Luke's Journal

of Christian Medicine & Dentistry
Vol. 23 No. 1 January 2018

CMDFA
CHRISTIAN MEDICAL
& DENTAL FELLOWSHIP
of AUSTRALIA Inc

Sharing Comfort through Christ

Pain & Faith

- Palliative Care Practice
- Pain – What's the Point?
- Pain Avoidance & Addiction
- Pain through a Cultural Lens

A History of Pain

Pain: A Theology on-the-fly

Living with/ Living without Chronic Pain

www.cmdfa.org.au

Luke's Journal

CMDFA

Published by the
Christian Medical and Dental Fellowship of Australia Inc.
ABN 95 084 292 464

Please submit all contributions to:

THE EDITORS
Dr Paul Mercer
Ph: 07 3348 9940
Email: reception@silkymed.com.au

Dr Catherine Hollier
Ph: 02 4957 5242
Email: LukesJournalCMDFA@gmail.com

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

SUB-EDITORS Sue Furby and Dr Winnie Chen

CMDFA

CHAIRMAN
Dr Ross Dunn
Ph 07 3822 6459 Mob: 0427 045 991
Email: chair@cmdfa.org.au

NATIONAL OFFICE
Unit 35A / 9 Hoyle Avenue
Castle Hill NSW 2154
PO Box 877
Baulkham Hills NSW 1755
Ph: 02 9680 1233 Fax: 02 9634 2659
Email: office@cmdfa.org.au

NATIONAL MANAGER
David Brown
Contact through the National Office

NATIONAL SECRETARY
Dr Yvonne Lai BDSc(WA)
Email: yvonne.yl.lai@gmail.com
Email: secretary@cmdfa.org.au

NATIONAL TREASURER
Gene Passe De Silva
Email: office@cmdfa.org.au

ReGS (Recent Graduates & Students)
Dr Joel Wight (recent graduates)
Email: joel.c.wight@gmail.com
Dr Jacki Dunning(students)
Email: jacki.elizabeth.dunning@gmail.com
Email: students@cmdfa.org.au

BRANCH SECRETARIES
NSW and ACT:
Dr Lauren Chong
Email: nsw@cmdfa.org.au

QUEENSLAND:
Dr Anthony Herbert
Email:anthonyherb@gmail.com

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

WESTERN AUSTRALIA:
Bianca van der Nest
Email:biancamay.vdn@gmail.com

VICTORIA (and TAS):
Elise Chen
Email: victoria@cmdfa.org.au

About Luke's Journal

This Journal is published three 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.
Stock photos: www.dreamstime.com

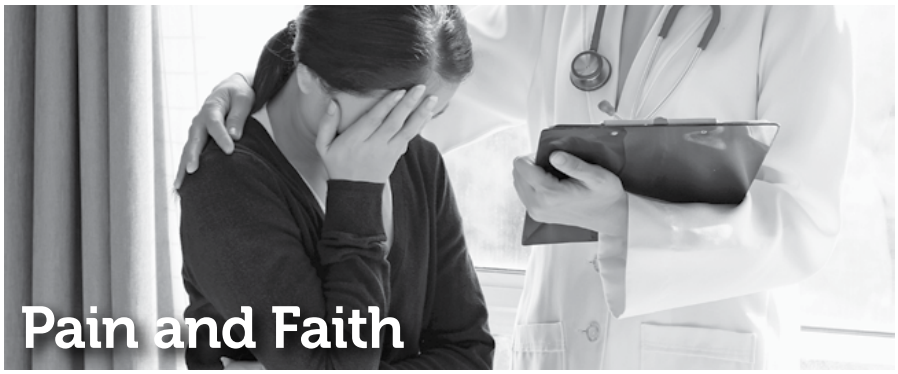
Back Issues

Back issues are available for the following Journals:

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

These back issues are free for financial members of the CMDFA and can also be accessed electronically on the ISSUU app at www.issuu.com . The cost is $5 for friends of CMDFA or non-financial members (including postage). Please email the national office for online payment or make cheques payable to CMDFA Inc. Other issues may be obtained from your Branch Secretary or from the national office.

guest editorial



Pain and Faith

Humans have a love-hate relationship with pain. Pain is unpleasant and we try very hard to avoid it. On the other hand, we are constantly reminded that there is no gain without pain. That can be the literal kind when you start exercising for the first time in years, or metaphorical as you strive to understand concepts and commit facts to memory in your studies.

Pain is defined as "An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." (International Association for the Study of Pain (2017)[1] Pain forces people to respond to avoid further damage. Pain is remembered, and avoidance of further pain is the motivation for many decisions we all make in life.

The absence of pain has catastrophic consequences. Paul Brand, a giant in medicine and openly Christian, discovered the pathology of leprosy was destruction of nociceptors by *Mycobacterium leprae*, and that the hideous deformities were the consequence of failure of the body to receive warnings that damage was being inflicted. Congenital analgesia, the absence of the sense of pain, is a fatal condition due to the accumulation of multiple and regular insults. (Brand P and Yancey P)[2]

The prevention and treatment of pain is a core role for physicians and dentists. We prevent further tissue damage if possible, sometimes inflict pain through surgery and try to minimise it peri- and post-operatively. On a daily basis we are confronted with people who have chronic pain, where signals are being sent to the brain from degeneration and disease and which constantly stimulate nociceptor and/or neural tissues. Where acute pain is useful in that it forces us to take steps to limit the pain, chronic pain is useless pain. There are no benefits to chronic pain and there are few steps available to us to mitigate the source of chronic pain. This is one of the greatest challenges in medicine.

How do the Christian faith and pain intersect? Believers and non-believers alike are severely challenged by the presence of unremitting pain, and the often irreversible or progressive diseases that cause them. On the one hand, we are encouraged to pray for healing of the sick. There is no doubt that this is scriptural: *"Is any one of you sick? He should call the elders of the church to pray over him... And the prayer offered in faith will make the sick person well."* (James 5:14-15). Many of Christ's miracles were physical healings and even raising people from death. However, there are other instances where healing was not immediate or granted. Paul's thorn in the flesh was not removed: *"Three times I pleaded with the Lord to take it away from me. But he said to me, 'My power is made perfect in weakness'."* (2 Cor 12: 8-9).

This paradox is puzzling to the believer and a roadblock to faith for the unbeliever.

continued over page

Contents

Luke's Journal

Themes for Next Editions:

Disabling Disability – We're all in this together
– copy by 28 February 2018

Hot Topics in Ethics
– copy by 1 July 2018

Perhaps the greatest example of the role of pain in Scripture is the crucifixion. Jesus knew it would be agonising, and pleaded for God to let this cup pass him, but *"not my will but yours be done."* (Mark 14:35-36). I am convinced that the mode of death Jesus endured was deliberately chosen by God because it was the worst possible suffering one human could inflict on another. Humanity and evil did its worst and appeared to win when Jesus cried : *"It is finished!"* (John 19:30). That was Friday, but *Sunday* was coming! (Campolo, 1990.)[3] Jesus endured the worst and triumphed over the grave, and we are all the beneficiaries of his journey through pain to triumph.

The "why" of unremitting pain and suffering is always a mystery to us, as is the apparent randomness of people being healed or not. However, we do not see the whole picture. God sees the past, present and future, and knows what the outcomes are going to be even before they actually happen. There may be a reason for delayed or non-healing that we are not privy to. A close friend once developed a mononeuritis which was chronically and intensely painful for three years, also leading to partial leg paralysis. Nothing medicine could offer him seemed to work. It ruined his future employment plans, and he was a depressed, angry man who turned to alcohol to dull the pain. He once met another friend at our home who was a Christian, and for whom prayer was a way of life. They got talking, and the praying friend prayed for healing. Three days later, the man in pain was offered a rarely used, old treatment which was thought to give temporary relief at best. Relief was instantaneous and he has had barely any pain since. He ran a half marathon a year or so later! In an email soon after the procedure, he asked the praying friend whether God would heal someone who did not believe in Him, and received an encouraging gracious reply. He became a Christian as a result. Would that have happened in the absence of his suffering?

I believe we should pray for our patients. There are differing views on this. Firstly, we can pray privately to God for each person who walks through the surgery door. Secondly, we can offer to pray for them. Personally, I do this when the Spirit nudges me to do so and not with everyone. Others may choose a more inclusive approach.

I believe we must seek to relieve pain to the best of our ability, and with the astounding array of treatments and expertise provided by God to us. We must also walk with those who suffer pain and other afflictions, not only by offering analgesia, but to let them know they are not suffering this alone. We must recognise that relief of the physical pain is only part of the solution, and also to seek understanding of the person who suffers the pain. Addressing both parts of the equation is vital to good management. With God's grace, we can be effective agents of healing. ●

Dr Geoff Mitchell

Editorial by Geoff Mitchell, a GP academic with research interests in end of life care and complex conditions.

References

1. International Association for the Study of Pain. IASP Pain taxonomy. Available from https://www.iasp-pain.org/Taxonomy [accessed 2 December 2017]
2. 2. Yancey P and Brand P.(1997) The gift of Pain. Zondervan Publishers, Grand Rapids, Michigan.
3. Campolo T.(1990) It's Friday but Sunday's coming! From: The Kingdom of God is a Party! Thomas Nelson, Nashville, Tennessee.

Toward a definition of 'pain'

The current definition of pain is about forty years old, has served us well and is still very clinically relevant. Our understanding of the neurophysiology has developed greatly in that time though, and this new knowledge could be reflected in an updated version.

The current definition, which you can find on the international association for the study of pain (IASP) taxonomy page is:

> *"Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or expressed in terms of such damage"*

When I give talks on pain to non-pain specialists, I try to make sense of this definition, which is long and wordy. The major points to highlight in the definition are:

1) Pain is a sensory AND emotional experience. We usually only talk about the sensory aspects of pain, which is ironic since it is the emotional aspects that are responsible for suffering. Emotions consist of thoughts, feelings, actions and behaviours, and there is a bidirectional relationship between the sensory aspects and thoughts, feeling, actions and behaviours. The biomedical treatments we use to treat pain are focussed on modulating the sensory aspects of pain and don't address the emotional aspects directly, which are best approached with a biopsychosocial model.

2) The phrase "pain is associated with actual or potential tissue damage" is telling us what pain's physiological function is – it is our alarm system, to alert us to damage or potential damage occurring to our body. The reason pain is unpleasant is so it motivates us to protect our body from further damage occurring.

"...chronic pain is a biopsychosocial problem, not a purely biomedical problem..."

3) "Pain is associated with actual or potential tissue damage or expressed in terms of such damage". The "expressed in terms of such damage" phrase tells us that our pain system, which is our body's alarm system can be faulty, just like a car alarm system or a house alarm system can be faulty. It is possible to experience pain in the absence of any tissue damage or potential tissue damage. The faulty alarm system can be seen in three different basic scenarios:

   - **Patient experiences pain, and no tissue damage has ever been identified.** This is the case in primary pain disorders, eg. fibromyalgia, chronic daily headaches, functional abdominal pain;

   - **There has been tissue damage, but it has healed and the pain persists.** The most common example is persistent post surgical pain;

   - **There is ongoing tissue damage or potential tissue damage, but the pain experienced is of higher proportion than expected for the level of tissue damage.** For example, someone with rheumatoid arthritis who has controlled disease with only low levels of inflammation, but still has severe pain.

From a neurophysiological point of view, it doesn't matter what the relationship between pain and tissue damage is, it is still the same neurophysiology in the conscious brain. Someone with fibromyalgia's pain experience is just as real as someone who has pain from a broken leg.

One of the biggest challenges when we see patients with chronic pain is helping them understand and accept that chronic pain is a biopsychosocial problem, not a purely biomedical problem. This is why a biomedically-focussed approach to its management is often not as effective as patients would like. ●

Dr Mark Alcock

Director of Pain Management Lady Cilento Children's Hospital, Brisbane. Mark is a Specialist Pain Medicine Physician and Anaesthetist, and the clinical lead of the Queensland Paediatric Pain Management Service at Children's Health Queensland. He has completed fellowships in Pain Medicine and Anaesthesia at the Royal Children's Hospital in Melbourne, University Hospital Geelong, and the Royal Melbourne Hospital.

Luke's Journal

Erratum and Apologia

We would like to bring your attention to Dr Peter Ravenscroft's excellent article on *Bringing Spirituality into Clinical Practice* (Healthy Service edition, Vol 22, No 2, Sept 2017, p20). Unfortunately, the diagrams were mis-formatted and so did not make sense with the text. Corrections have been made online at issuu.com where you can view the diagrams in colour. It is well worth re-reading the article with reference to the corrected diagrams.

PAIN – What's the Point?

I had the flu recently. For the first time in years, I couldn't get up to get breakfast for my kids. My head ached, my throat felt raw, turning over in bed felt like the biggest project I could contemplate. After a few days in bed, I started to feel my body mending before gastroenteritis threw me down again. Cramps, dry retching and aching everywhere.

On reflection, I have been struck by how pointless the whole experience seemed to me at the time. My prayer was that God would take the pain and discomfort away as soon as possible. It wasn't just that I wanted to get back to the tasks of life and ministry. It was also that I found the anxious sense of isolation and the vague notion that perhaps God was aloof from me deeply uncomfortable. I wanted the experience over. Having thus wilted in the heat of a mere couple of weeks of discomfort though, I wondered how I would ever cope with chronic pain, not only the physical pain but the mental and spiritual pain that creep in darkly beside it. Pain doesn't fit into my vision for my life. It seems a pointless interruption.

Is there, indeed, any point to pain? Does it have any meaning or purpose? Doctors assess, treat and help patients through their pain on a daily basis and sometimes do so while experiencing pain themselves. Ensconced in the intricate titrations of pain treatment, however, it can be easy to miss the bigger cultural and biblical stories that shape the meaning we give to pain. It is these meanings of pain that I am seeking to probe in this article. After briefly sketching the basic contours of pain, I will invoke Martin Luther to compare the meaning our culture gives to pain to the rich meaning and comfort that the gospel of Jesus Christ gives to our pain.

The concept of pain in much of the current practice of medicine is shaped by concern for finding successful analgesic therapies. Evidence Based Medicine (EBM), with its positivistic emphasis on reproducible, objective and quantifiable 'facts' about human pain, has become the key standard for assessing therapeutic legitimacy.[1] Behind EBM is a concept of human health and disease, shaped by philosophers of medicine such as Christopher Boorse, that is rooted firmly in biology, chemistry, physics and related natural sciences.[2] A particular aim of Boorse was to eliminate any vague value judgements about health and disease that might interfere with the pursuit of objective, explanatory truth.

While EBM has served pain treatment well, it has significant limitations. Psychiatrist and medical anthropologist Arthur Kleinman pointed out that medicine is for the benefit of human beings who are, of course, much more than mere biophysical entities. Treatment of pain and disease, according to Kleinman, must take into account how these are perceived, valued and given meaning within a community, as well as how they are biophysically understood.[3] The experience of pain is imbued with social and spiritual meaning whether we are conscious of it or not.

The Bible, however, pointed to the complexity of pain for many long years before the anthropologists and philosophers did. Physical pain intersects intimately with spiritual, social and emotional pain because God has created us as relational beings with body and soul intertwined. When Jesus commanded us to *'love the Lord your God with all your heart and with all your soul and with all your (physical) strength and with all your mind'* (Luke 10:27), he was not separating out discrete aspects of our being but speaking to every aspect of us integrated together. It is interesting to observe the way neuroscience illustrates the remarkable extent to which our body, mind and relationships are interconnected. Physical pain will profoundly affect the way we relate to God, our thinking and relationships. How we relate to God will profoundly affect our experience of pain.[4]

Reformer Martin Luther's sixteenth century writings speak with fascinating insight into the way our relationship with God affects our experience of pain. As we, dependent creatures, stand before God, experiencing any of the great variety of pains thrown up amidst the wreckage of a fallen world, Luther describes the two basic theologies by which we can interpret our experience. Actually, in his Heidelberg Disputation of 1518, Luther addresses his hearers more personally than that. He identifies the two kinds of 'theologians' we can be in this world: theologians of glory and theologians of the cross.[5] Here are three points of comparison between these theologians that are particularly important for us to hear as we grapple with pain in our current context.

Firstly, theologians of glory do not grasp the all-pervasive damage of

sin. They optimistically assume that people are better and more attractive than God says they are. They assume that their minds can readily understand themselves and the world, as well as discern right from wrong. The confidence of the theologian of the glory shows itself in a characteristic self-centredness. The world is made for them and their pursuit of the good life. Moreover, embracing the good life assumes that the life extends only as far as they can see. There is no greater story that extends beyond death – this life is all there is.

In *our* current culture, embracing the good life means prizing radical individual freedom: creating our own stories and meaning, freely expressing and fulfilling our dreams, refusing to be suffocated by the needs of others, holding fast to comfort, health, safety and control, and choosing to do what makes us happy.

If the meaning of life is to choose what makes us happy, then pain destroys that meaning and brings profound terror and despair. The only thing to be done with pain is to track down its source and get rid of it. This is so often the substance of our culture's response to pain. We flock to therapists who we hope can cure or patch over the problem of our pain with medication, exercise, diet, self-esteem, life coaching and distraction.

"...our secular culture is shocked by the interruption of pain and sees no purpose in it."

In his book *Walking with God Through Pain and Suffering*, Tim Keller observes that we are more undone by suffering in our western culture than were our ancestors.[6] While many cultures other than our own see pain and suffering as somewhat inevitable but also meaningful in light of life beyond this world, our secular culture is shocked by the interruption of pain and sees no purpose in it. Pain is a waste of time which takes away from the good life we want and expect.

Theologians of the cross, however, recognise and lament the awful, all-pervasive scourge of sin. They join with the psalmists, with King David and God's future Messiah in crying 'Why, O Lord', 'How Long O Lord?' and 'Lord, where is your love?'

O Lord, all my longing
is before you;
my sighing is not hidden from you.
My heart throbs; my strength fails me,
and the light of my eyes
– it also has gone from me.
My friends and companions stand
aloof from my plague,
and my nearest kin stand far off.
(Psalm 38:9-11)

continued over page

This misery can sometimes result from a person's sin as in this psalm (see 1 Peter 4:15) but at other times occurs in spite of innocence (Psalm 44). Theologians of the cross are not backward in recognising the terrible reality of pain that cannot be entirely eliminated by human therapy, technology or policy because its roots are too deep in this world's bondage to corruption and decay (Romans 8:20).

Theologians of the cross also recognise that the ultimate root of pain is the sin of all humanity in which they so deeply and wilfully participate, and for which they deserve judgement. The right disposition of human beings before God is that of humility due to guilt. As Luther says; 'Although the works of man always seem attractive and good, they are nevertheless likely to be mortal sins.'[7] For Luther, pain helpfully undoes people. It challenges human thinking about how life works and helps to dispel humanity's proud illusion that they have the competence and strength to rule their own lives.

Secondly, theologians of glory have a very small 'God'. Although our culture's story of the good life is largely atheistic, God isn't necessarily left out. In fact, He is often co-opted in, especially in situations of pain. The preconceived expectations of theologians of glory lead them to see God at work in powerful places of health, wealth, success and present happiness. In reality, however, such a 'God' is remarkably small and powerless. He is a projection of felt needs – there to help them realise their dreams and express themselves, boost their self-esteem and quickly take away their pain. He is a 'God' of cheap comfort rather than the Lord who claims victory over the greatest scourge of sin and death; a sentimental 'God' who has nothing much at all to say to the man in chronic, intractable pain, isolated from loving relationships.[8]

Theologians of the cross, however, know the powerful Lord who reveals Himself on His terms. Luther says: 'He deserves to be called a theologian […] who comprehends the visible and manifest things of God seen through suffering and the cross.'[9] In opposition to all human expectation, God chose to reveal Himself to sinners through the pain, weakness, humiliation and death of His Son Jesus on the cross (1 Corinthians 1:18-25; John 14:6). At the very point at which God seemed most absent and powerless, He was most wonderfully and sympathetically present in salvation, bearing the punishment of desperate sinners and breaking the bondage of sin and death.

> **"...while my pain is to be lamented and relieved where possible, it is also held in the purposeful hands of the powerful Lord who has shown He is for me."**

Those in pain, then, can look at the cross and see that God is near and He is for them. Despite the way things may appear, God's anger is turned away from them, and His love, compassion and power is turned graciously toward them. Theologians of the cross can look to Jesus' resurrection and know they are not abandoned to a world trapped in suffering but have the sure hope that sin and all the pain in its train will be definitively eliminated (1 Corinthians 15:50; Hebrews 6:19-20).

Finally, theologians of glory desire too little. As C.S. Lewis says, they desire only the shallow, momentary, this-worldly cures and distractions to the problem of pain, dismissing the cross as apparently lacking in power (1 Corinthians 1:18-25).[10] **Theologians of the cross, however, desire everlasting joy in Christ.** While lamenting pain, crying out to God for relief and thankfully accepting all the analgesia and human kindness that God provides in His daily grace, theologians of the cross also know that they have been mercifully caught up in God's salvation purposes. They can long for the new creation, hidden beneath the current creation, waiting to be revealed. In the meantime, they can trust that the God who shows His love to them on the cross has hidden purposes to their pain. He can use their pain to prise their fingers away from goods that will not last and help them cling to hope in Christ.

Reflecting on my brief viral sojourn, I realised that I had quite unconsciously slipped into the mindset of a theologian of glory. But as a theologian of the cross I can know that while my pain is to be lamented and relieved where possible, it is also held in the purposeful hands of the powerful Lord who has shown He is for me. I see now how precious is the help of fellow theologians of the cross who can point me to cross when it seems most hidden. In particular, I see how precious is the help of a doctor who can show me the Lord's mercy in my pain both physically and spiritually. ●

References
1. M. Goldenberg,'On Evidence and Evidence Based Medicine: Lessons from the Philosophy of Science'. *Social Science and Medicine*. 2006; 62: 2621-2632.
2. C. Boorse, 'On the Distinction Between Disease and Illness.' *Philosophy and Public Affairs*. 1975 Autumn; 5(1):49-68.
3. A. Kleinman, 'Medicine's symbolic reality'. *Inquiry*. 1973; 16:1-4.
4. Kelly M. Kapic, *Embodied Hope: A Theological Meditation on Pain and Suffering*. 2017. Illinois: IVP Academic.
5. Jaroslav Pelikan, H.C. Oswald, and Helmut T.Lehmann, eds. *Luther's Works*, 55 vols, 1999. Philadelphia: Fortress Press, 1999, 31:40.
6. Tim Keller, *Walking With God Through Pain and Suffering*. 2013. UK: Hodder and Stoughton.
7. Luther's Works, 31:39
8. Michael Horton, *A Place for Weakness: Preparing Yourself for Suffering*. 2010. USA: Zondervan.
9. Luther's Works, 31:40.
10. C. S. Lewis, *The Weight of Glory*. 2013. UK: William Collins.

Dr Robyn Bain

After many years working as a doctor in the Emergency Department, Robyn Bain now works in gospel ministry full time. She has recently completed a masters degree in bioethics and is continuing postgraduate study in theological ethics. She helps her husband, Andrew, teach ethics at the Queensland Theological College (Andrew is vice principal) where she also trains and ministers to women. Robyn is also the convenor of the Presbyterian Church of Queensland Committee responsible for addressing social and ethical issues (GiST). She especially loves raising her two daughters Guinevere (9) and Julia (6).

Dental Trauma and Treating Toothaches

Dr Catherine Hollier first met Dr 'Phil Akavity' at the CMDFA National Conference. She was keen to get a dentist's perspective on pain for this edition of *Luke's Journal*.

So tell us a little bit about yourself...
Some of you will already have realised that I am writing under a pseudonym. I don't quite have the freedom to speak openly, so please take what I'm about to say "tongue in cheek". I AM a "real" dentist, but patients that are eligible for government subsidies would often say otherwise.

I graduated from a British university, and have been blessed to have worked in five countries on four continents. Let's face it – I couldn't be out of work for long – even when I've tried! Being asked to share about life abroad is an honour.

What can you tell us about dental trauma?
Since I was recently asked to talk with Australian Emergency Department doctors about how to treat dental trauma, I'll use that as a starting point. The common signs of dental trauma are lacerations to the lip and face, broken teeth and avulsed teeth. Lacerations are simple for us all, but a whole tooth recovered from a dirty footy pitch is another.

The fear factor is often, "What if the tooth is inserted in the socket the wrong way round?" "Good!" is my response. A tooth can always be reshaped, but if it stays out of the socket too long or is too dry, then it won't reattach and we can do nothing with it. Evidence-based research shows that sixty minutes is the critical time. An 8 year old, with an open apex, within 60 minutes if the tooth is stored in milk or saliva has a 99% success rate, but the percentages drop quickly with time and dryness. Excitingly, recent studies have used auto-transplants


Dental extractions in Western Nepal!

from developing wisdom tooth buds into the upper anterior sockets, which are later reshaped, so that even the most experienced dentist would struggle to know the difference!

I know that lots of people fear going to the dentist because of pain, and toothache is one of the most severe pains that many of us experience. What can you tell us about treating toothache?
Those of you that have ever experienced it know that paracetamol or ibuprofen take the edge off the pain and morphine makes it feel like the pain is a metre away (not recommended by any dentist). Only local anaesthetic (LA) will bring true relief (at least for 2-5 hours).

You'd have to have a "bad" toothache to undergo an extraction without LA. In Nepal, that was common in the rural west. Although I was the "unassigned spouse" without a work visa, I couldn't sit around when I saw the local blacksmith doing extractions without local anaesthetic! Training for local health care workers began. Dental camps were arranged. When a trainee had extracted 100 teeth under local anaesthetic and supervision, I would provide them with their own full set of extraction forceps. I warned them, "If you ever take out a tooth without local anaesthetic – I'll pull out your own front tooth without local!" I meant it!

Standards at the dental camps were lower than Australian standards, but the instruments were nevertheless cleaned and sterilised in pressure cookers on wood or kerosene stoves. The gloves were washed, dried and powdered with flour. By the end of a week when the gloves were getting fragile, I was only wearing one glove on my left hand since this was the only one that touched the patient. The other merely held the forceps. The only pain felt was in my feet and back, thanks to the wonder of modern anaesthetic. We didn't stop until the last patient left.

I've often wondered if there are things that doctors could do that are usually considered the realm of the dentist. Maybe you could answer some of those questions for me. When do you need to do something surgical to a dental abscess?
When there is a fluctuant local swelling. It is easy to stab with a size 15 blade.

How do you pull out a tooth?
Actually you push in a tooth to break the root fibres and then it is easier to remove the tooth (usually in a buccal direction).

Are there any readily accessible resources for doctors that would like to learn more?
For those of you that would like more statistics or real teaching on dental trauma, check out www.dentaltraumaguide.org which is among the best in the world. There's a small joining fee ($25) but it's a fabulous resource! ●

Dr 'Phil Akavity' is a 'real' dentist in the public system who has recently moved to Australia after working abroad.

A History of PAIN

As doctors, one of our main functions is the diagnosis and treatment of pain.

From our earliest clinical training, the characterisation of pain and discovering its pathological origin has been our primary role. Seeking from our patients a description of pain – the site, character, radiation and aggravating and relieving factors – has been our method to deduce the diagnostic possibilities. Finally, finding the appropriate treatment has as its aim to relieve pain and, where possible, to deal with the source. In many ways, what makes us a good (or successful) doctor can be summed up in our capacity to reliably diagnose pain and relieve it to the satisfaction of our patients.

William Morton, anaesthesia: A painting showing the use of ether in dental surgery, 1846.

Despite this practical approach, there is the difficulty of defining what pain actually is. Pain is entirely subjective and felt by all humanity in one form or another. We can describe it, measure the effects and find the cause, but fundamentally pain remains a purely personal experience.

Through history, physicians and scientists have sought to define what is meant by pain. Although pain has always been enigmatic, in the last 150 years enormous strides have been made in our understanding.

The definition of pain is a more difficult question than might be imagined. The author Joanna Bourke in her book, *The Story of Pain*[1], states, "The English noun, *pain*, encompasses a host of incommensurable phenomena. Pain is a label that adheres to scraped knees, headaches, phantom limbs and kidney stones. It is assigned to heart attacks and heartaches. The adjective, *painful*, is so broad that it can be applied to a tooth-ache as easily as to a boil, a burst appendix and birth." The English physician, Peter Latham, in the 1850s opined that pain assumed many guises. In answer to the question, "What is pain?" contended simply that, "he knew himself perfectly well what pain is and he could not know it better for any words in which it could be defined. " Latham insisted, "Things which all men know infallibly by their own perceptive experience cannot be plainer by words. Therefore let pain be spoken of simply as pain."

For Christian doctors, pain is central to our thoughts of what it means to be human and the relief of pain is part of our God's loving providence. Christian doctrine is that pain is a consequence of the fall (Genesis 3:16). After Adam and Eve sinned, the outcome was human pain and suffering, but from Genesis 3:17 there is a hint of God's provision and a hope that the human race will not be abandoned. When God says, *"cursed is the ground for your sake"* (NKJV), he did not say for your punishment but rather for your sake – your welfare. In a sense the worse thing for a fallen humanity would be a state immune to pain, because pain is a signal that something is wrong and needs to be fixed.

It follows that Christian doctors cannot be in denial about the reality of pain and the ultimate solution that comes from our saviour Jesus. For clinicians dealing with pain on a daily basis, it is important to avoid pat answers or over-spiritualised theories about pain. Reading the book of Job helps to remind us about the inscrutability of pain and suffering. There is still a mystery of pain that demands our respect, and humility that we do not possess all the answers. But this we

do know – that we have a loving God who sent his Son to suffer the most horrendous pain and to die in our place. This is the central truth that we live by and apply our God-given skills to manage pain.

Although relief of pain has been central to the work of doctors, it is comparatively recently that therapies for pain have been at the clinician's disposal. In the 1830s, Sir Charles Bell in England and Francois Magendie in France elucidated the biological basis of pain in terms of motor and sensory functions of the dorsal and ventral roots of the spinal cord. Through the nineteenth century, scientific work defined the pain pathways from peripheral nociception to connections in the spinal cord, thalamus and cerebral cortex. More recently, neuroscience has defined pain as a type of neurological activity in the brain. Pain is the brain's response to noxious stimuli or, more specifically, it is the response of certain regions of the brain to nociception. Pain can thus be measured and revealed by functional MRI brain scans.

A modern definition of pain comes from the International Association for the Study of Pain (IASP) that states, "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." This definition emerged from the gate control theory of pain[2] (Melzak and Wall, 1967) that introduced the idea of a "gating mechanism" in the dorsal horn of the spinal cord that allowed the perception of pain to be modified. As such, the gate control theory and IASP definition make clear that sensory, cognitive, affective and emotional processes influence people's experience of pain. It follows that treatment of pain may be multifactorial, encompassing not just pharmacological treatments, but also social and psychological interventions.

A major milestone in pain relief was undoubtedly the development of surgical anaesthesia. William Morton first demonstrated ether anaesthesia in 1846 at the Massachusetts General Hospital (visitors can still visit the Ether Dome and Museum in Boston). Soon after, in 1848, James Young Simpson, obstetrician in Edinburgh, began to use chloroform for labour and childbirth.

Subsequently, there was an ethical debate about the use of anaesthesia which included some religious objection to pain relief in labour as being against 'God's will'. In fact, the opposition to Simpson's methods came from only a small number of clergy. Much of the resistance to obstetric anaesthesia resolved after Queen Victoria was administered chloroform during the birth of Prince Leopold.

"The body is a healthy body when it responds to pain."

Opiates derived from the opium poppy have long been used for the relief of pain as well as for recreational use. In the sixteenth century, laudanum (opium mixed with sherry) was developed as a painkiller. Morphine was extracted from opium in a pure form in the early nineteenth century and was widely used as a painkiller in the American Civil War. In 1898, the Bayer Company in Germany introduced diacetylated morphine, or heroin, as an effective painkiller although highly addictive. Bayer's chemists also developed acetylated salicylic acid, or aspirin, as a simple pain remedy. From earliest times the use of strong painkillers has come at a cost, namely, the potential for addiction. The search for newer synthetic compounds for pain relief without addiction has largely been unfruitful. methadone (Physeptone) in 1937, oxycodone (Oxycontin) in 1995 and more recently tramadol (Tramal) and tapentadol (Palexia) have each had their role in pain management, but none have been free of addictive qualities. Whilst recreational drug use has been the scourge of modern society, we are now witnessing an epidemic of abuse of prescription painkillers.

The development of multidisciplinary pain clinics has sought to rationalise medication and use psychological and other interventions. Unfortunately, such clinics are often under-resourced and scarcely able to meet the demand for chronic pain management in the community.

The great medical missionary, Paul Brand, worked with lepers and was well acquainted with pain and suffering. He reflected that one of the consequences of leprosy was that they could no longer feel pain in the leprous part of the body. He noted that pain protects and is part of God's love and provision. A leper without pain would burn his skin and never feel it. Pain tells us that something is wrong and protects us from harm. He stated, "If I had the power to eliminate human pain I would not exercise that right. Pain's value is too great."

Paul Brand also reminds us that pain unifies as he wrote, "I can tell the health of a human body by its reaction to pain. If the body does not react to pain, I know that something is terribly wrong." 1 Corinthians 12:26 reminds us that if one member of the church suffers, every member suffers. In the church we are bound together through the pain that we suffer. He notes, "You can tell something of the health of a church by the way that it responds to the hurting, the helpless, the homeless, the broken, the bruised, the battered, the bleeding and the impoverished. The body is a healthy body when it responds to pain."

Finally, pain corrects. There is a correcting purpose of pain that tells us something needs fixing and it directs us to the solution. In today's world, many seek relief of pain through drugs, alcohol or even denial. C.S. Lewis in his famous quote (from *The Problem of Pain*[3]) reminds us that pain is like God's megaphone to get our attention. Pain in itself has a purpose directing us to something amiss and allowing skilful medicine to elucidate its cause. God uses pain for good in leading us to Jesus, who suffered pain in our place, and pointing us to a heavenly home where pain and suffering will be no more. ●

References:
1. Bourke, Joanna, *The Story of Pain*, Oxford University Press, 2014.
2. Melzack, R. Wall, PD., *Pain Mechanisms: a New Theory*, Survey of Anesthesiology, April 1967. Volume 11, Issue 2. p89-90.
3. Lewis, CS, *The Problem of Pain*, HarperOne, 2015

Dr Don Todman
Neurologist, Brisbane.

Sharing comfort through Christ

Talk given at the National CMDFA Conference on 14.7.17 by Murray Lean. His Bible reading was 2 Corinthians 1:1-7.

Medicine and dentistry have always been professions that have attracted students with a bent towards altruism. I know I am speaking in generalisations, but I'm still idealistic enough to think that at least many medicine and dentistry graduates have a reasonable amount of compassion for their patients – they genuinely **do care**, they **want** to alleviate suffering, they **do** have empathy for their patients. And this is particularly so among Christian graduates.

Over the ensuing years some of these motivations can become blunted, but "caring" remains an important aspect of our professions. Perhaps that's one big reason why doctors and dentists are still among the most respected and trusted people by the general public. But I sense, and it's only a gut feeling, that the personal caring dimension of what we do is being questioned in some quarters these days. The "art of medicine" is being challenged and compromised by endless investigations, expensive machines, a media focus on horror stories, public discussion about waiting lists, Medicare rebates, and the economics of the health system.

As the world becomes less and less personal, the need for doctors and dentists who truly care and show compassion is as great as it has ever been.

The question for us is: where does the Christian fit into this world of algorithms, Dr Google, robotic surgery and 3D printing of body parts?

- Does our faith make a difference?
- Do our patients notice anything different about us?
- Are we any different from our colleagues?
- Do we see ourselves as more than professionals?

These are important questions for us to ask ourselves.

In these talks I am attempting to develop a Christian model of compassionate care, and this first session begins with the premise that compassion begins with a correct view of suffering.

The book of 2 Corinthians is the most personally revealing letter apostle Paul wrote, and in it he gives us a peek into his innermost thoughts and feelings. He suffered much in the course of his gospel ministry, and had a very painful relationship with the Corinthian church. So it is with a real sense of his own weakness and vulnerability that he writes to the Corinthians. We see a very human side of Paul come through repeatedly in this letter.

This is the letter where he lists his sufferings (2 Cor 11:23-30) and talks about his "thorn in the flesh" (2 Cor 12:7-10). You can't help feeling sorry for him as you read this letter. Yet what Paul is essentially saying is that weakness and a healthy sense of our own vulnerability is actually the way God intends it to be in those whom He wants to use in Christian service. The "Messiah complex" has no place in the self-identity of the Christian doctor or dentist! It doesn't matter what our patients say about us or what pedestals they might put us on, we must not play along with them and try to project an image of superiority.

Paul can help us a lot in this regard, as we see in our passage **2 Corinthians 1:1-7**. He immediately launches into the subject of "trouble" (NIV) or "affliction" (ESV). Literally the Greek word means "pressure", which summarises the whole spectrum of life's difficulties. In these few verses "comfort" is mentioned ten times, "trouble" three times and "suffering" four times. Directly or indirectly, the pain and struggle of life are alluded to seventeen times in the space of five verses! This raises for us the whole paradox of suffering.

The paradox of suffering a pain-free life?

Most people in the western world these days, including many Christians, don't know what to make of suffering. People expect to live a pain-free life, and doctors and dentists are the deliverers of this life.

"This is not some remote deistic God who distances Himself from His creation. This is a God whose heart beats with love for His people."

Even in some Christian circles we are being told that we should expect this pain-free life. We should be able to have Revelation 21:4 now (*"no more death or mourning or crying or pain"*). And by faith our prayers should be claiming these promises here and now. So somehow there is a "softness" around us today which makes it hard for our patients (and perhaps even ourselves) to relate clearly to the troubles of life. Any pain is bad, even evil, and must be resisted and rejected, especially by the medical profession.

The reality of suffering
Yet the Bible is full of teaching on this subject if we only take the time to check it out. Until Christ returns "trouble" is going to be a normal part of our human experience. Because of the fall Christians are not spared. We are called to a life of daily cross-bearing, whatever that may mean for each of us – but it doesn't sound particularly comfortable.

Now I'm not suggesting for a moment that we become cold or stoic in the face of suffering, or that we abandon our core business of alleviating pain and saving lives. But we need to be clear that suffering is always going to be a part of this life and that as health professionals we are never going to completely win the battle over it, hard as we may try.

Positives of suffering
On the positive side, God wants to use trouble in our lives for His good purposes. We must not forget that. Pain and struggle are actually an important pathway to growth and service in the Christian life. And even when we feel as though we failed our patients, we must remember that God, the Great Physician, is still at work:

- Refining character (Rom 5:3-5)
- Teaching patience, humility and trust (2 Cor 12:7-10)
- Disciplining in love (Heb 12:4-13)
- Calling us to greater dependence on Himself

As CS Lewis famously said: "God whispers to us in our pleasures, speaks in our conscience, but shouts in our pains: it is His megaphone to rouse a deaf world." (*The Problem of Pain*)

And Richard Baxter: "Suffering so unbolts the door of the heart that the Word has easier entrance." (*The Saints Everlasting Rest*)

Donald Carson commented in his book on suffering (*How Long, O Lord?*) that the danger for many Christians is that their theology of suffering is deficient.

- They are comfortable with God's power in healing but struggle to see God's power in someone who perseveres in the face of suffering
- They see sin and suffering as intrinsically evil but struggle to see how a sovereign God can use them for His loving purposes
- They have a theology of victory but without a theology of the cross

Can I urge you as Christian doctors and dentists to have a robust, biblical view of suffering? Don't fear suffering or be embarrassed by it. Confront it with the resources God provides, both medical and spiritual, but let Him have the final word. Notice how Paul concluded his battle with his "thorn": *"That is why, for Christ's sake, I delight in weaknesses, in insults, in hardships, in persecutions, in difficulties. For when I am weak, then I am strong."*

This brings us to the role of God Himself in our sufferings.

The God of compassion and suffering (vv. 3-5)

You cannot read verses 3-5 and not be struck by the personal nature of God's involvement with us in our troubles. This is not some remote deistic God who distances Himself from His creation. This is a God whose heart beats with love for His people. Psalm 103:13-14 put it like this: *"As a father has compassion on his children, so the Lord has compassion on those who fear Him; for he knows how we are formed, He remembers that we are dust"*. That's us! Dust! But we're very special to God.

Recently one of my friends drew my attention to the well-known verse: *"Cast all your anxiety on Him **because he cares for you**"* (1 Peter 5:7). So often we emphasise the first half of that verse, but what a difference it makes when we grasp the fact that we have a God who deeply cares about us. He's the "Father of compassion" and the "God of all comfort". And he wants to comfort us in the midst of our troubles in life.

Supremely he has demonstrated that in Christ:

- The One who became human so he could sympathise with us in our weaknesses (Heb 4:15)
- The One who wept at the grave of His friend Lazarus
- The One who wept as he looked out over Jerusalem knowing all that was going to happen to that city over the next 40 years
- The One who would suffer and die on a cross, bearing the sin of mankind
- The *"man of sorrows, acquainted with grief"* (Isaiah 53:3)
- The One who suffered the wrath of God in my place and yours

We cannot share literally in the "sufferings of Christ". Only the sinless

continued over page >>>

Son of God could suffer, die, be rejected by the Father and descend into hell as the only acceptable atoning sacrifice. So what does it mean for us to "share abundantly in the sufferings of Christ"?

For some it could be a literal physical suffering, as it was for Paul himself, and is today for many in the persecuted church. But for most of us it could be other forms of suffering – physical, emotional or spiritual – that we encounter in the journey of life as faithful, cross-bearing disciples of Christ.

The Christian experience involves our identification with Christ's sufferings by faith in His death and resurrection (Gal 2:20). His sufferings result in our comfort as we receive forgiveness and new life in Him. And in turn we take up our cross and follow Him, whatever suffering and sacrifice that might entail (Phil 3:10). First and foremost, our comfort comes from our relationship with Christ. **And it is the gospel that must be the source of our compassion toward others.** *"We love because he first loved us."* (1 John 4:19)

The value of suffering (vv. 3-4, 6-7)

Some years ago John Piper wrote an article following his diagnosis with prostate cancer entitled "Don't waste your cancer!" That seems to be the sort of thing Paul is writing here: "Don't waste your suffering". For all the tension that may have existed between himself and the Corinthian church, Paul wanted them to know that all the trouble and suffering he had been through had not hardened him against them but actually made him even more compassionate towards them.

His personal experience of God's comfort had somehow tenderised his heart and enabled him to love them even more (see vv. 3-4 and 6-7). He was able to see how all he had been through, even the pain the Corinthians had caused him, was a positive thing. God was using Paul's personal suffering to make him a more compassionate man through Christ. In fact, the implication is that he would be less effective in comforting others without having suffered!

What troubles have you experienced in your life? Don't waste them. Let them make you more aware of God's love for you, and better able to pass on His compassion to others.

Personal comment

My wife Debbie died nearly seven years ago from breast cancer. During her 10 year battle she was constantly under specialist care and spent many an hour in waiting rooms and at times hooked up to IV lines in Day Therapy Units surrounded by fellow patients. I was always amazed at the friends she made over the course of these visits. She'd keep in touch with them, ringing them and catching up to see how they were going. They were there at her funeral. Total strangers to me, but people who felt her practical, Christlike love. In a wonderful way she had learnt to *"comfort those in trouble with the comfort she had received from God"*(v.4). Her Christian faith had taken on a whole new legitimacy and power because she was able to share with others out of the comfort she experienced from God. Through Christ this comfort was very real to her. She actually looked forward to her appointments because of the opportunity they gave her. It became one of her ministries.

"What troubles have you experienced in your life? Don't waste them."

Final thoughts

Suffering is real. Whether our own suffering or the suffering of others, we cannot escape it. And for doctors and dentists it's the space we have to live and work in every day. But so is the comfort of the gospel. And as Christians we have the privilege of entering into the pain of our patients and passing on the compassion and comfort of our God.

I realise that time is often limited and the needs of our patients are far greater than we are realistically able to meet. People have complicated lives and often we feel out of our depth in trying to help them. But by God's grace there will be times during consultations, at the bedside, even in the dentist chair, when God opens a door for us to minister his love in a specific way – perhaps even a chance to share the gospel. As the Holy Spirit moves in us, so love… patience… kindness… gentleness… and compassion… will become apparent.

Sadly, our training emphasises the danger of "getting too close to our patients". We are taught to maintain a level of emotional detachment. I think Paul would disagree. Obviously there is a need for common sense and wise judgement here, but I think he would be saying, don't be afraid to let down your professional guard and be a real person. There is a real place for us to *"weep with those who weep"* (Rom 12:15).

When I first moved out of full-time medicine into pastoral ministry nearly 30 years ago, it bothered me that I had difficulty showing emotion in certain pastoral situations, such as comforting a family at the bedside of someone who was dying. I didn't want to be a cold detached pastor. I remember praying specifically about this at the time. Thankfully it's not a problem these days. Sometimes it's actually hard getting through a funeral!

- Draw on your own pain and disappointment, and experiences of suffering
- Reflect God's comfort in these times
- Marvel regularly on the sufferings of Christ for you in the gospel
- Use your own experience to reach out in comforting others

And who knows how the Lord may use you in different situations to bring glory and draw people to Himself. ●

Dr Murray Lean

Murray is Senior Pastor at City North Baptist Church Brisbane. Murray initially trained in Medicine and worked for ten years as a Missionary Doctor. Following this he studied theology and worked as a Pastor and medical doctor in the rural town of Biloela, Queensland.

When managing chronic pain can hurt

When asked by the editor to write an article on pain, it is presumably not because of any special insight into the topic, but rather the sharing of one's experience in managing this as a primary care doctor.

As compassionate Christian doctors, with our professional healing skills and gospel-given insight into the souls of patients[1], we are to treat them with permission, sensitivity and respect (to borrow the Saline process motto), and in partnership. Their chronic pain (non-cancerous for the purposes of this article) is often complicated by troubled lives which leads to varying responses from health professionals. The risk of regular, heavy usage of opioids is definitely an area of medicine fraught with danger for the patient, as well as the doctor, and so we need to be prayerful and wise.[2]

Chronic pain is certainly an important issue. The National Prescribing Service states that it "is a major cause of distress and disability in the community. It can become a problem in its own right, even when underlying predisposing conditions are being managed optimally."[3] AVANT, one of the Australia's main medical defence organisations, cautions that "the majority of matters related to drugs of dependence involve GPs who are at the frontline of prescribing opioids." [4] It points out that many doctors face challenges with those patients who are drug-dependent or seeking, and that this can lead to inappropriate prescribing, deaths, an undesirable black market, extortion of patients who carry opioids and so on. RACGP reminds us that "opioid overdose and dependence has become such a problem in the US – resulting in more than 90 deaths a day – that it has been declared a national crisis.[5] No doubt, many of the readers will have their own cautionary tales.

The article goes on to say that with the exponential usage of prescription opioids, there are some certain limited indications for usage of them. Without wanting to replicate a medical article, some agreed aims of medical management should be:

- to reduce distress to a bearable level
- to help the person function as well as possible
- to minimise the adverse effects of treatments[6]

Where it can become quite tricky is in educating patients to accept that pharmacotherapy should only ever be part of a multimodal plan, not the be all and end all of chronic pain treatment. There is limited evidence that drugs are of benefit (particularly opioids) in chronic non-cancer pain long term. As mentioned above, one harmful temptation is for patients to be prescribed opiates to blunt emotional rather than physical pain.

A helpful paradigm to monitor response is to review:

- **A**nalgesia (reduction rather than usually full elimination of pain)
- **A**ctivity (eg. walking, hydrotherapy)
- **A**dverse effects
- **A**ffect (the patient's feelings or emotions)
- **A**berrant behaviour (clues to unsanctioned use of prescribed opioids)

The last A is the hardest if warning signs are present. Once it's clear that patients are dependent on opioids for chronic non-cancer pain, explaining the multiple downsides and minimal upsides and then following through with medication intervention (methadone and buprenorphine) can be helpful.

What should be done, however, if patients do not acknowledge their dependence and are not willing to change despite the best medical advice to them? The Christian book on effectively helping poverty *When helping hurts*[7] addresses a response to people who are "simply unwilling to even consider any changes…Then it is not loving to enable them to persist in sin by providing them with handouts of food, clothing or shelter. Rather, the loving thing to do is to allow them to feel the burden of their choice in hopes that this will trigger positive change" (with a caveat about mentally incapacitated people). In trying to holistically care for our patients, sometimes as responsible doctors we need to be firm in pointing out the harms of opioids whilst offering to continue to help them, to point them to better options even though they may not acknowledge it at the time, or even over many years.

As Christians (and health professionals generally), we are not to abandon them but rather seek to *journey to the root cause of their situation, to pray for them, to remain open to them returning, to bring them to closer to what God wants for their lives.* They may reject our advice and approach but we are not to reject them. ●

References:
1. 1 Peter 3:15
2. Matthew 10: 6b
3. Principles of prescribing for persistent non-cancer pain page 1 Professor Milton Cohen. *Australian Prescriber* 2013:36:113-5.
4. AVANT. Prescribing drugs of dependence. April 2015
5. Good practice issue. RACGP. Pages 6-7. November 2017
6. Principles of prescribing for persistent non-cancer pain page 1 Professor Milton Cohen. *Australian Prescriber* 2013:36:113-5.
7. Page 217-220. Corbett/Fikkert. *When helping hurts.*

Dr Richard Wong

Richard is VR GP who hails from Sydney but in the last few years has been working a lot in areas of need around Australia and internationally as well by dedicating some of his time to short-term medical mission trips. He is currently at the general practice of Dr Paul Mercer, the chairperson of the board of Healthserve in Brisbane and complements this with regular hospital work. He is a long term member of CMDFA and was its NSW secretary for a number of years before switching to continue in a similar role in Queensland. He has shared in teaching roles over the years in both a bible and medical capacity. He has also been a long term supporter of TEAR amongst other Christian organisations and is a trainer for the Saline Process as well as a PRIME qualified tutor. He is interested in addressing the disparity of healthcare around the world by using his God-given resources to help in any way possible through the board of Healthserve.

Pain:
A Theology on the Fly

Pain – its meaning, significance and often-associated suffering – has exercised the thinking of philosophers and theologians, (indeed, most of us) since the beginning of time. This will continue for our generation.

We live during a time in history when we know a considerable amount about pain mechanisms, as well as benefiting from powerful treatments and technological advances. The dramatic increase in the use of narcotics worldwide in the past twenty years suggests a seismic shift in the way we accept or tolerate pain.

Chris Huebner[1] observes that "the church's life is on the run; it's theology is delivered on the fly". This observation about theology caught my eye as I thought about 'pain'. It offers a way forward for our rapidly changing context when we may have settled on systematic theological certainties. Huebner makes this further observation, "The Christian theologian does not function primarily as a broker of agreement but seeks to cultivate space for those meaningful disagreements out of which hitherto unrecognised possibilities, new expressions of faithfulness, might emerge". Many observers suggest we face a 'perfect storm' around pain and pain management issues, so now is the time for theology on the fly to swing into action!

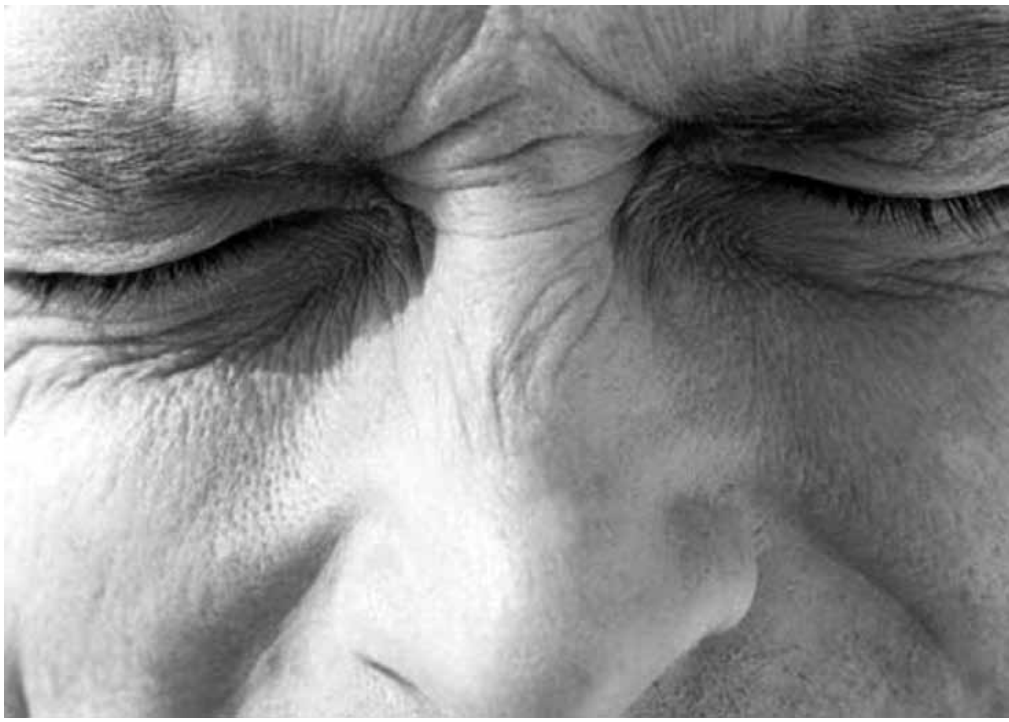
Where do we start? The unanimous advice of scripture is prayerful openness to God. Solomon coined the phrase, "The fear of the Lord is the beginning of wisdom," to catch our attention on this.

Prayer calls us toward humility. Prayer encourages the productive focus of "faith hope and love."[2] Prayer opens our lives to the Spirit who is given to "lead us into all truth". Prayer joins us with fellow pilgrims who bring the rich spread of grace in human life, the fellowship of the Spirit.

"Christians can work with quality information on the basis that it also contributes to God's work of 'reconciling all things in Christ'."

Theologians delight in reminding the church and the world that "all truth is God's truth," so from prayer our investigation could proceed on multiple fronts. I am aware that I don't have the capacity or skill to robustly explore all these possibilities. My hope is to suggest a way forward and seek to identify the "space" that Huebner has identified, to make a sketch.

As Christian health professionals, we may like to start with our strong suit. Evidence-based medicine (EBM) offers us much to consider about the human experience of pain. A biomedical approach encourages the discipline of asking the right questions. We will want to understand the issues around the reliability of research and also its interpretation. There is a very significant body of literature to master. To manage our enquiry we may try to identify a respected review article. Empirical research can be assimilated into a theoretical framework to understand pain and to predict the outcomes and benefits of treatment approaches. Theology on the fly doesn't have an unlimited time frame in which to operate. We may enlist the aid of an expert in fields of pain 'knowledge' to tutor us. While science flourishes under the gaze of



scepticism, Christians can work with quality information on the basis that it also contributes to God's work of "reconciling all things in Christ".[3]

A Christian's encounter with the world is always transformational, so theological reflection on pain mechanisms can trigger imaginative and Spirit-inspired outcomes and new lines of enquiry. The social sciences serve a theological project by identifying cultural, social and psychological forces at play – both in the experience of pain and how to work towards healing and acceptance. Consequently, we may need to recruit interdisciplinary skills to understand a holistic awareness of pain in our times.

Let us reflect on a little of the biomedical science around pain. Our sensory nervous system can identify a range of painful stimuli – pressure, heat, cuts, inflammation and chemical changes.[4] The body depends on nociceptors to warn about pain. Fast nociceptors respond to severe pain and so help a rapid body response. Slow nociceptors carry information about dull or aching pain. This isn't a "one size fits all" pain warning system. Furthermore, we should recognise there is a range of specificity and sensitivity. That will alert us to seek further layers of complexity in the nervous system. When nociceptors detect damage, they send electrical impulses up the nerve pathways toward the spine until they encounter a specialised type of nerve cell called an interneuron. Interneurons connect multiple nerves at the spine, and they act like gates, controlling which messages get through to the deeper structures of the spine and brain. Interneurons open the gate to painful stimuli. Voila! – the gate theory of pain. In the brain itself there are similar layers of complexity to the reception and response to painful stimuli, including emotional factors and the meaning of pain to us.

If we were to reflect on the nociceptor 'warning system', it may help us to consider the wonder of God's creation. The God of Creation needed to account for the possibility of pain. Undoubtedly our pain receptors have different challenges than that for Adam and Eve. There may have even been a few evolutionary adaptations along the way. Suffice it to say, Adam was already hardwired for the emergence of 'thorns and thistles' in the design of his neurology. The gate control mechanisms of the spinal cord also imply God's imaginative design specifications, which allow checks and balances on up-regulation of painful stimuli. As doctors, we know that our pain-afflicted patients will need self-help skills and stress-management practices to work at 'closing the pain gate' and re-establishing equilibrium. That our conscious will and training can impact 'pain gates', also points toward a degree of responsibility for individuals to control their pain. Gate-mediated reflexes to pain, in conjunction with limbic system responses, help another human being to recognise the impact of this pain, or its chronicity for an individual, and respond with compassion or skill, etc.. We should be hopeful that, over time, good science will help accurately interpret pain in its biopsychosocial context and help develop better treatments, and even cures, for chronic complex pain states.

"Illness arising from or disrupting the pain pathways help us recognise that, apart from the warning of acute pain, pain is essential to our survival."

As yet we haven't begun to consider disease of the pain pathways and chronic pain disorders. Bypassing the direct question of the 'why' of such pathologies, the reality of these problems both challenges and instructs our understanding of pain. That some individuals live with what appear to be overwhelming conditions and receive ongoing support from families is a testimony to the courage of the human spirit. Illness arising from or disrupting the pain pathways help us recognise that, apart from the warning of acute pain, pain is essential to our survival. The absence of a healthy pain regulating system also opens up connections to disability and congenital illness. For past generations, leprosy, with its resulting deformity and danger for individuals, compounded by social stigma, has been the 'pain disorder' to be feared. Praise God for dapsone and reconstructive surgery!

Chronic pain is defined as persistent pain lasting three months or longer. The term, "It's all in your head," came into our vocabulary to try and explain such pain. Why should an injury, for instance, fail to recover in terms of pain? We now recognise two such types of neuropathic pain exist:

1. Peripheral neuropathy, and
2. Centrally-mediated pain.

Peripheral neuropathic pain can intensify. We call this allodynia. Strength, reflexes, balance and co-ordination can be impacted. Similarly, central sensitisation can impact more than nociceptors. Any kind of sensation can now become very difficult to tolerate. Our ability to 'turn down the volume' of pain in these deregulated, sensitised states is currently less than perfect. EBM is pointing us toward a multidisciplinary approach that is tailored to each individual. This is somewhat of a sidestep from the naïve optimism that medical treatments, especially opioids, would free people from chronic pain. All medications which are useful in an acute context do not translate into good treatments for a deregulated, sensitised nervous system. Sadly, chronic pain often implies unemployment and poverty.

We have reached a point where we have recognised a rich complexity in the way the nervous system in the body handles painful information detected by the nociceptor warning system. We also recognise multiple disease conditions which may trigger acute or chronic pain states. Whatever the source of pain, we also have identified the challenging role of central sensitisation disorder in complicating chronic pain states. In this "Theology on the Fly" we can observe that all these components of pain provide valid entry points for theological reflection.

continued over page >>>

We have played our strong suit first up. Where to next? Learning the lessons of history is always wise. Reflecting on how past societies have managed and viewed pain grounds our current awareness. The philosopher, Martin Hegel, coined the phrase, "the slaughter bench of history" to capture the association of violence and suffering that has plagued humanity. Alcohol, primitive narcotics, restraints and even techniques such as a sharp jaw blow to initiate unconsciousness have been used as pain-modifying approaches over time. Essentially, pain control was a trial and error project, with most people enduring pain and living out life with courage. Often people were blamed for their own suffering, as 'sinner's deserving punishment' or some other infraction against the gods. The emergence of the anaesthetic agents, such as ether and nitrous oxide, were accidental observations, as these substances were in vogue as party drugs at the time. A theologian will want to reflect on suffering, courage and chance as components of faith-seeking understanding regarding pain. When Scottish Presbyterians gave the green light to pain relief during childbirth, a great leap forward was triggered.

Cultural forces are also worthy of exploration. We have already noticed some cultures tend to 'blame the victim'. Others, such as the Spartans, were infamous for denial and discipline in the face of pain. Some cultures have chosen to use pain, in the form of torture, as a political weapon. Some of the features of our own culture are relevant to the way we understand and respond to pain. Our age of autonomy is one of intense self-mastery. We set the pace of our own flourishing and pain is a threat to the good life. In part, this explains the rapid evolution of narcotic analgesia in the last 20-30 years. Ours is an age of narcissism. We become frustrated if we need to wait or to suffer. This can also precipitate inappropriate medical care as doctors sense the 'heat is on'. For some, euthanasia is the exit option from a life of pain. Another feature of our times is the commodification of almost everything. Medicine is moving

from a service to an exchange-of-goods industry, with an associated impersonal, mechanistic type of care. On the other hand, culture does hold many positives for humanity. The vision of the new heavens and new earth in Revelation where "The glory and honour of the nations will be brought into it", Rev 21:26 lead us into the scriptures as a resource of our Theology of Pain.[5]

How can we encounter scripture so as to understand the meaning of pain?

One process is to go on a text-mining expedition – to look for as many verses as possible that mention pain and then see if ideas emerge from this data. We hope it will speak to us in those scattered fragments of his Word. I spent a day laid up with acute back pain looking for such verses. "My back is filled with searing pain; there is no health in my body" jumped out at me in Psalm 38:7.[6] We easily develop an affinity for some verses as they do seem to reflect our own circumstances in life. A lament Psalm like this also encourages us to bring our struggles, our pain experiences, to God as a cry for help. Some verses seem to be a simple mandate for medical interventions. In Proverbs 31:6 the words, "Give beer to those who are perishing, wine to those who are in anguish," appear to be a mandate for a palliative approach when disease, pain and suffering are in the direction of the end of life. The Old Testament text, the Book of Job, is a neo-theodicy within scripture itself. Job 21:23-25 captures questions about the meaning of pain and suffering, "One man dies full of vigour, completely secure and at ease, his body well nourished, his bones rich in marrow. Another man dies in bitterness of soul, never having enjoyed anything good." Job's text ultimately takes us to the mystery of suffering, standing against the cosmic sweep of God's own interests. Sometimes the Holy Spirit will lead us to words of comfort in scripture. Unfortunately, we can also transfer our own needs into reading scripture this way. Self-fulfilling 'words' for our own desire will collapse under scrutiny. "Theology on the Fly" will need more. A theological framework might help a simple verse make robust connections. Linguistic, socio-cultural nuances will also help. The 4th century Christian theologian, Augustine, saw the scriptures as God's story[7] – a sort of autobiography about God's

great love for the world. Re-engaging with scripture as narrative is helping contemporary theologians face current challenges. A narrative approach can also help us see the insights and weaknesses in other world religions.

This noted, I want to stay on task and seek insight from the narrative of scripture. The Bible is not a 'flat text'. It starts strongly, "In the beginning...". The actions of God in creating the cosmos and giving it life, particularly to God's image-bearers, men and women, are documented as all being 'good'. A nervous system with a pain-perception capacity is part of this 'good' creation. God also creates an amazing opportunity for humanity. He says to the first humans, "Be fruitful and increase in number; fill the earth and subdue it." There is a sense that God wants his image-bearers to be involved in the finishing touches of creation, to manage the 'asset' of creation, to do good work and enjoy the beauty of the earth in harmony with God. To 'subdue' the earth suggests a residual chaos, or imperfection requiring further creation.

The other bookend of God's narrative is what we call 'the new heavens and the new earth'! The context of this creation will be quite different. Now, "the dwelling of God is with mankind, and he will live with them. They will be his people, and God himself will be with them and be their God," Rev 21:3. Among many blessings, there is a promise of the end of pain – here the "old order of things will pass away"! The new order includes a garden within a vast city. On either side of the river of the water of life can be found the tree of life, whose leaves are for the 'healing of the nations'.

Into the city will come "the splendour of the kings of the earth; the glory and honour of the nations." (Rev 21:26). With a little imagination we could find the science which has contributed to the diagnosis and effective treatment of pain among this honour. The God-given mandate to be "fruitful and increase in number, fill the earth and subdue it," etc. appears to come full circle in this hopeful, open ending to the narrative.

I am suggesting in a quick sketch of what a 'theology of pain' may look like today – this 'now, but not yet', in God's story. God's narrative starts with God's own observation that "all he had made was very good". Yet the final vision of the 'new earth' also contains the ideas of judgement and salvation. If we return to the start of God's narrative, we soon discover a story of brokenness. The primal image-bearers are required to accept one restriction – to not eat of the fruit of a particular tree, the tree of the knowledge of good and evil. Curiosity and temptation overtook Adam and Eve, and sin became part of the rest of history. God issues a number of curses, on humanity and on creation, because of the rebellion of sin. These curses will add struggle, angst, conflict and suffering to life.

"That Jesus experienced pain like us both affirms the good creation of the nervous system and participates in the redemption won for the rebellion of sin."

Death becomes a restrictive end-point to human flourishing, and pain is now a threat to human life: Eve is promised intensification of the pain of childbirth; working the land will now involve painful toil. God's narrative quickly reveals how sin and its attached curses invade creation. Violence with chaotic expressions of pain are suddenly with us – Cain kills his brother Abel; Lamech kills a younger man for an 'accidental' injury to his arm. Revenge, rape, oppression, ethnic cleansing and more rapidly unfold in the story. Augustine of Hippo sees sin as the consequence of human anxiety as we face the knowledge of good and evil alone, without God. Many pathologies around pain derive from such anxiety. God's hand regarding sin is quickly revealed in the narrative. God exercises both judgement and salvation in history – to both moderate the impact of violence and sin, and also to reignite the love this creator-God has for his image-bearers, and so desires from them in return.

A theology of pain will seek to learn from the interplay of sin, judgement and salvation and the stories of the old and new testaments which carry it. Among the mountains, valleys and places of wilderness in scripture, the story of Jesus of Nazareth demands particular attention. God's love for the word is so deep that he sends his only son into the world as a definitive salvation solution.

The technical term is incarnation. The life, death and resurrection of Jesus operate as a major historical earthquake. While we were still sinners, Jesus willingly died to pay the penalty of sin. Suffering, associated with pain, will forever stand in the light of this 'Christ event'.[9] God's love for the world is exceptional. His commitment to salvation fully engages with material reality. In His one and only son, God enters our world through the painful passage of childbirth. As a growing child, Jesus will learn the ropes of growing up through painful falls, cuts and bruises and the clumsy blows of other children. At work with his father, Joseph, Jesus will appreciate the painful toil of labour. He will take a Roman flogging from Pilate's guard and will accept the pain of nails being driven through his hands and feet. That Jesus experienced pain like us both affirms the good creation of the nervous system and participates in the redemption won for the rebellion of sin.

The promise of humanity, which was never realised because of sin, has been revealed in all its grace and truth in Jesus. The gospel writers challenge all to identify Jesus – "Who do you say that I am?" they ask us. Parting the heavens, we received God the Father's recognition, "This is my son whom I love; with Him I am well pleased".

Jesus lived the authentic human life that Adam recoiled from. The eventual

continued over page >>>

cross and resurrection of Jesus broke the curse of sin and so liberated humanity from the suffering of pain. God's love compelled him to suffer with humanity in all its pathologies of pain, so that in the new heavens and new earth, pain will be no more![10] As people of faith, our calling is to follow Jesus in living a cruciform life.

This paper is little more than a musing about the theology of pain. There are many areas to go deep and develop a "thick theology". Healing, compassion, the ethical choices of Jesus and much more are relevant. In his letter to the Colossians, Paul understands Christ as the Great Reconciler. Paul puts it this way, "For God was pleased to have all his fullness dwell in Him, and through Him to reconcile to Himself all things, whether things on earth or things in heaven, by making peace through His blood, shed on the cross" (Col 1: 19-20). God's love has motivated such a wholehearted and fully-engaged salvation in Jesus that we can proceed, hopefully as witnesses to this love which sets us and the world free from sin and its associated 'curse of pain'.

While we wait, and Jesus prepares the new heavens and new earth, we are given the gift of the Spirit. In the Spirit, God is closer to us than we are to ourselves. The Spirit is our comforter, the one who empowers us to 'put on Christ' in the world. The Spirit energises a ministry of healing and guides us into all truth. The Spirit helps us see pain as a gift and mediates the grace we need to live well in the face of suffering.

In the 'now but not yet' reality of God's kingdom, there is more 'good news' that God's salvation has "a people for God's name".[11] For the apostle Paul, the church is a critical component of the gospel. Here there is a community of fellowship in the Spirit, of love for one another that is both a glimpse of future hope and a living witness in the world battling with sin and pain.

The narrative of the scriptures has opened up many possibilities for an on-the-fly theology of pain. As we recognise the components of a clear vision of pain, we will want to test it.

"The eventual cross and resurrection of Jesus broke the curse of sin and so liberated humanity from the suffering of pain."

We can begin to do this as we listen to the stories of our patients. Where is the light of Christ? Where is the comfort of the Spirit? Where is the love of the people of God in these stories?

We could also review the way the church, through history, has humbly carried its witness to God's coming kingdom. Where have past 'theologies on the fly' brought us? The skills of critical biblical scholarship will be recruited to negotiate controversies and expose new potential options. If we truly believe the story of God's action in creating, judging and saving the world toward a new heavens and new earth, then we will accept the challenge of dialogue, of reading the story with diverse 'others'. Here our common experience of pain will test our theology. Is it a genuine theology of "faith, hope and love"?

Finally, any 'theology on the fly' needs to return to the scrutiny of the people of God. As the 'scripture project'[12] puts it, "faithful interpretation of scripture invites and presupposes participation in the community brought into being by God's redemptive action". This allows for an orderly, yet spirit-led, reflection. In this open space, we will be privileged to share the rich stories of grace unfolding in our lives. We will begin to discern new spiritual practices to live an authentic witness to God's great love in Jesus. To live with, and beyond, pain. Let us just do it! ●

Dr Paul Mercer

Paul is editor of *Luke's Journal*.

Bibliography

1. Huebner, C. K. (2006). *A precarious peace: Yoderian explorations on theology, knowledge, and identity.* Waterloo, Ontario: Herald Press.
2. von Balthasar, H. U. (1986). *Prayer.* San Francisco: Ignatius Press.
3. McLeish, T. (2016). *Faith and wisdom in science.* Oxford, UK: Oxford University Press.
4. Bruce, B. K. (2017). *The Mayo Clinic guide to pain relief: Course guidebook.* Chantilly, Virginia: The Teaching Company.
5. Middleton, J. R. (2014). *A new heaven and a new earth.* Grand Rapids, MI: Baker Academic.
6. *New International Version of the Bible* (Revision ed.). (2011).
7. St Augustine. (1997). *The confessions.* Hyde Park, New York: New City Press.
8. Davis, E., & Hays, R. (2003). *The art of reading scripture.* Grand Rapids, MI: Eerdmans Publishing Company.
9. Jinkins, M. (2011). *Invitation to theology: A guide to study, conversation & practice.* Downers Grove, IL: InterVarsity Press.
10. Fretheim, T.E. (1984) and reprinted (1987). *The Suffering of God: An Old Testament Perspective, ovetures to biblical theology.* Philadelphia, Fortress Press.
11. Fee, G. D. (2001). *To what end exegesis?* Essays. Grand Rapids, Michigan: Eerdmans Publishing Company.
12. Treier, D. J. (2008). *Introducing theological interpretation of scripture: Recovering a Christian practice.* Grand Rapids, Michigan: Baker Academic.

A Pain Vignette 1

A Doctor's Work is Never Done

Ally is a 61 year old divorcee, admitted to a nursing home because of a diagnosis of memory decline in association with falls and failing capacity for self-care. There's also history of episodes of self-harm and mood instability.

Other history features include:

1. Pronounced myoclonic jerks (thought by Ally to be epileptic)
2. Chronic headaches
3. Low back pain
4. Complex relationships with an only son
5. Very poor quality of sleep

Ally's medications included:

1. Sodium valproate
2. Sertraline
3. Donepezil
4. Quetiapine
5. Atorvastatin
6. Oxycodone PRN
7. Paracetamol

On encountering Ally, I discovered a person who was very devoted to her four year old granddaughter. She was using an iPad competently. She says she uses it to keep lists and records to help her memory. She regularly attends a church associated to the facility.

Prior to the admission, a memory clinic had made the diagnosis of frontotemporal dementia in the context of depression and borderline personality disorder. Ally was also thought to have epilepsy. It soon became clear that Ally was very keen for pain relief for headaches and back pain, and her myoclonic jerks seemed to have a stress association.

Ally's presentation was very unusual, and it caught my clinical imagination. Was this really a case of dementia? Why was this lady needing pain relief in this overall context?

In taking a "patient-centred" approach, I discovered that Ally was divorced in the context of humiliating domestic violence.

I tried to introduce NSAIDs, regular paracetamol and adjusted the sodium valproate dose for her headaches. Requests for PRN oxycodone appeared to be escalating. Some questions were emerging:

When do primary care practitioners need to question established tertiary care diagnoses?

How should we go about further assessment and management of Ally, in this overall context?

I tried to read the memory clinic notes as carefully as I could, and became aware that a neurology assessment had not occurred. Ally confirmed this. She had had a normal EEG, and her movements, which were quite dramatic at times, were considered by some of the team as pseudo-seizures. I was beginning to form the opinion that PTSD in the context of domestic violence in association with a borderline type personality might be a better diagnosis for Ally.

I continued to work hard at a good doctor-patient relationship. In this context, I asked her permission to arrange a neurology review. I put it to her that her headaches were becoming quite a problem. The neurologist repeated an MRI, and after seeing this and examining Ally, decided that there was no evidence of dementia and that PTSD and personality factors were indeed the most likely diagnosis. Another series of questions started to form in my mind.

How difficult is it to manage pain in a context like this? What are the options available?

I was now faced with breaking the bad news, that Ally didn't have dementia. She initially took it quite badly, and was very concerned that she would be asked to leave the nursing care facility. I reassured her at this stage that this wouldn't be the case, and that in fact, there was good news in the sense that she probably was going to live a much longer life than she initially expected.

Around the same time, blood tests demonstrated that her renal function had declined, and Ally retained quite a bit of fluid. In retrospect this was probably due to the persisting use of an NSAID, but it allowed me to cease her sodium valproate, meloxicam and sertraline and introduce duloxetine and try to stabilise her pain request with Targin 5/2.5mg bd.

I continued to see Ally regularly. As she became more confident in my presence, she disclosed that her sleep disorder at night was due to very violent nightmares. She had memories of near death experiences on at least three occasions at the hands of the violence she received from her ex-husband. These memories tormented her at night.

What was also beginning to be clear was that Ally was no longer requesting PRN oxycodone, and that indeed we had begun to achieve much more stability. Her myoclonic jerks were reduced in number, and I encouraged her at this point to enter into a relationship with the nursing care facilities chaplain, to explore the pastoral care implications of her past violence, and to begin to pray for healing of her memories.

My work is not yet done. While Ally is on Targin bd it means that there is still scope for getting her off narcotic pain relief altogether. But I think there is a good chance that with a holistic approach to her problems, she'll come through this and indeed one day may leave the nursing care facility as she becomes healed and well again. ●

Dr Paul Mercer

See A Pain Vignette 2 and 3 on pages 25 and 29.

Pain in Parturition and Procreation

It was eerily silent as I walked passed the labour and delivery suite. I was used to the groans, moans and screams of women who were in labour pain while in India. This had given way to the sounds of women pushing their baby out with minimal or no pain after an epidural block in labour (Graham, 2001[1]) in Australia. But this was different. It was as if the birth suite had been altogether eliminated.

The year was 2080 CE and indeed, there were no more birthing suites. Women had been completely 'emancipated' from the 'pain of parturition and procreation'. The so-called 'modern' blended family (remember the 'yours, mine and ours' era) had been replaced by 'matched' families, seen as the best way to have families since 2070. There had been no divorces, no domestic violence and the family court had been shut down for over a decade since the elimination of natural human reproduction – a major achievement and the result of the concerted effort of many medical scientists, social scientists and ethicists working together with industry experts developing the artificial placenta (Bird, 2017[2]).

In this brave new world, all men and women regularly contributed to a world-wide sperm and egg bank where both eggs and sperm were stored frozen. Large databases of the genomic characteristics of each sperm and egg were maintained and matched to have perfect genome in each offspring. Disease-bearing genes had been eliminated by CRISPR-Cas9 genetic engineering technology (Doudna, 2014[3]). No more pain, no more disease!

This brave new world assured marriage equality and gender fluidity with all gender-specific pronouns banned by law. Computer algorithms matched couples who would be able to live together, irrespective of gender, and they would be presented with a matched embryo. This would then be implanted into an artificial womb. (Women had long ago refused to be pregnant and experiments to make men pregnant were a failure.) At 40 weeks, the fetus would be declared born, taken out of the artificial womb and moved to the nursery where 'designed nannies' breastfed and trained the infant. From the nursery, the children moved to 'designated schools' where education and training of children occurred as 'discerned' by the computer program's analysis of a thousand parameters. There were no conflicts between parents and children! No more pain, no more diseases, no more tears! Paradise, it seemed, had been achieved. However, it was difficult to know if the absence of conflict established harmonious, loving relationship.

"...physiologic pain was presumably always present in creation as part of God's grand design."

The pain in parturition and in procreation had become a story from the dark ages. In fact, not many knew about the story of creation, the Fall or knew God.

It is often presumed that there was no pain before the Fall and therefore pain is a result of the Fall and part of the curse. In Gen 1:28 it is written that male and female had been created in the image of God and blessed to procreate and fill the earth with no mention of pain (NIV, 2011[4]). However, very few scientists would challenge the fact that the sensation of pain was part of original creation. The sensory pacinian corpuscles, the non-myelinated C fibres that transmit the electrical impulses, the spino-thalamic tracts and the sensorimotor cortex were all created to be part of original creation. Pain has a protective function, with a stimuli and response being part of most organisms. Therefore, physiologic pain was presumably always present in creation as part of God's grand design. Pain, in itself, is not a result of the Fall. The question then becomes when, why and how did pain become so pathological that most of medicine is devoted to pain and alleviation of pain? Could looking into the story of creation and the origins of life provide us with some answers?

John Walton has written an excellent book where he suggests that the first chapter of Genesis is not about material creation at all, but primarily about God stating his authority over light and darkness, over time, over seasons and over the living things (Walton, 2009[5]). This makes the changing scientific understanding of the origins of life authentic to the understanding of the time and God's ownership of the universe and its creation an eternal truth. This understanding would then allow our science students to explore the theories of origins of life or origins of the universe as integral scientific theories attempting to answer the question of "how" and leaving the question of "why" to theological statements. This gives me a perspective on Genesis 1-3 which allows me to have integrity of my faith and practice as a fetal medicine specialist.

Extending the same argument to Genesis 2 and 3, we can propose some of the basis for the origins of pathological pain. We understand that God created the entire universe

and humankind, male and female together, in His image in Genesis 1:27, blessed them and told them to procreate. However, in Genesis 2, man is stated as being created first and woman created as a helper suitable for man later on. Applying the Walton principle to Genesis 2, we can then see the chapter, not in terms of the chronological events stated there, but in terms of the theological statements and intentions in the chapter. Though not a theologian, I would venture to state Genesis 2 is about relationships – God's relationship with man; man's relationship with the plant and animal kingdom; and relationship between a man and woman.

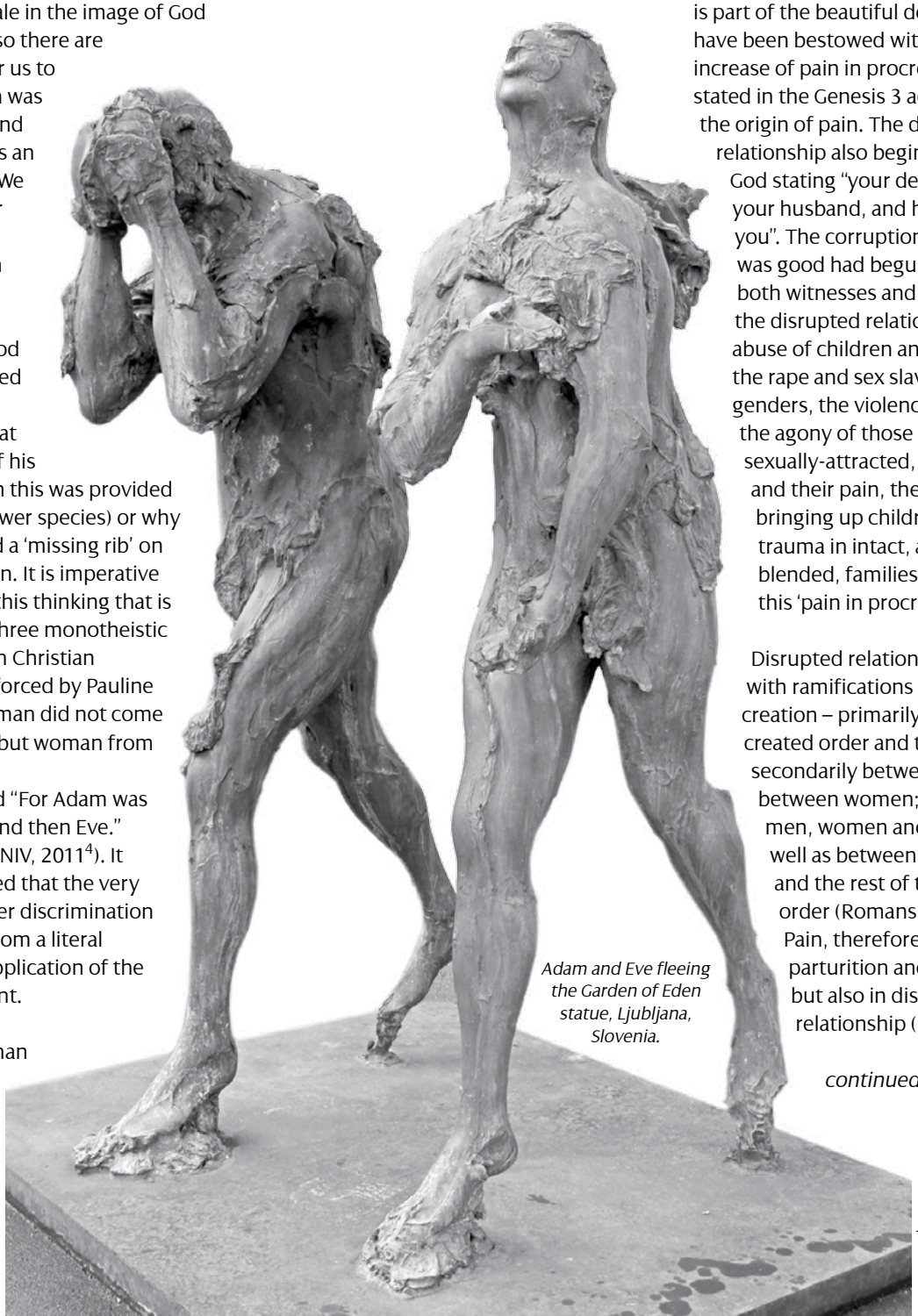
Genesis 1 establishes that God created male and female in the image of God concurrently, so there are no grounds for us to think that man was created first, and then woman as an afterthought. We then no longer need to find an explanation as to how the omniscient, omnipotent God 'forgot' the need for the female of the species at the epitome of his creation (when this was provided for in all the lower species) or why we cannot find a 'missing rib' on one side in man. It is imperative that we undo this thinking that is present in all three monotheistic religions and in Christian teaching, reinforced by Pauline writings, "For man did not come from woman, but woman from man."
1 Cor 11:8, and "For Adam was formed first, and then Eve."
1Tim 2:13-14 (NIV, 2011[4]). It could be argued that the very origin of gender discrimination begins here, from a literal reading and application of the Genesis account.

Additionally, man is seemingly presented in a better light than woman in Genesis 3 where Eve 'the woman' is the one to whom the serpent speaks and the one who sins first. We tend to ignore the fact that Adam 'the man' was "with her" and his silence, of course, then becomes deafening. However, it appears that Paul in his letter 2000 years ago to Timothy supports the account in Genesis 3, "And Adam was not the one deceived; it was the woman who was deceived and became a sinner."
1Tim 2:14. Again using the Walton principle, the scientific accuracy or the chronological sequence of the account in Genesis 3 is not what we look for, but the theological statements and the inherent intentions.

"We have worked hard to address pain and the problem of pain since the very beginning."

The outcome of the 'act of disobedience' by Adam and Eve was the loss of the blessings from God, the consequent disruption of various relationships and the resultant increase of pain. Whilst much has been written about the 'problem of pain', I tend to agree with Brand and Yancey, who state that pain is a gift from God (Brand, Yancy, 1993[6]). Essentially, pain is part of the beautiful design that we have been bestowed with. It is the increase of pain in procreation that is stated in the Genesis 3 account, not the origin of pain. The disruption of relationship also begins here with God stating "your desire will be for your husband, and he will rule over you". The corruption of all that was good had begun and we are both witnesses and participants of the disrupted relationships – the abuse of children and women, the rape and sex slavery of both genders, the violence in marriages, the agony of those differently sexually-attracted, single mothers and their pain, the agony of bringing up children and the trauma in intact, as well as blended, families is all part of this 'pain in procreation'.

Disrupted relationships extend with ramifications to all of creation – primarily between the created order and the Creator; secondarily between men; between women; between men, women and children as well as between all humans and the rest of the created order (Romans 1:21-32, 8:20). Pain, therefore, not only in parturition and procreation but also in disrupted relationship (sexual and



Adam and Eve fleeing the Garden of Eden statue, Ljubljana, Slovenia.

continued over page >>>

otherwise), has become pathological, with nothing and no-one exempt.

We have worked hard to address pain and the problem of pain since the very beginning. The epidural block in labour has become standard all over the world in spite of the original objections from the church. Anaesthesia, in its various forms, has made surgeries of all kinds a reality. Speciality 'Pain Clinics' and journals dedicated to pain have become numerous. Pain however, continues to be a major problem in life. It assumes sophisticated manifestations in the developed world with the very definition of pain being difficult (Todman, 2017[7]).

If the eradication of pain is all that is needed, then the scenario in 2080 would be Paradise restored and the consequences of the curses removed. However, the underlying disruption of relationship in pathological pain is ignored, and we continue to ignore this to our peril. The more we ignore the source of the 'increase in pain' without an understanding of the disruption of the inherent relationships, the less successful we will be in eradicating pain. Restoring these disrupted relationships cannot be addressed by legislation. Neither gender equality laws nor marriage equality laws will remove the rampant discrimination in humans everywhere. The primary disruption of relationship between God and man, as well as the loss of the presence of the Triune God should be recognised. The restoration of the fatherhood of God and the brotherhood of mankind through the work of the Lord Jesus and the Holy Spirit is foundational. The misuse of scripture to reinforce discrimination and exert power and control over one another should stop especially with regard to gender. When relationships are restored and there is harmony between man and God, man and woman, humans and the rest of the created order, pain will become physiological and part of life and living. Paradise restored! ●

Dr Joseph Thomas

Joseph is a Senior Specialist in Maternal Fetal Medicine and Obstetrics at the Mater Mothers Hospital in Brisbane. After training at the Christian Medical College Vellore, he worked at the Bangalore Baptist Hospital and Asha Kiran Hospital, Orissa, India till 2003. He subspecialised in Maternal Fetal Medicine in Adelaide after which he moved to Brisbane. He is passionate about human formation and currently he and his family worship at the Creek Road Presbyterian Church.

Acknowledgements

I gratefully acknowledge with thanks, Drs Frank and Val Garlick, Dr K George, Dr D Todman and the extended Thomas family for reading the manuscript and making valuable suggestions.

References

1. Graham, M. (2001). 'Quantitative assessment of motor block in labouring women receiving epidural analgesia'. *Anaesthesia*, 56: 470-6.
2. Bird. (2017). 'Artificial placenta: Analysis of recent progress',. *Eur J Obstet Gynecol Reprod Biol*, 208: 61-70.
3. Doudna, C. (2014). The new frontier of genome engineering with CRISPR-Cas9. *Science*, Vol. 346, Issue 6213.
4. NIV. (2011). THE HOLY BIBLE, NEW INTERNATIONAL VERSION®. Biblica, Inc .® Used by permission.
5. Walton JH. (2009). *The lost world of Genesis One*. Authentic books.
6. Brand P, Yancey P. (1993). *Pain: The Gift Nobody Wants*. Harper Collins.
7. Todman D. (2017). History of pain. *Luke's Journal*, Vol 22 No 3, 2017.

A Pain Vignette 2

A Broken Heart

"Bill" is a 63 year old truck driver who presented with recurrent chest pain. His pain was heavy, retrosternal and recurrent. He was an ex-smoker who was normotensive and had no signs of heart failure, and normal heart sounds.

The pain had been recurrent over a few months, and he disclosed that he had presented to multiple emergency facilities in our city. He had been actively assessed for ACS on each occasion, and no diagnosis of MI was sustained. A stress echo was normal. There was no costochondritis. Bill was anxious and uncertain about his health status. He seemed to be a defeated man.

How would you proceed at this point?

From a GP point of view, something is missing in this presentation. We could continue to explore the cardiac status with a coronary artery CT angiogram. We could establish a disciplined medical treatment programme. My internal search process suggested further history taking to establish a bio-psychosocial context.

I started with the question: "Was anything important happening in your life around the time the pain started?"

Bill burst into a flood of tears. Between sobs, he shared the crushing grief he was experiencing after the sudden loss of his wife. She had died of a sudden heart attack.

We stayed "in this moment" for some time. I was now in time deficit with the appointment schedule.

Bill agreed to get grief counselling and return for support. His pain quickly resolved. His broken heart was beginning to heal.

What would Bill's doctors have missed if they didn't inquire into his social circumstances? How important is a holistic history in your practice?

Are reframing skills helpful in patients like Bill? "Is it possible you have a broken heart Bill?" could be a useful question.

Dr Paul Mercer

A multidimensional approach to pain

from Genesis 3 to contemporary pain services

Modern neuroscience highlights the fact that the experience of pain is much about the brain and nervous system.

Two people may have the same bodily structural change, such as a lumbar disc prolapse, and yet one reports pain while the other does not. This discord is explained by the understanding that an interpretation is made at the level of the brain about the degree of threat - the greater the perceived threat the more likely the person to experience pain. Hence, pain can be seen as part of a response designed to protect us from danger.

Humans appear to experience pain in ways that the rest of the animal world does not. Our highly developed minds and complex social networks create ample opportunity for amplification of the pain experience. The way that we experience pain seems to relate to the unique way our consciousness has evolved.

In this article I will attempt an exploration of foundations in neuroscience and interpretation of Genesis before examining the building that is a modern multidimensional approach to pain.

Genesis 3

In considering the evolution of human consciousness, where better to start than Genesis 3? But before going back to the ancient wisdom, a little more contemporary neuroscience. The book *Thank God for Evolution* by Michael Dowd[1] makes for interesting reading in this controversial space. Dowd explores parallel unifying ideas in the Biblical account and modern scientific understanding. He proposes a 'quadrune' brain with each of the 4 layers being fundamental to our evolutionary development.

- Firstly, at brainstem level, is the so-called 'reptilian' brain. Primary functions relate to sustenance, sex and fight/flight or freeze mechanisms. These powerful drives relate directly to our ancestors' success, or otherwise, in passing on genetic material to future generations.

"Improving relational dysfunction... can often be part of the journey of recovery from chronic pain."

- Secondly comes the 'old-mammalian' brain. Dominant functions relate to social bonding and interaction. Think breast-feeding, skin contact and development of more complex social networks. The mid-brain and limbic system are key structural components.

- Thirdly comes the 'neo-mammalian' brain, with the capacity for critical analysis and scenario testing. Structurally, this correlates with development of the cerebral cortex. On the one hand a blessing, on the other a curse when we consider the challenges we now experience with rumination and seemingly never-ending cascades of thought.

- Lastly, related to development of the frontal lobes, specifically it seems the medial pre-frontal cortex (or 3rd eye in certain traditions), is our human capacity for transcendence, for higher consciousness, for salvation or enlightenment.

My life as an inhabitant of Planet Earth is clearly enhanced if I am aware of and grateful for the fourfold structure of my brain. I can become better equipped to tackle the challenges of my reptilian brain or 'lizard legacy' if I recognise that it developed in a bygone age for a specific purpose that does not necessarily align so easily with life in contemporary times. In observing the chatter of my 'monkey mind' I can be grateful for its analytical capacity, as well as reflective about its potential for harm and need for transformation. Learning about the potential for any of the brain areas to be dysfunctional in terms of contemporary life and its ability to lead us into temptation is an essential aspect of spiritual growth.

Now, back to the beginning, and a Genesis 3 perspective on the evolution of human consciousness. Clearly Genesis can be interpreted in many ways along the spectrum – from literal to allegorical. Perhaps a multitude of meanings does not make any single interpretation less true. However, it is interesting to consider Genesis in terms of evolutionary brain theory. From this perspective the tree in the centre of the garden may equate to the developing nervous system and the serpent our 'reptilian' brain. The knowledge of good and evil that comes with eating the fruit refers to the evolution of the human brain to

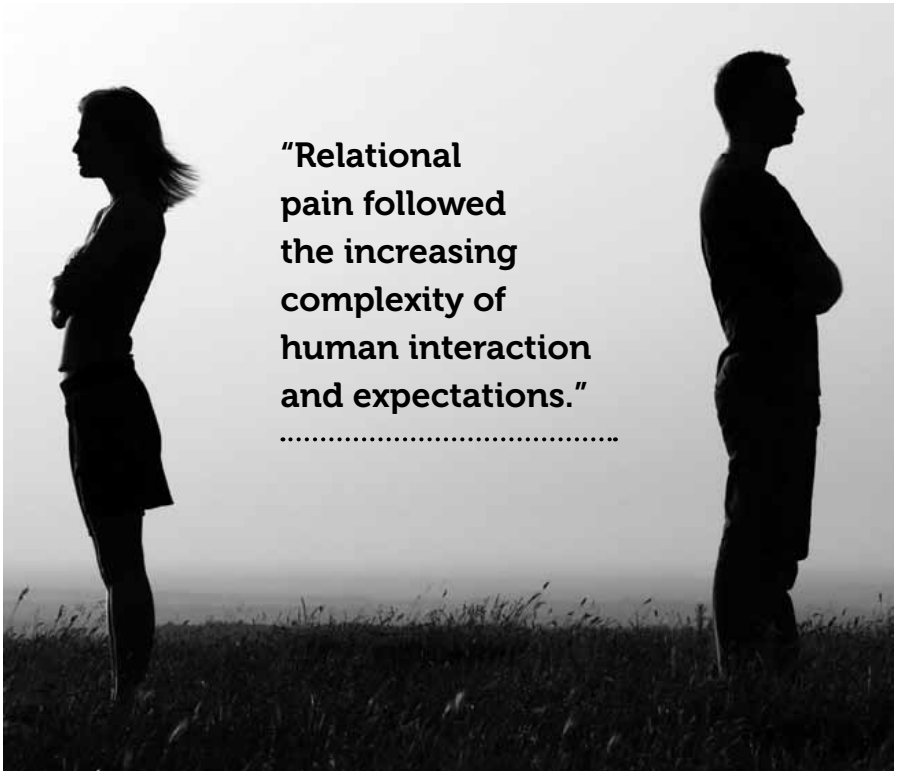
the point of self-awareness. At face value it seems true that we have a capacity to differentiate good and evil that is unique amongst living species on Earth. There came a fall from the state of innocence represented by the garden, and there were consequences. Enmity grew between the serpent and the offspring of the woman. What better metaphor for our very human struggles with our basic drives. Pain was amplified. Presumably pain exists even in the idyllic state of Eden.

However human brain development meant that pain became more multi-faceted. A social aspect crept in. The woman's desire would be for her husband but he would rule over her. Or perhaps equally, the man's desire might be for his wife and she might decline his advances. Relational pain followed the increasing complexity of human interaction and expectations. The earth itself became cursed and the ecosystem put under threat as a consequence of the evolving human brain. What better depiction of our current state of ecological crisis? We also became aware of our impending death in a way that the rest of the animal kingdom is not.

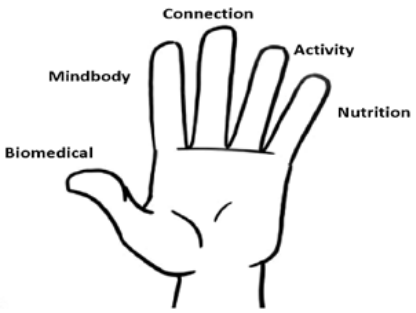
Finally, we were banished from the garden with cherubim and a flaming sword guarding the path back. Devastating as this picture is, it also raises the hope that a return to Eden is possible. Perhaps the garden remains deep within each of us. The return to this state of innocence is possible but only by way of the sword. We need to die to self. We need to be prepared to become like little children before we can enter the Kingdom of Heaven. Perhaps this is the Christ-like path that Jesus opens for us?

Multidimensional approach

Let us now return to a multi-dimensional approach to pain. We need to recognise that pain has a role even in an idyllic world such as Eden. If I touch a hot saucepan, pain allows me to quickly withdraw my hand before too much damage occurs. An acute pain response such as this is clearly a protective gift. However the evolution of the brain and humanity's fall from innocence meant that pain became a more complex gift, if indeed it remains a gift at all. The experience of pain amplified. Cognitively, our expectations, beliefs and fears have great potential to increase the experience of pain. In the modern world, an extensive social security capacity, along with technological advance, has contributed to disability rates unseen in societies where basic requirements for food and shelter are more difficult to attain. This disability can be seen as another factor contributing to the amplification of pain. Neuroscience clearly shows that reduced physical activity adds to nervous system sensitisation and increased pain intensity. Environmental degradation, mono-cropping and production of refined high caloric foods add a nutritional layer to nervous system sensitisation and amplification of pain. Pain is no longer the simple experience of the Garden of Eden.



Contemporary treatment of pain follows this multidimensional framework and often benefits from the input of multiple health professionals. A biopsychosocial approach is recommended. Recently this has been inverted and the term 'sociopsychobiomedical' coined. This recognises, in the context of chronic pain, that the sociological and psychological factors are generally more important than the biomedical in formulation and treatment.



I work as a pain medicine physician at Hunter Integrated Pain Service, John Hunter Hospital in Newcastle. Our team have found the term 'whole person' approach[2] to be more suitable than 'sociopsychobiomedical' in our discussions with patients. We then differentiate the holistic into five component parts illustrated by the guiding hand shown below left. Making change in any of the areas represented can help to retrain the nervous system and reduce the experience of pain. Behavioural change is the key that can unlock neuroplasticity, bioplasticity and beyond, to whole person plasticity. As human beings, we have the capacity to change at any stage of life if we choose to do so (*see figure left*).

Biomedical treatments such as medication and surgery can play a role in changing us for the better. However, they tend to be more effective for acute illness or injury and much less

continued over page >>>

so for chronic conditions. Hence the standard approach to treating chronic pain involves medication deprescribing and avoidance of surgery, except for very carefully selected indications.

The mindbody aspect recognises that what we think and feel has great capacity to change our physical state. Unhelpful beliefs and expectations can very directly impact our physical state – in part via nervous, immune and endocrine systems. Activation of the stress response rather than the relaxation response can contribute powerfully to negative health outcomes. On the other hand, activation of the relaxation response can be a strong contributor to healing.

The term 'connection' is multi-faceted and hence very useful. At one level it refers to connection with the people around us. Improving relational dysfunction such as that described in Genesis 3 can often be part of the journey of recovery from chronic pain. At another level there is environmental connection. This may be in need of restoration as we think of the ecosystem damage resulting from human behaviour. Spending time in a natural environment can be beneficial in calming an aroused neuroimmnue system. Connection can also be used as a term to introduce discussion of deeper purpose and spirituality. There is a body of research that correlates this deeper connection with well-being and longevity.

Addressing activity is a fundamental aspect of treating pain. The seemingly natural response is to rest in the face of pain. This can have brief benefit at the time of an acute injury. However, mobilisation becomes important at an early stage. From a pain perspective, and particularly in the context of chronic pain, maintaining, or often increasing, activity helps to wind down a sensitised nervous system and reduce pain intensity.

Nutrition is coming to be recognised as a component part of the treatment of chronic pain, just as it is for other chronic conditions, including diabetes and heart disease. A Western diet, high in refined food and sugars, produces low-grade bodily inflammation which can spill over to contribute to nervous system sensitisation and pain. Changing to a diet high in plant-based whole foods with reduced amounts of refined products and sugars has an anti-inflammatory effect that can contribute to pain reduction over time.

"Healthy individuals live in healthy societies, inhabit healthy ecosystems and recognise the spiritual connectedness of all things."

To use a de-identified brief case history, Sophia was a 30-year-old woman experiencing chronic pain and fatigue when she was referred to our team. When she attended our introductory education seminar, she particularly noted the importance of psychological aspects and nutrition. While awaiting a multidisciplinary assessment with our team, she started working with a local counsellor and changed her diet to reduce refined foods and increase vegetable intake. When she attended the assessment two months after the education seminar she had lost 5kg in weight. At the multidisciplinary assessment she reported that her pain and fatigue began when she was 13 years old. She was diagnosed with fibromyalgia and chronic fatigue syndrome by a rheumatologist the following year. When asked what else was happening at the time of pain onset, she said that her parent's marriage had ended and her father moved interstate. As the eldest of five siblings, she took charge of her brothers and sisters while her mother returned to work. In Sophia's words "my childhood ended", "the weight of responsibility settled on my shoulders". Sophia was able to recognise the possible link between her teenage emotional burdens and the pain and fatigue. Her therapeutic approach involved ongoing nutritional focus. She lost another 5kg over the following six months. She started a regular walking program. She continued to work through the mindbody impact of her childhood experiences. After six months of disciplined attention to her recovery plan, her pain and fatigue had both reduced by 80%. In attributing cause to her improvement, she felt that all aspects of her whole person plan were important, however, the mindbody aspect seemed most fundamental. She had been able to work through to forgiving her father for leaving the family home and his subsequent lack of contact and support. The anger and negative emotions suppressed at that time were brought to her conscious mind and released. Some time later she was able to re-establish contact with her father. There was a degree of healing of family connections.

Healthy individuals live in healthy societies, inhabit healthy ecosystems and recognise the spiritual connectedness of all things. The path to healing can be longer or shorter. A metaphoric return to the garden can often play a part. This incorporates a dying to self, a letting go of unhelpful cognitions, a mindful simplicity, a healthy connection with others and the planet. The ancient biblical book of Genesis offers intriguing insights into a multidimensional approach to pain for the modern era. ●

References
1. Dowd M. Thank God for Evolution. 2009 Penguin Random House
2. White R, Hayes C, White S, Hodson F J. Using social media to challenge unwarranted clinical
3. Variation in the treatment of chronic noncancer pain: the "Brainman" story. J Pain Research 2016;9:701-709.

Dr Chris Hayes

Chris enjoyed discussion of spirituality around the family dinner table as a child. After marrying Cate they attended churches from various denominations. They have a shared interest in the spiritual dimensions of healing. Chris has an ongoing fascination with the intent of Biblical writers and how ancient wisdom can inform modern life and health care. Chris trained in anaesthetics before plunging into pain medicine. He has been Director of Hunter Integrated Pain Service at the John Hunter Hospital in Newcastle since its foundation in 1997. He is currently Dean of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

A Pain Vignette 3

Resistant to Change

"Scott" is a 55 year old invalid pensioner. He has an aggressive persona and is heavily tattooed. Scott is a new patient to you. He had been seeing a kind, Christian GP who has retired. A State Health approval for prescribing oral morphine (Kapanol) 100mg bd was in place. He requests his "usual" script.

How would you manage this consultation?

If you suggest a dose reduction because the morphine use is for degenerative cervical and lumbar pain, Scott is very resistant. You feel his aggression and anger.

A good physical review is indicated. If the pain is correctly diagnosed, this dose of morphine is excessive. If the correct diagnosis has been slow to emerge, this is an opportunity for a careful review. Psychosocial and spiritual issues are highly likely. In terms of the "cycle of change" Scott is firmly a "pre-contemplator."

With these thoughts I am able to negotiate a physical examination in his next visit, providing the script today and asking for blood tests to exclude an inflammatory condition.

How important is developing a healthy doctor-patient relationship in this context?

Scott agrees to this plan, but indicates he is highly likely to resist change and is prepared to complain to the medical board if change is forced on him.

Should Christian doctors continue to see patients who pose professional risk?

Primary care medicine faces the full force of narcotic overprescribing. There are multiple factors:

- Rising complex pain rates in a world with only "imminent" significance.
- Associated rising levels of narcotic use (both prescribed and illegal).
- Pressure for early discharge from hospital leading to poorly planned pain pathways.
- The despair of failure to achieve self-mastery and success in life.

Without spiritual hope, narcotics are now the "real opiate of the people." Many primary care doctors are ill-equipped to manage these contexts. All doctors are aware of the undesirable consequences of long term, medically prescribed, narcotic use. However, on the ground support for individuals and practitioners through the cycle of change to de-prescribe is weak.

Scott's bloods are normal. X-rays confirms degenerative changes without operative solutions. Scott re-presents for his next prescription. He remains aggressive. Your heart is sinking.

What are the options for a Christian GP?

1. Recognise personal limitations and involve a pain service to do the hard work of rationalising narcotic use. This may mean an interim time period where you agree to simply provide monthly scripts. A State Health approval needs to be obtained. It can be made clear a zero tolerance option applies and Scott has the 100% responsibility to manage his monthly supply. You may suggest weekly pickups.
2. Accept that as a person made in the image of God, Scott needs healing in his life.

Is it appropriate to simply offer a gospel witness and decline further prescribing? Where would this leave the caring/witness of the previous senior colleague?

3. As in (2.) but recognise this will be a long journey. Serving Scott will mean respecting his integrity, creating the space to openly disclose the forces that have made "pain" such a powerful force in his life. It will mean ridding the bumps of "lost" tablets. It will mean keeping an eye on all the medical issues relevant to Scott, and always responding with integrity and compassion.

In a person so resistant to change, looking for authentic opportunities to move forward in the cycle of change are important. Both relational and professional roles need to be maximised.

Opportunities for "education" around pain, and the problematic use of narcotics long-term should always be accepted. Scott should be aware of the legal contractual nature of such an engagement. Developing a robust, dynamic pain management plan will be a priority. It may be useful to develop a treatment contract.

If Jesus made friends with tax collectors and sinners, can a doctor develop a "professional friendship" relationship with someone like Scott?

Dr Paul Mercer

See A Pain Vignette 1 and 2 on pages 21 and 25.

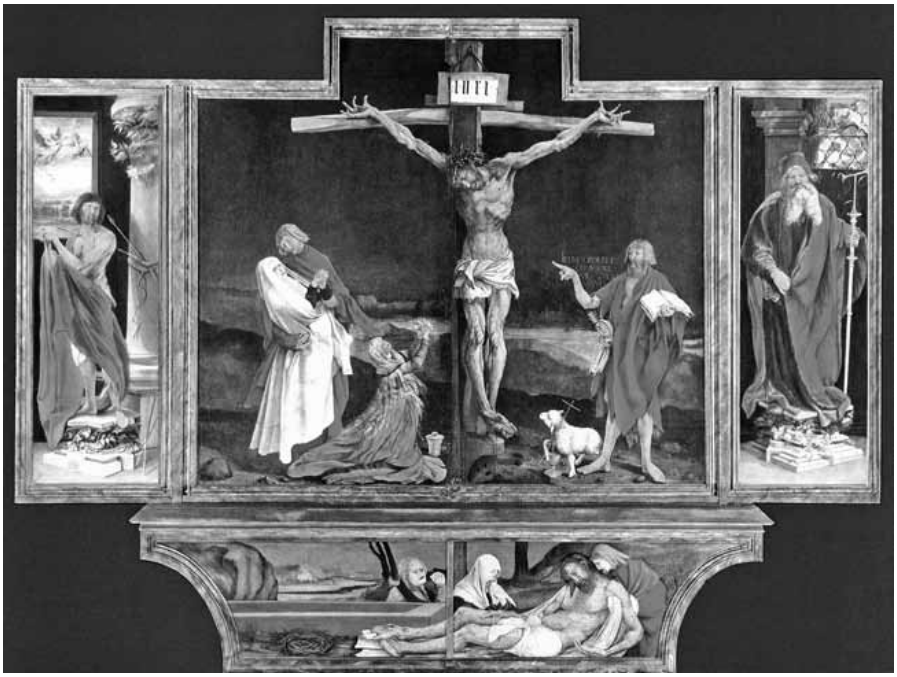
Christian Doctors, Chronic Pain and Addiction

A personal reflection

I was stunned by the Isenheim Altarpiece at the Colmar museum in Alsace.

Grunewald had graphically painted the crucifixion and burial of Jesus. Jesus' body was covered with the ischaemic sores and gangrenous digits of a person suffering from St Anthony's fire. I could not recall the exact condition but I was struck by the intensity of the suffering and also by the ignorance of the people looking after the victims. All the carers could do was to pray and to care – and they did. No doubt many got better, though others died as carers looked on helplessly.

A Google search quickly dispelled my ignorance. These people were suffering from ergot poisoning, due to eating rye infected by the fungus *Claviceps purpurea*. I admired the skill of those who had worked this out, and of course I have never seen anyone with this condition today. But I was struck by the courage of those of the order of St Anthony who looked after these sufferers. How would they have approached the condition? Did they bluff their way through like we doctors do when we encounter symptoms which we don't understand? Did they confidently suggest electric treatment as John Wesley did for St Anthony's fire? Did they postulate blood-letting and purging as Benjamin Rush, the American Psychiatric Association poster boy did, and probably killed more people than he saved? Rush probably did not see St Anthony's fire but he seemed to have prescribed his interventions for many other conditions.



Isenheim Altarpiece painted by Matthias Grünewald at the Colmar museum in Alsace.

While we know a lot more medicine, there is still a lot we don't know. Chronic non-malignant pain often falls into that category. While we insist on a proper clinical diagnosis, often there is none and we are forced to treat the symptoms without addressing the unknown underlying pathology. I call this red-light medicine. Imagine driving a car and a red light comes on in the dashboard. A sensible driver would investigate why that red light has gone on. A silly driver picks up a hammer, smashes the red light and keeps driving. Chronic pain treatment is a bit like that – treating the symptoms not the cause. But sometimes we are forced to do just that.

Not that we are all that effective. Our pain management tools are limited, and we often have to sit with people in distress feeling helpless in the face of pain not well controlled by our medicines. Just as well, for Paul Brand in his book, *Pain – the Gift Nobody Wants*[1], points out that patients with leprosy and diabetes who have anaesthetic peripheries lose their digits. This happens because injuries and sores are not felt and therefore not recognised, and part of patient education is to teach them to inspect their limbs every day to ensure there are no new sores, and if there are, to treat them carefully.

How do we as Christian medical professionals respond to such distress? Some versions of Matthew's classification of the diseases Jesus treated in Matthew 4:24 identify

chronic pain or severe pain as a specialty of our Lord. (KJV 'divers diseases and torments', NRSV 'various diseases and pains', NIV 'various diseases and severe pain'). So we are disciples of a healer who had a special gift. His compassion is highlighted. Not for him the dispassionate rationalism so beloved of the enlightenment. He had compassion and he healed. We also can have compassion, but the healing is a bit more difficult.

Thomas Sydenham, the English Hippocrates and the Father of English medicine, a committed Christian, commented that, "one of God's greatest gifts to humankind is the gift of opium." But like all potent tools it can be misapplied. Opioids have three basic actions. They relieve pain, they stimulate the limbic system (the pleasure centre of the brain), and they relieve withdrawal symptoms in those dependent on opioids. Not every person taking opioids feels the rush of addiction. A lot of my post-operative patients say they do not understand the addict, their opioid did not give them a buzz. Others comment that they now understand what 'the junkies' see in opioids. However, even the latter group do not automatically become addicted. Other circumstances are needed for addiction to occur. I believe the latter group is vulnerable if their pain became chronic and their doctor was generous in their prescribing. Here the compassionate Christian doctor is vulnerable, for in their attempt to be kind they give in to repeated requests for more analgesia, and hence the patient can develop a dependence on their opioids and their doctor. Iatrogenic opioid addiction is a function of the doctor-patient interaction. One of the great unconscious seductions is the line, "Doctor you understand. You are not like all the others."

Yet these patients crave compassion and understanding, and an unfeeling dispassionate professional is not therapeutic. Chronic pain patients often find themselves referred to many specialists who may not be very helpful. Whenever a patient does not fit into neat management categories specialists take refuge in the line 'not my specialty' or the latest buzz phrase, 'not within my scope of practise.' This leaves General Practitioners out on a limb. They tend to have to manage these complex and difficult diagnoses and people within the restrictions of their time-limited consultations and busy waiting rooms.

Not only are the diagnoses difficult, chronic pain tends to occur in patients who have difficult personalities. Many have been damaged by life's events and they crave love and understanding. Most lack resourcefulness and resilience and they believe a magic potion will give it to them. And it does! Opioids, after all, stimulate the same pleasure centres that are stimulated by intimacy, hugs, maternal care, the love of a lover - both sex and affection.

"Chronic pain treatment is... treating the symptoms not the cause. But sometimes we are forced to do just that."

However, the initial powerful effect of opioids fades and more and more opioids are required to relive the original buzz of the first dose. This is the basis of addiction – the desire for pleasure thwarted by increasing tolerance, compounded by the patient developing a withdrawal syndrome if they suddenly stop the offending substance. The desire for that buzz becomes more and more insistent, and swamps all other needs and drives – like the need to save money, to feed oneself and to care for others.

Pain is a subjective sensation. It is unhelpful to say to a patient that they are not in pain when they say they are. With time, education, and insight, they may be able to differentiate between pain relief from opioids and the pleasure addictive drugs may give them, and they may then decide whether the analgesia they receive from their drug is in fact the stimulation of their pleasure centre. With this insight, they may then successfully withdraw from opioids. This will help to decide whether opioids should be stopped or continued.

Attitudes to opioids for chronic non-malignant pain have changed over the last twenty years. From initial caution in prescribing opioids at all, to the recognition that not everyone who needs opioids for pain develops tolerance, to the idea that even if they develop tolerance that is a simple biological phenomenon requiring a higher opioid dose. Thus Stimmel's book *Pain and it's Relief Without Addiction*[2] (1997) advocated increasing the dose without any dose ceiling in an attempt to keep the patient functioning well. The bottom line here was how well the patient functioned in the community, not an arbitrary ceiling dose of milligrams of morphine equivalent (MME).

The picture is quite different a decade later. With the increase in bad opioid prescribing, particularly of the oxycodones, and the increase in opioid deaths in the community, there has been a public health backlash against uncontrolled prescribing of opioids and an attempt to limit the dose and duration of opioid prescription. This is a very different strategy to the successful use of methadone for patients who are opioid dependent, who do not have any pain. In their case there is no limit to the duration or dose of substitution pharmacotherapy, but there are strict limits on the prescribing and dispensing of methadone. For methadone there is only one trained prescriber who has the permit to prescribe, and who sees and reassesses the patient regularly. Dispensing is supervised so that methadone is not given to the inebriated or the sedated patient. Take away doses are limited to one or two doses per week to reduce the risk of overdose, and patients are only slowly trusted with further take aways. Methadone prescribers are trained before they can prescribe so they understand the risks of what they are doing. By contrast any doctor can prescribe opioids for chronic pain and there are no dispensing precautions.

In the liberal 1990s, doctors identified pseudo-addiction as a condition where the patient had 'legitimate pain' but was forced to act out as if they were addicted because no one would prescribe the appropriate opioid. The pseudo-addicted behaviour would disappear when a caring doctor

continued over page >>>

prescribed the right opioid and the patient was then happy! In the more cautious present, sceptics suggest this concept may have led to the rise of the iatrogenic opioid addiction epidemic driven in part by the pharmaceutical industry.[3] Of course to criticise the concept of pseudo-addiction because it is not an objective phenomenon calls for an objectivity which cannot exist. We are dealing with symptoms like pain and pleasure which by definition are subjective. The debate continues.

One of the best services we can offer patients suffering from pain is to take their distress seriously and to listen carefully to their whole story, listening as they tell their story - not just to the timing and rate of change of symptoms, but also to the emotions that may accompany that – the fear, the anger, the frustration, the abandonment, the outrage at incompetence and bureaucratic blunders that may be compounding their pain experience. We need to hear of the unrealistic promise and the disappointment of thwarted care and of the therapeutic errors that may have occurred in all they have experienced. We need to hear of the indifference shown to them by some of our colleagues, and show compassionate understanding.

As we take a history we need to be aware of face-saving events (FSEs). These FSEs are a certain spin patients can have on their history. They describe that up until that event life was good, even perfect, but then disaster struck. That event can be a car crash, a workplace injury, a traumatic interpersonal event, or the death of a loved one. Since then, life has been a disaster. However, careful, cautious sensitive questioning will usually reveal that the patient's resilience prior to the event was not strong, there were plenty of warning signs of later trouble, and that they have rather romanticised their story. Further, by blaming where they are now on such an event, they are stuck and cannot change. They have an unrealistic expectation that somehow they will be rescued from that disaster. Legal restitution, a withheld apology, or some other factor external to the patient prevents their recovery. Here they need to recognise the futility of their expectation and find strength within themselves to manage as well as they can within their limitations.

Chronic pain sufferers will tell of these 'pain multipliers' as they tell their story. Their pain is exacerbated by their past traumas, by previous perceived incompetence and indifference, by fear, by ignorance, by unrealistic expectations and by thwarted hopes. All of these dimensions cannot be addressed by a single session or by a single therapist. Physiotherapy, occupational therapy, group therapy and other psychological interventions are all important in helping patients to manage to live with uncertainty of diagnosis, prognosis and the opprobrium of health practitioners who blame the patient for the patient not getting better. While fear and ignorance are best treated with truth and astuteness, very often the honest therapist has to sit with the patient in their uncertainty and ambiguity.

Chronic pain management, then, is an ongoing journey requiring patience, perseverance, hope, and resilience. It calls on both the doctor and the patient to live with uncertainty and even to acknowledge our ignorance. It requires firm boundary setting on unrealistic expectations and yet an acknowledgement of legitimate requests which will be met compassionately and even cheerfully. Treatment is emotionally costly to the carer and the carer needs to make sure their own care is not neglected in this difficult struggle. I have found John Greenleaf Whittier's poem extremely inspiring – see panel right. ●

References:
1. Brand, Paul. Yancy, Philip. *Pain - the Gift Nobody Wants* Zondervan. 1982.
2. Stimmel, Barry. *Pain and its Relief Without Addiction* Routledge, 1997.

A/Prof Alan Gijsbers

Alan is Head Addiction Medicine Service RMH, Medical Director Substance Withdrawal Unit, The Melbourne Clinic Richmond and President ISCAST, ICMDA Board Member, Former Chairman CMDFA.

Christ healing the Sick by Gustave Dore.

THE HEALER

John Greenleaf Whittier
To a young physician...

So stood of old the holy Christ
Amidst the suffering throng;
With whom His lightest
touch sufficed
To make the weakest strong.
That healing gift He lends to them
Who use it in His name;
The power that filled
His garment's hem
Is evermore the same.
For lo! in human hearts unseen
The Healer dwelleth still,
And they who make
His temples clean
The best subserve His will
The holiest task by Heaven decreed,
An errand all divine,
The burden of our common need
To render less is thine.

The paths of pain are thine.
Go forth
With patience, trust, and hope;
The sufferings of a sin-sick earth
Shall give thee ample scope.
Beside the unveiled mysteries
Of life and death go stand,
With guarded lips and reverent eyes
And pure of heart and hand.
So shalt thou be with power endued
From Him who went about
The Syrian hillsides doing good,
And casting demons out.
That Good Physician liveth yet
Thy friend and guide to be;
The Healer by Gennesaret
Shall walk the rounds with thee.

Reflections on Pain from a Nursing Student

Pain is your friend! Just breeeathe! Relax! Imagine yourself in a quiet place beside water! Close your eyes and listen to your inner voice! You can do this! You're doing so well! It's not really that bad! It's all in your head!

Anyone who has experienced pain will probably have heard these expressions at one time or another. Some are rather inane, some may be helpful and others are just plain ridiculous! I can personally say, after having given birth to six large healthy babies, that being reminded to breathe while your perineum is being stretched to an alarming width makes you want to attack someone with your birthing stool!

And yet, we all feel pain. Want to relieve it. Attempt to relieve it. Maybe even with some of those lines above. We feel so wretchedly helpless watching a patient, dear friend or family member struggle with that familiar enemy. Everyone experiences pain at some time during their life and for a myriad of different reasons. It is our ever-present curse.

Methods for managing pain are diverse and personal. We hear the expression "he/she has a high or low pain threshold" meaning that he's quieter than we expect or she's more demonstrative in attempting to cope. People in pain can surprise us. The patient with a staggering array of traumas takes it in his stride stoically – real blokes don't admit they're hurting! The next patient insists on medication for her torn fingernail. Some rely silently on an inner strength. Others vocalise, causing havoc for the rest of the ward. Some choose music therapy, aromatherapy, hypnotherapy,

"We feel so wretchedly helpless watching a patient, dear friend or family member struggle with that familiar enemy."

relaxation or visualisation. And there's always paracetomol!

As health professionals, we're trained to recognise and relieve pain. Where is it? How long has it been there? Sharp? Achy? What makes it worse? Does anything relieve it? The one to ten scale, the Wong-Baker faces etc. I'm a nursing student beginning my journey with patients and pain. I'll learn to tell the difference between patients wanting free drugs and ones desperately needing medication but not asking for fear that it denotes failure. I'll learn how a hurting body presents and how to combine my compassion for it with an ability to step back emotionally and treat it effectively.

And we know of course, that pain isn't just physical. Our hearts break when loved ones attack and reject us, or run after foolishness. Our minds shatter when we experience guilt, failure, disillusionment or the ultimate grief - death. Being alive hurts!

But the best thing we know about pain is that it can't last. There will be eternal relief from it one day – far outdoing any earthly analgesia. Sin brought pain and death into God's perfect world. One day, He will recreate a world for those who love Him in which they will never feel pain again. He is our ultimate source of pain relief as we wait for that world.

In the meantime, take some ibuprofen and just breeeathe! ●

Ruth Minter

Ruth has been married to her favourite man for twenty-two years and they have three sons and three daughters aged between 21 and 15. She home educated her children and is convinced she wouldn't have survived this without a good sense of humour, blood pressure medication and a cat who purrs loudly at 3am. She has a degree in music, half a degree in nursing and, if she has spare time, digs in her garden, reads a good book or chases the aforementioned cat off her piano.

Pain avoidance – the role of addiction

This essay looks at the role of pain in the development of addiction, and how we as the church can potentially minister to sufferers of addiction.

From the book of Genesis, we see that an increase in the experience of pain is linked to The Fall. Man was excluded from the Garden of Eden where he could potentially eat from the Tree of Life and live forever. Scripture indicates that these impositions were necessary to limit the effect of man's disobedience and for God's order to be preserved (Gen 3.22), but by deduction (God's love for man), for the good of man as well. C.S. Lewis points out that in the absence of pain, we would never seek God; he speaks about pain as God's 'megaphone to rouse a deaf world'.[1] Similarly, physical pain imposes a limitation on damage occurring to the body by compelling the individual to act.

The suffering consequent upon the Fall is described as affecting the sexes differently – man in his role as provider is burdened by frustration and hard work; woman by the pains of childbearing. Similarly, pain (or more correctly suffering), manifests in the various dimensions of our being, e.g. childbirth (physical pain), loss (emotional pain), hopelessness (mental), frustration (the will), shame (moral), loneliness (social) or meaninglessness (spiritual). Pain always reflects something wrong in the structure of either us or the surrounding environment (physical, psychological, social or spiritual), and, as such, it is a necessity if we are to avoid destruction.

Within our medical role, we gain a unique insight into the mysterious unity between body and spirit. For example, antidepressants are a class of drugs that can 'lift the spirit' or allow some patients to feel hope again where counselling and social support has failed. There are some substances which are able to mimic aspects of human experience to the extent that they can be very attractive. However, inevitably there are downsides. For example,

- methamphetamine can overcome fatigue and increase attention, or in higher doses produce such an intense reward that whatever actions went into achieving that state, will be repeated to the exclusion of important responsibilities;

"C.S. Lewis points out that in the absence of pain, we would never seek God."

- hallucinogenic drugs can produce a sense of spiritual enlightenment. Unfortunately these effects are not based on reality and can lead to permanent perceptual distortions;

- opioids produce a relief from various types of pain, emotional and physical, but can also cause a deadly dependence;

- the drug MDMA ('Ecstasy') is being studied for its potential benefits in PTSD through its action of releasing oxytocin and promoting social bonding,[2] but this effect is non-discriminatory, and presents other risks as part of the dance-party scene.

The unique qualities of many drugs can be used powerfully to do good (or feel good), but they remain a relatively blunt instrument, and one that can also do much harm if used unwisely. Therefore, drug use is traditionally regulated by society through laws, social rituals and boundaries.

In relation to pain experienced by human beings, there is indeed much that we can do as health professionals to both cure disease and alleviate suffering. However, when faced with pain in the absence of a cure, our instinct to help can lead us to do harm. Indeed, the attempts by our profession to alleviate pain contribute to over 550 deaths per year in Australia,[3] and a staggering 17,500 deaths per year in the USA from prescription opioid use.[4] The interconnectedness of all things means that nothing can be changed without an unintended consequence. We, as doctors with experience, become more and more aware of the limitations of our profession, that pain in some form is often unavoidable, and that man's attempts to *completely* avoid it lead to other problems (often more serious).

The question of why we must suffer is ultimately a mystery, (however as far as reason can go, Lewis' book *The Problem of Pain* is recommended).[1] Knowing God's full character as revealed in Christ, we can safely say that pain must have been unavoidable in God's deeply laid plans for creation, which included His foreknowledge of The Fall. Jesus himself was not exempt from experiencing pain. Indeed, his incarnation and suffering is profoundly integral to our salvation. We yearn to know the reasons for suffering, but God usually does not reveal it, e.g. in the story of Job, he never knew of the heavenly challenge by Satan of God to test Job's fidelity. We could ask too, if knowing would make pain any easier to bear, and could we understand such an immense and complex

truth? Ultimately, despite all rational understandings, (or rationalisations), suffering can only be acceptable by knowing that God suffers with us, and that eternal joy will be the final outcome. In His providential love, He has also provided science and medicine to relieve suffering, and even today new understandings of neuroplasticity give us reason to believe that chronic pain *can* be managed. Yet there is suffering – a mystery which we must learn to address, not with 'why' questions, but 'how' (how can I respond)?

Even with a relationship with God through Christ, sinful man inevitably responds to suffering in ungodly ways, which will be dysfunctional and lead to more pain in the long-run. A cycle develops of seeking another form of relief or distraction, followed by disappointment leading to a deepening despair. Thus, the soul tortured by pain and disappointment comes to one of two positions – either crying out to God and turning to Him, or expressing anger toward God. This latter interaction with God is not necessarily evil as we see in Job, as it is an interaction which opens the way for a response. Even rebellion towards God is evidently something with which He can work, as shown by Jesus' preference for hot or cold, rather than lukewarm faith (Rev 3.16).

Substance abuse and addiction are consequences of one of the ways man seeks relief from the suffering of life after The Fall. There are other more 'socially acceptable' ways to do this, such as workaholic behaviour, taking up 'causes', seeking entertainment/ social activity, personal achievement, accumulation of money, etc.. There are some less socially acceptable ones such as anger and violence to others, dysfunctional coping mechanisms such as projection or self-directed anger, stealing, ungodly pleasure-seeking, etc.. Irrespective of society's values, substance misuse is no greater a sin in God's eyes than any other ungodly method of coping. Nevertheless, it is often a very self-destructive one, and the humbling effect of addiction does place the sufferer in the same category as 'sinners and tax-collectors', people with whom Jesus spent a lot of time.

"...pain in some form is often unavoidable, and that man's attempts to *completely* avoid it lead to other problems (often more serious)."

As Christian doctors, we should be no more surprised at substance use than any other sin we see in mankind. However, dealing with it can be very confronting and perplexing. So-called 'normal' people will tend to boost their sense of moral self-esteem by comparing their own behaviours to others further to the left on the bell-curve of a given moral criterion. We as Christians cannot do that if we are honest with ourselves. This is not to say that dealing with people with addiction is straightforward. On the contrary, it takes a very different perspective on progress and an approach which reflects the multi-dimensional nature of the problem. To the 'bio-psycho-social' model we add 'spiritual', since ultimately the presence of suffering and man's dysfunctional approach to it can only be fully understood from that perspective.

How should we approach addiction? Various dimensions to the problem have come to prominence over the years, but the idea of moral failure is a widespread belief that contributes to severe stigma around addiction and reduces in society's eyes 'worthiness' of help. Yet modern mainstream understandings of addiction acknowledge that moral failure is only a relatively small contributor to the development of addiction. Peer pressure is a factor, but less important than concerned parents often imagine. Public policy on legal availability and taxation of addictive substances is a powerful determinant of addiction prevalence. However, individual vulnerability probably plays one of the greatest roles in determining addiction, including genetics/epigenetics, and personality development. Trauma,

continued over page >>>

neglect and parental influences have a big effect on vulnerability. Those little kids that we see in our practices, being raised under circumstances of psychosocial inadequacy, become the substance use patients of tomorrow.

The implications of this causality are that there is much more to do for substance-addicted patients than simply detoxing followed by a three-month course of recovery meetings. Of course, this works in some cases, but these are generally people with 'intact' personality foundations who have slipped into addiction. In most established cases there is long term restoration and developmental work to be done, and this can take five, ten or twenty years, along with life-long attention to relapse prevention.

In the case of opioid addiction, the trauma history is such a profound influence that if I meet someone without a history of childhood sexual abuse (which occurs in 90% of cases) then I am looking for a major psychiatric illness (or assume that it is too painful to disclose at present). Opioids work very well for people with co-occurring Cluster-B personality traits simply because they address the pain of trauma. I have seen people who try to do a detox from their opioids (because that is what is expected of them by family), quite rapidly start to re-live past traumas to the extent that they must restart their opioids. The reason why opioid maintenance treatment is so effective, and abstinence-based treatments are so ineffective and dangerous (from lethal overdose), is because it treats the pain and stabilises the patient whilst they work through the developmental deficits and traumas. This trauma aspect of opioid addiction is not widely appreciated. Consequently, almost without fail, the first question people ask me after I tell them that I prescribe methadone, is 'how long before you get them off it?' Childhood trauma is a profound problem taking an average of twenty years for a person to achieve a fair level of stability. Abstinence-based approaches are associated with a fifty percent mortality rate over the same period without Opioid Substitution Treatment, a high price to pay for an ideal.

Getting back to the spiritual dimension of substance use, what is the unique contribution that the church can make in this area? Should we be trying to cast out the demons of addiction – is it simply a matter of deeper and more heartfelt repentance? Or can we make people better by taking them away to a Christian environment and make them attend chapel? Is AA/NA the only type of self-help we should endorse (or better still, transform it into a fully Christian format)? There are robust observations in research over the years, showing that religiousness is inversely associated with alcohol and drug problems, and that people entering treatment for addiction have a low level of religiousness and spiritual practice. Attendance at AA and learning meditation has been associated with lower rates of relapse, yet the causality of these relationships is far from being clarified scientifically.[5] Nevertheless, psychosocial treatments and medical treatments do work, even in the absence of an 'epiphany'. Much of the work of recovery is personal growth, and in view of the contribution of personal developmental difficulties, it is not surprising that generic assistance is comparable to, if not as good as, Christian assistance. In the same way that good parenting is good parenting, good therapy is good therapy, and some services offered by well-meaning Christians can even be bad therapy.

"...religiousness is inversely associated with alcohol and drug problems, and that people entering treatment for addiction have a low level of religiousness and spiritual practice."

But here's where the church can help: generic recovery services simply are not available in sufficient quantity and quality to help the vast numbers of people who need help. Long-term healing of the personality developmental deficits and disorders that so often accompany substance addiction is not well addressed by mainstream services and results in the repeated cycling through services over a long period of time. Personal development in fundamental areas such as trust, identity, shame, belonging, value, etc. is spiritual development, because it is building a healthy sense of fatherhood and sonship so essential to relating to God. These aspects of child-psychology (and adult personality disorder) are core business for us as churches, because we are Christ's body and true family. Families are places of both love and structure, places where people are nourished and grow under the Father's (and fathers') protective hand. They are also places for restoration – as sinners saved by grace, we are all 'in recovery'.

So, in practical terms, how can the church interact with these very broken and needy members of society, helping to bear their burdens, being the missing role-models of brothers, fathers, sisters, mothers, yet not endangering the structures and people in those communities?

There is no place for spiritual pride amongst Christians, and we all want to be as vulnerable and honest with each other as possible. Yet clearly there is a potential for compromise if, say, a police officer and a known recurrent offender attend the same church or the same 'connect group'. In theory it could work, but personal sharing about struggles might be inhibited. There must be structures and boundaries in place, for the same reasons that a business deal between friends must be backed up with legal contracts. Human sin and iniquity, and the work of Satan, can wreak havoc. We only need to think of the terrible stories coming out of the Royal Commission into Institutional Responses to Child Sexual Abuse to realise the awful consequences of thinking 'it couldn't happen in the church.'

Clashes of culture or personal habits can also arise, not only the difficulty posed, for example, by the very bad body odour of the homeless man you've invited home for lunch, but the recipient of the generous welcome may feel very uncomfortable too. When people who have been raised in various kinds of poverty (social, financial, moral) are immersed in a community full of genuinely 'nice' people with nice things, nice manners, educated and thoughtful, not necessarily even snobbish, the potential is created for a sense of inadequacy or jealousy, such that it overwhelms the newcomer. This is not to say that we should only aspire to the lowest common denominator, but it means we must be realistic, (and not proud). In this regard, there is often cultural clustering of people within churches and into churches. This is just as normal as ethnic clustering in certain churches. We need to affirm each other's calling and strengths and mutually support each other. A wealthy middle-class church community is generally a time-poor community. Though they may not have time to give to ministering to certain groups, they may be able to support a ministry financially. Another example is a mature responsible church person in a busy and demanding job. They might not have time to give to a cause, but may be able to mentor a less mature Christian who has more time for service. Such networking between and within churches could be enhanced by more conscious sharing of needs, perhaps even social media.

In the case of people who have experienced a distortion or poverty of parental care, or been victims of abuse, such people may have been through a series of churches, leaving a trail of burnt bridges behind them. These are the group for which we need a dedicated sub-group of informed and mature helpers within churches. It should not fall to just one or two people to try to manage such sufferers, but a network, even a roster of people. Crises are make-or-break moments and should be prepared for in advance with professional input and contingency plans. Events such as self-harm, court matters, outbursts, fights, mental health deterioration, substance relapse or bingeing, should not cause the church shock and withdrawal, but be handled calmly – bedding down another experience of a parent-like response in the sufferer, which cumulatively leads to growth and a more accurate picture of fatherhood and sense of identity as His child. Behaviour management plans may need to be developed to encourage desirable, and discourage dysfunctional, patterns of coping in the person with the disorder. There is no shortage of professionally-trained people in churches who have skills to impart, but there is a gap in the recognition of this somewhat specialised caring ministry within churches. With a little planning, the necessary expertise could be disseminated. We have a majority of fairly 'normal' people in our churches, even 'boringly normal' people who are, in fact, an enormous resource for helping people.

"The abundance of stability and good values that we take for granted in middle class churches, is a valuable resource that is rare in the circles that many addicted people come from."

Regarding the teachings of Jesus about radical generosity and hospitality, we haven't had a lot of help integrating these teachings with the practical aspects of present day culture, e.g. should we welcome a homeless stranger into our house out of obedience to Christ's teaching? We are called to be gentle, but wise also. Ministers of the Word need to drill down to the practical applications of some of these tricky areas so that members are not left vulnerable to exploitation.

The abundance of stability and good values that we take for granted in middle class churches, is a valuable resource that is rare in the circles that many addicted people come from. I would love to see us tap into that resource but, more importantly, bring the added spiritual depth to healing from these issues that is lacking in purely medical and psychosocial approaches. ●

References:
1. Lewis CS. *The problem of pain*. London: Collins; 2012.
2. Yazar-Klosinski BB, Mithoefer MC. Potential Psychiatric Uses for MDMA. *Clin Pharmacol Ther*. 2017;101(2):194-6.
3. ABS. 3303.0 – Causes of Death, Australia, 2016. In: Australian-Bureau-of-Statistics, editor. Canberra: Australian Government; 2017.
4. NIDA. Overdose Death Rates. In: National-Institute-of-Drug-Abuse, editor. September 2017 ed: *National-Institutes-of-Health*; 2017.
5. Miller WR, Bogenschutz MP. Spirituality and addiction. *South Med J*. 2007;100(4):433-6.

Dr David Outridge

David is a GP in Newcastle with a special interest in addiction medicine. He and his wife Loraine work alongside an Anglican NGO supporting people with substance use problems and those exiting custody.

Pain in palliative care practice

the special contribution of Christian physicians

This year marks the 50th anniversary of the opening of the first modern hospice – St Christopher's hospice in London.

Improving pain management was one of the first challenges. It is appropriate to reflect on the achievements of the hospice/palliative care movement, in particular to note the contribution of committed Christian physicians. From the hundreds of dedicated doctors worldwide, who have laboured to improve the care of the dying, I have chosen five for special mention: Cicely Saunders and Robert Twycross in England, Balfour Mount in Canada, Norelle Lickiss and Peter Ravenscroft in Australia.

Dame Cicely Saunders. Photo: https://cicelysaundersarchive.wordpress.com/

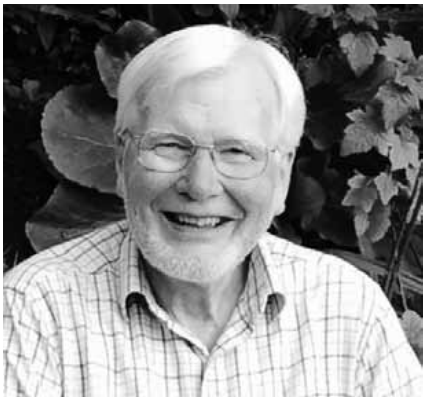
Dame Cicely Saunders is credited with being the founder of the modern hospice movement. As a young Anglican nurse working in St Joseph's hospice in London in the 1950s, she observed the unsatisfactory approach to managing pain.

The analgesic efficacy of opioids had been known for hundreds of years. Thomas Sydenham (1624 to 1689), "the father of English medicine", is credited with the following quotation:

> *"Among the remedies which it has pleased Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium."*

Despite this knowledge, morphine and heroin (diamorphine) were given in inadequate doses, and only when the patient was experiencing severe pain. With fierce determination and meticulous record-keeping, Saunders documented the safety and efficacy of morphine in more than a thousand patients.

As well as her research on the benefit of oral morphine, she soon realised that a patient facing death experiences more than mere physical pain. She coined the term *"total pain"* to describe the suffering that encompasses a person's physical, psychological, social, spiritual and practical struggles.



Dr Robert Twycross. Photo: twitter

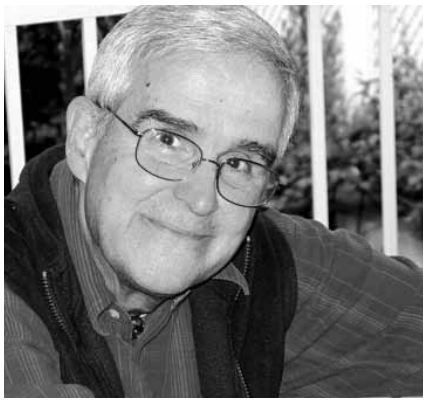
In 1971, she recruited **Dr Robert Twycross** as a Clinical Research Fellow at St Christopher's. He set a high standard of academic excellence, supervising crucial studies on the use of opioids for pain control, further demonstrating the safety and efficacy of regular oral morphine. From 1988 to 2005 he was the Director of the World Health Organisation's Collaborating Centre for Palliative Care. He played a major role in the establishment of palliative care in Poland, India and Argentina. In 2004 he helped establish **palliativedrugs.com**, a unique website providing an evidence base for palliative care pharmacotherapy, with a special emphasis on pain management. The free website has more than 30,000 members from 169 countries. The editorial team publish the **Palliative Care Formulary**, now into its 6th edition, which has achieved global recognition.

As a committed Christian, Twycross was aware of the spiritual dimension of suffering, which no amount of morphine could relieve. In the Oxford Textbook of Palliative Medicine, first edition, 1993, he wrote:

> *"Terminal anguish is a tormented state of mind which relates to longstanding unresolved emotional problems and/or interpersonal conflicts, or to long-hidden unhappy memories often with guilty content. These problems have festered in the mind but have never been brought into the open. As long as the patient is well enough to control his/her thoughts and as long as denial can function, all appears to be well.*
>
> *With increasing weakness, the onset of drowsiness and inability to control thoughts, hidden matter in the unconscious mind is able to surface...*
>
> *The possibility of such an outcome highlights the need to make every effort to deal with psychological "skeletons in the cupboard" before the patient becomes too weak to address them. A few, however, resist*

every attempt to share what they have been hiding."

Listening: a potent analgesic without side-effects



Dr Balfour Mount. Photo: http://alexschadenberg.blogspot.com.au

Dr Balfour Mount was a urological surgeon at the Royal Victoria Hospital, Montréal, Canada. He discovered to his embarrassment that the care of the terminally ill in his hospital was grossly inadequate. Searching for answers, he spent a week visiting Cicely Saunders. "Once I saw St. Christopher's, I saw there were solutions to that unnecessary suffering..."

He was eager to establish a Hospice unit in Québec, but his French speaking colleagues informed him that "hospice" had an inappropriate connotation in French. He therefore coined the term "palliative care". Dr Mount was steeped in the Christian tradition of compassionate service. His father was a missionary doctor working with Sir William Grenfell, serving the Eskimos and fishermen of Newfoundland. With a deep sense of vocation he changed direction and has been full-time in palliative care ever since. He is the undisputed leader of palliative care in North America.

Although highly skilled in the use of medication to relieve pain and other symptoms, his greater contribution was his emphasis on the psychospiritual distress of palliative care patients and their families. The treatment of this distress he describes as "healing", a "relational process leading to an experience of integrity or wholeness". The doctor's role is intensive, focused, compassionate listening. A dramatic example is portrayed in an excerpt from the DVD *The Choice is Yours*, which was produced at his initiative. In the DVD, a patient, Roslyn Saxe, talks about her encounter with Dr Mount, and he responds with his reflection on the interaction.

Roslyn Saxe: *"Not only was it a diagnosis of cancer, I was in stage IV. My prognosis was 6 months... they decided on very heavy duty chemo. My world collapsed. I was going to die. I did not think I would survive it.*

I spoke to somebody when I was in a crisis and she suggested that she would call Dr Bal and he would see me for a consultation one time. I was totally depleted. I did not think I could carry on with any more chemo. I went to see him, and 3 hours later, after talking to him... he validated me as a person, and made me feel very comfortable."

Prof Balfour Mount: *"The person I'm seeing who has advanced cancer, who frequently is experiencing very severe symptoms... if she's upset or anxious or anguished, her symptoms are out of control. And by the time we'd been talking and chatting and I had been listening and we had been interacting and I'd been learning from her, she said "It's just the strangest thing: the headache is gone. And my fingers, my legs... don't pain anymore".*

Roslyn Saxe: *"And that went on for 2 years where a lot of healing took place.*

What astonishing humility: "I had been listening... and I'd been learning from her!"

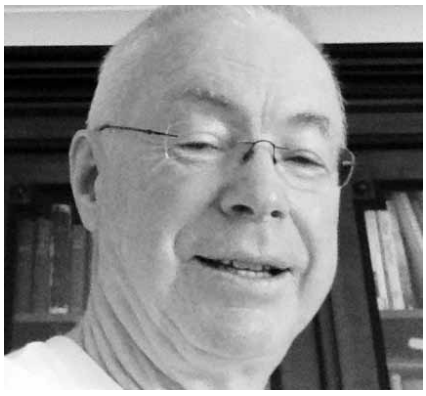
How do we teach ourselves, colleagues and medical students to utilise the immense healing power (including the analgesic potential) of the therapeutic relationship?

Teaching and administration as spiritual gifts?

In the development of palliative care, Australia has been blessed with many excellent, wise physicians. In the 1980s and 1990s there was an appreciation of the need for certification and standards. Palliative medicine was viewed with some scepticism and needed energetic, gifted champions to ensure that it developed as a credible

Prof Norelle Lickiss. Photo: http://aphn.org/

"...pain control in palliative care requires a comprehensive, multidisciplinary approach. The relief of total pain requires a total solution, including physical, psychological, social and spiritual elements."



Prof Peter Ravenscroft. Photo: www.researchgate.net

specialty. **Professors Norelle Lickiss and Peter Ravenscroft** were at the forefront of this journey towards academic recognition. In response to the persistent efforts of these two outstanding leaders, the Royal Australasian College of Physicians eventually agreed to recognise

continued over page >>>

palliative medicine as a separate specialty. Over a period of more than 10 years, an advanced training program was devised, and eventually, in 2000, a separate Chapter of Palliative Medicine was established within the College.

Most doctors are attracted to medicine for humanitarian reasons. Few enjoy administration. However, being in a position of authority provides the opportunity for setting standards. The committee who wrote the curriculum for advanced training in palliative medicine recognised that spiritual issues become more important as patients face the end of life. They therefore required that advanced trainees demonstrate competence in addressing the patient's spiritual needs.

Although this was clearly documented in the curriculum, for twenty years no attempt was made to teach trainees, or assess their ability to meet the requirements. Finally, this year, the RACP established a Spirituality Training Working Party, charged with developing a training module in this challenging area.

The terminology is difficult and imprecise. We may speak of spiritual distress, terminal anguish, an existential crisis, or simply of agitation. What is undoubted is that such distress increases pain, and increasing the dose of opioid medications is unlikely to solve the problem.

In conclusion, pain control in palliative care requires a comprehensive, multidisciplinary approach. The relief of total pain requires a total solution, including physical, psychological, social and spiritual elements. But even with the world's best practice, we will not be able to eradicate all pain and suffering. That final solution belongs to the next world. As the ageing apostle John recorded in his apocalyptic vision, *"He will wipe away every tear from their eyes, and death will not exist any more – or mourning, or crying, or pain"*. Rev 21: 4 ●

Editor's note: For more information on the practicalities of addressing spirituality in clinical practice, and of Doug's work in Palliative care, please see:
Ravenscroft, P. Bringing Spirituality into Clinical Practice. *Luke's Journal of Christian Medicine and Dentistry*, p20, Vol 22, No. 2, September, 2017
Bridge, D. Dying Healed: A Source of Hope. *Luke's Journal of Christian Medicine and Dentistry*, p52, Vol21, No. 3, December 2016.
View *Luke's Journal* at www.issuu.com

Dr Doug Bridge

Doug is married with three sons. After training as a general physician and in tropical medicine, he lived for two years in a Bangladeshi village. Upon returning to Perth in 1979, he helped pioneer the development of Palliative Care in Australia and Asia. He was the Head of the Palliative Care Service at Royal Perth Hospital 1993-2013. He is a Clinical Professor of the School of Medicine and Pharmacology, University of Western Australia. He was the President of the Australasian Chapter of Palliative Medicine 2014 to 2016. His special interest is the psychospiritual challenges of dying.

Bullying in Medicine

"I have told you these things, so that in me you may have peace. In this world you will have trouble. But take heart! I have overcome the world." John 16:33 NIV

I confess that the words "Christian persecution" brought to mind images of gladiators in big arenas , or of being held at gunpoint for professing to be a follower of Christ.

I know that this is still a reality for some, but for many of us the wolf is very much in sheep's clothing. The Bible says we will face trials of many kinds. Just as our Lord and saviour suffered, so may we, and we are instructed to "Be on your guard" and expect it.

I admit I thought I was too old to be bullied. I expected after my years in medicine and in life that behaviour like that didn't exist anymore and was left behind in high school. Even if it did exist, I thought I would have the self-confidence and maturity to withstand it.

I wasn't armoured.

I wasn't ready.

"Finally, be strong in the Lord and in his mighty power. Put on the full armor of God, so that you can take your stand against the devil's schemes." Ephesians 6:10

There is a song by Casting Crowns called *Slow Fade*. It talks about how when people fall away from Christ it is rarely an overnight process, but a gradual accumulation of little, seemingly meaningless, decisions and events.

That was what bullying was like for me.

Every time I was knocked down I would get up thinking I needed to try harder. Slowly I became more and more isolated and withdrawn.

Staying later and later, working weekends and missing church, only taking breaks to sleep and get up and do it all again.

The longer I spent in that environment, the more I believed I was everything they accused me of being. I believed lies I would have laughed at and dismissed only weeks earlier.

I was in a new place isolated by work and location. I was drowning and I couldn't understand why I couldn't make things work.

"At night I would... pray that God in his mercy would take me to be with him so that I didn't have to face one more day in that place."

As the bullying got worse I would hang my head and wait for the pain to be over. I would let them yell, accuse and embarrass me, often loudly and very publicly. I refused to be who they wanted me to be. It felt like my spirit was only a flicker, but with whatever I had left, I chose to hold on to my God and not compromise. It meant the pain continued and people awkwardly watched and continued on their way not wanting to be involved.

At night I would fall into bed and pray that God in his mercy would take me to be with him so that I didn't have to face one more day in that place.

Thankfully, he didn't answer my prayer. Instead, he blessed me with beautiful friends and family that reminded me of who I am in Christ.

Even though I felt lost, God knew exactly where I was and what his plans were for me. Not only did I have family and friends, I had a mentor through the CMDFA who regularly prayed with me and for me. I had nothing left, and it meant everything to have someone pray with me and read the Bible to me when my strength was fading.

Our Lord warns us that this life may not be easy, but he also promises he will never leave us nor forsake us. We may face trials, but we never face them alone.

"And surely I am with you always, to the very end of the age." Matthew 28:20 NIV

I'd like to encourage each one of us to stay anchored to Christ, not only for our own sakes, but so that we also may have courage to stand firm and stand up for our colleagues who may be being bullied.

You may never face a firing squad for your faith or run for your life in an arena, but I put it to you that every time we are doing what God calls us to do and be where he calls us to be we need to be prepared that we may face opposition.

That is our persecution.

"We are hard pressed on every side, but not crushed; perplexed, but not in despair; persecuted, but not abandoned; struck down, but not destroyed."2 Corinthians 4:8

So do not give up meeting together. I know work schedules sometimes mean working on Sundays happens all too often. Can I challenge you to make it a priority to support one another and remind each other of the hope we have? Even if it is a prayer over the phone or a cup of tea.

May God direct your hearts in God's love and Christ's perseverance.

Peace be with you xx ●

Anonymous
Article written by a doctor in training.

The person and the field

– exploring the life and contribution of Cicely Saunders

The words "palliative care" have a ready acceptance both in the medical and lay conversation around death and dying. The strong recognition of this term is deeply indebted to Dame Cicely Saunders. In an era of incredible advances in biomedical care and, indeed, life expectancy, Dr Saunders defined and articulated a vision around the dying process in our context which is making a telling contribution to the craft and reputation of medical care. Dr Peter Whan is a Christian doctor who is working toward a PHD in palliative care studies at Prince Charles Hospital in Brisbane. His following material is taken from the introduction to his discourse. It is enriching to hear a story like this.

Although others in recent centuries have been involved in, or have written about, the care of dying people, Cicely Saunders was the first doctor of our times to devote the whole of her clinical, administrative and scholarly work to such care.

Dame Cicely Saunders.
Photo: St. Christopher's Hospice, London

She was suited to her role as founder of this kind of care by her experience as lay carer for dying friends and relatives, combined with her training and experience as a formal carer, not only as a professional in the fields of nursing, allied health (medical social work) and medicine, but also as a volunteer. Her experience as a para-professional support worker (medical secretary) was also of benefit.

She was also suited by the qualities of her personality. As the British newspaper the *Telegraph* noted in its obituary, "Though she was widely revered as a sort of secular saint, it was only through being tough and authoritative, and often downright difficult, that she succeeded in forcing the medical profession to acknowledge what medicine can do for the dying."

Born Cicely Mary Strode Saunders in Barnet, Hertfordshire, on 22nd June 1918, the shy and gawky eldest child of a well-to-do estate agent, her childhood and school years at Roedean were unhappy. She began studying Politics, Philosophy and Economics at Oxford, but left to study nursing after the outbreak of war. Having excelled in her studies during her training at St Thomas's Nightingale School of Nursing, and gained in social confidence, she was unable to continue in this profession due to a long-standing back problem.

She then returned to Oxford and gained a war degree and a Diploma in Public and Social Administration.

In 1945, the same year which saw the break-up of her parents' unhappy marriage, she had a dramatic change of spiritual outlook, exchanging her long-held agnosticism for an actively evangelical Christianity. (This was a position from which she later moved, adopting a more ecumenical approach).[1] She then trained as a lady almoner (medical social worker) and began working for the Northcote Trust, based at St Thomas's Hospital.

In 1947 she became involved in the care of David Tasma, a Polish Jew dying of rectal cancer. They had a brief, loving friendship during which they discussed her thoughts about how she wished to spend her life in the service of suffering people, perhaps involving the creation of a "home" for people in David's situation. He left her £500 in his will, having said, "I'll be a window in your home". She continued to work as a lady almoner, and began to work one evening per week as a volunteer registered nurse at St Luke's Hospital, Bayswater, where she observed the beneficial effect of regular administration of opioids.

At the same time, she began to work part-time as a medical secretary for the thoracic surgeon Norman Barrett, one of the doctors whose patients she assisted in her social work role. When she confided to him that she was considering a return to nursing to care for people dying in pain, he responded, "Go and read medicine, it's the doctors who desert the dying and there's so much more to be learnt about pain. You will only be frustrated if you don't do it properly and they won't listen to you." She thus returned once more to St Thomas's, this time as a medical student, and graduated in 1957.

Her special interest had not waned and, through a tennis acquaintance of her father, she gained a clinical research fellowship in the Department of Pharmacology at St Mary's Hospital Medical School. During this time she was based at St Joseph's Hospice in Hackney where she put the principles she had observed at St Luke's into practice, to the initial concern (but rapid delight) of the nuns in charge. She then experienced another close, loving relationship with a Polish man, Antoni Michniewicz. Grief at his death in St Joseph's in 1960, as well as the deaths in 1961 of "Mrs G", a beloved friend and patient, and her own father, almost overwhelmed her, but also intensified her sense of purpose.

She persevered in her project to create an environment where not only care, but also teaching and research related to the physical, psychological, social and spiritual needs (the "total pain"), of dying people and their families could be provided. She used networks of religious, social, family and professional contacts to pursue this goal and began to disseminate her ideas. This included lecture tours to the US in 1963, 1965 and 1966, as well as presentations in conferences and lectures in Europe and the UK, together with letters and articles in journals, and compact books. The project progressed with the purchase of land, the construction of a building, the provision of capital and recurrent funding from various sources, including the National Health Service, and culminated in the opening of St Christopher's Hospice in July 1967. Cicely Saunders was the founding medical director, in which position she served until she became Chairman (sic) in 1985, and then President / Founder in 2000.

In 1980, following the death of his estranged wife in Poland, she married the émigré Polish painter Marian Bohusz-Sysko, whom she had first met in 1963. She received many civil, professional and public honours, degrees and awards, including the OBE in 1967, DBE in 1980, and OM in 1989, and fellowships of the Royal Colleges of Medicine, Nursing, and Surgeons. Her husband died in St Christopher's in 1995 aged 92, and after being diagnosed with breast cancer in 2002, she also died in the hospice she had founded, on 14 July 2005, aged 87.

The field

For many people, "palliative care" is a term shrouded in a cloak of mystery and misunderstanding. This is ironic because the word "palliative" comes from the Latin word *pallium*, meaning a cloak, and a palliative measure is one designed to cloak, or cover, disagreeable realities. Unless their lives have been touched by it, few people understand that palliative care aims to relieve, as far as possible, whatever makes far-advanced, progressive, life-shortening illness distressing. This brief introduction is designed to assist any reader unfamiliar with the area to gain a better appreciation of the research reported in this thesis, by drawing aside the cloak of unawareness that often shields palliative care from a more extensive perception and understanding.

As the ideology of high modernism became increasingly dominant in health work during the early and middle portions of the twentieth century, increasing emphasis was placed on the technical rather than the personal. Although this meant that a number of previously intractable illnesses could be treated, many people still came to a point where serious illness caused suffering, cure was not an option, and there was significantly shorter time for them to live than previously hoped or expected. To a large degree, the very success of positivist health science was responsible for many such situations. On the one hand, a person's biological existence could be (and frequently was) extended beyond the time when they enjoyed psychological, social and spiritual well-being. On the other hand, many interventions (including the settings and means in and by which they were delivered) militated directly against such well-being, producing significant suffering even if they prolonged life.

Thus there was a depth of dissatisfaction with the care being provided even in the most impressive temples of modernist medicine, and many of those caught up in such situations, whether as patients, family, community members or health workers, realised that a fresh approach was needed. Two strong-minded women in particular challenged the predominant ethos and began to change the way dying people and their families were cared for. Cicely Saunders in the UK, and Elisabeth Kübler-Ross in the US believed passionately that there was value in spending time and effort in being with such people, learning from them, reflecting on the issues that faced them, and working to change the ways in which care was given to them. The work of these women and other pioneers resulted in the emergence during the final third of the century of a distinctive cluster of initiatives related to people affected by mortal illness. These thoughtful and purposive approaches to *being* and *acting* with and for dying people, their families, and the communities in which they live, [14] were initially known as hospice, hospice care or the hospice movement, but now also bear the name palliative care. They have several characteristic features:

- The "unit" for whom person-to-person care is provided includes both:
  - the *patient* whose mortal illness gives rise to the need for care , and
  - those who function as the patient's *family*. This includes those who are significant to, and/or close carers of the patient, because of a biological relationship, formal commitment, or friendship.

continued over page >>>

"She persevered in her project to create an environment where not only care, but also teaching and research related to the physical, psychological, social and spiritual needs (the "total pain"), of dying people and their families could be provided."

- Care is provided to meet psychological, social and spiritual, as well as biological needs.

- Death is acknowledged as a normal part of human life, and care is focussed on maximising comfort, capability and dignity. That is, the aim is to *heal* (bring wholeness to) those affected rather than to *cure* the underlying disease.

- Care is offered once it is clear that the patient's illness is life-shortening, and this continues after their death, as support is provided to family members in their bereavement.

- Care is flexible, provided at whatever location best meets the needs of patients and their families, by multi-professional teams whose members draw on each other's insights and skills.

It is probably true that no single feature from the above list is unique to Palliative Care. As an anonymous writer stated in the sixteenth century, the aim of health care should be: "to cure sometimes" and "to relieve often", but "to comfort always". However, in combination, the above features represent a unique approach to the nurture of human life and its potential. The motivation for providing such care is usually expressed in terms of respect accorded to the unique value and dignity of every human being. This is sometimes, but certainly not always, articulated within the framework of specific religious belief. Cicely Saunders' words summarise such aims and motivation.

> *You matter because you are you,*
> *and you matter to the last moment of your life.*
> *We will do all we can, not only to help you die peacefully,*
> *but also to live until you die.* ●

References:
1. For the sake of clarity and candour I believe at this point I should state that my own spiritual convictions are those of evangelical Christianity. I trust that I have been able to maintain an attitude of deep respect and admiration for the personal qualities and extraordinary achievements of someone with whom I expect I would have disagreed on some issues.
2. Or rather, "strong poets", to use the term appropriated by Richard Rorty from Harold Bloom.
3. This is a person who has a progressive, life-shortening illness, usually with a life expectancy measured in weeks or months. Most palliative care patients have far-advanced cancer. However, some have other illnesses such as far-advanced heart, lung, or kidney failure. Most are older people, but palliative care is provided for people of all ages.

Other references??

2. du Boulay S. Cicely Saunders: The Founder of the Modern Hospice Movement. London: Hodder and Stoughton; 1984.
3. Dame Cicely Saunders [Obituary]. The Times 2005 15 July.
4. Dame Cicely Saunders, OM [Obituary]. The Telegraph 2005 18 July.
5. Richmond C. Dame Cicely Saunders: Founder of the Modern Hospice Movement [Obituary]. The Independent 2005 15 July.
6. Saxon W. Cicely Saunders Dies at 87; Reshaped End-of-Life Care [Obituary]. The New York Times 2005 31 July.
7. Richmond C. Dame Cicely Saunders: Founder of the Modern Hospice Movement [Obituary]. BMJ 2005;331:238.
8. Oransky I. Dame Cicely Mary Strode Saunders [Obituary]. Lancet 2005;366(9486):628.
9. Hanks G, Forbes K. Dame Cicely Saunders, OM, DBE, FRCP, FRCN [Obituary]. Pain 2005;118(3):283-4.
10. Shotter EF. Dame Cicely Saunders [Obituary]. J Med Ethics 2006;32:309.
11. Doyle D. Tributes to Dame Cicely Saunders. International Association for Hospice and Palliative Care; 2005 <Accessed July 2007>; Available at: http://www.hospicecare.com/newsletter2005/aug05/cicely-saunders.html
12. Twycross RG. A Tribute to Dame Cicely Saunders - Given at the Memorial Service in Westminster Abbey on 8 March 2006. International Observatory on End of Life Care; 2006 <Accessed July 2007>; Available at: http://eolc-observatory.net/history/cicely.htm
13. Getz F. Medicine in the English Middle Ages. Princeton, NJ: Princeton University Press; 1998.
14. Kellehear A. Health Promoting Palliative Care. 1st ed. Melbourne: Oxford University Press; 1999.

Dr Peter Whan

Peter is a Christian doctor who is working toward a PHD in palliative care studies at Prince Charles Hospital in Brisbane.

Pain through a Cultural Lens

Ram, 35 years old, has a spinal cord injury following a fall from a tree three months ago. Sita, 58 years old, has residual leprosy-related disability affecting her hands and feet, and significantly reduced sensation. Both are currently inpatients, who complete a survey questionnaire admitting to experiencing severe pain, rated at 8/10, with impact of pain on sleep, mood and daily activities rated at 8 or 9/10 for each domain. Neither has mentioned pain as a problem to the nurses or doctors. Why not?

Elderly Nepalese woman taking care her cow. *Photo: Dreamstime.*

Brennan et al[1] review pain management and quote research that up to 1:4 adults and 1:2 of those over 65 years old suffer from chronic pain. Differences in chronic pain processing and impact are multidimensional and include pathophysiology, individual neuroregulation and socio-cultural factors. The range of physiological and psychological costs add considerable economic and social burden across the world. Pain management is an important aspect of health care and has been flagged as a fundamental human right by Human Rights Watch.[2,3]

Religious cultures

In Nepal and many Asian countries, culture is strongly religious, and religious practices are deeply rooted and intertwined with all significant community and family events. Nepal has ethnic and cultural ties with India. It is predominantly Hindu and Hindu-Buddhist thought pervades all areas of life.

In a 2014 review of research literature to better understand the effect of cultural experiences on chronic pain perception, Pillay et al[4] define culture as an "enduring pattern" consisting of perceptions, structures and beliefs that are stable across various contexts, OR the assemblage of "received knowledge" enabling groups to make sense of their experience and direct their behaviours. Cultural resources provide frameworks of meaning or culturally-based strategies for patients coping with chronic pain.

"...older Nepalis, especially in rural areas, have no concept of "retirement" as in the West. The expectation is to keep mobile..."

Cultural influences are noted to be stronger in the elderly.[5] Interestingly, older Nepalis, especially in rural areas, have no concept of "retirement" as in the West. The expectation is to keep mobile, keep tending food production in the garden or fields and even to sit on the floor. In a recent survey in a rural area we heard, "If I stop working, I will die," and this is probably a common attitude. This encourages older people to maintain purpose and mobility longer, and is a positive cultural resource.

Whitman (2007)[6] reviewed the major concepts of Hinduism related to pain and suffering and highlights acceptance as both a central concept in Hinduism and an approach that has been studied in the pain literature. She notes similarities between acceptance-based strategies and the equanimity and detachment desired in Hindu thought, where suffering is accepted and perceived as a just and natural consequence of past action and is not only regarded in negative terms.

Acceptance theory in pain medicine

McCracken (2004)[7] suggests that pain control is useful when achieved and when it leads to better overall long-term functioning for the patient. However, if efforts to control pain dominate, the quality of living may be sacrificed. Paradoxically, efforts to control emotions, thoughts and sensations can decrease pain tolerance thus increasing pain experience. Excessive

continued over page >>>

avoidance of chronic pain is associated with greater suffering and disability. McCracken argues that acceptance theory plus change are a more helpful approach than control-based strategies (reducing problematic thoughts, feelings, experiences). He defines acceptance of chronic pain as "an active willingness to engage in meaningful activities in life regardless of pain-related sensations, thoughts, and other related feelings that might otherwise hinder that engagement. It is about not engaging in unnecessary struggles with private experiences, struggles that often intensify the aversiveness of those experiences and enhance their life disrupting influences". (p4)

Chronic pain in Nepal

Chronic pain is a significant problem in Nepal and other Asian cultures. One Indian study[8] looking at 50 pain and palliative care patients in one district of Kerala, found pain was the predominant physical symptom. Benefits of the palliative service included considerable reduction in pain levels which earlier had been unbearable, and in the maintenance and strengthening of hope.

In a clinical audit of pain experienced by 95 leprosy-affected (LA) and 41 spinal cord injury (SCI) patients undertaken in a mission hospital in Western Nepal[9], we found 82% LA and 98% SCI had experienced pain in the past week, with 52% LA and 76% SCI suffering more than one pain. Moderate-to-severe pain was experienced by 67% LA and 83% SCI. There was a moderate-to-severe impact of pain on sleep in 75% and 48%, on mood in 85% and 70% and in activities of daily living in 90% and 60% of LA and SCI patients respectively. These results suggested cultural factors might be leading to the under-reporting of chronic pain experience of patients in Western Nepal. In focus groups, reasons for under-reporting included:

- being told previously to expect pain and therefore not complaining even when the pain was significantly impacting their quality of life; and
- pain and suffering were not only regarded negatively – they could potentially deepen a spiritual journey.

Patients, however, were happy to accept appropriate pain medications when offered. This highlights the need to ask patients and families not only about their pain experience, but also the meaning and impact of that pain.

Nepali Cultural Beliefs impacting Pain Experience

Acceptance

Acceptance has roots in beliefs about karma – that pain and suffering in the present is a natural outworking of consequences of past sins or failures. With acceptance of pain and suffering, people show stoicism about enduring symptoms or problems without complaining.

> **"The 'western' concept of autonomy is not usual in Nepal where decision-making is communal."**

Punishment

Pain and suffering can sometimes be perceived as a direct punishment from God or higher powers, so the powers need to be appeased.

High view of spiritual healing

Traditionally, Hindu holy men have had a key role in healing by appeasing spirits which are understood to be causing the suffering.

The church in Nepal has just celebrated 65 years, and in this short time there has been considerable growth. Many Nepalis have come to faith through healing or miraculous experiences, either of themselves or a family member. Prayer for healing is an integral part of Christian communal life – within regular services, small home groups and other fellowship meetings – as people regularly bring their various illnesses and ailments to the Lord, expecting His grace and power. People ask for prayer before seeking medical help, and expect the leaders and church community to visit and actively pray for members who are in hospital. Mission hospitals can have a significant witness to the healing love of Jesus.

Holistic Care and Cultural Impact

Health Expectations:

With previous high incidence of infectious diseases, surgical conditions and maternal and child health issues, outcomes from short-term medicine or surgery generally resulted in either cure or death. Nepal is undergoing a transition as people live longer – those over 65 years old increased from 4% to 6% of the population in the seven years prior to 2011.[10,11] As multimorbidity increases from a rise in non-communicable diseases, compliance with medication can be an issue, as people need lifelong medication without cure of the underlying disease.

Indirect patterns of communication:

The purpose of communication in Nepal is culturally based around relationships rather than transfer of information. To honour another person (especially if perceived as more important), the best answer is what you think the other wants to hear, rather than information that might disappoint. Finding out whether a patient is taking medication you have suggested, or whether there were associated side-effects or problems can be challenging. Initial simple answers are usually not the real story.

Patients can expect doctors to discern their history (as a spiritual healer would know) without them needing to offer this information. So in pain management it is particularly important for the clinician to ask direct questions about pain. The routine use of pain scores and promoting pain as the 5th vital sign can facilitate this process.

Communal or hierarchical decision-making:

The 'western' concept of autonomy is not usual in Nepal where decision-making is communal. It is normal for the patient to leave the consulting room while the doctor discusses diagnosis, treatment and prognosis with the family. A patient may therefore not know details of their condition or treatment options, but expects the family to know and make the best decisions. If the patient is first asked if they want to be involved in

discussions, the principles of autonomy can still be met but in culturally-acceptable ways.

Caring for people with chronic conditions including pain management requires building trust and moving toward a direct relationship with the patient, whilst simultaneously appreciating that in Nepal, family involvement will still be central. Communication skills are vital, and holistic (physical, psychosocial and spiritual), person-centred care has the potential to be transformative, leading to compassionate and excellent care.

Conclusion

Cultural influences and norms have a significant impact on chronic pain management. In the Nepali context, this can be both a positive resource (when linked with acceptance and getting on with a meaningful and active life), but also negative (if this view prevents the person looking for other simple physical resources that would improve their quality of life). Spiritual resources are a very significant element in religiously-based cultures like Nepal. ●

References:

1. Brennan F, Carr DB, Cousins M. Pain management: A fundamental human right. *Anesth Analg*. 2007. doi:10.1213/01.ane.0000268145.52345.55.
2. Brennan F, Carr D, Cousins M. Access to pain management-still very much a human right. Pain Med (United States). 2016. doi:10.1093/pm/pnw222.
3. Human Rights Watch. *"Please, Do Not Make Us Suffer Any More ...": Access to Pain Treatment as a Human Right*; 2009. https://www.hrw.org/sites/default/files/reports/health0309web_1.pdf.
4. Thivian Pillaya Hendrik Adriaan vanZylb DavidBlackbeardc. Chronic Pain Perception and Cultural Experience. 2014. https://doi.org/10.1016/j.sbspro.2014.01.022.
5. Sakauye K. Cultural influences on pain management in the elderly. *Compr Ther*. 2005;31(1):78-82. doi:10.1385/COMP:31:1:078.
6. Whitman SM. Pain and Suffering as Viewed by the Hindu Religion. *J Pain*. 2007. doi:10.1016/j.jpain.2007.02.430.
7. McCracken LM, Carson JW, Eccleston C, Keefe F J. Acceptance and change in the context of chronic pain. *Pain*. 2004;109(1-2):4-7. doi:10.1016/j.pain.2004.02.006.
8. Santha S. Impact of pain and palliative care services on patients. *Indian J Palliat Care*. 2011. doi:10.4103/0973-1075.78446.
9. Powys R. Audit of pain incidence and impact on QOL at GPHRC, Nepal. In: *23rd International Congress of the Indian Association for Palliative Care, Pune*, India. ; 2016.
10. Mishra SR, Neupane D, Bhandari PM, Khanal V, Kallestrup P. Burgeoning burden of non-communicable diseases in Nepal: a scoping review. *Global Health*. 2015;11(1):32. doi:10.1186/s12992-015-0119-7.
11. Munday D, Powys R. Reflections on the challenges and opportunities for palliative care in Nepal. *Christ J Glob Heal*. 2017;4(3). http://journal.cjgh.org/index.php/cjgh/article/view/194/445.

Dr Ruth Powys

Ruth graduated from Melbourne University in 1980 and is a palliative care specialist. With her husband Gordon, over the past 35 years, they have spent more than 15 years in various parts of Nepal, sent by CMS Australia. They are currently seconded to work with International Nepal Fellowship (INF), based in Pokhara, Western Nepal.

Blinding Pain

This article is written by John Mark, CEO of Newcastle's Christian radio station 99.7 "Rhema FM", who has just celebrated 25 years service in Christian Ministry with Rhema FM. He is not only an administrator in his role, but has also been a broadcaster for the past 25 years. This article is from John's experiences after a traumatic road accident.

Most people, when they meet or see someone with chronic neck/ headache pain, are not necessarily aware that this person is suffering in some way.

There may be no obvious signs. On the outside, they can look well, but underneath the façade that chronic neck pain sufferers sometimes 'put on', often lies a very different reality. In many ways, chronic neck and headache pain is not only silent, it is sometimes invisible to those around us, until they learn or are told about it. It is quite hard for people to grasp or understand how you're feeling, given they cannot see any physical signs. Sometimes chronic neck/headache pain can be seen in the eyes of the sufferer, or in their movements, sometimes revealing a small glimpse of what's really going on.

All too often people will say to me "But you look so well – I had no idea!" Or they might say, "You never told me." As a sufferer, it's not that I am attempting to cover up my chronic pain. However, I get tired of telling the 'story', and so I often say nothing. Is this good or bad? That's a good question!

On 25th March, 2004, whilst driving to work, I entered an intersection with the green traffic lights in my favour. What happened next was more shocking to experience than anything I'd ever heard about in the media regarding head-on car collisions. This time it was me.

Another vehicle, travelling in the opposite direction, made a sudden right-hand turn directly in front of me, ignoring the red no-turn traffic signal, The result was a combined 80 km/h head-on collision, that saw my 4-wheel drive (no airbags) stop in less than one metre. The force of the impact was so great that the spectacles I wore at the time came off, hitting the windscreen and ending up on the passenger seat floor. The whiplash was like nothing I had ever experienced. At impact, everything went slow, but in an instant it also went horrendously fast in forward motion. I was in neck, chest and back pain and I was taken by ambulance to hospital in a neck brace.

"Doctor, here's what I want, I want my 'life' back. And so does my wife and children. That's what I want."

X-rays were carried out on my neck but showed nothing. X-rays revealed I had a fractured sternum. No X-rays were carried out on my lower back. Eventually, I returned to work, but the neck and headache pain continued. Visits to my GP resulted in prescriptions for painkillers in the hope I would get over the whiplash pain. I didn't.

It would be almost two-and-a-half years after the accident till there would be any improvement. During this time, my pain continued to get worse, with heavier reliance on painkillers and severe neck and headache pain that was almost blinding.

My insurers (Workers Compensation) didn't believe there was anything wrong with me and sent me to their own specialists, whose aim, it appeared, was to discredit me. One such specialist (acting for the insurers) said "What is it you really want, Mr. Marks, how much?" I responded, "Doctor, here's what I want, I want my 'life' back. And so does my wife and children. That's what I want."

In complete frustration, and with my GP's agreement, I arranged for my own MRI to be done. It revealed that I had had wedge fractures in my thoracic spine at T2 and T3 as a result of the severe whiplash experienced in the car accident. The insurers panicked, and immediately ordered I be sent out of the region for another 'independent' MRI. The result was identical to the findings of the first. My case was finally accepted and liability admitted. Only then did treatment begin for my accident.

I was referred by my GP to Dr Anthony Schwarzer – pain specialist in Newcastle. This proved to be the best thing my GP ever did. At first, it was a case of conducting 'block' injections of cortisone to identify what would block my pain, at what joint. It was a carefully planned strategy to identify what worked and what didn't, with only temporary relief achieved.

Finally, radiofrequency neurotomies (RFs) were performed to burn away damaged nerve endings growing in all the wrong places and the joints. The RFs burn each nerve that supplies the joint – one or two per joint. It took some experimentation with the RFs before a combination was found that worked. The pain specialist did multiple burns to ensure he captured the whole nerve. Basically, the pain message from the damaged joint and surrounding soft tissue is blocked, even though the damage remains. There is no cure for the actual damage.

At first the RFs lasted from three to six months, with pain relief treatment on one side of the neck only. Later, it would be discovered there was a need to conduct an RF on the other side as well. Then success was achieved, with longer periods now occurring between RF procedures. Now I only need RF procedures on both sides of my neck once a year or thereabouts. My personal recovery from the RFs often takes five to six weeks. I know someone else with similar injuries, and he recovers much faster. Neck and head pain like this is a personal and individual issue.

What significantly and positively impacted my recovery on a much faster basis (post-procedure) was my request for physio treatment to aid with neck stiffness after the RFs. Over the years I have been to various physiotherapists with some success. At other times I have tried massage therapists and even an osteopath, with little or limited relief. However, thanks to my pain specialist, I was referred to Damien Cummins, a physiotherapist who specialises in neck pain. His ability to understand and quickly grasp the impact of my injuries and to implement the best treatment plan was remarkable.

At last, after so many years, I had a pain specialist who understood and could act to relieve my neck and headache pain through RF procedures that returned me to almost normal levels of pain. This, in combination with a post-procedure physio who understood what RFs were about, and who worked in liaison with my pain specialist, achieved good results. All of this has kept me working and given me a relatively normal life with my family.

Someone once asked me, "Why would God let this to happen to you? Where was His protection in all this?" My answer is, "I may never know the answer to this whilst on this earth. However, what I do know, is that on that day I could have died, but I didn't. All these long years since that accident, I've never known what was going to happen next, until it unfolded before my eyes. It was like the best 'care' for me was all orchestrated without me even knowing. I was led, guided and directed into 'hands' that could help and care for me.

For this I thank my GP, Dr Ken Lambert, my pain specialist, Dr Anthony Schwarzer, and my physiotherapist, Damien Cummins. Also, my wife, Kay, and children, to whom I owe a great debt of gratitude. Finally, to God for His grace and mercy, that I'm still here alive and well (well almost). One day, my miracle will come, when I live in no more pain. All that is required for this, on my part, is faith, belief and trust. ●

John Mark
CEO of Newcastle's Christian radio station 99.7 "Rhema FM"

Seeking Volunteer Editors

Do you have writing, editing, blogging, or IT skills?

Luke's Journal is seeking committed Christians to help the editorial team in:

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

If you are interested or would like to discuss the role further, please contact Catherine Hollier (editor) at: **LukesJournalCMDFA@gmail.com**

Erratum

Luke's Journal would like to apologise to Dr Denise Cooper and Dr Catherine Hollier. Denise Cooper's article "Hot Buttons and Cool Reason" (*Luke's Journal* Standing Together in the Public Square, Nov 2015) was wrongly attributed to Dr Catherine Hollier.

A Light Momentary Affliction

Living with Chronic Pain

I was 10 hours into my usual 12-hour shift as a paediatric registrar at Gosford Hospital when the pain started. An unfamiliar, dull, 6/10 ache in my left precordium developed as I washed my hands after assessing a febrile neonate. Matter-of-factly I said to my resident: "I have chest pain", to which she questioned with similar matter-of-factness: "Is it muscular-skeletal?" "Probably." And we resumed working.

It was not muscular-skeletal. It was pericarditis and marked the beginning of many years of daily chest pain. It was the first clue to my diagnosis 9 months later, of the "great pretender": systemic lupus erythematosus. Since then, lupus has ravaged at least one new body system each year. I experience ongoing pericardial pain, pleurisy, mouth ulcers, arthritis, focal headaches and stroke-like symptoms from cerebritis, neuropathic pain from thoracic myelitis, heat intolerance from an autonomic neuropathy, bladder dysfunction, poor vision from optic neuritis, burning and tingling from peripheral nerve involvement, and numerous side effects from the 20 medications I am currently on. The various pains are all made worse with exertion. At times I cannot walk more than 10 metres without pain and have spent many months housebound. In the past 7½ years, I have had fewer than a week's worth of pain-free days in total.

What It's Like

For me, the physical sensation of pain is relatively bearable. What I find the hardest is my anxiety about the implications of pain: Could I have a PE? Do I need to go to hospital? Does this mean that my lupus is out of control? Do I need to increase my steroid dose again? Do I need to cancel my plans? Will this mean I can never have children? Why would God allow this pain? What if this pain never goes away? And the most unsettling thought being: *Is this all in my head?*

C.S Lewis said: *"Pain insists upon being attended to. God whispers to us in our pleasures, speaks in our consciences, but shouts in our pains. It is his megaphone to rouse a deaf world."* God has certainly used pain to awaken me, but I wonder if it is not so much God who has adjusted His volume up, but rather my stubbornness in listening to Him. Before lupus, I had let the inviting soundtrack of the world drown out God's voice. Then, as the helplessness of pain shattered the illusion that what I had was of my own making, it was as if this music was turned off and I could start to hear God again. Chronic pain is akin to the unpleasant experience of having years of accumulated earwax syringed so that I can hear God who has been speaking to me all along clearer still. There are other times when pain can be so consuming that it feels like our senses are numbed. However, the anguish also presents a unique opportunity to choose where we seek comfort. Will we look for it in success, acceptance, relationships, food or entertainment? Or will we run to the God of all comfort (2 Cor 1:3) who speaks to us with compassion, grace, love, patience and peace?

When the Apostle Paul wrestled with physical affliction, he saw that God used it to keep him from being conceited. Chronic pericarditis feels very much like a 'thorn' in my flesh, and like Paul, I have pleaded with God to heal me from lupus (although many more than 3 times!). God has given me the same answer: "My grace is sufficient for you, for my power is made perfect in weakness." (2 Cor 12:7-9) Pain and the limitations that come with it demolish my delusions of strength and self-sufficiency. It forces me to see my dependence on our dependable God. Although God never delights in our pain, it is by His grace that He allows us to suffer momentarily in this life to shift our hope from present things to the riches of eternity with our Saviour.

"Chronic pain is akin to the unpleasant experience of having years of accumulated earwax syringed so that I can hear God who has been speaking to me all along clearer still."

What I've Tried

God has provided a plethora of ways to relieve pain – some more helpful than others in different situations. Among them I have tried paracetamol, ibuprofen, codeine, oxycodone, fentanyl patches, amitriptyline, pregabalin, mindfulness, meditation, psychology, psychiatry, immersion therapy, heat, ice, physiotherapy, exercise physiology, pilates, massage, acupuncture, turmeric, magnesium, Manuka honey, different diets, Netflix, comfort eating, prayer for healing, Scripture, study, reading books on suffering, a range of immune-modulators to treat the underlying disease process of lupus, and I have seen 6 different neurologists.

What Has Worked:

Addressing My Heart with Scripture

What has made the greatest impact on my experience of chronic pain is a deepening in my personal relationship with God through the study of biblical counselling. Biblical counselling is simply connecting the truths of Scripture to life, so that we grow in our love for God and others, by the power of the Holy Spirit within us. This has helped to address my anxiety surrounding the experience of pain as I look at what is happening in my heart towards God. What do I fear when I am in pain? How does that fear impact my relationship with others? What does Scripture say about my fear and pain? What does it look like to trust God with my fears? How can the Psalms help in providing the words with which to cry out to God in the midst of pain? What does it look like to honour God when I'm in pain? How does that impact the way I treat others? When I am in pain, my natural inclination is to turn inward with selfishness, self-pity and to protect myself from further pain. The presence of pain magnifies my everyday choices between serving myself or others.

Community

God comforts us in our affliction so that we can comfort others with His comfort (2 Cor 1:3-4). Another opportunity pain has brought is special access to support others through many different kinds of pain. In God's good design, the more I look to how I can serve others, the less I worry about the details of my own suffering. I've also learnt how to accept help from the body of Christ. Receiving help blesses others as they get to serve with their God-given gifts. As the different parts of the body work together, it builds up the body of Christ in love (Eph 4:15-16) and this is beautiful to be a part of.

Contentment

Learning to be content is the most powerful defence against the temptations of living with chronic pain. Thankfully, Paul divulges the secret: we can do all things through Christ who strengthens us (Phil 4:11-13). We can trust Him – with our health, our finances, with today, tomorrow, and all the days after that. When we are weak, the power of Christ makes us strong in the ways that really matter. The times I am most content are when what is important to God is also important to me: His glory, His gospel, and that I love Him with all my heart, soul, mind and strength, and help others to do the same. I know that God can heal. If He chooses to heal me, I will absolutely rejoice in that. But I can be content that He is in control and is working all things together for good (Rom 8:28). The pain I continue to feel and woke up with

"Over time, through the refining fire of chronic pain and illness, God has given me the deepest joy I have ever known."

today may not end until Jesus returns or calls me home. However, if my lifetime of lupus means that God will be more glorified, more people will know Jesus, and that I leave this world more like Christ – it is well worth my soul.

Over time, through the refining fire of chronic pain and illness, God has given me the deepest joy I have ever known; joy which has not been shaken even as the lupus continues to progress. I may never practice medicine again, become a mother, or be pain-free, but what I have gained in Christ is so much more than what I have lost or could ever lose in this life. Even the best of what I can hope for here is only a foreshadow of something even better in Heaven with Jesus. For me, to live is Christ, to die is gain (Phil 1:21).

Looking to Eternity

There is purpose in pain. Not only does it expose my sin and idols, my pain unites me with Christ. Jesus knows pain – the anguish of imminent death, the hurt of betrayal and loneliness, and the immense physical pain of His crucifixion, which He endured for me and for the joy set before Him (Heb 12:2). Pain reminds me of the price paid for my sins and therefore the extent of His love for me. As I look to the joy of eternity to come, I can endure my present pain. God has provided several forms of common grace that provide some welcome, temporary relief, including good lupus control, some dietary changes, gentle exercise, health-fund subsidised massages, PRN paracetamol and edifying escapism.[1] However, what sustains me is the hope of the day when pain no longer exists because of our Saviour's grace.

To describe "chronic pain" as "light" and "momentary" may seem like an oxymoron, but it reminds us that even chronic pain is always temporary. We are given a short amount of time on earth to love, know and serve God and others, and chronic pain is no obstacle to that.

"So we do not lose heart. Though our outer self is wasting away, our inner self is being renewed day by day. For this light momentary affliction is preparing for us an eternal weight of glory beyond all comparison, as we look not to the things that are seen but to the things that are unseen. For the things that are seen are transient, but the things that are unseen are eternal." (2 Corinthians 4:16-18 ESV) ●

References:

1. Such as enjoying God's creation e.g. nature, music, nutritious food, or doing something creative such as writing, drawing, crochet, sewing. Even escapism can serve others e.g. making something for someone else like a meal or a present.

Resources:

Chronic Pain: Living by Faith When Your Body Hurts by Michael R. Emlet. A booklet by the Christian Counseling & Educational Foundation (CCEF).

Why Does it Have to Hurt? The Meaning of Christian Suffering by Dan McCartney

Be Still, My Soul – Embracing God's Purpose & Provision in Suffering. 25 Classic & Contemporary Readings on the Problem of Pain edited by Nancy Guthrie.

Many thoughtful blogs, podcasts and articles at www.ccef.org

Dr Andrea Schofield

Andrea is a Newcastle medical graduate (2005) and is married to Tyler, a GP. She was a paediatric trainee until becoming ill with lupus. Through suffering, she has learnt to trust the sufficiency of God's sovereign grace. Andrea and Tyler ministered in Alice Springs until returning to Newcastle in 2013, where they helped plant Gospel Church. Andrea has served as worship director, in women ministry, and is currently studying biblical counselling with the Christian Counseling and Educational Foundation (CCEF), where she is growing in connecting the truths of Scripture to everyday life and struggles. She, together with Dr Catherine Hollier, coordinates CMDFA Newcastle and local mentoring.

Reflection on Prayer

A marker of humility is prayer.

1 Thessalonians 5:16-18 exhorts us to rejoice always (v16), pray continually (v17) and give thanks in all circumstances (v18), for this is God's will for us in Christ Jesus.

Since graduation about three years ago, one of the biggest challenges I have faced has been the issue of prayerfulness. The apostle Paul exhorts the believers of Thessalonica to 'pray continually' and I found it extremely difficult to practice that in my daily work. Despite going to work in my car energised to do so, I often realised that I left God behind in the car.

Oftentimes, I thought I was merely busy and that busyness had distracted me from God. Many times I thought, "I just need to make more time." But frequently I found myself coming full-circle, back to where I had started. Why was that?

That is when I came to listen to a sermon on prayer with the analogy of a cupboard – that we pray when our cupboard is empty, and that we need to *realise* that our cupboard is empty. This has helped me to realise that our prayerfulness is deeply related to humility.

Consider these two cases.

Consider that there really is a God who is larger than anything that you can imagine. That He has said, '"Let there be light" and there was light' (Gen1:3). A God who is so large that this world cannot contain Him. That 'all things are from Him, through Him and for Him' (Rom 11:6). Consider that such a God is victorious over death, has 'overcome the world' (Jn 16:33) and that He is the 'King of kings, and Lord of lords' (Rev 19:16).

Then consider, in comparison to such a God, who we are. That we have been formed 'from the dust of the ground and [God] breathed into his nostrils the breath of life, and the man became a living being' (Gen 2:7). That we have been 'enriched in every way' (1 Cor 1:5) and that there is nothing that we have not received. As the apostle Paul puts it, 'For who makes you different from anyone else? What do you have that you did not receive?' (1 Cor 4:7).

We were also 'dead in our transgressions... and it is only by grace that we have been saved' (Eph 2: 1,5). We were powerless to save ourselves, and yet, at the right time, Christ demonstrated His own love for us (Rom5:6).

In considering these two cases, a question remains – Why do I not pray? What stops me from praying?

I cautiously explored my heart, and found that the issue lay at the core of my old self. There was pride at the centre of my lack of prayer. It was the old desire for self-sufficiency, for which the only cure is the Gospel itself, that tells me the new identity that I have in Christ.

Before, we were 'powerless to save ourselves' (Rom 5:6), but now 'the old has gone, and the new has come' (2 Cor 5:17) through the saving work of Christ who has 'transferred [us] from the kingdom of darkness into the kingdom of the son He loves' (Colossians 1:13).

Incomprehensibly, God has *adopted* us as children of God and we are able to call on God as "Abba, Father" even though we were still dead in our sins, undeserving of any mercy. Hence, we no longer belong to the old master, Sin, and we belong to Christ. We are His heirs and co-heirs with Christ. We are now 'more than conquerors' (Romans 8:37) and we can join in with our Lord on His triumphal procession (2 Cor 2:14).

Our cupboard is always empty – and yet, in Christ, it is also always over-flowingly full. This amazing grace has transformed our lives, not because of what we have done, but because of what He had done.

Despite multiple definitions and interpretations for the exhortation to 'pray continually', I think the marker of humility is the attitude of prayer. These two are inseparable for those who rely on God. Regardless of our level of training and competence, we can only rely on God more, not less.

Etymology is often a helpful way to understand the meaning of a word. Humility derives from the Latin word *humus*, which means *ground*. We can only guess as to why its derivatives evolved to represent humility, but I think today we have another way to look at it – we have been formed from the 'very ground' – the *humus* – and that is who we are.

I pray for all of us that we would remain deeply rooted in our *humus* identity and realise the magnitude of God and our place in relation to him, transformed through Christ by no merit of our own. In order to provide for the sick and the lost, humility is vital for the compassionate care Christ commands of us. We can only do so with prayer. ●

Peter Park

Peter is a PGY3 based in Western Health and from CMDFA Victoria.

BOOK REVIEW

The Problem of Pain

CS Lewis 1640 (1986) Collins

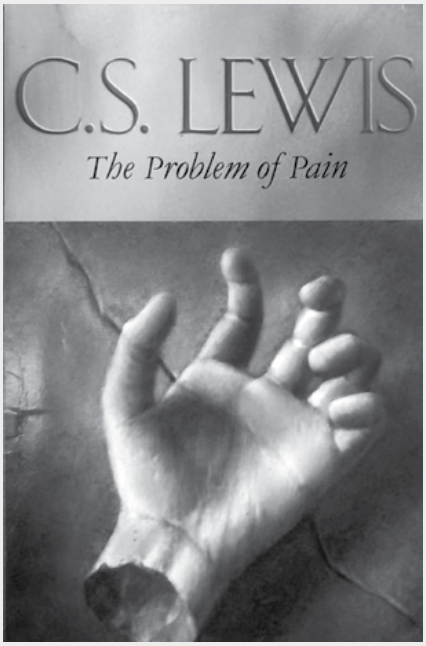
When it comes to "pain", this text by highly regarded Christian author CS Lewis, invites attention.

When others seek to write about pain there will be quotes from Lewis's discourse. Perhaps the most famous is that pain "insists on being attended to". God, says Lewis, "whispers to us in our pleasures, speaks to our conscience, but shouts in our pain: it is His megaphone to rouse a deaf world" (p.74). This is a key observation for Lewis. This book is a theodicy - it is a reasoned attempt to explain the pain and suffering we will almost certainly encounter in life. As a theodicy, it seeks to avoid bringing pain back to God as its source. While God may have a role in pain and suffering, for Lewis the human experience of pain can always be located with us. It is a consequence of free will.

> *"If God were good, He would wish to make His creatures perfectly happy, and if God were almighty He would be able to do what He wished.*
> *But the creatures are not happy.*
> *Therefore God lacks either goodness, or power, or both."*

This is the problem of pain, in its simplest form. Lewis uses the skill of a classic scholar with additional solid theological skills, to assert the "doctrine of the free fall," that is, in Adam and Eve, the choice to eat of the fruit of the knowledge of good and evil was a choice away from God. For Lewis, the creation story in Genesis (he is not a seven day creationist) suggests the "proper good of a creature is to surrender itself to its creator – to enact intellectually, volitionally, and emotionally, that relationship which is given in the mere fact of its being a creature. When it does so, it is good and happy."

Genesis guides us to the conclusion we are rebels. Our self-will is inflamed and swollen with years of usurpation.



While what we call "our own life" remains agreeable, we will not surrender it back to God. Lewis argues that "no doubt pain as God's megaphone is a terrible instrument; it may lead to final and unrepentant rebellion. But it gives the only opportunity the bad man (person) can have for amendment. It removes the veil; it plants the flag of truth within the fortress of a rebel soul."

Lewis develops his arguments through traditional theological categories, i.e. creation, fall, sin, suffering, hell and heaven. While he acknowledges that humanity can achieve "simple good', he argues that when our souls become wicked (turned away from God to our self) they will certainly use this possibility to hurt one another, and this perhaps accounts for fourth-fifths of the sufferings of men.

The surrender of the self to the love of God in Christ is crucial for all humanity. This side of eternity, Lewis is cautious about the complete transformation of people who are now in Christ. While God desires to fill us with love, this requires a continual self-abandonment – an opening, an unveiling, a daily surrender of itself. Lewis is pragmatic here. Our free will is readily rebellious and so he appeals to Jesus' observation of an "ongoing tribulation" till he returns again.

To help us move forward from this point, Lewis moves from argument and logic to suggest the image of a dance. It is a dance where the self is "flying to and fro" with the great master leading the revelry. As we draw "nearer to its uncreated rhythm, pain and pleasure sink almost out of sight. We recognise that God is love, God is good. In the end this happy, good, loving God does not exist for us, but we for God.

So, should Lewis' work be the last word on the problem of theodicy? The answer is no. Why not?

1. It is written in 1940. Not only is its language and take on the world a little quaint for us today, it is not aware of the diabolical genocides of Hitler's Germany, of Russia's salt mines, of Rwanda and Cambodia's killing fields.
2. The argument of the "free fall" has merit to a point but fails to deal with the impact of natural disasters and genocidal events.
3. It assumes a certain creational stability (God-given) in life that is now challenged by the science of chaos.
4. Lewis acknowledges he applies his own imaginative bias to some of the challenges he is aware of.
5. Lewis is a Western, male academic. Weaknesses are apparent because of these contextual realities.

Undoubtedly, however, this theodicy has enough substance to remain an ongoing contribution to the "problem of pain". ●

Dr Paul Mercer

Thy Word is our Food

The author spent forty years in a spiritual desert, without the Word, and came to Christ after living and working in Italy. Italy has a Biblical link to Jesus and his disciples – in particular to Paul, who was imprisoned by the Romans. Almost twenty-five years of her working life was spent in a medical institute involved in research on diabetes, nutrition and metabolism which referenced ancient Aramaic, Greek and Latin Christian texts on these topics. She was baptised in the waters of Port Stephens seven years ago.

From the pyramid of the Mediterranean diet to the temple of the spirit

This paper aims to take us together on a short biblical journey from the Old Testament Exodus out of Egypt to modern times.

It is meant as a guide to the importance of being healthy to better serve both the Lord and the people we support and care for in our professional lives. We will acknowledge that the water and salt in our food and bodies (which are the temple of the Spirit – 1 Corinthians 6:18), and the use of some herbs, spices and ancient foods are to be maintained in balance for our well-being: "as we offer through Jesus a continual sacrifice of praise," Hebrews 13:15.

Do not be worried

Even before Jesus came, the ancient Jews knew of God's creation and provision of food and drink (Psalm 104). However, in Matthew 4:4 it is recorded that Jesus said: "People do not live on bread alone, but by every word that comes from the mouth of God." This was His answer to the Devil after spending forty days and nights in the desert without food. More than physical food and drink, we need the Word of God. We are reassured in Matthew 6: 25 to keep the faith, "That is why I tell you not to worry about everyday life – whether you have enough food and drink... Isn't life more than food, and your body more than clothing?"

Take responsibility

God has given us all the responsibility of taking care of and feeding our bodies (Ephesians 5: 29-30) and our spirit (Fry, 1982) as members of the Body of Christ. In fact, God speaks to us about the quality of the food that we eat and even as far back as in Leviticus He explained that food offered as a communion sacrifice must be eaten the same day or the day after. In those days, food was kept in storage wells (Jeremiah 38) and whatever was left on the third day must be burnt. If it were eaten on the third day it would be rotten and not acceptable.

"Spiritually, we need the Word of God to keep us alive, and physically, we need salt and water for our bodies to survive."

This may also be taken as a warning to us in modern times not to eat food that is left over for more than 3 days as it could (even in a fridge) contain bacteria harmful to our health. Wise advice is given in Leviticus 6 and 7, 11 and 19 regarding foods we may eat and how they are to be prepared. Types and modes of food preparation can be found in Ezekiel 9 and 1 Chronicles 22.

Water

Jesus said, "Anyone who is thirsty come to me" John 7:37. By this He means thirsty for the Word of God. He was confirming the words of the prophet Isaiah (Isaiah 55:1-2). We also need water to maintain our bodies, which are 60% made of water.

Yeast-free bread

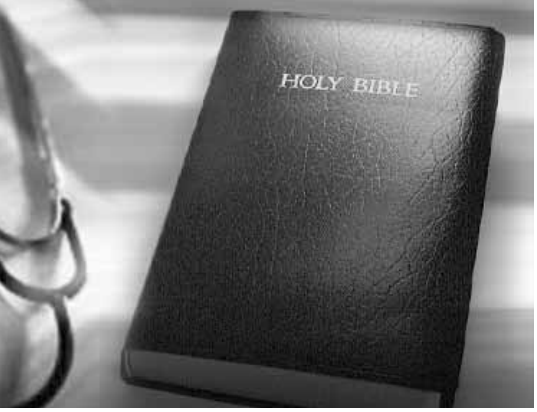
In Exodus 23 God gave Israel the instructions for the Feast of Unleavened bread, and Jews partake in this experience at Passover. Christians remember that Passover meal as Jesus prescribed at the Last Supper – we can drink of the wine and eat the bread, knowing we are doing this in memory of Him (Matthew 26). Buckwheat was used to make this bread, which even today is recommended for those who are intolerant to gluten.

Salt and water

Jesus said, "You are like salt for the whole human race. But if salt loses its saltiness, there is no way to make it salty again. It has become worthless, so it is thrown out and people trample on it," Matthew 5:13. Modern medicine steers us away from taking excessive salt, yet we need a balance of water and salt in our bodies to keep us healthy and able to function. Research has looked at the various types and sources (Psalm 104:10, Fidanza, 2000) of water and salt, and how they affect our physical and spiritual health (Batmanghelidj and Day, 2008). The SALINE Process alludes to the importance of the physiological balance of salt and water to sustain healthy life. Spiritually, we need the Word of God to keep us alive, and physically, we need salt and water for our bodies to survive.

Stay healthy

Remember that a healthy tree bears good fruit (Matthew 7:17; Luke 6:22) and that the harvest is large. But since there are few workers to gather it in, "Pray to the owner of the harvest that he will send out workers to gather in his harvest," Matthew 9:37-38. In order to be able to serve the Lord we need to



pray to Him to provide what is needed to sustain our bodies and spirits, and be part of that workforce that goes out for Him. He has done this also by providing doctors of medicine and other healthcare workers to assist us in these efforts (Sipser and Lew, 2008).

The Bible mentions many foods, herbs and spices that are for us to eat, eg. figs and grapes, honey and almonds, lamb, mint and cinnamon. These you will, or have already, tasted. God would not have mentioned these if they were not good for us, and He wishes us to enjoy them (see recipes)![*]

So perhaps it is time to look at how healthy we are – both physically and spiritually, to scrutinise what we eat and drink, how and when we pray, and, at times when the Lord asks us, to abstain from food or drink (or something else in particular) so that He can heal and start something new within each of us. ●

References:
Batmanghelidj, F. and Day, P. (2008) *The Essential Guide to Water and Salt*. Credence Publications. Tonbridge, UK
Benson, H. and Stark, M. (1996) *Timeless Healing; The Power and Biology of Belief*. Simon and Schuster Ltd, London, UK
Fidanza, F. (1998) The Mediterranean Diet and Health: The Seven Countries Study. *ANDID Notizie*, Italgraf Publisher, Rubiera, Italy
Fidanza, F. (2000) In search of the ancient roots of the Mediterranean diet. *Diab.Nutr.Metab.*, Kurtis, Milan, Italy
SALINE Process: IHS Global www.international saline.org/ resources: accessed 28 May 2017
Sipser, W. and Lew A. (2008) *Seven Things Your Doctor Forgot to Tell You. A guide for optimal health*. Rockpool Publishing, Sydney, Australia
Holy Bible , New Living translation (2007) Tyndale Publishers, Carol Stream, IL, USA
Fry, T (1982) *The Rule of St. Benedict of Norcia*. The Liturgical Press, Minnesota, USA

Footnote:
[*]Recipes published in *Luke's Journal*, Vol. 22, No. 2, September 2017, p41

Georgina Hoddle

Georgina is a Registered Nurse who returned to the profession eleven years ago after a long sojourn overseas. She has attained a Masters in Applied Linguistics (TESOL; Macquarie Uni) and has worked on projects involving understanding multicultural communication in healthcare with two Australian Universities. She is currently a Clinical Nurse Educator with an Agency and is seconded to a Government department. Georgina is also Vice-President of Nurses Christian Fellowship Australia (NCFA) and the NCFA SALINE Co-ordinator for nurses.

Neurobiology of *Glossolalia*

***Glossolalia* is the experience of "speaking of tongues" as described in Christianity. According to Goodman[1], glossolalia is described as an induced dissociative hyperarousal state while others have described it as a state of possession in different cultures. However, the exact physiology of it remains uncertain.**

According to James[2], glossolalia is composed of four main criteria. First is ineffability, which states that the experience defies a standard expression. It is a unique experience with varied patterns of sounds and words individualised to a specific person at a specific time. Second is a noetic quality, which states the experience carries a specific value to the practitioner while holding a sense of authoritative knowledge. The remaining components are transiency and passivity.

Neuroimaging studies have shown that attention-focusing tasks require increased frontal lobe activity via perfusion scans. According to Newberg et al[3] who performed the first SPECT scans on active glossolalists, reduced cerebral activity was recorded in the prefrontal cortex, supporting the passivity and dissociative aspect of glossolalia. Furthermore, there was a lack of clear lateralisation of the frontal lobes which, surprisingly, suggests that expressive language areas of the brain may not be affected by glossolalia. However, limitations of the study included the subjective nature of reporting and the limited sample size. As is written in Romans 8:26b, *"for we do not know what to pray as we ought, but the Spirit Himself intercedes for us with groaning too deep for words."*

Originally, glossolalia was believed to be a form of psychopathology by the scientific community. However, small scale studies have shown no difference in personality traits or risks for mental illness such as depression, anxiety, psychosis and mania. Furthermore, it has been found that 80% of practitioners of glossolalia have greater emotional stability and reduced neuroticism than those who do not practice glossolalia.[4] However a few other studies have not shown the same results.[5]

Glossolalia has been shown to have stress-reducing benefits in non-worship activities. Whilst practicing glossolalia, a reduction in circulatory cortisol and an elevation in α-amylase activity (common biomarkers of stress reduction in the saliva) has been shown.[6] However, there were increased levels of physiological stress during worship.

In conclusion, the neurobiology of glossolalia continues to remain a mystery. With the limited sample size, research studies and financial resources, we are unlikely to achieve a good understanding of the neurobiological processes surrounding glossolalia. However we can ascertain the ineffability, noetic quality, transient and passivity components of glossolalia based on the observational and neuroimaging studies. As is written in 1 Corinthians 14:2, *"For anyone who speaks in a tongue does not speak to people but to God. Indeed, no one understands them; they utter mysteries by the Spirit."* ●

Bryan Yap

Bryan is a 4th year UQ medical student.

References
1. Goodman, F. D. (1972). *Speaking in tongues: A cross-cultural study of glossolalia* (1st ed.). Chicago: University of Chicago Press.
2. James, W. (2004). *The varieties of religious experience*. New York: Barnes & Noble Inc.
3. Newberg, A. B., Wintering, N. A., & Morgan, D. & Waldman, M.R. (2006). The measurement of regional cerebral blood flow during glossolalia: A preliminary SPECT study. *Psychiatry Research Neuroimaging*, 148, 67-71.
4. Francis, L. & Robbins, M. (2003). Pesonality and glossolalia: A study among male evangelical clergy. *Pastoral Psychology*, 51, 5.
5. Louden, S. & Francis, L. (2015). Are catholic priests in england and wales attracted to the charismatic movement emotionally less stable? *British Journal of Theological Education*, 11(2), 65-76.
6. Lynn, C. D. (2012). Glossolalia is associated with differences in biomarkers of stress and arousal among apostolic pentecostals. *Religion, Brain & Behavior*, 1(3), 173-191.

Zoe's Place

There are very few topics of conversation that are more likely to cause either an awkward silence, or a heated debate of nuclear proportions, than that of abortion.

The subject of life before birth seems capable of stirring such strong and intense emotion that we don't often broach it, for fear of waking the sleeping beast of opinion. We fear that our own opinion might offend. We fear that our opinion won't be liked. We fear that we don't know enough to support our opinion. We fear that we, as a person, won't be liked.

And so I must admit that I, too, almost succumbed to fear, and was filled with just a little apprehension when I was approached to consider accepting the position of Executive Director of Zoe's Place. Zoe's Place is a pregnancy support centre that provides free counselling to women negotiating the storm of an unexpected pregnancy in the Newcastle and Lake Macquarie area of New South Wales. Zoe's Place also provides post-abortion counselling, as well as mentoring to women who choose to continue their pregnancy. At the time I was offered this position, Zoe's Place was still in the planning and preparation stages and had not officially been launched.

Despite the fact that I am passionate about all things 'women and families', and consider myself a champion of child protection, I still felt a little anxious about accepting this role. And it wasn't just because the job description went for three pages! My apprehension was because my assignment, if I was to accept this position, meant signing up for a front row position in a battle of epic proportions. It is a battle that the enemy is waging primarily through lies, and through the dissemination of misleading or deliberately false information. And it is a battle where the daily casualties are precious little lives.

Each year in Australia it is estimated that 80,000 children are lost through surgical abortions.[1] This number is only an estimate, as no precise figures are kept on abortion in Australia. This estimate comes from South Australia, Western Australia and Northern Territory figures, and from Medicare rebates paid to private patients.[2] The real numbers, I suspect, are probably devastatingly higher.

Needless to say, I accepted the position of Executive Director at Zoe's Place in 2015, and I can honestly say that I have not regretted that decision, even for a moment. That's not to say it has been an easy journey. I was labelled "naive and gullible" by a close family member for taking on such a position with "a group of people who obviously have a hidden agenda". A work colleague advised me that women with unwanted pregnancies "should just put them in a bucket and get on with their life". Another work colleague advised me that "there's absolutely nothing positive about a 15 year old that's pregnant."

"She thought, like most other deceived women in her position, that it was just a simple procedure that would allow her to move on with her life."

However, there have been so many moments at Zoe's Place that have far outweighed those difficult times a thousand-fold. I am so thankful that the Holy Spirit has given me extraordinary empathy for the women we see at Zoe's Place, which has enabled me to listen to their struggles and circumstances in a non-judgemental way. The story of Jesus' encounter with the woman at the well in John chapter four is a constant reminder to me of what true Christ-like love looks like. Jesus spoke with tenderness and kindness to this woman who found herself tangled up in the world of prostitution. Jesus knew her history, but still accepted and ministered to her. We don't find Jesus standing beside the well, condemning and shaming this woman with placards displaying disturbing images of the effects of prostitution. As a good friend of mine says, "we want to be known for what we're for, rather than what we're against".

At Zoe's Place in June, I met an international student Sophie[3] who is studying at the local university. She had returned to Australia after a recent holiday to her home country to visit her fiancé, only to discover she was pregnant. During Sophie's first counselling appointment, she talked about all the reasons why she couldn't have this baby. As we talked together about her options for this pregnancy, the obstacles fell away one by one, and God's truth replaced the false beliefs that crowded her thinking. Her baby was not merely "a clump with no brain or organs" as a friend had informed her. She even laughed in disbelief when I told her that at 6-7 weeks gestation her baby's heart had most likely already started to beat. Sophie was surprised to learn that there were possible complications from having an abortion that may affect her ability to conceive

or carry a child later. She also seemed genuinely surprised to hear of the psychological impact abortion would have. She thought, like most other deceived women in her position, that it was just a simple procedure that would allow her to move on with her life.

Sophie returned for her second appointment at Zoe's Place the following week. I was absolutely delighted to learn that Sophie had decided to keep her baby. I showed her a picture of what her baby looked like at this early stage. Her hands flew up to her face and she said "I think I'm going to cry!" Later that week, I spoke with Sophie after she'd seen her baby for the first time at an ultrasound. I'll never forget the joy and animation in her voice. In just one short week, Sophie had fallen in love with the little life growing within her. God's truth, spoken in love, undoubtedly sets people free.

It is so easy to feel overwhelmed by the magnitude of the struggle against the tide of abortion. But, as Edmund Burke once said, "All that is necessary for the triumph of evil is that good people do nothing."

As a medical professional in your local community, there is so much that you can do, should you be willing to engage in this battle. Firstly, become equipped with accurate information about abortion. Did you know that around 97% of babies who are aborted are perfectly healthy?[4] Were you aware that abortion due to rape accounts for less than 1% of all abortions?[5] Or that only 0.35% of all abortions performed are to save the mother's life?[6] Don't be fearful, but instead be prepared to engage in a conversation about abortion and be able to support your beliefs with truth. We need to start having these difficult conversations that we seem to fear.

I was deeply saddened recently to hear the story of a young woman from a loving Christian home who, at 25 years of age, found herself unexpectedly pregnant after a one-night stand with a friend. She went on to tell me that it was her mother who had suggested that "maybe you should get rid of it". Indeed, her mother accompanied her to the abortion appointment, driven by her father. I found this story simply heart-breaking. Why is there no difference in a Christian household? Perhaps because Christians too are fearful of having these awkward conversations.

"...only 0.35% of all abortions performed are to save the mother's life?"

Secondly, find out about your local pregnancy support centre. Become familiar with the services that they offer to your community. Consider partnering with them or being available to receiving referrals from them. Women who continue their pregnancies will need a general practitioner to care for them. At Zoe's Place, we are fortunate enough to have five wonderful local Christian general practitioners that have agreed to accept referrals from us and care for our women. It's reassuring to know that we can trust these professionals to love and care for our clients in the same Christ-like way. If you have a patient who is unexpectedly pregnant, refer them to your local pregnancy support service so that they can receive the counselling and support they need.

Thirdly, you can partner with your local pregnancy support centre financially. Zoe's Place is a not-for-profit organisation and we rely solely on fundraising to provide our services free of charge to the women we see. Most other pregnancy support services operate in a similar manner. Financial and prayer support from you individually, or through your church, means more women in your community can be reached and lives saved and changed.

Fighting in a battle requires weapons and you can't fight the enemy's attacks without being adequately armed. Our weapons must include Christ-like love and empathy, as well as the spiritual armour of God. The spiritual war has already been won by Christ, but until the very end, the battle against abortion will continue to be waged. My constant and fervent prayer is that eyes will be opened, ears will begin to listen, and God's people will step up and take their positions on the front line of this battle. ●

References:
1. Pratt, A., Briggs, A. & Buckmaster, L. 2005 Parliamentary Library research Brief. How Many Abortions Are There Each Year in Australia? Retrieved from https://www.emilysvoice.com/get-informed/abortion-facts/
2. https://www.emilysvoice.com/get-informed/abortion-facts/
3. Name has been changed to protect privacy of client
4. https://www.emilysvoice.com/get-informed/abortion-facts/
5. Ewing, S. (2005). Women and Abortion: An Evidence-Based Review; a meta-analysis of Australian and International research on why women have abortions. Compiled for a Women's Forum Australian parliamentary submission. Retrieved from https://www.emilysvoice.com/get-informed/abortion-facts/
6. Croft, S., Cotton, D. & Cotton, C. (2006). Abortion on Australia into the 21st Century. NSW Right to Life, citing Australian Bureau of Statistics figures, citing Dr David van Gend. Backyard Distortions: Putting the Abortion Campaign in Perspective, Bulletin of Ovulation Method Research and reference Centre of Australia, 26 (2), 12-16. Retrieved from https://www.emilysvoice.com/get-informed/answers/

Useful Websites :
Emily's Voice – www.emilysvoice.com
WECARE (World Expert Consortium for Abortion Research and Education) – www.wecareexperts.org.au
Pregnancy Help Australia – www.pregnancysupport.com.au
Elliott Institute – afterabortion.org

Helen Bell

Helen is a 39 year old happily married mother of two small boys. Helen was appointed Executive Director of Zoe's Place in 2015, and is currently employed one day a week. Helen also works part-time as a registered nurse in her local Emergency Department, a position she has held for the past 13 years. Prior to her nursing degree, Helen completed a Bachelor of Music degree. She has also completed an Advanced Diploma Counselling and Family Therapy (Christian), and has spent time working with Family and Community Services as a Child Protection Caseworker.

It's better to give...

The Bible is explicit regarding the Christian's attitude to giving: "Do not lay not up for yourselves treasures on earth", "The Lord loves a cheerful giver", "It is better to give than to receive", "The love of money is the root of evil" and a plethora of other such verses. As followers of Christ, we try to live out these principles, but, being human, we do it with varied success.

Considering the Bible's clear teaching about giving, fundraising for Christian causes should be more effective than that of the general community. However, no one is completely free from temptation: Scottish theologian and preacher, William Barclay, gives an example of a congregation singing the well-known hymn *Take My Life* as the collection is taken. As the collection plate nears him, one parishioner surreptitiously feels amongst the coins in his pocket, trying to find a couple of low value ones. As the plate reaches him, the singing reaches the line "Take my riches and my gold, not a mite would I withhold…"

The principles of fundraising are different from the principles of Christian giving. However, when fundraising is directed towards Christians and Christian groups, bearing the Biblical principles of giving, in conjunction with the broader principles of community fundraising, will be beneficial.

The following seven principles combine these concepts, without sacrificing the merit of either.

1. Appeal to the donor's emotions, if possible.
Even the most rational individual can be influenced by powerful stories that tug at their heartstrings. This is one of the reasons that children's charities can be so successful: the need of a sick or suffering child evokes a strong sense of sympathy. Although Christians know not to be manipulative, an honest and truthful appeal, pitched to win the hearts as well as the minds of donors, has a higher chance of a successful campaign.

2. Show donors the difference they're making.
Donors want to see their donations being used to help others. That is why personal campaigns where an individual sponsors a child, or buys material to help a family from a developing country build a vegetable garden, etc. are so effective. Donors are actively able to engage with the real people they've helped provide for. Whilst Biblically this shouldn't drive our desire to give, it is a good way to encourage and assure donors that their gifts are truly contributing to the cause.

"Donors want to see their donations being used to help others."

3. People like to give towards things that they can touch, that they can see and that last.
Many donors like to give towards something that is specific and that they can see, perhaps even with a plaque attached to it bearing their, or their fundraising group's, name. Hence, a specific piece of equipment may be more appealing for an individual, or a community group, to purchase. Very few can afford an entire building, so dividing it into parts, such as a lecture theatre, a study room, or a library may be more attractive. Even 'selling' individual bricks or pavers can be effective in helping people feel connected to their contribution. Some donors appreciate being able to name a portion of a building in memory of a loved one, feeling that they have made a gift that will last.

4. Donors like to be thanked.
Some donors like public thanks and having their name mentioned and displayed. They may see this as a way of encouraging others, as well as recognising their own contribution. Some request no displays of public recognition. Others prefer anonymity. Anonymous displays of generosity are good and have Biblical precedents. However, all donors, including anonymous ones, appreciate being thanked. While public displays of recognition may not be desirable to some, a simple personal acknowledgement, such as a handwritten note or a phone call, is always appreciated. If the thanks is expressed by someone senior in the organisation, it is even more powerful. Good fund-raisers know the difference between public acknowledgement that is sought by some, and personal thanks that is appreciated by all.

5. Be honest with donors about overhead costs.
All charities have to use some of the donations they receive for fundraising and administrative expenses. In order to gain the good faith of donors, fundraising and administration expenses should be transparent. Australian research by Givewell, says that on average, 19% money raised by charities goes towards fundraising expenses and administration. However there is wide variation – between 4-50%, depending on the charity. It is worth doing some homework before donating to see where your money actually goes. Some telemarketers and on-street fundraisers operate under a system where they are enabled to keep a significant amount of the donation. As Christians we have a responsibility to use our money, including our donations, wisely. This means that in general, rather than donating through a third party, it is wiser to donate directly to the charity. Being upfront with donors about what percentage of raised funds goes towards the stated cause is a great way to establish trust.

6. Nurture and inform donors.
Donors give when they care about a charitable cause. If they care, they may donate regularly as they can afford it. They are more likely to do this if they are thanked appropriately and told about what their donation is

helping to achieve. Some fund-raisers think donors should be asked to give more generously in subsequent donations. Others have found that this may alienate a donor. Where the organisation can't go wrong is to be genuinely grateful and to keep in touch.

7. Respect the wishes of donors.
It is hard for a donor to know what an organisation needs unless the organisation makes it clear. Sometimes a donor may approach an organisation with a specific project in mind. This may pose a challenge if the project is not in line with an organisation's needs, or if the donor thinks their gift will achieve far more than it can. The solution is to respect what the donor wants to do, talk to them about what your organisation needs and then try to find a way where the needs of both can be accommodated.

"...in general, rather than donating through a third party, it is wiser to donate directly to the charity."

I have seen two donors approach different organisations with requests that the organisations rejected, even though the proposed gifts were each over $1 million. One organisation said the idea didn't interest them. The other said the proposed donation wasn't enough. The donors then went to other organisations that were able to work out a way that the principle of what the donor wanted could be aligned with the organisation's needs. The donors then made the gift and, because their wishes were respected, continued to contribute to those organisations.

Conclusion
When planning to fundraise for a worthy cause, keep the above principles in mind in order to maximise the chance of success. Tailoring the request and following up with gratitude will encourage "cheerful givers". ●

Emeritus Professor Kim Oates
Kim is a paediatrician whose various roles have included Professor of Paediatrics and Child Health at Sydney University and Chief Executive of the Children's Hospital at Westmead. He has a long standing interest in child development and the problem of child abuse. He now teaches patient safety and leadership at several medical schools here and overseas. Kim has been a member of CMDFA for as long as he can remember and with his wife, Robyn, worships at St Philip's Church, York Street, Sydney.

GIVING BACK

50% of profits donated to mission

EXPLORE THE WORLD WITH US.

Christian Leisure Tours | Holy Land and Bible Tours | And more

European Adventure Cruise
2-16 June 2018

Japan Cherry Blossom
9-19 March 2018

Faith & Food: Spain
13 April -3 May 2018

Holy Land & Bible Tours
Multiple Departures

Whether it's a medical mission or a well-earned holiday, next time you book your travel, book with us! We have access to exclusive mission fares with over 42 airlines, offering higher baggage allowance and more flexible conditions. We offer a broad range of Holy Land and Bible tours and Christian Leisure tours giving our clients the option of travelling with like-minded people. Check out our range of tours on our website.

MISSION travel

www.missiontravel.com.au | 1300 554 654