in explaining his resignation from the Army. He made this observation, "Look how the biggest crimes in the history of humanity were carried out by very few people. Most people were just bystanders, on-lookers. They didn't take part actively – They just let it happen." Avner went on, "I realised there was no privilege in being a bystander… If you didn't oppose the occupation, you were with the occupation, because you let it go on." (p111)

There are many risks to professional involvement: paternalism, disempowerment, unconscious conflicts of interest and so on. Yet conscience can call us to become advocates for suffering and naturally dependant patients. There are times for solidarity, compassion and simply for love. Professional training has pointed out that patient centred method is a way of integrity when we stop being a bystander and walk the extra mile.

"Professional training has pointed out that patient centred method is a way of integrity when we stop being a bystander and walk the extra mile."

Hannah Arendt has identified that Thoureavian dissent was an entirely "negative" rule of conscience. Quote "They do not say what to do; they say what not to do. They do not spell out certain principles for taking action; they lay down boundaries no act should transgress. They say: Don't do wrong for then you will have to live with a wrongdoer." (p123) Avner Wishnitzer was not like this. He said no to the army and the politics of settlements and yes to the cause of peace and the rights of Palestinians. As time passed he became more and more aware of atrocities and the hardness

>>>

of heart of settler ideology. It made Avner angry and frustrated. He became aware of moving from being vilified as a traitor to something more exasperating; the loneliness of being ignored. Robert Lifton is a psychologist who studied soldiers involved in war massacres in Vietnam. He identified a type of guilt that some combatants experienced for not trying to stop the slaughter. Press observes "lacerating guilt is not normally viewed as a healthy emotion, but in Lifton's view, it can serve a revitalising purpose as combatants reflect on the suffering they have witnessed and come to assume what he called "the anxiety of responsibility," a new mission to rid the world of this suffering and themselves of complicity in it. (p126)

Lacerating guilt is not far from any of us. A tragic misdiagnosis, ill-considered words, blatantly selfish practice can all haunt our careers and motivate such 'anxiety of responsibility.' It is possible that this apparent altruism can set up a professional person for burnout.

With the help of Eyal Press we are exploring some of the complexity of conscience. We have also noted a connection between conscience and God. This can be traced in the history of the Greek word *synteresis* which means conscience, divine spark or reason. In both Greek and Hebrew thought, conscience is regarded as the knowledge of good and evil. In Socrates we discover a person regarded as 'a god', who held a reputation for great wisdom, knowledge and moral teaching. Socrates and other great Greek philosophers, privilege reason as the most spritiual part of us; capable of leading us to immortality.

"Lacerating guilt is not far from any of us. A tragic misdiagnosis, ill-considered words, blatantly selfish practice can all haunt our careers and motivate such 'anxiety of responsibility.'"

While Christian New Testament authors were undoubtedly influenced by both Hebrew and Greek thinking, how do they present the concept of conscience to us?

There is no specific word for conscience in the Old Testament. Hebrew writers were not unaware of an inner conscious world. Terms such as "the heart", "Secret thoughts" are strong clues to such awareness. It is not until the inter-testamental period that we encounter the word "suneidesis". Conscience is explored more readily by New Testament writers especially Paul. For instance, 1 Corinthians 4:1-5 is a passage where Paul is able to express that he has a clear conscience in his role as a servant of God and a steward of the mysteries of God (Ch 4v 4a). His argument is that a human court and his conscience are essentially

incompetent to judge the truth of his claim to faithful service. For Paul, the only competent tribunal is "the Lord."

Romans Chapter 2 is also an important passage. For Paul, both conscience and the law (of God) written in the heart are aspects of the image of God with in us. Paul also recognises the relevance of the conscious and unconscious to our experience of conscience and this law in our hearts. Furthermore he is keen to connect the impact of "sin" (rebelliousness toward God) into this inner context. The idea that God knows everything implies that this includes the human consciousness/unconsciousness spectrum. It is interesting however that it is only after the New Testament period in people such as Clement of Alexandria that the omniscience of God becomes a fixed theological theme (seeing all things, knowing all things, hearing all things.) So four aspects of divine omniscience are mentioned in scripture. (p84-86 Theissen)

1) God knows "everything" i.e. 2 Samuel 14:20 and 1 John 3:20
2) God knows "secrets" i.e. Mark 4:22 including "good" secrets ie Matthew 6:4,6,18
3) God knows the future
4) God's omniscience extends to the human heart i.e. Psalm 139:1-2,5,7 and 1 Corinthians 14:25

The evolving awareness of this 'all-knowing' character of God allowed New Testament writers to recognise that God can judge now or in the future i.e. Hebrews 4:12-13. Into the space of conscience biblical writers also introduced other metaphors, such as "darkness" and "light"; a curtain of forgetfulness; a veil (as in Moses i.e. 2 Corinthians 3).

These metaphors explore the boundaries between conscious/unconscious; glory/sin/the law. 'Conscience' picks up on the predicament of the human condition caught between the image

of God and the pervasive impact of sin. The New Testament writers want to tell a powerful story of transformation. That Christ delivers us from the present evil age (Galatians 1:4) and renews us (2 Corinthians 3:18) The hope of new creation for humanity has implication for our "conscience.") Christ as the 'light' of the world, allows Paul to recognise in terms of the conscious/unconscious that "he will bring to the light the things now hidden in darkness and will disclose the purposes of the heart" 1 Corinthians 4:5.

In his text *The Psychological aspects of Pauline Theology*, Gerd Theissen[2] recognises three elements of consciousness that have Old Testament roots which are present in Romans 8:26-27.

1) God is omniscient and searches the heart
2) We don't understand our own intentions
3) There is a sigh that comes from the deepest places of the human heart that is a significant inner reality.

While it is always dangerous to consider the Biblical data on consciousness though a modern understanding of constructs, here it can be argued in a positive way that the life, death and resurrection of Jesus is an integrating power in a human life. God was in Christ reconciling the world to himself! This has positive implications for conscience. Before Christ, sin and the law impacted on conscience. Paul in 2 Corinthians 3:4–4:6 unpacks his metaphor of veil. We could say three things.

1) Since the fall, all human experience of God is veiled because of sin.
2) To all appearances the Mosaic law is surrounded by splendour and glory, but the law's shadow sides had to be concealed from consciousness through a veil. Christ exposes the failure, the dark side of the law (it kills: 2 Corinthians 3:6) Prior to Christ, conscience is a witness to the law, both 'written on our hearts' and 'written.'
3) Without the grace of God, the true glory of Christ is also veiled to humanity.

Paul wants us to recognise that the great love of God to the world in Christ has amazing possibilities. (p151)

1) The radiance of Christ reaches our innermost consciousness (2 Corinthians 3:18)
2) In Christ we experience the process of renewal and recreation.
3) The 'god of this world' (Galatians 1:4) is an enemy to this process
4) Christ is a revealer of the true nature of God to us. At the same time God has planned that we are destined to be conformed to the image of his Son. (Roman 8:29) Christ is the "coincidence of opposites". He is the true likeness of God and simultaneously the true determination of man. In Christ conscience is liberated from self and transformed by love. If we accept the transformative aspects of the Gospel at work in human experience we humbly acknowledge the experience of knowing the mind of Christ and taking on the character of God. There is a 'now and not yet' balance to this hope but at the same time a real transformation, a real lifting of the veil is taking place.

For a Christian Doctor or Dentist the practice of virtue ethics, the ethics of a truly transformed character will constantly challenge our clinical choices. The clinical context is also a context of grace where the reconciling, healing, peace-desiring work of God will become surprisingly apparent. Our conscience will affirm this.

Supporting Texts
1. Eyal Press "Beautiful Souls" 2013. Picodor
2. Gerd Theissen "Psychological Aspects of Pauline Theology" 1987, Fortress Press

LUKE's journal

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.

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

Christian Conscienc

Christians will be aware of the increasing push towards secularisation in Australian society. A genuinely secular society embraces and respects a wide range of perspectives; both religious and non-religious, but does not privilege any one belief over others. But an extreme form of secularism seeks the removal of the religious from every area of life except the purely private. This ideology, perhaps given impetus recently by the New Atheists, underlies the challenges, for example, to Religious Education in public schools, to school chaplaincy, and to tax concessions for religious organisations.

A manifestation of this ideology in the healthcare context is the challenge to the view that conscience (often assumed to arise from religious convictions) ought always to be respected. For example, the Victorian Abortion Law Reform Act (2008) obliges a registered health practitioner who has a conscientious objection to abortion, to "refer the woman to another registered health practitioner in the same regulated health profession who the practitioner knows does not have a conscientious objection to abortion". While the subsequent national code of conduct, which is likely to override the Victorian legislation, does affirm the importance of acting according to conscience, the ongoing presence of this Victorian legislation is of great concern.

Similarly, in the *MJA* last year (2011), ethicist Julian Savulescu argued that "conscientious objection by doctors, as is commonly practised, is discriminatory in medicine" that it may clash with "agreed and justified moral standards', and that "freedom to practise religion does not imply freedom to impose religious values on others in a secular liberal society".[1]

It is within this context, and with these challenges in mind, that the Ethics Committee of the CMDFA offers this reflection on Christian Conscience in healthcare.

Christians and conscience

The word "conscience" does not appear in the Old Testament or the gospels; however Paul describes the characteristics of "conscience" in the epistles. He gave the name *syneidesis* (Greek for *conscience*) to this reality, an inner aspect of a person's life where a sense of right and wrong is developed,[2] and which is personal, individual and subjective.

The concept of conscience is often expressed in the image of the 'heart', the symbol of the inmost depth of the person: "I hold fast my righteousness, and will not let it go; my heart does not reproach me for any of my days" (Job 27:6). Because God has created all human beings in His image as moral beings, the experience of conscience is one of the most fundamental aspects of being human. "When Gentiles, who do not possess the law, do instinctively what the law requires, these, though not having the law, are a law to themselves. They show that what the law requires is written on their hearts, to which their own conscience also bears witness; and their conflicting thoughts will accuse or perhaps excuse them on the day when, according to my gospel, God, through Jesus Christ, will judge the secret thoughts of all" (Romans 2: 14-16).

But because we live in a fallen world where everything is affected by sin, our conscience is distorted and often unreliable. If a person's conscience is persistently ignored or violated, it may become desensitised or "seared" (1: Timothy 4:2). The conscience may accuse where there is no reason, or remain silent when it ought to accuse. Even the apostle Paul could write, "My conscience is clear, but that does not make me innocent" (1 Corinthians 4:4). Christians may have a "weak" conscience, which is overly sensitive and calls some activities "sins" which are not morally wrong in themselves (1 Corinthians 8:1-13). Even when we do not agree with another's conscientious objections, and regard their conscience as weak, **we should never urge them to violate their conscience** (1 Corinthians 8:7). On the other hand, the person with the weak conscience should guard against judging others for doing things that their own conscience condemns.

Therefore, while conscience is a useful "alarm", it cannot be the ultimate or decisive moral guide. Conscience requires instruction if it is to help us. This will come from the scriptures: 'All scripture is God-breathed and is useful for teaching, rebuking, correcting and training in righteousness so that the man of God may be equipped for every good work' (2 Timothy 3:16, 17). While the authority of scripture is primary, church tradition, reason and experience (including guidance from the Holy Spirit) may also provide instruction.

The conscience of a Christian health professional will be influenced not only at a personal level by their faith, but also by the traditional moral values of their profession. As will be explained below, in modern societies, a code of conduct is linked to professional registration. In Australia, this is found in the Australian Medical Council's *Good Medical Practice: a Code of Conduct for Doctors in Australia* (2009)[3] (*Good Medical Practice*). As those known for their love of their neighbour (Matthew 22:39), Christians will be careful to fulfill their responsibilities in this regard.

Christian doctors and dentists aim to care for their patients to the best of their ability, within the constraints of available resources and public health requirements. In this process, their desire to look to the best interests of their patient is complemented by their respect for the autonomy

Written by the CMDFA Ethics Committee
Principal authors
***Dr Megan Best** (Deputy chair)*
***Dr Denise Cooper-Clarke** (Chair)*
Approved by CMDFA Board - May 10, 2012

e in Healthcare

of the competent patient, looking to them to guide their actions when decisions need to be made between legitimate courses of action. We recognise respect for autonomy as due to all human beings who are made in the image of God.[4] Respecting the autonomy of the doctor does not necessarily limit that of the patient. Ideally, the two factors work together in a complementary fashion to ensure optimum care for example in 'patient-centred care'. In the doctor-patient relationship, the doctor draws on their knowledge and training to empower the patient to make wise choices through being appropriately informed. Without this assistance from the doctor, the patient would usually be unable to exercise their autonomy in an authentic way. The professional who does not give their opinion when asked on which of many treatment options to pursue, is probably assuming too much knowledge on the patient's part.

However, this opinion is not to be delivered in a morally judgmental manner. Doctors are obliged to hold in balance their personal and professional autonomy. *Good Medical Practice* requires *'avoiding expressing your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.'* (8.2.3). A doctor's expression of their personal moral values (when appropriate), if in conflict with the desires of the patient, should be gentle and non-offensive and not imply that the patient is obliged to adopt similar values.

Criticism of conscience in contemporary medicine

The role of an individual doctor's conscience is controversial in contemporary bioethics. On the one hand, the attack on health professionals' rights to express personal values is surprising, given that most Human Rights instruments recognise the right to freedom of thought, conscience and religion. For example, Article 18 of the Universal Declaration of Human Rights says:

> *Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.*

In Comment 22, the Office of the High Commissioner for Human Rights says that this right is "far-reaching and profound", and that "It does not permit any limitations whatsoever on the freedom of thought and conscience or on the freedom to have or adopt a religion or belief of one's choice. These freedoms are protected unconditionally"[5]

On the other hand, it is not surprising that the role of conscience for doctors is under attack, given the trend in secular bioethics towards elevation of respect for patient autonomy as the overriding principle. One of the disturbing features of modern medicine is the downplaying of any sense of the doctor as moral agent who makes significant moral choices, either as a member of a profession with distinct values and standards or as an individual with their own moral commitments. Priority is increasingly given to the values of the patient over those of the doctor. In early 2006 Australian bioethicist Julian Savulescu argued in the British Medical Journal that "a doctor's conscience should not be allowed to interfere with medical care".[6]

Savulescu's article provoked a flood of negative responses from doctors around the world. Common themes in the responses were the need to respect the autonomy and freedom of choice of doctors as well as patients, that doctors who practice without values or a conscience would be dangerous, and that society should not require people to behave in ways that go against deeply held convictions.

Good Medical Practice supports these sentiments: *'No code or guidelines can ever encompass every situation or replace the insight and professional judgment of good doctors. Good medical practice means using this judgment to try to practise in a way that would meet the standards expected of you by your peers and the community.'*[7] Such observations support the notion of the medical practitioner as a moral agent.

Confusion of the issues

Part of the confusion in discussion of medical right of conscience is due to the fact that there are at least two frameworks of ethical standards operating at any one time for the practicing doctor. As we have seen, on the one hand there is a standard of professional behaviour to which all registered practitioners are required to adhere, and then there are personal ethical values that will be shaped by one's worldview. In order to understand the issues within both spheres, we will address them separately.

Professional medical ethics

Medicine has traditionally been understood as a profession with a distinctively medical morality, and medical education as a process whereby students are trained to understand their role-specific ethical obligations as well as medical science and skills. These include defined codes of behaviour. For example, doctors have particular reasons (in addition to the general reasons that exist) for believing that it is wrong for doctors to kill their patients, or breach their confidences, or have sexual

>>>

relationships with them. Such standards are uniform for all doctors and linked to the right to practice.

However, this understanding is being challenged in contemporary bioethics, with medical ethics being regarded as simply an extension of general ethical theory to the particular issues which arise in medicine, rather than a practice which generates its own "internal" morality. Traditionally the morality of medicine has been decided from within the profession, rather than by those outside it. While it is understandable that no-one wants to go back to the days when the doctor unilaterally decided what was best for a patient (paternalism), at the same time, given the unique privileges of doctors to gain access to private information and individuals' bodies, it is appropriate that they be held to high moral standards.

A review of the historical and philosophical arguments about an internal morality of clinical medicine suggests that, while not uncontentious, the idea that medical morality is generated at least in part from internal norms, which are derived from the goals and limits of medicine, is both powerful and plausible. This is one of the reasons why doctors reject the premise that they should be seen as mere service providers for their patients, doing whatever the patient requests.[8]

Individual ethical views

The view of a doctor as a value neutral service provider is in fact the product of a particular values system: Western liberal individualism. But even as an expression of liberalism this view fails because it results in the patient effectively imposing his or her moral view on the doctor. The patient determines whether a particular act is right or wrong, and yet it is the doctor who is the agent, the one who acts. This is likely to become the norm as fundamental Judeo-Christian values are replaced by humanistic liberal values in society. There is increasing acceptance of the myth that secularism is morally neutral. We reject this form of secularism that claims to be morally neutral and exclusively claims the public sphere for itself, relegating individual religious belief and practice to a private sphere of non-engagement with public moral issues. Rather we endorse a view that in a pluralistic society, the contribution of religious thinking and practice are valid and indeed essential contributions to the viability and health of the wider community. We all have a moral view based on our own understanding of how we decide right from wrong. None of us is neutral.

Conflicts in medical conscience

There are thus two levels at which conflicts of conscience may occur for doctors; on the one hand there are 'structural' standards to consider in law or professional codes to which we are expected to adhere, and then there are 'individual' standards resulting from one's personal morality.

'Structural' sin

Doctors have always recognised that patient advocacy, whether at an individual level or with regard to public policy, continues to be an established good within public health. However, it is possible that a government may legislate to compel Christian doctors to do that which violates their conscience (examples include current Victorian abortion legislation, or possible future laws involving euthanasia for the mentally incompetent). As members of a democratic society we are free to lobby and protest against coercion of citizens to act against their principles, just as we are free to advocate for our patients in matters of healthcare. The lack of such protest by German doctors in the Second World War with regard to government-sanctioned euthanasia is now condemned.[9] Living in a fallen world can also lead to situations of inequity against which doctors may be led to protest, for example some of the practices of pharmaceutical companies, and illegal body parts trafficking. Such a path requires much wisdom, but 'who knows but that you have come to (this medical) position for such a time as this?' (Esther 4:14).

The right of conscientious objection

A point of contention which is a greater challenge for Christians, is where their personal morality conflicts with individual patient preferences for treatment or with colleagues' expectations for practice (such as when determining group policy or research protocols).

There are two situations in which the doctor and patient may find themselves in conflict regarding expression of personal autonomy: those situations where the requested treatment is not in accordance with standard medical practice and those where it is.

If, in the doctor's considered opinion, the procedure requested by the patient is inappropriate, the conventional practice is to advise against this path, giving reasons, and to suggest appropriate management. This constitutes beneficent behaviour on the part of the doctor. There is no need for the doctor to discuss their personal views in this scenario and to do so would take advantage of the patient's vulnerability in the doctor-patient relationship. For example, a doctor may advise against treatment which they consider to be overly burdensome compared with benefit, or not locally available. In Australia, a doctor is never obliged to provide a treatment which is understood by the medical community to be futile, even if the patient requests it.

However, if the requested procedure is a standard and legal treatment option for the patient's condition, the doctor is professionally obliged to recognise it as such, but this does not mean that they cannot (gently and non-offensively) ensure that the patient is aware of other appropriate treatment options. Furthermore, if the treatment is a standard care option, the doctor is obliged to mention it even if the patient does not, in accordance with the professional responsibility to ensure that patients receive all information required to make

an informed choice, even if some of these options are not in accordance with the doctor's own moral views.[10] In the same way, the mentally competent patient's refusal of recommended treatment must be supported, even when this choice is regarded as unacceptable according to the doctor's personal and/or professional morality.

If a doctor has counselled a patient regarding other options and the patient perseveres in their choice for a treatment which is legal but opposed by the Christian doctor on ethical grounds, the patient is free to seek that treatment elsewhere. However, some may insist that the doctor in question should refer the patient to an appropriate service provider. This raises the issue of complicity.

Complicity refers to association, partnership or involvement with wrongdoing. For example, is referral to another doctor who performs an abortion of the same moral gravity as performing it oneself? Some Christians would think so. They would argue that while we are somewhat distanced from the act itself when we refer, we are still helping the patient achieve their goal and thereby implicitly indicating that the patient's choice is a valid therapeutic option.

Other Christians do not see referral (for a morally problematic procedure) as an act which is morally equivalent to performing the procedure themselves. They see that there are some moral arguments for referral. There is the obligation to do good and not harm to the patient. The 'duty of care' to the patient will require that their ongoing care is appropriately transferred to another doctor. Another reason to support referral is in the interests of making a future relationship with the patient possible. Patient safety is another issue. The doctor's motive is care for the patient and the intention is to make sure the procedure is done safely. As Christian doctors living in a fallen world, we will expect to have patients who differ from us in their choices and this may be painful for us, but we have no right to impede the informed choices of mentally competent patients. But neither does the patient have a right to make a doctor violate their conscience. There are ethical arguments for both referring and not referring. Committed Christian doctors exist at both ends of the spectrum.

There are some matters of conscience over which Christians will disagree. While this paper has argued the importance of the individual's conscience, there is also a strong scriptural emphasis on the role of the community of faith. After prayer and discussion with other Christians, each should do what they believe is right. Those doctors who consider that referral constitutes complicity in wrongdoing should not refer, as acting against our conscience is sin (Rom 14:23). In such a situation, discontinuation of the doctor-patient relationship may be the only ethical option.

Conclusion

In summary, all Christians are called to live in accordance with scriptural principles, regardless of societal norms. Christian doctors are no exception. While there is often no conflict between moral guidance from medical codes of conduct and Biblical tenets, in contemporary medicine there are increasing opportunities for conflict, which are likely to expand as technology extends further control over the limits of human life.

There are several ways for a Christian doctor to deal with a request to perform actions contrary to their own moral convictions:

1. to withdraw from certain fields or even all of medical practice, in order to avoid moral complicity (for example some have avoided assisted reproduction due to concerns about embryo wastage), or

2. to continue to work within the field, but to not participate in a defined set of practices (an example being palliative care physicians who have indicated refusal to perform euthanasia should it be legalised in this country), or

3. to recognise that living in a fallen world is messy, and that engagement in medicine, as in many other areas of life, may, indeed does, sometimes entail sadly witnessing patient choices we regret while continuing to hope that we can be agents for positive change (such as a mentally competent patient refusing potentially life-saving treatment). Our Medicare levies fund abortion, gender reassignment and organ transplantation, to each of which some Christians have moral objections.

4. There may be an additional path if legislative challenges to our morality exist: to witness to our Christian faith through protest and civil disobedience.

Each of these paths, we trust, will be a way to act as salt and light (Matthew 5) not just for our patients but also for our community as a whole. We must prayerfully decide which path God calls each of us to take in each situation.

References

1 Savulescu, J. (2011). "Should doctors feel able to practice according to their personal values and beliefs?" MJA 195 (9) 7 November: 497.

2 Atkinson DJ, Field DH. (Eds.) (1995). *New Dictionary of Christian Ethics and Pastoral Theology.* Leicester: IVP, 251.

3 Medical Board of Australia. (2009). *Good Medical Practice: a Code of Conduct for Doctors in Australia.* Available at: http://www.amc.org.au/index.php/about/good-medical-practice

4 Obviously, in a medical setting, exceptions will occur when a patient is mentally incompetent.

5 http://www.unhchr.ch/tbs/doc.nsf/0/9a30112c27d1167cc12563ed004d8f15

6 Savulescu, J. (2006). "Conscientious objection in medicine." *BMJ* 332(7536): 294-297. Savulescu included a discussion on doctors who refuse, on religious grounds, to be involved with abortion. The Victorian *Abortion Law Reform Act* (2008) denies doctors the right of conscientious objection to referral for an abortion or to performing it themselves in an emergency. *Good Medical Practice* has subsequently reaffirmed the right of conscientious objection for doctors practicing in Australia. The Victorian law has not yet been tested in the courts.

7 Medical Board of Australia, op. cit., (1.1).

8 For further discussion of the internal morality of medicine, see CMDFA Ethics committee. (2012). *What is the basis for a professional morality of medicine?* Unpublished.

9 Pross, C. (1991). "Breaking through the postwar cover-up of Nazi doctors in Germany." *J Med Ethics* 17(Suppl.): 13-16.

10 An exception may be if the doctor has previously advertised that such treatment will not be offered, for example by a notice in the waiting room.

by **Dr Daniel Thomas**,
physician, current fellow in Hematology Division, Stanford Medicine; previous chair of CMDFA(SA)

Bringing Hope to **Ghana's Inmates**

Mission trip to Ghana in August 2011

Our purpose was to bring a message of hope, practical help and Christ-centred counselling to inmates of prisons in Ghana, many of whom were yet to face trial or were innocent victims of village witchcraft. A social worker, doctor and English teacher from Adelaide were recruited to work with local pastors.

In 12 days, with express permission from the government of Ghana, we visited 12 different prisons located in southern Ghana in the greater Accra area, each housing from 300 to 600 inmates. All up, by the grace of God, we did medical screens and counselling with an overt Christian message for over 2000 prisoners. We visited one women's prison and an orphanage as well as local churches. We saw many come to confess Christ, and receive healing prayers including Muslims. We administered treatments for HIV, TB, wound infections, dermatitis, haemorrhoids, wound infections and educated and encouraged infirmary nursing staff.

I heard a sermon by an African pastor, James Baidoo of Atomic Hills Baptist Ghana, who has long been involved in prison ministry in Africa, speak at a local Australian Indigenous church in Adelaide South Australia and saw the need and felt the calling to help him.

Historical context

Ghana, otherwise known as the Gold Coast, on the West coast of Africa was the first and the busiest slave-trading arena for over 3 centuries until Wilberforce legislation in Britain was passed in 1897. Spine-chilling castles that used to house slaves until ships arrive can still be visited today. Slavery was not just a white-man affair – the Ashanti tribe with their capital Kumasi were cunning in organising inland slave routes. Controversially many Africans and travelling anthropologists (such as Mary Kingsley: *Travels in West Africa*) argue that the bondage of the fear of witchcraft prior to the arrival of missionaries was just as terrible and more crippling than physical slavery.

A journalling snapshot

We were very nervous approaching Winneba coastal prison which actually utilises an old slave fort. 40 inmates per cell 4-6 metres all with scabies and haemorrhoids and we get locked in with them!.. Praise be to God they were mainly young adult boys... listened attentively to our message and opened up whole-heartedly about their plights... inmates ran back to hear the rest of the prodigal son story... many Muslim boys prayed to Jesus with tears. Treated many skin infections. Guards were moved when we washed a black man's feet. One boy definitely has TB.

Key Kingdom learning points for short term medical mission

- **Pray before you go.** We barely had time to pray effectively once we were there but before we left we met for 6 weeks and prayed together and practised simple sound-byte sermons with powerful illustrations. This preparation brought great fruit as the opportunities to speak were many and varied.
- **Work with the prison nurse.** Check the infirmary supplies. If the patient looks extremely sick, assume the worse and treat it on spec.
- **The majority of maladies presented were the result of unmet psychological pain, not physical illness.** This is why we had two counsellors on the team that I could refer the patients to straight away and they had time to listen and pray while the medical people did screening. The local pastors on our team provided continuity for those who were sick or who had made commitments to Christ.
- **Know the conflicts of interest in everything you do, the potential for harm as well as good.** Work through them, be prepared to give an answer for why you are doing what you are doing and bring the tricky issues before God.
- The world doesn't need more "professionals". What is needed is **people who are willing to listen, identify, pray and heal in the name of Jesus.** Yet my medical qualifications and affiliation with CMDFA opened the doors for our team to go to all the prisons!

Conclusions

Do it. Do mission. Save your money to do mission. Build teams of trustworthy, merciful, joyful disciples and do it. Your medical qualifications will open doors for the team. You put in your 10%, your Father will put in 90%.

For more information about this and other mission opportunities contact dthomas@stanford.edu

by **Dr John Sturt**

John graduated in London 1953. He and his wife spent 21 years in PNG. They have five children and 14 grandchildren. He retired from medical practice this year, and enjoys time with family, writing, and friendship evangelism. He lives in Auckland, NZ.

Healing & Wholeness

"The journey is as important as the destination."

Faith for me means a relationship and companionship with Jesus through life. Integrating faith and medicine, Scripture and counselling, the secular and the spiritual are important to me. I am so grateful to my wife of 55 years, who has walked the same path and worked together with me.

Ever since my teens I wanted to serve God as a medical missionary. I wasn't an 'A-student' so had to work extremely hard – or so it seemed – to get through ten years of undergraduate and postgraduate training. Part way through my medical course in London I ran out of money, so applied for a Government grant. I remember the occasion vividly. I was the last applicant for the day and felt overawed before the council of elderly gentlemen sitting around an oak table.

The chairman asked, "What is your objective for doing medicine?"

"Well, sir", I replied, "My goal is to be a medical missionary."

There was half a minute's silence. Then he slapped the table and said, "You're the first person today, son, who's wanted to do anything for anybody. Your application is granted."

I thanked God for another confirmation that I was on the right track.

After six years in London, I returned to New Zealand to marry Agnes Broughton. She grew up on a farm in Canterbury, did her nursing training in Christchurch and came to England to qualify as a Certified Midwife. We were engaged in London. After marriage, I spent 3 years at Christchurch Public Hospital, gaining as much experience as possible as a house surgeon and surgical registrar. We were both keen to serve God in a third world country.

In 1956, Agnes and I found ourselves in Papua New Guinea. After working for the Health Department in urban hospitals, we joined a missionary team to set up a medical program in the steamy jungle of the Sepik Province. This was with tribes who were just emerging from the stone-age. Some had seen European men before but few had seen white women or children. They welcomed us, but with suspicion. Our mission leased 100 acres of rain forest near a river. It contained mill-able timber and enough flat land for an airstrip. We were several days walk from the nearest town. Our first task as a team was to build an airfield, with the help of a few hundred men from surrounding villages.

The first wheel many of the people had ever seen was on the aeroplane!

Eventually 500 metres of flat ground was ready for a Cessna aircraft to land. The first wheel many of the people had ever seen was on the aeroplane! Missionary Aviation 'planes then brought in our medical and general supplies, as well as a tractor and saw mill in parts. Before long we transferred from a temporary hospital built from bush-material to a sawn timber one. This contained everything needed in a medical centre: out-patient treatment room, operating theatre, recovery room, x-ray, laboratory and training school for medical orderlies and nurses.

Back to Basics

The local shaman, or witch-doctor, set up his 'hospital' on the other side of the river. This is how my journey to holistic medicine began! I became aware of his presence when patients from villages on our side were carried right past the hospital, across the airstrip and over the river to see the 'real doctor'. Taro performed magic rituals to remove the problem which they believed was caused by evil spirits in the jungle, the spirit of a relative who'd been offended, or by sorcery. The patient would then be carried back to our hospital to try out the 'white man's medicine'. Incidentally, Taro charged for his services whereas our treatment was free. What you pay for must be better. Right?

Frequently the river was in flood and impassable, so patients were unable to visit Taro first. This provided me with a controlled experiment in the wards – some patients with pneumonia, who had seen the shaman and others with pneumonia who hadn't. I observed that those who'd been treated by my 'colleague' recovered faster than those who came to me first, though they all received the same

>>>

treatment. This set me thinking, "What's going on here?"

I realised that because of my training I focussed primarily on the "WHAT?" of illness: "What's the diagnosis? What evidence can I gather from clinical examination, x-rays or laboratory tests?" Taro was unaware of bacteria and viruses or other physical causes of illness. He was only interested in the "WHY?" of illness. "Why are you sick? Which spirit have you offended in the bush or what relationship have you upset?" When I examined new patients I worked *centripetally*: starting on the outside and going inwards: identifying the diseased organ, perhaps examining blood, sputum or a biopsy specimen under the microscope to find the precise cause of the illness and guide treatment. Taro worked *centrifugally*. He also started with the person but moved outwards, exploring their environment, relationships and the malevolent spirit world.

Neither approach is adequate on its own. What's needed is a holistic approach to illness. Taro and I never did go into partnership, by the way! (Actually, he was a patient of mine, suffering from leprosy.) But I started to understand more clearly that dis-ease, whether physical, mental or spiritual, affects the whole person. My job there was to care for the physical and spiritual needs of thousands of people in the district as well as the large missionary team. I was theoretically aware that all illness is psychosomatic – affecting the body and the mind in varying degrees – but in practice I'd split the two. The vast majority of my patients suffered from obvious physical illness. A few died, apparently well, but after having had 'the bone pointed at them'.

"They had more sophisticated ways of discovering the cause, from CAT scans to genetic analysis. However, little attention seemed to be paid to the "Why?" of illness."

For the last 6 years in PNG I was employed at the University in Port Moresby to run the Student / Staff Medical Service. PNG students, who had grown up in a communal society, were now in a situation where survival depended on individual achievement and competition. Dangers could no longer be dealt with by fighting or running away. I noticed that they developed psychosomatic symptoms (that were not common in the rural population) almost to the same degree as the expatriate students did.

Back in New Zealand after 21 years in PNG, I was disappointed to find the medical system there still operating primarily on the basis of the "What?" They had more sophisticated ways of discovering the cause, from CAT scans to genetic analysis. However, little attention seemed to be paid to the "Why?" of illness. I worked at Auckland Hospital for 10 years, where first class medicine and surgery was practised, but scant notice was taken of a patient's life-style, relationships, emotional, social or spiritual needs.

Caring for the Whole Person

This epiphany challenged my approach to medical practice and I realised the importance of whole person care: attending to the physical, emotional, intellectual and spiritual needs of patients. I call this "moving from clinical medicine to people medicine." Agnes and I re-trained in counselling over a 4-year period, part-time.

While this holistic approach is an ideal style for a doctor, clearly it's not possible for one person to attend to all these needs adequately. It requires a team. On returning to NZ, we both had the vision of setting up an agency which could care for the whole person. So in 1979 we set up the Christian Care Centre in Auckland.

I started with a small medical practice, which I handed over to a full time GP after a year and we focussed on counselling, mainly working with couples together. Others joined us in this venture and we slowly built up a team of over 20 people: doctors, nurses, counsellors and administration staff – all Christians drawn from several denominations. We rented a building in a central suburb and worked with the co-operation and support of neighbouring churches. People who attended with medical problems and had emotional issues could be referred for counselling and vice versa.

As you would expect, in the 1970's and 80's there was resistance from some Christians, to whom counselling was a dirty word... "Christians don't have problems, do they,? If we did we wouldn't go to a counsellor or psychologist!" But before long we had a three month waiting list for counselling, which never got any shorter, despite having six counsellors on staff (only one full-time.) We had tapped into a deep well of need – people in churches who hadn't been able to get help for their issues and had now found a "safe" place to go. Moreover, it was not connected with their home church, where confidentiality often was not preserved. Many non-church people also came for counselling.

We developed seminars on a range of topics, such as: Creative Listening, People Helping Skills (counselling basics), Stress and Burnout, Building Self Esteem, Depression, Anger Management, Grief and Loss, Journaling, Inner Healing, Marriage and Family. The best way to learn is to teach, and I loved teaching. Teaching can be an important part of counselling and should be included in a medical consultation. After all, the word 'doctor' means teacher. Thousands of people attended these courses over the years, which helped break down resistance to counselling in the Christian community.

Agnes and I developed Marriage Enrichment in NZ. Our program grew out of our reading and counselling. At some stage we were holding a marriage seminar one weekend a month. Over the years, at least 2,500 couples attended these marriage retreats. Some people, often husbands, are reluctant to go to a workshop on marriage…...

"What's wrong with our relationship that we can't fix ourselves?" So the slogan we used for our seminars was: *You don't have to be sick to get better!* Our goal was to help people turn good marriages into great ones. Of course, running marriage seminars sharpened our own relationship, and teaching with my wife present kept me honest! We also produced a series of 20 videos, covering the content of the sessions.

But I had a problem. As a doctor I had to un-learn as well as learn counselling skills. I was a trained medical advice giver. The contract with patients is: "I have a health problem, Doc, what should I do about it? What do you advise me to do?" There's nothing wrong with appropriate advice giving but this is not counselling. I had to learn how to empower people to find their own answers in order to make the changes they needed. This was a new skill. Clients know what they need better than I do. It's not my place to tell them.

I discovered that the Bible is the best 'text book' on counselling available – not providing zap answers to problems but true wisdom for life. All effective counselling principles that have been "discovered" in the past hundred years or so are actually found in Scripture! For example, the Bible has a lot to say about listening, particularly in Proverbs and James. Jesus said repeatedly, *"He who has ears to hear, let him hear!"* Scripture provides much guidance for the craft of counselling.

I've learned more from a study of how Jesus worked with people than any text book.

As a counsellor, I'm aware of my own pain and problems – not pretending to have it all together. Being a 'wounded healer' doesn't mean sharing our wounds with clients but bringing both our healing and our wounded-ness to the task. This insight has become more real to me since the death of Agnes – my lover, friend, companion, co-counsellor and spiritual encourager, four years ago. We spent a life time together, working with and caring for people in many ways. We also wrote several books together on personal growth, self-esteem, marriage, intimacy and wholeness, and used these in conjunction with our work. Books don't wear out like counsellors do!

Wholeness

Jesus didn't come just to save souls but to make people whole. He said, "I am come that they might have life to the full" (John 10:10) He usually started where people were and with the need they presented, whether physical, intellectual, emotional or spiritual. The Greek word *soteria* is used in the NT to refer to salvation in the spiritual sense, but also to physical health or being 'made whole'. (Mark 5:34; Luke 8:48; James 5:15)

Jesus didn't just teach whole living but set the pattern for wholeness. As Luke describes it (Ch. 2:52): "Jesus grew in wisdom (intellectually and emotionally), stature (physically) in favour with God (spiritually) and man" (socially). Of course, Jesus was already perfect and whole, but as a man he modelled for process of growth in all areas for us.

Jesus also said, "Be perfect as your heavenly Father is perfect." (Matthew 5:48) This seems an impossible task until we understand that the Greek word translated here 'perfect' is *'telios'* meaning 'whole'. This word has a range of meanings: finished, fulfilled, complete, perfect, full grown. So we can appropriately paraphrase this statement as: "Be perfectly who you were created to be as your Heavenly Father is perfectly who he is." What a challenge! If we're going to help our patients become whole people, we need to be modelling wholeness ourselves.

"I've learned more from a study of how Jesus worked with people than any text book."

Paul saw wholeness as the goal of the Christian life. He writes: "Until we all reach unity in the faith end in the knowledge of the Son of God and become mature (*telios*) attaining to the whole measure of the fullness of Christ (Ephesians 4:13; Romons 8:29) He also said his objective was "to present everyone perfect (*telios*) in Christ." (Col. 1:29, 29) This doesn't happen suddenly but is a growth process (Hebrews 6:1; 1 Peter 2:2) Growth to wholeness is our birthright. It was marred by sin but God is at work restoring wholeness in us and in those he brings along our path.

God is in the business of healing and wholeness, but we are all responsible for **our own growth**. "Offer your *bodies* as a living sacrifice, wholly and pleasing to God – this is your *spiritual* act of worship. Do not conform any longer to the pattern of this world but be transformed by the renewing of your *mind*." (Romans 12:2) Body, representing all that I am, my mind and my spirit are to be renewed and given to God for his service.

We are also responsible for **each other's growth** to wholeness, because as members of Christ's body "we should have equal concern for each other" (1 Corinthians 12:25; Romans 12:15; Galatians 2:6; Philippians 2:4) May we become whole people so that we can be agents of healing and wholeness to our patients.

"The glory of God is a man (human being) fully alive" St Irenaeus AD120-200.

Dr Nell Muirden

Died 9th June 2013, aged 81

Nell's father, Robert Cruikshank was a Presbyterian minister. She had a huge admiration for both her parents, and their lives greatly influenced her life and led her to her dedication to helping others and her strong religious beliefs. She was born in Sydney and had a younger sister and brother.

Another influence in her life was Albert Schweitzer. It was his work and achievements that inspired her to study medicine to become a Medical Missionary. Being the daughter of a minister, money was tight, but she gained a scholarship to Sydney University graduating in medicine in 1954.

The next year she commenced her internship in the small mining town of Kurri Kurri near Cessnock. The hospital board told her they preferred female staff. The female staff always came when they were called and were never drunk!

"Nell started the first family planning clinic and training courses in PNG. She travelled the country training nurses and health care workers on how to teach contraception and planned parenthood."

The Presbyterian Mission Board asked her to relieve Dr Knox Jamieson for a year as the Medical Superintendent at the Mission Hospital at Vila in the New Hebrides (later extended for another year so Knox could work with the "Big Nambus" people in Malekula Island). She offered to go as the ship's doctor. The ship's captain was looking out for the new doctor, then, he said, along came this girl. By this time Nell was 23 years old and did not appreciate that he thought that she was still a child. There was also a French hospital on Vila but their only common language was Pidgin English.

She felt she needed more skill before doing more missionary work so went for 6 months to Roland House, the Deaconess Training Centre in Melbourne. The trainees were allowed to attend the Theology students' lectures which had such outstanding teachers such as Davis McCaughey on New Testament.

She then worked on a busy rotation involving the Women's, Eye & Ear (there doing dozens of tonsillectomies) and Royal Children's Hospital where she was working on the last night of the last weekend. This resulted in her arriving at Fairfield Hospital too late to do another 24 hour shift. I was asked to take over her shift! This was the start of a partnership of a lifetime!

The next year Nell was based in Geelong to learn some surgery while I was based at Box Hill resulting in much travel up and down the Geelong road! We married in 1961 and then studied Tropical Medicine in preparation for work with the Australian Administration in Papua New Guinea.

First stop in PNG was Malahang "Native Hospital" 7 miles from Lae with a limited power supply. Nell worked in infant welfare and became a mother herself in 1962 with the arrival of Colin.

In 1963 we moved to Samarai. I would perform the operations and Nell would do the anaesthetics, and be in charge when I went on the Health Department boat to places such as the Trobriand Islands. In 1964 Nell became pregnant and went into labor around midnight just after I went to sleep. She did not want to disturb me or the hospital nurses so waited until I woke in the morning to say we should walk across the road to the hospital. An hour later I was able to help in the delivery of Paul.

That was classic Nell, even in the last couple of weeks at the Austin; she never wanted to ask the nurses for help, as she didn't want to be a bother.

In 1967 we were sent to Mt Hagen in the Highlands. Nell practiced obstetrics where often the women came to hospital only when there were difficulties, with many cases of obstructed labour. Doug was born in1967 and 6 weeks later both he and Nell had whooping cough (too early for pertussis vaccine to work). Doug was very unwell and with no pediatrician available, Nell had to nurse him back to health herself, even though she was also unwell.

We had two years in Melbourne where she did school medicals while I studied radiology. In 1972 we were posted to Port Moresby where I became Radiologist. Here the children could attend an International High School, avoiding boarding in Australia.

It was here that Nell started the first family planning clinic and training courses in PNG. She travelled the country training nurses and health care workers on how to teach contraception and planned parenthood. She was devastated when the politicians abolished the programme shortly after she left. In 1975 we were both awarded the Independence Medal when PNG became independent.

Due to education and security problems we returned to Melbourne in 1978. Nell joined the

Pain Control Clinic at Peter MacCallum Cancer Institute, eventually becoming in charge. In September 1987 she commenced the palliative care programme at the hospital.

She retired in 1998 and in 2000 was made a Fellow of the Australasian Chapter of Palliative Medicine of The Royal Australasian College of Physicians.

Post retirement she worked for 10 years as distance learning coordinator with the Melbourne University Post Graduate Palliative Medicine and Psycho-oncology Diploma courses.

In 2001 she was asked to advise on Palliative Care in PNG. This resulted in trips there every year till 2008 when her booklet *Pain Management Guidelines in PNG* was published. During this time we were also both made Honorary Members of the PNG Medical Society.

The church has always been a very important part of Nell's life. She was on the Uniting Church Bioethics Committee and at St Aidan's was an elder and on Education and Worship committees.

She supported numerous charities and helped set up the Cruikshank Library at the Talua Theological Training College in Vanuatu.

Nell also had many other pursuits that brought her great joy, like reading Agatha Christie novels, seeing Gilbert & Sullivan Operettas or going for bush walks. Every day she carefully read *The Age* and was able to produce paper cuttings on news items old or recent on almost any subject.

Our 3 sons (one is a medical graduate) are all happily married and we have 4 grandsons including one family in England.

For 20 years Nell had had mild peripheral neuropathy due to Waldenstrom's Macroglobulinemia. With increasing globulin levels she commenced treatment in early April. Her symptoms became worse and 6 weeks later she developed unresponsive pneumonia.

In her last illness in the Austin Hospital she was alert almost to the end enjoying reliving family memories.

John Muirden

INTERNATIONAL HEALTH & DEVELOPMENT NEWS

intermed

… 17th Summer School in medical mission ...

core course:

5-24 January 2014

A unique 3-week **intensive professional course** for doctors, nurses, and other health development workers headed for or returning from the mission field in less developed and disadvantaged societies.

Optional 4th week (25-30 Jan) & optional 2 week outreach (mid-2014)

To be held mostly at
Tabor College, 181 Goodwood Road,
Millswood, South Australia,
and some sessions at other locations
in Adelaide

For further details and application form contact:
Dr Douglas Shaw (Course Coordinator)
Prof Anthony Radford (Course Advisor)
INTERMED SA
PO Box 36, CRAFERS,
South Australia 5152 Australia
Phone: (08) 8339 8603 or 0408 679 347
Email: intermedsa@adam.com.au
or visit **www.intermed.org.au**

No one should go out in medical mission without doing this course.

Judy Steel, Uganda

Seeking expressions of interest ...

International Health & Development News

Thinking of Medical Mission?

This International Health & Development course is offered by INTERMED, a consortium of health professionals, health pro-fessional organisations, mission groups and Christian educational institutions.
A team of well-qualified and highly experienced lecturers contribute to the presentation of the program.

The course provides a Christian perspective on poverty and development issues, and intensive teaching on clinical and public health issues, including: maternal and child health care, clinical tropical medicine, health and development, the organisation and management of health services and community development. In addition, doctors and labor¬a¬tory scientists study parasitology and microscopy, and nurses develop basic clinical skills.

Credit towards a number of Tabor Adelaide's government accredited course can be obtained. Most health professionals can obtain Continuing Medical Education by submitting details to their relevant authority. Credit may also be sought from other universities and colleges.

To be held at
Tabor Adelaide, 181 Goodwood Road, Millswood, South Australia,
with some sessions at other locations in Adelaide.

A non-refundable deposit of $200 is required.
Core course (3 weeks): $2100 (earning), $1575 (low/no income), 25% discount for spouses.
Course for academic credit: to be advised
Optional 4th week: $525
Early bird rebate: $150 discount if full fees are paid by 1 November 2013.

Scholarship considered for missionaries on furlough or awaiting assignment, and those on low/no incomes but going overseas for more than short term in the year of the course. Please request Scholarship Application form.

intermed

... 17th Summer School in medical mission ...

core course:

5-24 January 2014

A unique 3-week **intensive professional course** for doctors, nurses, and other health development workers headed for or returning from the mission field in less developed and disadvantaged societies.

An optional 4th week and/or optional practicum will be available to interested participants.

Optional 4th week: 25-30 January 2014

Optional practicum: later in 2014

For further details and application form contact:
Dr Douglas Shaw (Course Coordinator)
Prof Anthony Radford (Course Advisor)
INTERMED SA
PO Box 36, CRAFERS,
South Australia 5152 Australia
Phone: (08) 8339 8603 or 0408 679 347
Email: intermedsa@adam.com.au
or visit **www.intermed.org.au**

CMDFA News

Congratulations for members mentioned in the Queen's Birthday Honours.

Professor Robert Norman appointed OAM – for distinguished service to medicine in the field of reproductive health through significant contributions as a researcher and clinician.

Dr Clifford Smith appointed OAM – for service to medicine, particularly in Papua New Guinea.

What is the CMDFA?

Aims

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

Origins

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

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

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

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

Why join the CMDFA?

• Fellowship • Evangelism • Discussion • Mission • Student Work

CMDFA seeks to:

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

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

By Joining the Fellowship you can:

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

LUKE's journal

Dear Contributor,

Attached is a Copyright Agreement that we request you complete and forward with your article.

Please note the section of the agreement granting ***Luke's Journal*** permission to reproduce your article on the ***CMDFA web page***.

I,.....

.....

(insert name)

of.....

.....

.....

.....

(insert address)

agree to grant a non-exclusive license to the **Christian Medical and Dental Fellowship of Australia Inc. (CMDFA)** for the reproduction of my article entitled

" .....

.....

.....

....."

in full or edited form in ***Luke's Journal***. This article has not been published elsewhere, or if it has, permission has been obtained for publication in ***Luke's Journal***.

I further ☐ agree
☐ do not agree *(please indicate)* to grant a non-exclusive license to the ***Christian Medical and Dental Fellowship of Australia Inc.*** for the reproduction of my article in full or edited form on the ***CMDFA web page***, to be included and removed at the discretion of the Editors of Luke's Journal.

This permission is granted free of consideration.

Signed: .....
(Licensor)

Dated:.....

CHRISTIAN
MEDICAL
& DENTAL
FELLOWSHIP of
AUSTRALIA Inc.

www.cmdfa.org.au