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editorial

SECOND OF TWO SECTIONS

Hot Topics in Ethics

This 2nd section of *Hot Topics in Ethics* addresses recent changes in legislation and increased coverage in the media of these ethical issues. In our post-modern, post-Christendom world the challenge of ethics, both personal and corporate, requires consistent, thoughtful effort. Truth, morality, justice and compassion are often important considerations as we enter the ethical playing field.

How and where to start can be a difficult first step. New information, new options, funding pressures and shifting social forces all squeeze any ethical position we may take. For some, science now sets the pace in ethics. Oxytocin has been identified as a significant molecule that carries the basis for a neurobiology of ethics.[1] It is clear ethics is about people and communities working together and yet we commit to ethical decision-making as individuals.

Through the force of argument, quality research, conscience, social instincts and (for Christians) a suite of spiritual resources, a path is negotiated towards an ethical position. We often yearn for a simple, straightforward approach to ethics, yet ethics is more like the creation of a tapestry or a consensus of good ideas with different origin points.

We have chosen a "hot topics" approach. This allows current challenges to be addressed. We recognise there is no set ethical model that we have chosen to guide the authors. Rather we accept that, beyond the preference for a bioethical approach in most health-based professions, there is indeed a plurality of ethics we must encounter and work with.

A good example of this approach is contained in Steve Wilkens' punchy text, "Beyond bumper sticker ethics".[2] Here the author identifies nine ethical approaches, all of which claim Biblical merit. The chapter headings, such as "When in Rome, do as Romans do" or "Cultural relativism"; "Be good" or "Virtue ethics"; and "God said it, I believe it, that settles it" or "Divine command theory" capture complexity in ethics with a pinch of humour.

Ethics is never a one trick pony.

In the wider community, determinism tends to hold sway in the debate with free will. This poses significant challenges for Christians thinking ethically. When it is coupled with a consequentialist, utilitarian perspective, the ground on which ethics stands appears to be heading for major change.

By offering a variety of materials we hope to stimulate conversations and responses which contribute positively to the integration of work and faith of Christian health professionals. I have deliberately chosen to write into the difficult space of "discernment of ethics". In the swirling and changing environment of ethics, this will help us all to journey further with integrity. If we consider Jesus as our model for ethics, two things stand out – Humility and Love. Jesus calls us to follow in his steps of changing love from a noun to a verb. May the fire that refines gold catch hold for you in this material.

Paul Mercer
Editor

Works Cited
1. Churchland, P. (n.d.).
2. Steve, W. (1995). Beyond bumper sticker ethics. Downers Grove, Illinois: InterVarsity Press.

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Themes for Next Editions:

Breath of Life
– copy by 14 July 2019

#CMDFAlyf
– copy by 15 October 2019

Removing Restrictions on Cannabis

A submission to the Senate enquiry into an *Amendment (Removing Commonwealth Restrictions on Cannabis) Bill 2018*, otherwise known as the *Bill for an Act to Remove Commonwealth Restrictions on Cannabis and for Related Purposes.*

Dear Committee Members,
Thank you for agreeing to receive this late submission, as agreed over the phone, before I recently left for a two-week study trip to Bangladesh. I appreciate the latitude and, as agreed, forward this submission soon after my return.

As I understand from the *Explanatory Memorandum* circulated under the authority of the proposer of the Bill, Senator Leyonhjelm, the Bill would allow any state or territory to legalise and regulate the distribution of cannabis. This is based on the grounds that adults should be free to make their own choices as long as they do not harm others, that criminalisation increases pressure on the judicial system and induces organised crime, and that legalisation would both save and earn money for the government.

Whereas I can empathise with the above arguments, respectfully. I would like to draw attention to the collateral damage associated with the adult freedom of choice: 'others' inevitably *will* be harmed, especially the unborn and adolescents, and the marginalised in society. Also, whereas the *Explanatory Notes* provide an overview of fiscal advantage in terms of reduction of policing costs and increase of taxation, they do not mention the direct and indirect costs of increased cannabis consumption on mental and physical health. Lastly, whereas the Bill is declared to be "compatible with human rights because it protects the right of self-determination", if enacted, it will surely result in increased exposure of the unborn, children and adolescents to the adverse effects of cannabis and thus challenge *The Declaration of the Rights of the Child*, which declares: "The child shall enjoy special protection and shall be given opportunities and facilities, by law and by other means to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner… in the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration."

"Exogenous cannabis has the potential to disrupt implantation, placentation and the development of the unborn baby in numerous ways."

Why would the passage of the Bill not be in the best interests of Australian children?

• Because exposure to cannabis will influence the balance of the child's innate endocannabinoid (eCB) system.
Cannabinoids are manufactured in the human brain where they exert a widespread, complex, fundamental influence on brain development and function.[1] Cannabinoids are also manufactured in certain plants from which they can be extracted and imbibed for euphoric and other effects. Extractions from plants are not pure or predictable, but represent a variable mixture of some 400 chemical compounds, including cannabinoids, terpenoids and flavonoids that each produce individual and interacting effects.[2] 9-Tetrahydrocannabinol (THC) is the principal psychoactive component, however, its proportion in any extract varies with the breeding of the plant, as well as with such local factors as the position of the bud in the plant, the season, humidity, temperature and fertiliser. As well as THC, there are some 70 other cannabinoids with individual effects on the brain, and their modifying effects on the action of THC. Cannabidiol, for example, may counter the psychomimetic effects of THC.[3] The effects of the innate endocannabinoid system within the brain are closely controlled, with effects regulated by release of minute amounts of particular components and their metabolites. These, in conjunction with other compounds, function for brief, controlled periods of time according to the needs of the body.

Exogenous cannabis is lipid-soluble and, therefore, crosses the blood-brain barrier to infuse itself in large, interacting, variable quantities and qualities into the intricacies of the innate system. Not only is the innate system subjected to large volumes of various types, the length of exposure to the foreign compounds will extend much longer than the natural because of the prolonged half-life of their metabolism. Given the essential role of endocannabinoids in neurodevelopment, it is not surprising that laboratory studies confirm the susceptibility of the growing brain to adverse effects of intrusive exogenous cannabis.[4,5]

• Because the lipid solubility of cannabis components permits them to cross the placenta from mother to unborn baby.
As well as influencing brain development in ways not yet fully understood, the endocannabinoid (eCB) system also plays a fundamental role in reproduction itself. Exogenous cannabis has the potential to disrupt implantation, placentation and the development of the unborn baby in numerous ways.[6]

a) Length of gestation. Studies with Australian authors have concluded "increasing use of marijuana among young women of reproductive age is a major public health concern", being a 'significant risk factor' for premature birth if smoked before 20 weeks of gestation, and for restricted foetal growth if smoked for longer.[7] Not surprisingly, the greater the consumption, the more premature the birth: taking cannabis 100 times in the three months before 20 weeks of gestation was likely to induce labour by 36-37 weeks of gestation, even if smoking had ceased by that 20 weeks. Considering the Australian component of this international research, the authors concluded "almost 12% of SPTB (spontaneous preterm birth) could be attributable to maternal marijuana use".

Other studies, however, have been unable to confirm such serious findings. For example, reports published in 1995[8], 2005[9] and 2010[10] did not find an excess of premature labour, but most of such early studies were undertaken before legalisation of marijuana in the United States and, therefore, maternal acknowledgement of consumption is likely to have been under-reported. Furthermore, in those earlier years, the strength of street cannabis was markedly lower.

Recent laboratory research on mice confirms 'smoking marijuana during pregnancy even at low doses can be embryotoxic and fetotoxic'.[11] The study revealed that pregnant mice exposed to five minutes of daily (low dose) exposure produced pups with a mean reduction of 9.9% in body weight, associated with significant reduction in weight of brain, lungs and thymus. The placenta was hypertrophied and the ratio of its weight with that of the foetus was markedly increased, suggesting failure in its ability to transfer adequate nutrition to the foetus.

Reviews highlight the importance of eCB in the process of implantation and placentation, and thus the overall development of the baby[12,13] and warn that exogenous cannabis may interfere with the process. Indeed, the levels of endocannabinoids should decrease as pregnancy progresses: lower levels are necessary for normal progression of pregnancy.[14] Smoking marijuana leads to sustained elevation in the level of placental and foetal systems and runs the risk of causing miscarriage and growth restriction.

b) Formation of the baby. Components of the innate endocannabinoid system have been identified in the foetus from as early as 16-22 days from conception.[15] They are known to have a role in development of the central nervous system and as the fundamental structure of the brain is being laid down at this stage, it is not surprising that a "significantly increased risk of anencephaly" has been described after exposure at that time.[16] In this tragedy, the brain does not develop, and the cranium remains vacuous space.

After involvement in the laying down of the basic template of the central nervous system, the eCB goes on to "shape neuronal circuitry in the developing foetus as well as modulating development of various neurotransmitter systems…".[17,18] Exogenous cannabis may be expected to "target the cannabinoid receptor… disrupting migration, differentiation and synaptic communication in the developing neurotransmitter system",[19,20] thus explaining "the neurobehavioural deficiencies… observed in newborns exposed to marijuana",[21] and neurodevelopmental problems in growing children and adolescents. Whether or not exposure to cannabis induces defects in other foetal structures has been debated. A number of studies have not found any major consequences, but most were conducted before legalisation of marijuana and, therefore, rely on maternal reporting of consumption which has been considered inaccurate. Use of Bayesian models to assess the effects of such under-reporting in the US *National Birth Defects Prevention Study 1997-2005*, revealed a positive statistical association of maternal cannabis consumption with the major foetal abnormalities of oesophageal atresia, diaphragmatic hernia and gastroschisis, with odds ratios around 1.7 after correction for exposure misclassification.[22]

Gastroschisis is a strange birth defect in which there is an opening in the anterior abdominal wall near the umbilicus through which intestine protrudes. It is not uncommon in northern Australia, where the incidence in Indigenous mothers was revealed by a research team (in which I was involved) to be greater than published for any other ethnic group in the world.[23] Fortunately, it usually responds to early surgery and prolonged intensive care.

c) Morbidity and mortality of the baby. An association between maternal cannabis use (as confirmed by analysis of the concentration of the drug in umbilical cord tissue) and stillbirth has been found,[24] as has an association with neonatal illness and death. Serious neonatal problems were found in 14.1% of users compared with 4.5% of non-users, with infection morbidity in 9.8% compared with 2.4%, and neurologic morbidity of 1.4% vs 0.3%.

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After adjustment for confounding consumption of tobacco, maternal use of cannabis was still associated with a three times higher rate of neonatal morbidity and death.[25] Additionally, cannabis-exposed babies were shown to have almost twice the risk of being admitted to a neonatal intensive care unit.[26]

• Because legalisation has resulted in higher rates of use.
Laws and policies related to marijuana in the US have changed markedly in the last 20 years with 'medical marijuana' now legalised in 28 states and Washington DC and, since 2012, 'recreational marijuana' now also legalised in 9 states and Washington DC. A survey of consumption undertaken in 2015 suggested marijuana use had doubled since 2001-2, and that use was more common in residents of states which had legalised its medical use.[27]

A later study examined data from adults who had participated in the former but, using different methodology, found a lower increase in consumption, but still one in which the "overall number of marijuana users increased from 21.9 million in 2002 to 31.9 million in 2014". It found daily users had increased from 3.9 million in 2002 to 8.4 million in 2014. On a population basis, it found use had increased from 10.4% of the population in 2002 to 13.3% in 2014. In that time, in accordance with increased use, it found the prevalence of "perceiving great risk of harm from smoking marijuana once or twice a week" had decreased from 50.4% to 33.3%.

Consumption of marijuana had particularly increased after 2007 and was significantly higher in non-Hispanic black adults with reduced education and employment, higher use of tobacco, alcohol, drugs, and other psychotherapeutic agents.

Yet another study reported annual prevalence of any marijuana use by US high school graduates aged from 19-28 years had increased from 29.3% in 2002 to 31.6% in 2014. In the same group, daily use had increased from 4.5 to 6.9%.[28]

Research on the effect of legalisation of marijuana for recreational use in Colorado and Washington states in November 2012 has revealed, in Washington, a reduction in the perception of its harmfulness by 14.2% and 16.1% in 8th and 10th grade children respectively.[29] In contrast, in states which had not legalised recreational marijuana, perceived harmfulness decreased by 4.9% and 7.2% in similar aged children.

"Marijuana alters brain development with detrimental effects on structure and function."

After legalisation, consumption of marijuana had increased by 2% and 4.1% in 8th and 10th graders in Washington but, in that period, consumption had actually decreased by 1.3% and 0.9% respectively in states which had not legalised the drug. No change in consumption or perception of risk was noted in Colorado after legalisation for recreation, probably because of the publicity associated with the prior legalisation of marijuana for 'medical purposes'. Thus, rates of harm perception were already lower, and consumption was already higher in Colorado compared with Washington and non-legalising states. Before legalisation for recreation, consumption in 8th graders was reported to be 8.9% in Colorado, 6.2% in Washington and 7.6% in non-legalising states. After legalising, rates were 8.9, 8.2 and 6.3% respectively.

In 10th graders, before legalisation for recreation in those states, consumption was 17, 16.2 and 17.3% respectively, changing to 13.5, 20.3 and 16.4%. And, in 12th graders, consumption before legalisation was 27.4, 21.2 and 22.3% changing to 25.5, 21.8 and 22.1% respectively.

Other studies in Colorado since legalisation for recreation have been scarce, but an upward trend in use has been confirmed.[30] More significantly, another study measuring marijuana levels in neonatal meconium revealed the concentration had increased from 213 to 361ng/g, suggesting increased consumption and/or potency.[31] Indeed, in the last two decades, the average THC content in cannabis has increased from 4% to 12%, and levels as high as 30% have been detected as the legal cannabis market has inspired selective growing methods to increase profits.[32]

These epidemiological studies reveal the extent of cannabis consumption in adolescents in association with the progressive legalisation of marijuana in the United States in the last 20 years. This is of great concern because, as the American Academy of Pediatrics declares, "marijuana alters brain development with detrimental effects on structure and function".[33]

• Because of the association of cannabis consumption with psychosis and behavioural problems.
One alarming feature of the increased exposure to cannabis in children from the unborn to adolescence is that it is

co-incidental to stages of great brain development. It should be emphasised that brain development is known to continue into the mid-twenties, with vital changes in organisation and pruning of neuronal connections in association with the widespread and complex effects of natural endocannabinoids.

Association of cannabis consumption with psychosis has long been observed, but proof of causality has been difficult to establish because of the rightful impossibility of controlled trials. Nevertheless, a number of cohort studies strongly suggest that cannabis is causative.[34] The Swedish Conscript Study revealed a dose-response relationship between cannabis use by age 18 and onset of schizophrenia by age 45, with a threefold increase in risk if cannabis had been consumed more than 50 times by age 18.[35]

A Dutch study found cumulative cannabis use was associated with psychotic outcomes three years later.[36] A Californian study reported a large association with cannabis use disorder and later hospitalisation for schizophrenia.[37] A study out of New Zealand found association between cannabis dependence and psychosis after adjustment for confounding influences.[38] A meta-analysis published in *The Lancet* in 2007 reported "the risk of psychosis increased by roughly 40% in people who have used cannabis, and there is a dose-response effect, leading to an increased risk of 50-200% in the most frequent users".[39] An accompanying comment on the review, written by psychiatrists from Copenhagen University Hospital, declared that a causal relationship "would mean that 14% of psychotic outcomes in the UK might not occur if cannabis was not used". They warned the findings of the review had "tremendous implications for young people, their families, and society". Extrapolating, they concluded "around 800 yearly cases of schizophrenia in the UK could be prevented through cessation of cannabis consumption".[40] The accompanying editorial declared that "although in 1995 The Lancet had uttered the much-quoted words: "the smoking of marijuana, even long term, is not harmful to health"... research published since then... leads us now to conclude that cannabis use could increase the risk of psychiatric illness".

Apart from the worry that cannabis consumption may at least precipitate, if not actually cause psychosis, other neurological adverse associations have been observed: chronic use before 18 years of age has been reported to result in greater decline in intelligence by 38 which persisted despite reduction of consumption in the preceding year.[41] Interference with attention, memory and inhibitory control have also been reported regularly[42] and would be expected to interfere with education. Overall, a cannabis addiction rate of 10% is likely to compound all the above problems, by rendering desistance much more difficult. While these above studies relate to adolescents, some studies have suggested significant decline in cognition after exposure before birth. One review of research concluded there was "growing evidence that psychological health may be particularly vulnerable to the adverse effects of in-utero exposure".[43] It concluded that increased aggressive behaviour and attentional problems in early childhood, followed by hyperactivity, impulsivity and delinquent behavior, depression and anxiety in later childhood, were associated with maternal consumption of one or more joints per day. Heavy maternal use was associated with delinquency, and with the early onset smoking of marijuana.

"...increased aggressive behavior and attentional problems in early childhood, followed by hyperactivity, impulsivity and delinquent behavior, depression and anxiety in later childhood, were associated with maternal consumption of one or more joints per day.."

• Because Indigenous Australians are very exposed to cannabis.
Research into why Indigenous women continue to experience rates of stillbirth, preterm birth and low birth weight two to three times higher than other women in high income countries, revealed 1 in 5 women used cannabis in pregnancy and 52% smoked cigarettes, with an almost 4 times higher risk of negative birth outcomes.[44] (Adjusted OR low birth 3.9). The weights of the affected babies were on average 565 grams lighter than expected (OR 6.5) and were disproportionately small for gestational age (adjusted OR 3.9), suggesting interference with in-utero growth. Overall, "51% of mothers using cannabis experienced adverse perinatal outcomes compared with 30% of

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mothers smoking cigarettes alone, and with 24% of mothers not using either substance during pregnancy". Overall, younger mothers were more at risk: 26.8% of mothers aged 14-19 at the birth of their first child reported marijuana consumption, as did 31.5% of those aged 15-19 at the time of the study. Also, cannabis use was increased in those with lower levels of education, lack of employment and with those suffering adverse, stressful events in their lives. Another study has concluded that 15% of indigenous women reported a "mean of seven cones or joints per day during pregnancy".[45]

The relatively high rates of gastroschisis in North Queensland may be associated with this high intake of marijuana, especially because, internationally, the incidence of this birth defect is known to be higher in the younger mothers.

• Because low birth weight from maternal consumption is associated with both acute and chronic complications.
The importance of low birth weight is that whether or not it *is* associated with prematurity or reduced growth for gestational age, it is associated with increased morbidity and mortality. The acute complications of premature birth include immaturity of lungs and, therefore, dangers of respiratory failure; cardiac instability and reduced oxygenation of the brain; decreased feeding and therefore failure to thrive; and susceptibility to anaemia, low blood glucose, high blood bilirubin, and infection. Acute complication of reduced intrauterine growth is related to the cause, e.g. placental malfunction leads to foetal undernutrition which may impact upon brain growth. Long term complications include neurological impairment including cerebral palsy, decreased IQ and educational achievement, and increased psychopathology.

Apart from the actual effect of the cannabinoids in cannabis, other components of the smoke may adversely affect the unborn, e.g. increased levels of carbon monoxide will compete with oxygen for transport in the red blood cells. Other substances known to have contaminated cannabis include cyanides and pesticides.

• Because of increased presentations of children to hospital emergency departments,[46] and an associated increase in road accidents.[47]
World-wide, regular use of cannabis has been associated with an increase in vehicle accidents, drug-induced psychotic symptoms and psychiatric disorders, HIV, hepatitis B and C, infective endocarditis and tuberculosis.[48] Some of these, of course, are not relevant to Australia but confirm the contribution of cannabis to the health burden.

"A question is… will legalisation of marijuana reduce or increase the 'gap' between Indigenous and non-Indigenous health?"

Conclusion

I have emphasised the effects of exposure to cannabis on neonates, children and adolescents because of Senator Leyonhjelm's caveat that adults should be free to choose their behaviour as long as it does not harm other people. I have emphasised the harm that can be inadvertently inflicted on children by an adult's freedom to smoke marijuana: harm from actual exposure to cannabis, as in the case of the unborn, or harm by reducing the perception of danger and thus indirectly increasing use. Such reduced perception is induced by observing adult consumption and by the advertising associated with marketing. Even if promotion of cannabis is restricted to 'adult hours' in the media, merely walking down main streets in 'legalised states' is sufficient to observe attractive outlets. Thus, legislation for medical and then for recreational use has been associated with increased consumption by mothers and adolescents, as it has reduced the perception of harm, rendered the drug more available and even lowered its price by competition. In accordance with demand for more euphoric effect, cannabis with greater THC content has entered the market, rendering the effect increasingly potent.

One sadness is that consumption has been shown to be highest in those less able to handle it: the youngest, the poorest, marginalised, uneducated, psychologically unstable and those already burdened by significant stress in life. Indigenous Australians are a case in point. A question is… will legalisation of marijuana reduce or increase the 'gap' between Indigenous and non-Indigenous health?

Freedom of 'normal adults' to consume marijuana is likely to increase the health burden and the social and educational difficulties of the marginalised in society. Rights are thus challenged by responsibilities. *Noblesse oblige* pertains. We *are* 'our brother's keeper'.

Senator Leyonhjelm is rightly concerned with fiscal responsibility, but his considerations do not include the costs of health care imposed by cannabis consumption. If it is true that 12% of low birth weight deliveries could be prevented by reducing cannabis consumption, in that small area alone, savings will be considerable in costs of actual care and preserved potential. Incalculable savings would accrue from preservation of intellectual and motivational potential. If cannabis use is associated with 800 new cases of

schizophrenia each year in the UK, the financial and social costs are enormous.

Who will benefit from legalisation of marijuana for recreational use? Relatively few consumers will be stable adults who can afford and tolerate the distraction. Most users will be the marginalised poor in society.

Who will receive their money? Attendance at an investor's conference in Denver revealed to the author that the real beneficiaries will be those poised to invest in 'big agriculture' with industrialised growth of plants under automatic control of temperature, fertiliser and humidity, in glass house conservatoria to maintain the best growing environment and protect from the vicissitudes of weather and insects. Reaping will be automatised and travelling laboratories will measure and ensure potency.

The concept of a few plants being available for private consumption is fanciful: it is a delusion distracting from the reality of agricultural mechanisation for large scale production. At that conference, millions of dollars were said to be waiting upon legalisation to be made in Australia. If that happens, agricultural profit will accrue from the addiction of the marginalised. Is that profit to which the government should aspire? Is that upholding human rights, when we are supposed to be protecting the best interests of children?

Lastly, will legalisation decrease criminalisation? Even that is arguable: the government will be seeking to tax production and sale and will, therefore, add to consumer price. Law enforcement will be needed to prevent and punish private, unregulated production and distribution.

If passed, Senator Leyonhjelm's Bill is likely to be followed by unconsidered consequences. Costs of preventative and actual healthcare and reduced potential can be expected to rise. Profit is likely to be disappointing and tainted by its origin. Human rights will be challenged by responsibilities: no construction of the argument will persuade that legalisation is in the best interests of children. Unlimited freedom to smoke cannabis will not be matched by unlimited freedom to produce it. Criminals will still exist. ●

by Prof John Whitehall

John is Professor of Paediatrics and Child Health at Western Sydney University. He trained as a paediatrician in Australia, Africa and England and has worked in a number of developing countries. In mid-professional life he retrained as a neonatologist but is now back in general paediatrics, especially as an educator. As a neonatologist he took a special interest in teratogens and brain development.

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Gender Dysphoria

Ethical Considerations in General Practice

At this cultural moment in Australia, many patients are presenting to GPs around Australia expressing a felt sense of gender dysphoria[1] and seeking medical help.

The dominant narratives promoting the concept of gender transition have been remarkable in their social and personal impacts, especially in the past five years. As a result, young people hold increasingly strong beliefs about this diagnosis and expectations about what treatment they should receive. The shifting presuppositions and demands of young patients has made work in this area substantially more difficult. The wider social conversation has also led to a dramatic epidemiological increase in young people attributing distress they experience (from a myriad of causes) to gender dysphoria. Fuelling the demand for medicalised treatment and actively recruiting patients, nine large tertiary hospital gender centres have sprung up around the country. They have been zealously promoting stories of gender transitions through all media, and have been heralding the exponentially rising number of children on hormones as a marker of success.

Managing Gender Dysphoria with Compassion, Integrity, Openness and Wisdom

I work with a lot of young people with Gender Dysphoria. Trying to take good care of these patients in a way that is faithful to God's design has been the most heart-wrenching challenge of my professional life. They have many different stories, and are at different stages of their journeys when I first meet them. Some have already been started on testosterone injections by an endocrinologist. Others are compressing their developing breasts against their body with chest binding garments. Often these young people will dress in loose, androgynous clothing to hide their bodies. Many have adopted a different name and seek to be identified as the opposite gender. Amongst this group, an extraordinary range of self-descriptors are used for both expressed gender and sexual interest. Many of these young people have never been in a romantic relationship.

For the past ten years I have been working in adolescent medicine as a GP. My work takes place within a multidisciplinary adolescent mental health clinic that is part of a larger network. I working openly as a Christian in an aggressively pro-LGBTQ organisation. At national conferences, workplace in-services and in a meeting with an activist and my manager, it has been demanded that I give specific

"It has been demanded that I give specific advice which clearly encourages young people to pursue cross-sex hormones."

advice which clearly encourages young people to pursue cross-sex hormones. It has repeatedly been said that those who refuse to conform should be bullied or coerced until they leave or submit. And yet, I continue in this work. Despite such demands, I continually strive to provide better, more honest and, ultimately, more helpful care. Some GP psychological medicine colleagues have compared my approach as akin to the refuge provided by a small island in the middle of a torrential river. My consult room acts as a place where young people can catch their breath, take time, look around and think carefully about whether or not to jump back into the chaotic waters of gender transition.

By God's grace, my work in this context has proved instrumental and timely in the lives of a number of young patients. I have young people in my care that were on a trajectory which almost certainly would have led to them being placed on exogenous hormones. Instead, we worked together to help them navigate their complex feelings, thoughts and relationships. They have been able to get meaningful support in dealing with past abuses, current hardships and anxieties about the future. With support, they have carefully considered who they want to be and decided they could do this without medical interference. Of my large cohort of patients with gender dysphoria, it is this group (who have not been put on hormones or had surgery) who are really thriving personally and in their relationships. In contrast, my patients who pursued hormonal treatments through other clinicians are irrefutably the most socially withdrawn, functionally impaired and profoundly psychologically unwell.

It is a great tragedy to see unscrupulous treatments being offered with a promise of relief and failing so predictably. There is great personal and social cost due to the medical community getting this wrong.

Recent Guidelines and Current Care

One of the Australian children's hospitals has sought to have their suggestions established as the national standard for managing gender dysphoria in Australian children and adolescents.[2] Much of the document is ideologically driven and incongruent with Scriptural truth. Amidst the document are some significant recommendations and admissions. It is suggested that a decision to begin hormonal treatments:

- Should have consensus agreement that it is in the best interests of the young person.

- Should be in the context of parental support and family work done over time.

- Should only ever be considered when there has been a thorough consideration of each of the following domains:
  - Assessment and treatment of co-existing mental health difficulties, including appropriate referrals for optimal management
  - Assessment of family support, dynamics and functioning
  - Assessment of developmental and family history
  - Assessment of cognitive, emotional, educational and social functioning
  - Comprehensive exploration of early developmental history, emotional functioning, intellectual functioning, peer and other social relationships, family function as well as immediate and extended family support.

Young people with gender dysphoria would be very well served by such an assessment! From my work with many dozens of young people, I have never experienced anything resembling a quality assessment of teens who have all been hastily commenced on hormonal treatments. Genuine

"Thorough assessments are being disregarded in favour of streamlined questionnaires designed to arrive at one certain, predetermined outcome: exogenous hormonal treatment."

assessments, designed to inform wise clinical decisions, are intentionally replaced by meaningless questions which function as a perfunctory, medicolegal bare minimum. Thorough assessments are being disregarded in favour of streamlined questionnaires designed to arrive at one certain, predetermined outcome: exogenous hormonal treatment.

Is such malpractice occurring in other parts of the country? From what I have heard directly from the doctors overseeing the nation's gender clinics I would say such negligence is widespread. For distress, or even vague questioning, about gender, hormones are promoted as the great panacea. The doctor overseeing Australia's most prominent gender clinic bragged at a public lecture that "95-98% of children and teenagers presenting to Australian gender clinics are commenced on hormonal treatment."[3]

Language is increasingly used to bully or harangue dissenting doctors, parents and teachers. Helping an adolescent with the normal tasks of adjustment and becoming at ease and comfortable with themselves (socially, biologically, mentally, emotionally and spiritually) is reframed and labelled as an unethical attempt at change[4] which may cause lasting damage.

The group collating the Australian 'guidelines' envisions an ideal candidate for hormonal treatment as: *a person with insistent, persistent and consistent expressions of gender dysphoria, a supportive family, an affirming educational environment and the absence of co-existing mental health difficulties.* In contrast, they cite "a study of the mental health of trans young people living in Australia found very high rates of ever being diagnosed with depression (74.6%), anxiety (72.2%), post-traumatic stress disorder (25.1%), a personality disorder (20.1%), psychosis (16.2%) or an eating disorder (22.7%). Furthermore, 79.7% reported ever self-harming and 48.1% ever attempting suicide."[5] Based on mental health comorbidity alone, considering their guidelines alongside the statistics they cite, the vast majority of these patients are far from ideal candidates for hormonal treatment.

It is widely recognised that Autism Spectrum Disorder (ASD) is highly overrepresented in those associating distress with gender. This seems to have increased sharply with the national conversation promoting gender transitioning as a simple solution to distress. Intense fascination with a particular topic is very common in those with ASD and a marked preoccupation with transition can result for a season. My patients with ASD have often expressed deep suicidality when they felt the narrative of transition was obstructed for any number of reasons. Of note, those who continued without hormonal intervention have with time found other areas of interests while concerns about gender have faded. Those

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who have started on hormones, on the other hand, have been greatly distressed when it failed to bring the promised solution to their difficulties with interpersonal interactions and comorbid mental health issues. It is heartbreaking to hear the deeply personal accounts[6] of young people who feel devastated by the failure of treatment and a sense of utter betrayal by doctors who misguided them with false promises of relief.

Sadly, a very high portion of young people expressing gender dysphoria have had abuse perpetrated against them. Victimisation through acts of physical or sexual violence in childhood dramatically distorts a person's view of adult manhood and womanhood. In the wake of wicked cruelty, many of these young people desperately seek to avoid being part of any further cycles of abuse. I commonly witness young men who despise the man who abused them, and feel far more connected with their abused mum and other women. In these situations, gender dysphoria can arise from a strong subconscious impulse to emulate what is good in womanhood, and abjure the abusive patterns they have witnessed from men.

Similarly, young women who experienced tragic sexual violence will often experience great anxiety in the time leading into to puberty. The normal self-consciousness of early adolescence is further magnified by a profound fear of being further targeted and abused. In this scenario, I care for a very large cohort of young women who have (often subconsciously) sought to masculinise themselves to avoid being the object of sexual attention. At the simplest level this can be wearing clothes that conceal the figure. For young women with conspicuous chests, binders are sought, not because of distress about breast tissue itself, but in a desperate attempt to dissuade lecherous men from leering at their chests.

A further level of gender dysphoria seeks to actively masculinise – a deeper voice and facial hair seek to act as an attempt to reduce further victimisation. Sadly, this cohort are placed on inappropriate hormonal treatments long before they reach a maturity where sexual assault counselling can generally be manageable and helpful. For these young women, as they get quality counselling and come to terms with the horrendous mistreatment they suffered, they also must wrestle with a permanently changed appearance, voice and the irreversible loss of future fertility. While abusers have stolen parts of their childhood, clinicians have later stolen parts of their future, including the capacity for parenthood.

"While abusers have stolen parts of their childhood, clinicians have later stolen parts of their future, including the capacity for parenthood."

Young Australians struggling with their gender should never be thoughtlessly started on hormonal treatments. Adequate assessments should seek to clarify why a person has gender dysphoria. A proper understanding of the person should lead to appropriate clinical care and counselling, address underlying causation and promote psychosomatic cohesion and social wellbeing.

Subverting Medical Science's Understanding of Human Bodies

The proposals for the changing concepts of gender identity are thoroughly ideological. Dr Deanna Adkins (Professor of Paediatrics at Duke University's School of Medicine and Director of Duke Child and Adolescent Gender Care) has offered a number of extraordinary pronouncements: "Gender identity is the only medically-supported determinant of sex". She also says, "It is counter to medical science to use chromosomes, hormones, internal reproductive organs, external genitalia, or secondary sexual characteristics to override gender identity for the purposes of classifying someone as male or female." For a person in such prominent roles to hold these positions is extraordinary. We live in strange times! What Adkin's summarises as "a person's inner sense of gender" is suggested as the guiding determinant of medical science![7]

Presuppositions of Transgender Ideology:

- Your physical identity and psychological identity are different and untethered.
- Your body may be lying to you about who you really are.
- Society is to blame for oppressive gender roles.
- There are no fixed genders or gender roles – everything is fluid and shifting.
- There is no design or intent for your body – you are to make your own reality.
- All you need for happiness is physical change.

Concerning Features of Transgender Ideology:

- Explanations and demands constantly change and morph, including the demands upon medicine.
- Differing positions or concerns raised by loving parents, caring doctors or thoughtful researchers will not be tolerated, and must be censored.
- Insists on coercion and is highly defensive. It nervously seeks to evade all scrutiny.

Statistical outcomes:

Without puberty blocking by use of Gonadotropin Releasing Hormone:

- Desistance: 80-95% of children with gender dysphoria resolve without treatment; they come to fully accept their biological sex and are emotionally well by late adolescence.[8]

With puberty blockers:

- 0% resolution, 100% persistence of gender dysphoria in children commenced on GnRH. Every child ended up on cross-sex hormones.[9]

At Australian hospital gender clinics:

- 95-98% of children and teenagers presenting to Australia's gender clinics are commenced on cross-sex hormonal treatment.[10]

Longer term outcomes:
A survey of more than a hundred studies was conducted by the ARIF research arm of Birmingham University. Despite most studies being skewed to promote transitioning, the review found "*no conclusive evidence that gender reassignment is beneficial for patients.*"[11] Instead, even in the rare clinics with very careful and conservative patient selection, the meta-analysis showed that "large majorities of patients remain deeply troubled after treatment, many to the point of suicide." A fifteen-year follow-up of Swiss patients showed lower satisfaction with general health, person, physical and social impacts from their treatment.[12]

The most rigorous study, conducted by Gothenburg University, found that, despite the full gamut of treatments – including ongoing hormonal treatments – outcomes were far worse in post-operative transgender patients.[13] Even after adjusting for past psychiatric treatment, they had three times the rates of psychiatric hospitalisation when compared to the control group. They had lower general life satisfaction scores, lower quality of life, increased social isolation, a lack of improvement in social relationships, and increased dependence on welfare. Suicide attempts were five times higher. Death by suicide was nineteen times higher. Those who did not have surgery showed a statistically significant improvement in wellbeing over time.

Clearly these procedures don't always alleviate the mental health issues they promise to resolve. Despite countless injections and operations, the investment of many years and thousands of dollars, patients' lives are worse than ever. This is a terrible, terrible solution.

A Philosophical Divide
This opens up an important philosophical divide:

Uninterrupted natural puberty in those with gender dysphoria allows almost all adolescents to become comfortable with an identity in harmony with their biological sex. In contrast, puberty can be vilified as undesirable or unhealthy for a person with gender dysphoria. In these patients, interrupting puberty always interferes with normal neurological, hormonal, physical and psychosocial development. By doing so, it increases the alienation of adolescents who are left behind by their peers as they remain children. It consolidates and reinforces gender dysphoria in 100% of young people who are hormonally manipulated in this way. It therefore makes them far more likely to end up seeking lifelong hormonal treatments and surgical sex reassignment. This means a lifetime of medically-induced social marginalisation.

"The meta-analysis showed that 'large majorities of patients remain deeply troubled after treatment, many to the point of suicide.'"

There is no way for any doctor to know if a nine-year-old experiencing gender dysphoria is one of the 5-20% who will continue to experience this dysphoria in adulthood. But a doctor can be sure that promoting medical treatments will result in a self-fulfilling protocol with a single, inevitable, irreversible outcome. Lifelong hormonal treatments, monthly visits to the endocrinologist, and a permanent inability to have children cannot be ethically or morally justified based on the self-diagnosis of a child or adolescent. It is highly dangerous to make such a decision in the context of the confounding mental health comorbidities that are ubiquitous in this population. Such drastic and experimental treatments on unwell children, and the doctors who promote this, warrant harsh scrutiny. Such treatment is certainly not something that I can recommend as a Christian who cares for my patients.

I would like to think that our major hospitals make sure that only really exceptional cases are treated with hormones, but I can tell you that Australian data indicates that between 95 and 98% of all children and teenagers who attend Australian hospital-based gender clinics are started on hormonal treatments which then are continued for life.[14]

My great concern is that an exponentially growing cohort of children and adolescents who may never have struggled, or struggled only for a season, with their gender identity are now presenting to clinics around the country insisting that puberty-blocking, potent hormones, and radical surgery on their healthy bodies is their only means to happiness and that medicine is the essential solution. At this cultural moment, a campaign is currently convincing young people to accept a lifetime of medicalisation. The outcome will be social marginalisation, ongoing disability, and terrible long-term psychological health.

Surely, quality medical practice will aim to promote human flourishing based on healthy development of one's own body, and also promote relating to others in a healthy way with an integrated union of body, mind and soul. It is imperative for physicians to have the ultimate, long-term benefit of our patients in mind.

We appreciate that even the most intense sense of gender dysphoria involves misinterpretations, incorrect social assumptions and a whole gamut of complex psychosocial issues. However, medicine must be based upon the goal of physical and mental health being restored. This requires us to be sympathetic and compassionate toward various types of suffering. For psychosomatic misinterpretations, this means helping suffering patients to manage the distress about concerns they have about their healthy, functioning bodies. It cannot, and should not, be simply a matter of acquiescing to patients' harmful desires or bowing to social

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pressure. As Christian doctors, we cannot allow ourselves to capitulate to wicked cultural demands which ask us to betray what we know to be right, true and in the best interests of our suffering patients.

Does Scripture address Gender Dysphoria?

The Bible does not speak explicitly about our modern concept of gender dysphoria, nor the current medical phenomenon of hormonal treatments for the alleviation of distress. It does, however, speak vividly about human personhood, about how we conceive of ourselves, about suffering and distress, and about our longings for change and relief. I will briefly offer four thematic points of Biblical reference.

1st : Gender and gender roles are addressed richly throughout Scripture. Great detail is contained in the chapters of Genesis and reiterated by Jesus. We can turn to countless other texts such as Ephesians 5 and 1 Peter 3. In Scripture we find explicit boundaries of gender roles within marriage and church life. But outside of these there is a distinct lack of prescribed, rigid stereotypes. Instead, there is a beautiful vision of healthy personhood and flourishing throughout Scripture. There is great freedom to find a full personal expression of who we are, as we are, as God made us – body, mind, heart and soul. God graciously, purposefully and lovingly shapes the bodies he intended specifically for us. It is within these bodies that we live our lives within the family, community and society that God places us in. It is a vision which offers great freedom of expression.

2nd: Everything is not how it should be – sin distorts us and society. Scripture's narrative about sin originates as Satan questions the goodness of God and the benefits of keeping the one boundary God had given. Adam fails to lead Eve and humankind sets itself on a course of craving self-rule and autonomy: we want to set our own rules, we want to decide, we want to act like God. As a result – brokenness corrupts God's good creation and we experience guilt and shame, sin and hiding. Our flawed bodies are definitely not a secure basis for personal identity. The Fall impacts our minds – with mental illness, confusion and rebellion against God following. Sin also devastates families and wider society by poisoning all of our relationships.

Many of my young patients see a landscape of calamity in their broken families. They experience a hurting society, marred by hyper-sexuality, distorted gender roles and wicked pressures. They are overwhelmed with fearfulness about having to live out the disfigured cultural caricatures of manhood or womanhood, and begin to think, "I can't do this!!!" In this tragic context, the promise of gender transition seems to offer a lifeline. Prompted by a society that rejects God, they begin to question the goodness of how God has created them. They begin to doubt the basic foundations of life, relationships and even their own bodies. A great paradox exists when our society encourages young people to doubt their bodies, when their body may be one of the few clear pointers in their life to God's intentionality and purposeful design.

3rd: The Gospel is all about producing radical personal and societal transformation. A deep yearning for radical change is the driving force of transgenderism. As Christians, we recognise that only the Gospel can bring about such profound personal and societal redemption. Ultimately, we Christians share a similar desire to that of gender activists – to see people deeply transformed – but we have radically different ideas about what true change looks like and how real change can happen. Without Christ, self-identity-making projects are doomed to fail. Without Christ, no amount of surgery, hormones or social transitioning can bring the sweet relief we all long for. Can we not cry with these folks? Because alongside them, we also recognise how broken we are, and how much we need the transforming work of God. Because we are Christians, we know Christ, and we are granted the task to share his life-giving message to the marginalised and outcast of our society. Who is more marginalised and longing for radical transformation than the transgender community?

4th: Identity – do we make our own? Or do we find our identity in Christ? Our truest identity is defined by God. Because He made us and has called us His own – He gets to say who we are. No longer suppressing our knowledge of God as Romans 1 describes, our newly revealed knowledge of God and our relationship with Him help us to more truly know ourselves. Other, self-made, sources of identity are no longer primary. Our truest identity is now relational – as Ephesians emphasises, we are with Christ, we are in Christ. Christ is our stable reference point. In Christ, we experience the work of God's sanctification – we get to experience living transformation and true freedom. And this gradual transformation through sanctification will one day be complete. 1 Corinthians 15:52 promises: "We shall all be changed, in a moment, in the twinkling of an eye." Whilst it is good to desire change, true change is ultimately only possible through Christ.

My approach:

For young people, I consider it essential to explore the feelings and thoughts that create a link between their biological sex and concerns about future social roles, relationships and expectations. It is important to me that children are supported in healthy psychosocial and sexual development, including addressing misapprehensions about stereotypes and the actual meaning of their biological sex. There are likely to be predisposing, precipitating and perpetuating factors involved in feelings of gender dysphoria.

I seek to explore personality, family dynamics, family mental health history and its impact. Exploring peer relationships with both sexes is essential. Relationships with parents, instability in the family home and the quality of attachment all have a profound impact on whom children identify with and the way gender roles are perceived. Personal temperament

also plays a large role – overactive girls and underactive boys are far more likely to identify with the other sex as a result of differing playtime interests, such as an aversion to rough play, interpersonal interactions and sensitivities. In such cases it is a great relief for children to know that it is okay to be a sensitive boy, or a girl who likes to participate in full contact sports. In all of their personal preferences, young people can come to understand that they can be comfortable with who they are.

In the common presenting request to transition, I seek to slow things down. I explore with my adolescent patients what they expect and hope that gender transition would change in their life and the benefits they anticipate. I also explore aspects of transition that may cause them to be hesitant or uncertain.

It is really important to help the large portion of adolescents with autism spectrum disorders and gender dysphoria to understand what contributes to a sense of not fitting in, of not belonging, or of interpersonal interactions being exhausting. It is also important to recognise the intense, obsessional and very rigid thinking that promotes these patients to see gender in very black and white terms. To challenge these obsessions hastily, without sensitivity and love, can produce severe anxiety.

We can't afford, as Christian doctors, to apply simplistic treatments to these young people. It is not sufficient to have a five-minute consult, give a jab of testosterone and say "see you next month". As a parallel situation, if a child was stressed out about their ethnicity, we would always seek to help them appreciate the various dynamics involved. For example, we would never encourage someone to bleach their skin in order that they might feel more comfortable amongst lighter-skinned peers. In a similar way, good medicine requires us to care more. To care about the "Why?" underlying a sense of gender dysphoria. We want to help promote healthy attitudes and feelings towards our God-given bodies. We want to establish an understanding of healthy differences between the sexes and the ability to challenge restrictive stereotypes. We seek to promote a richer understanding of the diverse scope of healthy manhood and womanhood.

"I continue to support these young people, and care for them with compassion. The same cannot be said for the clinicians who take their money, treat them with hormones and are extraordinarily uninvolved.'"

Ultimately, I want young people to be able to flourish and become comfortable with who they are in a complex and broken world. Caring for this population is a tremendous challenge and a great privilege. I have many dozens of young people who have come to see me, deeply convinced of a trans identity. A few have started transitioning through other doctors and they are in terrible shape. Almost universally in this group, chronic suicidality is relentless. The social impact is terrible. I care for numerous patients who feel substantial regret for starting hormones, but feel that they cannot turn back. Some say, "*I have already put my parents through too much for me to change my mind.*" Or, "*The T (testosterone) makes me feel so awful, I'm angry and explode all the time. I hate it, but I can't stop or I'll be stuck; I won't be a man or a woman.*" Others struggle with the prospect of ridicule and shame, feeling that they were wrong, but not wanting people to torture them about their mistake.

For those that continue, they live with this solitary goal… "I hope that I pass." "I hope that I pass for being a woman." "I hope that someone doesn't question my patchy facial hair." "I hope I don't get attacked." I continue to support these young people, and care for them with compassion. The same cannot be said for the clinicians who take their money, treat them with hormones and are extraordinarily uninvolved. Amongst all of my patients, these young people are overwhelmingly the most psychologically unwell.

My experience of patients under the care of psychiatrists who persuade and induce adolescents to transition, and the endocrinologists and surgeons who facilitate it, is of tragedy. Despite varied backgrounds, (of social anxiety, of feeling different, of broken families or living in the rubble and aftershocks of abuse) the results are remarkably consistent – increasing feelings of alienation, marginalisation from the wider family, distress at hormonal side-effects, and reinforced desperation about themselves. Transitioning not only fails to bring the promised relief, it seems to worsens the un-dealt-with anxiety, depression, ASD, social brokenness and impacts of trauma which contributed to the initial gender dysphoria.

Another common scenario is of thoroughly disabled adolescents, barely able to engage in self-care or socialise, unable to work, trying to save up Centrelink payments for a bilateral mastectomy. "*I feel heaps worse than before treatment, but I'll start feeling better once I have top surgery.*" In the lives of a substantial number of my patients, the well-intended medical interventions are unmitigated failures. Because of my care for them, it is personal to me, and it is heartbreaking.

By God's grace, the vast majority of my patients who have come to see me in the primary healthcare setting with a sense of gender dysphoria are on the journey of acceptance, of healthy relationships and flourishing. Clinically, we are taking it slow and we are making headway. Most are swimming against the current by not starting hormones. We try to address all of the things that are going wrong. We are treating depression and anxiety. We are organising quality sexual assault counselling. I'm making sure that my patients on the autism spectrum

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are given good support to help with their interpersonal interactions. I am helping to facilitate better parent-child relationships. I am helping young people to consider what healthy relationships look like.

Rather than accepting the simplistic and superficial treatments of gender transition, we are working towards fuller, more authentic lives. We are hunting for and celebrating the good stuff, God-given character and gifts. We are working through the discomfort and pain and trauma. I'm praying for them, and sometimes with them. They get to witness the love of God in me, through consistent care and in my words. I've grounded my care in Scripture and seek the Spirit's leading. I take the time to cultivate meaningful conversations about what is most important in life, including spiritual wellbeing, and I prayerfully seek God's help in the way I work and walk alongside them.

A number of these patients are starting to explore the Christian faith and are becoming involved in local churches. In God's sovereignty, He placed these folks in a pro-LGBTQ clinic, with an openly Christian GP, who seeks to be a faithful witness to them by offering consistent, holistic care.

As you will almost certainly care for some of these young people in your own careers, I'd like to leave you with these encouragements:

- The Gospel is the most wonderful agent of change and transformation.
- Jesus, the great high priest, sympathises with us in our weakness – follow his example.

As Gospel-fuelled doctors please know your patients well, listen closely, care deeply, speak with great honesty, and point them always to their very real and ultimate source of hope in Jesus Christ. Overflow with Christ's compassion and love. As terrific as our medicine is, our patients need Jesus' living water far more than they need our medicine. Please be doctors who are brave enough to share the living water of the life-changing Gospel with your patients. ●

For parents seeking your help:

- Encourage them to not overreact, to ask good questions of their child, support a clear perception of reality and social adjustment without transitioning.
- Reinforce that blocking puberty has a huge negative impact on social wellbeing and outcome.

Suggestions when counselling young people with Gender Dysphoria

- Allow the person to be deeply known by you.
- Don't get overwhelmed or panic.
- Don't let anger at society impair your sensitivity and care for individuals
- Don't let gender dysphoria become the sole focus.
- Be ready to explore the fuller sense of what gender means to them.
- Consider that different approaches are essential for different people. "If you've met one person with gender dysphoria… you've met one person with gender dysphoria".
- What are the bases for this person's identity?
- What shapes this person's worldview, vision of personhood and questions of faith?
- What other issues that may be contributing: victimisation and traumatising exposures, social expectations, roles and stereotypes, difficulty relating to others and those on the Autism Spectrum. NB: A different approach is needed for those who are expressing gender as experimenters, as activists, and as older men (who often have eroticised reasons for pursuing transition).

by Anon

Anon is a Christian seeking to incorporate faith into his work as a family GP in the care of complex patients and family relationships. For a decade, Anon has worked two days a week in numerous adolescent mental health clinics. Anon feels most fulfilled at work when Anon can assist unbelievers to experience God's loving kindness, and can demonstrate how the Gospel is vividly applicable in suffering. Anon loves witnessing God bringing restoration to human calamities, giving life to the spiritually dead, and producing joy to the praise of His glory. Feel free to contact the author directly via office@cmdfa.org.au

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At the Border of Life

I have held a baby born at 22 weeks, the youngest age of the premature babies in our hospital nurseries.

All babies like her who are born over 20 weeks require a birth certificate and, if they die, a death certificate. They are little Queenslanders under our law.

If someone had tried to attack that little baby while I held her, I would have protected her. Yet Labor's Termination of Pregnancy Bill 2018 allows adults to put their unborn baby to death up to 22 weeks of age on demand, no questions asked, and any doctor who tries to protect that baby will be breaking the law of the land.

This is a time for civil disobedience. Labor's abortion law not only declares open season on entirely healthy babies of entirely healthy mothers up to 22 weeks of pregnancy, but also crushes the conscience of doctors who object to this barbarism.

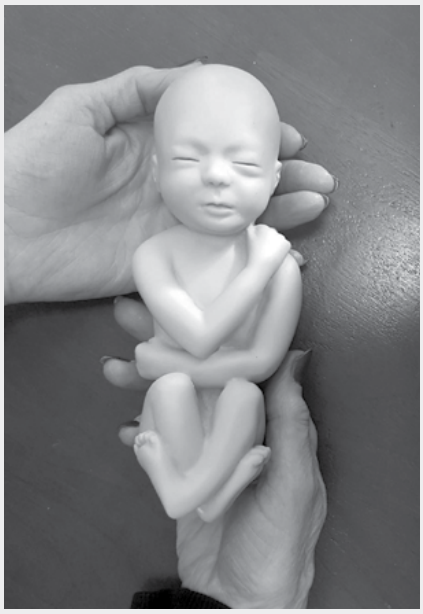
A GP colleague of mine, Mark Hobart, has already faced this coercion of conscience under section 8 of Victoria's Abortion Law Reform Act 2008, which mirrors section 8 of Queensland's proposed law.

Section 8 compels a doctor to collaborate in a patient's request for termination of pregnancy, even if the doctor thinks it is medically unjustified and morally wrong.

Dr Hobart was approached by an Indian couple at 19 weeks of pregnancy who wanted an abortion because they were having a girl and they only wanted a boy.

By refusing to give a referral, Dr Hobart broke the law in Victoria – just as GPs in Queensland will be breaking Labor's law if we refuse to sentence a 19-week unborn baby girl to death for the crime of being a girl.

We will refuse. We will defy this "unjust law which carries the hallmarks of totalitarianism". That was how Frank Brennan, former chair of the National Human Rights Consultation Committee, described the Victorian abortion law, which it now appears will be replicated in Queensland.



A model depicting a 20-week baby.

"...under the Palaszczuk/ Trad Labor government, principle has given way to ideology; the stilettos of sexual liberty and feminist power will stamp on that silent innocence."

ACU Vice-Chancellor and Professor of Law Greg Craven described section 8 of that law as "fascist". The late hospital ethicist, Professor Nicholas Tonti-Filippini, said, "expecting a doctor to act against his conscience is totalitarian". And the mild-mannered father of general practice in Australia, Professor John Murtagh, denounced section 8 as "Stalinist".

With virtually identical legislation due to be voted on in Queensland next week, we need courageous legal and medical voices to denounce this evil.

Queensland law always has allowed for abortion in those rare, tragic cases where it is needed to save the mother's life.

Our law has also been principled and just in defending the weakest members of the human family, with Justice McGuire's ruling from 1986 declaring, "The law in this State has not abdicated its responsibility as guardian of the silent innocence of the unborn".

But under the Palaszczuk/Trad Labor government, principle has given way to ideology; the stilettos of sexual liberty and feminist power will stamp on that silent innocence.

These are dark days. We know our culture is brutalised when we violently repel these little asylum seekers at the border of life. We know our politics is brutalised when we enshrine intentional killing in our law.

As to that baby I held at 22 weeks, in the end we could not save her. Before she died, her mother asked a nurse to christen her, we dressed her in the tiny gown that volunteers knit for premmie babies, and she took a few small breaths on her mother's breast.

Isn't that the right way to treat a 22-week baby, Premier Palaszczuk? Think of her as you cast your vote on a life-destroying law that carries the hallmarks of totalitarianism. ●

by Dr David van Gend

David is a Toowoomba GP and senior lecturer in palliative medicine, married to Jane with three adult sons. Since 1994 he has been Queensland Secretary of the World Federation of Doctors who Respect Human Life, an organisation founded by the late Dr Jerome le Jeune. David wrote a best-selling book for the marriage campaign, *Stealing from a Child* (Connor Court, 2016) and is drafting a new book on the last quarter century of bioethical battles in Australia.

This article was first published in *The Courier Mail* on 16 October 2018.

Homosexuality and Same Sex Marriage

We've had the nationwide vote; arguments, voting and jubilation in national parliament; new and ongoing same sex marriage ceremonies and now the follow-up concerns from Christian groups about other freedoms – of religion, thought, speech, public expression and education.

How are our lives as medical and dental professionals impacted – in family, community and professional practice? There are many areas which could be examined – psychological, sociological or political but I will explore only the scriptural basis for our beliefs. I discuss this in some detail in the recently published: *Malcolm Dunjey, 136 Questions about God's Word and his World*.[1] Here I will use the framework of a dedicated chapter in that work and expand relevant areas.

The Old Testament

The key texts are Leviticus 18:22; 20:13 and Genesis chapter 19.

Let us first examine the second Levitical passage, Lev 20:13:

> *"If a man has sexual relations with a man as one does with a woman, each of them has done what is detestable. Each of them is to be put to death; their blood will be on their own heads.".*

As 21st Century Christians what are we to make of this dramatic statement and brutal sentence? Here are some quick points:

- God's attitude on homosexuality in the Old Testament (OT) is crystal-clear: detestable.
- This penalty is "over-the-top" by our current standards but in keeping with a very wide range of OT death penalties for offences such as blasphemy, cursing parents, adultery, bestiality and so on.
- To whom were these teachings directed? The commandments, penalties and teachings were part of God's covenant relationship with Israel, his chosen people. They were not, along with the rest of the OT given to the surrounding Gentile nations who made no profession of faith in YHWH, the personal name of the God of Israel.
- While Christians accept the OT as inspired scripture, it doesn't mean we practice it in its entirety, ie. the death penalty for homosexuality.

The following are the key points in deciding which parts of the OT are for practice for us today:

- If it is repeated in the NT we accept it.
- The proclamation from the Jerusalem Council in the letter to the Gentiles was specifically to clarify what the Jewish believers in Jerusalem thought was obligatory for Gentile believers to observe from the OT:
  "You are to abstain from food sacrificed to idols, from blood, from the meat of strangled animals and from sexual immorality" (Acts 15:20).
  This is very interesting in the things it didn't mention. The new Gentile believers weren't required to keep the Law of Moses: they didn't have to be circumcised (the major issue). This proclamation is not inspired but is indicative and historically important.

- There are no death penalties in the NT and Jesus seemed to not approve them.

The Genesis 19:1-29 passage.
This is an amazing OT story which precedes the above discussion on the Levitical texts. The setting is pre-Mosaic – Sinai and the giving of the Law – and these texts has not yet been given. There is no OT and no written revelation from God, although the stories of creation, the Garden and subsequent events up to the time of Abraham must have been orally 'preserved' up to the time when Moses recorded them (presumably during the 40 years in the wilderness prior to the entry into the promised land of Canaan). Revelation from God during this period was by personal appearances, often through angels ('messengers' being the Hebraic word), when sometimes one of the angels seemed to be God.

"In our modern society there is almost a glorification of same-sex relationships."

The account begins two chapters before in chapter 17, when the LORD (YHWH) personally appears to Abram, initiates a covenant, changes their names to Abraham and Sarah and announces that Sarah will become pregnant. In chapter 18, the LORD appears again to Abraham with two angels revealing the forthcoming destruction of Sodom and Gomorrah because of their "so grievous sin" and Abraham negotiates with the LORD over the destruction. In chapter 19, two angels come to Lot who has settled in Sodom and the story proceeds.

This concerns Lot, the angels and the attempted homosexual rape of the angels and the destruction of Sodom and the cities of the plain. The passage is too long to reproduce here but it would be important for you to read it before reading my analysis (Gen 19: 1-29).

The story is Eastern in character – it's so unusual – but it has to be true, especially with the extraordinary postscript in 19:30-38 – the story of how a drunken Lot fathered the Moabite and Ammonite nations through sex with his two daughters who had made it out of Sodom with him.

The story is also noteworthy for the following:

- Lot's unbelievable interpretation of his obligatory protection of his two visitors. Did he suspect they were heavenly in origin? He would surely have done so by the time the whole episode was over with entire plain turned into a smoking ruin.
  "YHWH rained down burning sulphur on Sodom and Gomorrah… he overthrew those cities and the entire plain, destroying all those living…dense smoke rising from the land…like smoke from a furnace", (19:24-25, 28).
- Lot's also unbelievable offering-up of his two virginal daughters, attempting to deflect the sexual rage of the men of Sodom. "You can do what you like with them" (19:8).
- Lot's wife's punishment. She disobeyed the angels "don't look back" (19:26) possibly lingering and being caught up in the judgement. She might have initially come from Sodom.
- The OT does reveal God's intervention in acts of punishment for sin in which the destruction of Sodom and Gomorrah and the settlements on the plain was a key event, preceded by the Flood, followed by conquest of Canaan.

All this is the context to the "vexed" texts in Leviticus, 18:22:

You shall not lie with a male as with a woman; it is an abomination.

For the full picture we must read the unexpected expansion on the sins of Sodom in Ezekiel 16:49-50:

"Now this was the sin of your sister Sodom: she and her daughters were arrogant, overfed and unconcerned; they did not help the poor and needy. They were haughty and did detestable things before me."

Subsequently, Jesus, 2,000 years later in sending out the Twelve to preach, states if "anyone will not welcome you or listen to your words…it will be more bearable for Sodom and Gomorrah on the day of judgement than for that town" (Matt 10:14-15) – surely an interesting comparison of sins and judgement. Keep all that in mind!

The New Testament

There are several relevant texts in the New Testament. Let us start with Romans 1:18-32:

"The wrath of God is being revealed against all the godlessness and wickedness of the people… for since the creation of the world God's invisible qualities – his eternal power and divine nature – have been clearly seen… so that people are without excuse… Therefore God gave them over in the sinful desires of their hearts to sexual impurity for the degrading of their bodies with one another… Even their women exchanged natural sexual relations for unnatural ones… men were inflamed with lust for one another… men committed shameful acts with other men… so God gave them over to a depraved mind".

There were other sins, of which homosexuality was part:

"every kind of wickedness, evil, greed and depravity…full of envy, murder, strife, deceit and malice. They are gossips, slanderers, God-haters, insolent, arrogant and boastful; they invent ways to do evil; they disobey their parents; they have no understanding, no fidelity, no love, no mercy (v.29-31)".

In our modern society there is almost a glorification of same-sex relationships which the post-vote scenes in our Parliament typified and against which God's deeper analysis needs to be compared.

It is relevant to examine one further NT text, 1 Corinthians 6:9-10:

"Neither the sexually immoral nor idolaters nor adulterers nor men who have sex with men nor thieves… greedy… drunkards… slanderers… swindlers will inherit the kingdom of God. And that is what some of you were. But you were washed… sanctified… justified in the name of our Lord Jesus Christ".

In the Greek the phrase "men who have sex with men" uses *malakoi* (the

continued over page >>>

passive participant) and *arsenokoitai* (the active participant) thus covering both aspects of the homosexual act. Although the sentence of not entering the kingdom of God sounds fixed, it could be reversed as it had been for repentant Corinthian Christians. Once again homosexuality takes its place in a long list of other sins as it does in the letter to the Romans.

Homosexuality is not singled out as being the worst of sins nor does it attract a special penalty.

Same Sex Marriage

There is no scriptural prohibition to intense same-sex friendships, of either sex, providing they do not become physically sexual. The friendship between David and Jonathan is often referred to as an example. The biblical teaching on marriage is that it is heterosexual, life-long to the exclusion of others and, if the participants are able, it usually produces children. Same-sex marriage is not discussed anywhere in the Bible. However, because it is sexual and same-sex, it falls under the 'umbrella' of homosexuality and therefore the condemnation of scripture. This is the scriptural argument against same-sex-marriage as brief as it is.

The scriptural references to marriage start in the Garden of Eden when

> *"a man leaves his father and mother and is united to his wife and they become one flesh. Adam and his wife were both naked, and they felt no shame" (Gen. 2:24-25).*

Jesus reaffirmed this in

> *"Haven't you read that at the beginning the Creator made them 'male and female' and 'For this reason a man will leave his father and mother and be united to his wife and the two will become one flesh?'" (Matt 19:4-5).*

"At the political level we should fight for our freedoms: of religion, thought, speech, choice and education, including what some teach our children."

Paul quotes this again,

> *"For this reason a man will leave his father and mother and be united to his wife, and the two will become one flesh". He then adds "This is a profound mystery but I am talking about Christ and the church" (Eph. 5:31-32).*

This is a new and overwhelming statement: that the intensity of physical, sexual and spiritual love between a husband and wife is overshadowed by that between the individual believer and our heavenly lover, Jesus – God himself, who gave his life and love for us. For this reason, same-sex marriage is tragic, unscriptural and has God's condemnation. It has no role to play in this earthly/heavenly drama.

'Pastoral' and Community Implications

We must be clear in our own minds as to the scriptural teachings outlined above. Many people get entangled in psychological and sociological arguments which have no end. If we are defending our position we must stick with scripture.

We are entitled to a community voice and have not become disenfranchised as some would claim. At the political level we should fight for our freedoms: of religion, thought, speech, choice and education, including what some teach our children.

It is not our role to condemn others personally. We cannot be censorious with family members, patients, colleagues or community. In my long career as medical practitioner, pastor and missionary I have never been asked for my opinion, face-to face, on an individual's chosen lifestyle. If I had, I would have replied along the lines of an inclusive, friendly "All of us answer only to God for our lives".

The Spirit of Jesus is to live out in us through the "fruit of the Spirit… love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control" (Gal. 5: 22-23). ●

by Rev Malcolm Dunjey

Malcolm and Audrey Dunjey, married for 61 years, have a large family including 5 great-grandchildren. They were Interserve missionaries in Bangladesh, Pakistan and Yemen and worked with government in WA, NT and PNG. Malcolm is an ordained Baptist minister with a post-graduate BD from MCD and has qualifications in public health medicine as well as medical administration. He has written an autobiography *To the City of the Great King*,(Ark House:2009), and *136 Questions about God's Word and his World*, (Ark House: 2017). Malcolm is currently studying Biblical Hebrew and Modern Hebrew from Hebrew University, Jerusalem.

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VALE

Dr Margaret Joy Payne

15.2.1938 ~ 10.8.2018

Margaret was born the first child of school teacher parents. In fact, Margaret's Dad was one of her early teachers. Clearly he had a very intelligent student.

After school Margaret went on to study pharmacy. Whilst doing hospital pharmacy work she was inspired to study medicine, and supported herself working part-time in pharmacy during her medical degree at Sydney University.

Post-graduate study in her chosen specialty of Obstetrics and Gynaecology was undertaken at Crown St Women's Hospital in Sydney. Margaret began private obstetric practice in Tamworth, NSW. Over her lifetime, she is said to have delivered over three thousand babies in Tamworth.

Margaret's pastoral care and listening ear led her to a career in counselling once her obstetric days were over. In order to prepare herself for the role of Christian counsellor Margaret did a theological degree through Ridley College in Melbourne.

Margaret continued to serve the Christian medical community by becoming a part-time staff worker for CMDFA NSW. In this role she continued as an active mentor for many students and young doctors. She was involved in organising conferences (including being on the ICMDA Sydney 2006 organising committee), arranging dinners for CMDFA NSW and, more locally, on the Central Coast of NSW.

Margaret returned to Tamworth in the last few years of her life. There she had the joy of reunions with hospital staff and patients.

Margaret lived to serve her Lord and Saviour each day. Hers was truly a life well lived. ●

by Dr Sue Armstrong

VALE

Dr Alex Brown

16.3.1948 ~ 14.8.2018

We met our dear friend, colleague and brother-in-Christ, Alex Brown, as medical students in the sixties.

Alex, Blair Campbell and Warwick Britton were, like us, very much part of EU (AFES). We renewed acquaintance when we moved to Tamworth. Alex and I either followed one another into medical roles, or worked as associates, over twenty years. Alex was a compassionate Generalist, and made a great contribution to aged care. He was excited about new technology, and was the first in Tamworth to carry a mobile phone - a Motorola 'bag-phone'.

In addition, Alex was dedicated to prayer and ministry, particularly in music. He played inspirational keyboards for a decade at St. Paul's, West Tamworth, and then at Oxley Vale for another decade until

disabled by Motor Neurone Disease (MND). As we shared morning tea in our Werris Creek practice, Alex and I would debate genres of church music and forms of worship. Though we often disagreed, we never ceased to love and support one another in Christ.

Alex ran the musical team at many CMDFA conferences, often with Judy and myself leading the singing. I recall on several occasions meeting up with Margaret Payne (also from Tamworth) and Alex and Lyn prior to conference to set up the sound, write names on tags and collect the money!

Alex's last words to me, chair-bound and almost inarticulate, were a croaky "I can still pray ……and listen to worship music".

To both Alex and Margaret I say, "Well done, good and faithful servant". ●

by Dr Richard Thornton

Same-Sex Marriage

Implications for Christian Health Professionals

This presentation was first given to CMDFA Newcastle in March 2018.

Introduction

I teach law at Newcastle Law School[1] and lately I have been teaching a course on "Law and Religion" to upper level law students. I also run a blog on this topic.[2] So I have done a bit of thinking about same-sex marriage, which raises a number of law and religion issues (for reasons I will outline shortly).

My own position is that same-sex marriage was not a good legislative development, but of course I recognise that not all Christians agree, and I accept that some may support it for a range of reasons. But I hope that even if you personally think it was a good idea, you will see why it raises a number of important religious freedom issues for many other Christian health professionals, and this paper may equip you to understand the issues and to respond to the challenges, either for yourself or others, with godly wisdom.

What I want to say is structured in this way: I will provide a brief update on the legal position of same-sex marriage in Australia; I will then review legal protections in Australia for religious freedom (some of which will be relevant for issues other than marriage); and then I will aim to offer some comments on how same-sex marriage may raise difficulties for health professionals.

Background- Same-Sex Marriage in Australia

So, where are we up to with same-sex marriage in Australia? Most of you will know we have had a lengthy debate and legislative process about this for the last few years, and I won't review any of that for the moment.

Australia has now joined those other (mainly Western, developed) countries which recognise same-sex marriage.[3]

The law of Australia on this topic was, following a popular vote in a "postal survey", officially changed on the commencement of the *Marriage Amendment (Definition and Religious Freedoms) Act* 2017 (Cth) on 9 December 2017.

At a broader level, though, the change means that many religious groups are now opposed to the wider societal consensus on the question of sexual morality, and questions are raised as to whether they will still be able to play a role in the public life of the community.

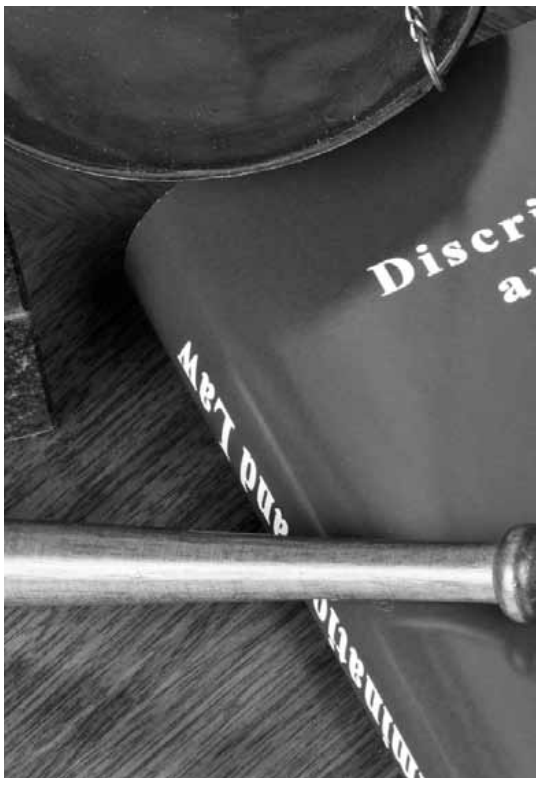
"Representatives of religions have long been involved in conducting weddings. Questions now arise as to whether they will be required to solemnise same-sex unions."

The title of the amending legislation seemed to promise that careful attention would be paid to the topic of 'religious freedoms'; but as it turns out, the protections formally provided were fairly minimal. As I will note, this leaves some problems for those Christian believers who are convinced that the Bible's teaching is that homosexual behaviour is sinful. (There are various passages that one could point to, but perhaps the most persuasive and clear are the three main passages in the New Testament, Romans 1:26-32, 1 Corinthians 6:9-10, and 1 Timothy 1:10.)

Adoption of same-sex marriage raises religious freedom issues because the move effectively amounts to a change in our nation's 'public morality', and takes a stance on the issue of what kind of sexual activity is legitimate, which is in sharp opposition to the views taken by mainstream religions for many years.

There are obvious issues for clergy and those involved in solemnising marriages. Representatives of religions have long been involved in conducting weddings. Questions now arise as to whether they will be required to solemnise same-sex unions. Similar issues arise for believers involved as small businesses in the 'wedding industry'.[4]

It is worth noting that many of these matters are issues which would have come up even if the Australian public had not voted to change the definition of marriage to include same-sex couples. Religious groups have been "out of step" with the broader Western culture's views on sex and marriage for some decades.[5] But the formal step of Parliamentary approval of sexual activity officially disapproved by most



mainstream religious teachings brings these issues into sharp focus.

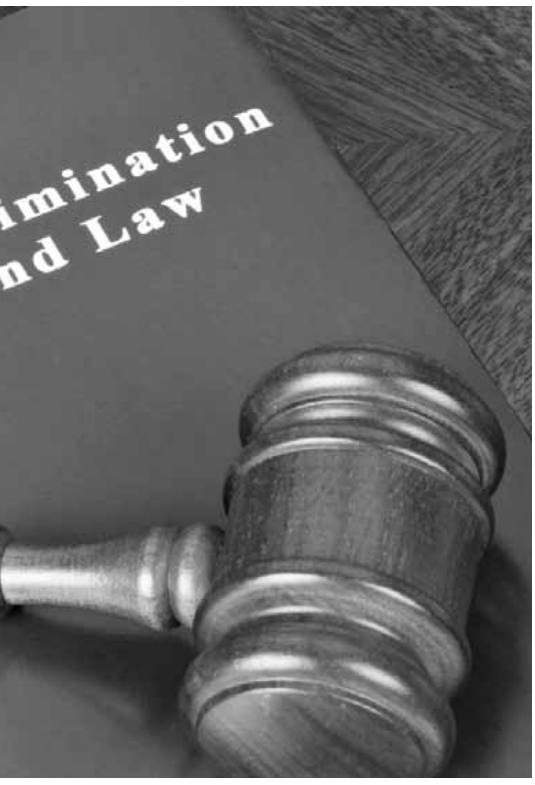
Religious Freedom and its legal protection in Australia

There are some laws protecting the right of religious persons to live out the commitments of their faith in their lives. But these laws are very patchy and not very strong in Australia.

As was noted by the Interim Report of a Parliamentary Committee currently examining the matter,[6]

> *legal protection of religious freedom in Australia is limited. Australia is unusual among modern Western democracies in that it lacks a codified bill or charter of rights. While a culture of religious freedom has thrived, and the common law has respected religious freedom to a large extent, the legislative framework to ensure this continues is vulnerable. (at viii)*

In broad terms, religious freedom is legally protected in Australia through Section 116 (s116) of the Commonwealth Constitution, some specific Charters in two jurisdictions, and the operation of discrimination laws in the various jurisdictions (either explicitly making discrimination on the basis of religious belief unlawful, or by inclusion of "exemptions" or "balancing clauses" allowing religious belief to operate in ways that would otherwise be proscribed by those laws.)[7]



In particular, s116 as a Constitutional protection of religious freedom is not very strong, at least as it has so far been interpreted in the courts. It provides:

> *The Commonwealth shall not make any law for establishing any religion, or for imposing any religious observance, or for* ***prohibiting the free exercise of any religion****, and no religious test shall be required as a qualification for any office or public trust under the Commonwealth. (emphasis added)*

It seems clear that the ban on "prohibiting the free exercise of any religion" is only applicable to the Commonwealth Parliament, leaving State Parliaments able to do so if they choose.[8] In addition, a number of the (fairly few) cases that have considered the meaning of the "free exercise" clause of s116 have suggested that it would only be breached by laws the main and obvious purpose of which was to prohibit free exercise. (I have argued elsewhere that this view is too narrow, and that comments in the primary authority on the provision, *Adelaide Company of Jehovah's Witnesses Inc v Commonwealth* (1943) 67 CLR 116, suggest that the test should be whether there is "undue" impairment of free exercise through the operation of the law.[9] But the question is by no means clear.)

The other avenue through which religious freedom is protected is through discrimination laws, in two different ways.

First, some laws around Australia forbid discriminating against someone on the basis of their religion. But laws doing this are not found everywhere, and in particular there is no general prohibition of religious discrimination in NSW.[10] You would be entitled, for example, when advertising for a new staff member for your practice, to specify that the person should be an active Christian believer, and you would not be breaching NSW law. On the other hand, someone engaging staff would also be entitled, as the law now stands, to say that they would not employ a Christian! Thankfully the general social norms of our community (and, I have to say, ignorance of the law!) means that this does not happen very often.

The second way that discrimination laws protect religious freedom is by allowing, in some cases, an exemption from the operation of the law where religious beliefs are involved. I prefer to call these provisions "balancing clauses" rather than exemptions, as the purpose of such laws is to allow the balancing of religious freedom rights with other rights not to be discriminated against.[11] Perhaps the most obvious example is that laws forbidding sex discrimination, all have provisions allowing religious groups which have classically only ordained men as clergy to do so and not be in breach of the law.

In NSW there is a general balancing clause of this sort, in s56 of the *Anti-Discrimination Act* 1977:

> *Religious bodies*
> *56. Nothing in this Act affects:*
> *(a) the ordination or appointment of priests, ministers of religion or members of any religious order,*
> *(b) the training or education of persons seeking ordination or appointment as priests, ministers of religion or members of a religious order,*
> *(c) the appointment of any other person in any capacity by a body established to propagate religion, or*
> *(d) any other act or practice of a body established to propagate religion that conforms to the doctrines of that religion or is necessary to avoid injury to the religious susceptibilities of the adherents of that religion.*

However, as with most other such laws around Australia, this clause only applies to "religious bodies" or a "body established to propagate religion". It might be applicable in the medical context to a Catholic or other religious hospital, however. As far as I am aware there is no direct authority as to whether a religious hospital could be said to be a "body established to propagate religion". But I have to say that there is a case from Queensland

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which is not very promising on this point.

The case of *Walsh v St Vincent de Paul Society Queensland (No 2)* [2008] QADT 32 raised an issue of discrimination on the basis of religion. Here a lady who was in charge of a local St Vincent de Paul branch was told that she had to step down as she was not a Roman Catholic. There was an attempt to apply the provision of the Queensland legislation which allowed a "religious body" to be exempt from the Act in terms of appointment of priests and ministers, training of such, and appointment of people to carry out "religious observances".[12]

In the end the Tribunal found that the provision did not apply because the St Vincent de Paul Society was not a "religious body"! This somewhat surprising conclusion was expressed as follows:

> *[76] On my reading of the constitution documents, the **Society is not a religious body**. It is a Society of lay faithful, closely associated with the Catholic Church, and one of its objectives (perhaps its primary objective) is a spiritual one, involving members bearing witness to Christ by helping others on a personal basis and in doing so endeavouring to bring grace to those they help and earn grace themselves for their common salvation. That is not enough, in my opinion, to make the Society a religious body within the meaning of the exemption contained in sub-sections 109 (a), (b) or (c).*
>
> *[77] Likewise, and despite the particulars which have been provided of the functions of the president relied upon, and the religious observances and practices said to be relevant, it does not seem to me that the fact that a conference president performs some functions (such as leading prayers) and has some duties (among a long list of duties), some with spiritual aspects and some with practical aspects, means that what happens at conference meetings, or what the president does in the discharge of his or her duties, involves "religious observance or practice". (emphasis added)*

While most people would see "Vinnies" as providing services to the poor rather than religious services, it does seem a bit odd that an organisation which can be described as it is in para [76] is not "religious".[13]

For those medical professionals who do not work for a church organisation, then there is really no direct protection under s56.

"...a calm and reasoned discussion of Biblical views, or a rational presentation of medical evidence, should not be caught. Having said that, with the temperature rising in this area..."

Religious Freedom implications for health professionals

Let's see how some of these principles might play out in health practices, in relation to same-sex marriage.

- **Public statements by professional bodies**

One worth mentioning, simply because we have seen what happened, is the context of public statements that are made by professional bodies. During the debates around the "postal survey" on same-sex marriage, a number of peak professional bodies issued ringing endorsements for a change of the law. This was done by the NSW Law Society and the NSW Bar Association, and myself and a number of other Christian lawyers issued a formal press release expressing our disagreement with this view, and disappointment that the statement purported to be on behalf of all lawyers in NSW, when it most certainly was not.[14] In fact, not because of our statement, but because of some other threatened legal action by Robin Speed from the "Rule of Law Institute", the Law Society later issued a clarification confirming that the views it had expressed did not represent the views of all their members.[15]

Most of you will be aware that a similar statement in support of same-sex marriage was made by the AMA in May 2017. There was then what I regard as an excellent response prepared by a group of doctors who disagreed, in a careful medical argument: see Why the AMA should retract its statement on 'marriage equality' at https://critiqueama.wordpress.com (published on Aug 5, 2017) . For whatever reasons, the AMA did not retract its comments, which many people would also have seen as representing universal support for same-sex marriage by Australian doctors.

While the NSW Law Society seems to have been susceptible to pressure by a group of its members, the national peak medical body seems to have felt it did not need to respond to the objectors from within its ranks.[16]

There seems to be little legal recourse for those members of the AMA who objected to its published stance on the issue. However, the events do raise another question. Did those who objected, by simply citing medical evidence showing that there were some studies showing that children of same-sex couple did have worse outcomes in a number of areas, themselves break the law by "vilifying" homosexual persons?

- **Statements expressing disapproval of same-sex marriage**

This is the second major area I want to mention. The law of NSW does make it unlawful to "vilify" someone on the basis of their sexual orientation.

This prohibition on "homosexual vilification" is contained in s 49ZT of the *Anti-Discrimination Act* 1977 ("ADA"), which could in theory provide a ground for complaint about a view conveying a criticism of the institution of same-sex marriage on medical grounds, or indeed a comment noting the Bible's view that homosexuality is a sin.

Homosexual vilification unlawful

49ZT (1) It is unlawful for a person, by a public act, to incite hatred towards, serious contempt for, or severe ridicule of, a person or group of persons on the ground of the homosexuality of the person or members of the group.

(2) Nothing in this section renders unlawful:
(a) a fair report of a public act referred to in subsection (1), or
(b) a communication or the distribution or dissemination of any matter on an occasion that would be subject to a defence of absolute privilege (whether under the Defamation Act 2005 or otherwise) in proceedings for defamation, or
(c) a public act, done reasonably and in good faith, for academic, artistic, religious instruction, scientific or research purposes or for other purposes in the public interest, including discussion or debate about and expositions of any act or matter.

The first thing to note is that the provision requires a "public act", defined in s 49ZS. While not entirely clear, the intention seems to be that this would not cover a private conversation with a patient or (probably) even a couple of patients. It seems to be aimed at more widely published material – a public speech, or a newsletter, or a sign on a wall in a surgery, say.

It also requires a reasonably serious level of speech. The comment would have to "incite hatred towards, serious contempt for, or severe ridicule of" homosexual persons. Hence it seems to me pretty clear that a calm and reasoned discussion of Biblical views, or a rational presentation of medical evidence, should not be caught. Having said that, with the temperature rising in this area, it might be possible that a court could hold that "contempt", for example, was expressed by stating that God's judgement would come on sinners, and that homosexual sex was a sin.[17]

Note, however, that the defences applicable here are fairly wide. It would seem likely, for example, that those who put forward the critique of the AMA position would have a defence against a claim under this provision in s 49ZT(2)(c), that the comments were "done reasonably and in good faith, for academic… scientific or research purposes or for other purposes in the public interest, including discussion or debate about and expositions of any act or matter". The local GP who preaches in church occasionally, or leads a Bible study in the CMDFA, and presents the Bible's view on the issue, should be able to rely on the "religious instruction" defence.

I have to issue one warning, though I hope it won't be necessary soon. While the law of NSW contains fairly reasonable limits on this type of provision, the same cannot be said about the law of Tasmania. There is a controversial provision in that State making it unlawful to merely "offend" someone on the basis of their sexual orientation, in s 17 of the *Anti-Discrimination Act* 1998 (Tas). The most general defence provision under that Act, s 55, does not apply to "religious purposes". Under this law the Roman Catholic Archbishop Julian Porteous was sued for distributing a leaflet outlining the Roman Catholic view of marriage to pupils in Roman Catholic schools.[18] While the action did not ultimately proceed, there is little in the current Tasmanian law that would prevent such an action being brought again.

Could the publication of a piece of medical research reporting negative consequences of homosexual behaviour, be punished under this provision? At the moment it seems it might, in Tasmania. But what is even more concerning is that there have been some cases where someone from one State has sued the resident of another State, for breaching the complainant's home state laws on sexual orientation vilification! (In the Archbishop Porteous litigation, documents were sent around at one stage by the Tribunal there to Roman Catholic bishops all over the country!)

A decision of the NSW Court of Appeal last year found that these sorts of actions were unlawful – that a resident of one State could not sue a resident of another State in a local tribunal.[19] This case has now gone on appeal to the High Court of Australia, as it involves the inter-State jurisdiction of tribunals generally, not just in the discrimination area.[20] I hope (with some reason, I think) that the High Court will agree with the NSW Court of Appeal on this issue.[21] It will then be up to the States to decide whether they want to allow such inter-State actions to be litigated in courts as opposed to tribunals, but even if they go down that path I think the matters will be better handled by courts.[22]

Another question worth considering is whether a person may be sacked from their job because they express a view opposed to same-sex marriage. This actually happened to a contractor in the ACT during the same-sex marriage "postal survey".[23] Protecting someone from dismissal because of religiously-motivated comments of this sort is arguably a matter that should be dealt with under a general law prohibiting unjustified discrimination on the basis of religion. As noted, while some individual States and Territories have such laws, there is no law of this sort at the Commonwealth level, or in NSW. Enactment of such a law ought to be an important option discussed by the Ruddock Committee in its current enquiry.[24]

Another important question that may arise is whether financial support currently offered to religious organisations who provide important services to the community will be conditioned on support for same-sex marriage. This has become a significant issue overseas, where some Christian groups have had their funding revoked or been forced to close after not accepting the legitimacy of same-sex relationships.[25] Again, this is not dealt with under the amending legislation and may be the subject of future litigation. It may affect health professionals who work for religious organisations who want to adhere to a Biblical view of marriage.

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Treatments that would usually only be provided for married couples?

It seems to me that the introduction of same-sex marriage, a form of marriage that many Christians regard as contrary to God's will, raises some important issues for Christian medical practitioners. Most of these issues arise because a practitioner may be asked to facilitate or support behaviour which they regard as sinful.

It is perhaps worth spending some time on this question of facilitating or supporting. All professionals, of course, will be asked to provide services to sinners, since we know that all people (ourselves included) are sinners! In particular, professionals are often asked to provide services to people who themselves are actively engaged in sinful activities. A doctor may be asked to provide medical care to someone who was injured because they had been the instigator of a violent assault. (Lawyers of course face this issue all the time, as for many the sole characteristic their clients share is that they are likely lawbreakers!)

Patching up someone who is a criminal a health practitioner is not condoning or assisting that person's violent behaviour, even if one's experience of life suggests that the person being treated is likely to go out and do that again. But it does seem to be a different situation if a professional is asked to themselves actively assist in behaviour which is clearly sinful. Most Christians would see a clear example here in providing assistance for the conduct of an abortion, in many (if not all) circumstances.

In this area, then, are there situations where your provision of health services would be arguably contributing to what you regard as sinful behaviour? In particular, it seems to me that the issue arises when a health practitioner is asked to provide a medical service which will directly assist activity that should only take place between a married couple, so that to some extent the provision of this service amounts to an affirmation that the relationship between these clients is morally identical to the relationship between a married couple.

These issues will usually arise, then, in relation to sexual activity between the parties to a relationship. Now let me remind you that I agreed up front that not all Christians will have the same views about these matters. Some may judge that the philosophy of "harm minimisation" means that even if the behaviour in question is sinful, the consequences of not providing a service are so bad that this is a "lesser of two evils" choice. But I think there are some practitioners who would say that they ought not to be involved in provision of such a service.

"How should a health professional respond if asked to provide a service that will allow sex to take place more easily between an unmarried couple, or a same-sex couple?"

Let's take the example of contraception. It is, to say the very least, a plausible reading of the Bible to say that it teaches that sex should only take place in the context of a marriage between a man and a woman. How should a health professional respond if asked to provide a service that will allow sex to take place more easily between an unmarried couple, or a same-sex couple? (I am not here addressing the question, on which of course Protestants and Roman Catholics have traditionally differed, as to whether contraception itself is always immoral, even in a marriage. But of course, that would be another example where a Roman Catholic GP may face the issue.)

To be perfectly frank, I have no idea how most Christian health professionals deal currently with this issue in relation to an unmarried heterosexual "de facto" couple. But I would have thought that at least some might come to the view that they should not assist in providing contraception here, as they know that the very aim of the requested service is to allow the patient, or patients, to engage in sinful sexual activity.

We can then broaden this issue out to a request to provide assisted reproduction techniques to produce a child. A Christian health professional may be willing to provide some of these techniques to a married heterosexual couple, but because they regard a same-sex couple as not married in the Biblical sense, may be unwilling to assist such a couple in this area. (Assisting a same-sex couple to 'have' a child, of course, will mostly require the use of at least some genetic material from outside the couple, and for men will involve issues of surrogacy which raise many moral and legal issues we don't have time to discuss here.)[26]

Or suppose a same-sex married couple comes to a Christian health professional and asks for help to improve their sex life?

Suppose in one of those examples offered, the Christian practitioner politely says: "I'm sorry, because of my religious beliefs I am unable to provide that service to you". What are the legal consequences?

The first question is as to what the ground of the decision was. Suppose a practitioner who has regularly refused to provide contraception to any patients who are not married. In fact, it has to be said that such a ground of decision has been unlawful under most discrimination laws, before the same-sex marriage amendments. The *Sex Discrimination Act* 1984 (Cth) makes it unlawful to discriminate against someone on the grounds of "marital status" in the provision of "services": see s6 (defining "marital status" discrimination), and s22:

22 Goods, services and facilities

(1) It is unlawful for a person who, whether for payment or

not, provides goods or services, or makes facilities available, to discriminate against another person on the ground of the other person's sex, sexual orientation, gender identity, intersex status, marital or relationship status, pregnancy or potential pregnancy, or breastfeeding:
(a) by refusing to provide the other person with those goods or services or to make those facilities available to the other person;
(b) in the terms or conditions on which the first-mentioned person provides the other person with those goods or services or makes those facilities available to the other person; or
(c) in the manner in which the first-mentioned person provides the other person with those goods or services or makes those facilities available to the other person.

While there is a "balancing clause" under the SDA, s37, as will be seen it only applies to religious organisations, not to individual believers:

37 Religious bodies

(1) Nothing in Division 1 or 2 affects:
(a) the ordination or appointment of priests, ministers of religion or members of any religious order;
(b) the training or education of persons seeking ordination or appointment as priests, ministers of religion or members of a religious order;
(c) the selection or appointment of persons to perform duties or functions for the purposes of or in connection with, or otherwise to participate in, any religious observance or practice; or
(d) any other act or practice of a body established for religious purposes, being an act or practice that conforms to the doctrines, tenets or beliefs of that religion or is necessary to avoid injury to the religious susceptibilities of adherents of that religion.

(2) Paragraph (1)(d) does not apply to an act or practice of a body established for religious purposes if:

(a) the act or practice is connected with the provision, by the body, of Commonwealth-funded aged care; and
(b) the act or practice is not connected with the employment of persons to provide that aged care.

But now a practitioner who declines to provide contraception services to a couple who are "same-sex married", will *also* be committing unlawful discrimination under s22 based on that couple's "sexual orientation".

"...we have to be aware that there are some people who will be so offended by any suggestion that their relationship is not approved by everyone in society, that litigation may be an option."

The same logic would seem to apply to a decision not to assist in provision of assisted reproduction services, or sexual counselling, where these services would have been provided to a heterosexual married couple.

One example may be mentioned which started in the UK, and ended up in appeal in Europe, although the law there is slightly different (and in fact provides *broader* protections than the law of Australia does.) The decision in *Eweida and others v The United Kingdom* [2013] ECHR 37 involved four separate UK cases involving people who had been penalised in the workplace for their faith commitments. One of the cases involved Mr Macfarlane, a Christian who had taken a job as a "sex counsellor". He was dismissed after doubts were raised about his willingness to counsel same-sex partners. While the European Court of Human Rights (ECtHR) correctly accepted that there had been a *prima facie* burden on his rights of religious freedom under art 9 of the European Convention on Human Rights, the court held that this burden was effectively justified by the interests of the State in promoting "non-discriminatory" workplace practices.

Mr Macfarlane's case was always going to be hard to justify, as it seems he had taken on the role knowing that counselling of same-sex couples might be involved. (One might also ask questions about a person seeking to live by Biblical standards being engaged in counselling heterosexual unmarried couples in this area.) But it does illustrate that the law may in some cases penalise Christian professionals for deciding not to be involved in certain procedures on moral grounds.

Another illustration, though not from medical practice, can be found in an early decision under the NSW *Anti-Discrimination Act* 1977 in *Burke v Tralaggan*,[27] which held that a Christian couple who refused to allow an unmarried couple to rent a flat they owned, on moral grounds, had unlawfully discriminated on the ground of "marital status" under s 48 of the Act.[28]

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There may be pragmatic reasons why there are not many of these cases so far against health professionals. One may be that prior to the same-sex marriage legislation it was at least regarded as a possible moral stance for someone to take, that they would not be involved in supporting a same-sex relationship. But it may be that there will now be increased pressure in these areas in the future.

One response that is sometimes suggested in the area of service provisions, is that in most cases it will be possible to avoid being involved for scheduling or other reasons. "I'm too busy" or "we don't have facilities" or something of the sort might be used. But I see, as I'm sure most of you also do, major problems with that as an option. Lying is not a moral option except in the most extreme cases. In any case, if there is inconsistency of treatment of patients it may well become apparent, especially in these days where almost everything is shared on social media!

Of course, most people would not want a medical professional involved in their case, if that person had indicated that they would not support the outcome for moral reasons. But we have to be aware that there are some people who will be so offended by any suggestion that their relationship is not approved by everyone in society, that litigation may be an option. If it becomes an issue for you, there is an organisation in Australia now which is willing to defend religious freedom cases, and it may be necessary to contact them to see if a negotiated solution may be reached, or if in the worst-case scenario, it gets to litigation.[29]

Concluding remarks

This paper has been focussed on the specific issue of implications for health professionals of the same-sex marriage changes. There is of course much more that can be said about challenges to the religious freedom of health professionals in other areas, most particularly around beginning of life (abortion) and end of life (euthanasia) areas, but those are topics for other occasions. For example, the Freedom for Faith submission noted previously refers to the case of a doctor who was penalised by his local professional body for declining to be involved in an abortion which he judged to be requested on "sex selection" grounds.[30] There are other examples which will have to be wrestled with in the coming years, especially as we see a renewed push for "assisted dying" (ie suicide) laws.

The future may also hold more pressures. Since the change in the marriage law there seems to be increased pressure to remove "balancing clauses" in discrimination legislation which allow Christian groups (such as religious hospitals, for example) not to employ someone whose views are opposed to Biblical teaching on this issue. Recent comments refer to the supposed incongruity of someone being "married to their same-sex partner on Sunday, and sacked on Monday".[31] Of course, there is nothing inherently incongruous about this at all. No-one would imagine that "joined the Liberal Party on Sunday, sacked from working for the Labour Party on Monday" was in any way odd. Where an organisation exists to live out particular fundamental commitments, someone who chooses to act contrary to those fundamental commitments should not expect to keep working for them. Balancing clauses of this sort have been present in Australian law ever since discrimination laws have been in operation and are designed to strike a balance between the rights of religious freedom (an essential part of which is the right of a religious group to operate in accordance with its faith commitments), and rights not to be the subject of discrimination on irrelevant grounds.[32]

What we have seen is that Australia provides some protection for religious freedom, particularly for organisations, but by no means adequate protection for individuals whose conscience may not allow them to support some procedures supporting same-sex marriages. I and many others have made submissions to the Ruddock Panel, which is currently inquiring into the state of religious freedom protection in Australia in light of discrimination laws.[33] That Panel has received over 16,000 submissions, and its reporting deadline was extended to 18 May 2018.[34] It would be good to see the Panel produce a report which recognises the serious nature of these issues, and makes recommendations for improved religious freedom protections.

Australia, like many other Western countries, is a "diverse" society, providing home to those from a wide range of ethnic, political and religious backgrounds. We celebrate "diversity". Our country ought to do so, but such diversity must include recognition that, as well as differences in ethnic origin and sexuality, for example, there are many diverse views on moral and religious matters.

A person's religious views are not simply random preferences for one type of religious meeting or another. They represent a whole "world-view", a view about the meaning of life and the purposes of the universe. A religious person will often believe that they have, not only a preference for a specific view, but a *duty* to follow and live by views about morality and life which are consistent with those laid down by their God.

Hence the importance of religious freedom to individuals who take their religion seriously. Defending the right of people to live in accordance with their fundamental beliefs has been an important theme of Western societies generally, and international human rights instruments in particular.

While there has been a shift in the "public morality" of Australia on the topic of marriage, there is no need to pretend that everyone in Australia agrees with that, or to seek to impose an artificial uniformity of belief on the topic on those whose religion tells them that this is not good. The perceived benefits of same-sex marriage can be enjoyed by those in support of it, while recognising that there are differences of opinion which remain. A mature and tolerant society will, it is to be hoped,

allow space for respectful disagreement on this issue and for believers to live in accordance with their fundamental convictions.

In the meantime, those involved in the health professions as Christians will, I have no doubt, continue to serve their patients to the best of their ability, while seeking to remain true to the convictions about reality and human flourishing spelled out in the Word of God which motivates them to serve. If a thoughtless application of "non-discrimination" principles leads to Christian medical professionals deciding that they can no longer operate under Australian law in these areas in good conscience, that will be a disaster for the Australian community at large. Hopefully sensible recognition of the freedom of believers to live in accordance with their religious commitments will avoid that outcome. ●

by Assoc Prof Neil Foster

Neil is an Associate Professor of Law in Newcastle Law School at the University of Newcastle, NSW, Australia. Neil teaches, publishes and researches in the areas of Torts, Workplace Health and Safety Law, Law and Religion, and Property. He is a member of the Editorial Board of the *Torts Law Journal*, a co-author of the 6th – 8th editions of the Luntz & Hambly Torts text, sole author of a 2014 Supplement to that book on *Defamation and Wrongful Interference with Goods*, responsible for a new chapter in the 10th edition of *Fleming's Law of Torts*, and co-author of *Property Law in NSW* (4th ed, 2017). He is the author of *Workplace Health and Safety Law in Australia* (LexisNexis Butterworths, 2nd ed 2016), and an e-book published by Matthias Media, *Pressure Points* (2014) dealing with potential clashes between the Christian faith and recent laws. He has published a number of articles in the area of Torts, WHS law, and Law & Religion. He blogs on law and religion issues at https://lawandreligionaustralia.blog . As well as undergraduate and postgraduate qualifications in Law (BA/LLB from UNSW, LLM from Newcastle), Neil is a graduate of Moore Theological College (BTh ACT; DipATh Moore). He is married with 4 children, 3 children-in-law and 9 grandchildren, and actively involved in Hunter Bible Church in Newcastle, where he serves as an advisor to the Elders' Committee.

Domestic Violence

An Overview

Domestic violence is as old as the Fall,[1] as current as the latest news, and can be regarded as an intimate and familial outworking of the ancient desire for power and control over others.

Christian doctors and health professionals are well placed to make a difference for our patients by identifying and responding to domestic violence in our practices. We can also support the work of others who provide resources to churches and other organisations which seek to respond to domestic violence with hope and justice for broken families and hurting individuals.

Domestic violence is a pattern of behaviour based on abuse of power and abuse of trust. Effective confrontation of domestic violence involves detecting and responding to the violence occurring in individual situations, as well as helping to change behaviour in our community through teaching and modelling healthy relationships. True Christian relationships are based on the pattern of our Lord who humbled himself and came to serve and who challenged those who "lord it over others' (Matt 20.25-28, Philippians 2:6ff).

How widespread is the problem of domestic violence?

The stories shared by people who have lived with domestic violence (DV) help provide an understanding of DV's persistence, secrecy and power to create trauma. (Domestic Violence resource centre Victoria : https://www.dvrcv.org.au/stories.) Australian Bureau of Statistics figures of 2012[2] indicate that 1 in 6 Australian women and 1 in 19 Australian men had experienced physical or sexual violence from a current or former partner. The term 'intimate partner violence' includes a partner whether or not they live in the home, and of either sex, and is inclusive of ex-partners. Violence within same-sex intimate relationships (whether male or female) appears to be equally as common as violence in heterosexual relationships, but the statistics are incomplete.[3] Female-to-male intimate partner violence also occurs.

Of women who have ever been abused 1 in 2 were abused when pregnant and 1 in 5 for the first time when pregnant. Only 20% of persons experiencing domestic violence in Australia have ever reported to Police.[4]

Domestic violence includes abuse which is neither physical nor sexual. This includes psychological denigration, emotional intimidation and financial abuse. Controlling behaviours such as isolating a spouse from friends and family can make the person experiencing domestic violence easier to control, while simultaneously making it harder for her[5] to seek help. Controlling behaviours may be falsely attributed to a needy and jealous 'love' such as stalking, or be presented as 'supportive' behaviours such as picking the person experiencing domestic violence up after work when the intention is actually to avoid her having time on her own. Persons experiencing domestic violence describe their chronic fear and how abusers can systematically reduce their confidence and strength so that the person experiencing domestic violence may begin to think that she is incapable or crazy or that no one will believe her if she reports her situation. *The Duluth Power and Control wheel (Right)* can be a helpful tool in unpacking and understanding some of the interlinking aspects of abusive relationships.

Patterns of domestic violence vary. In some cases DV is angry and explosive. This violence may be intermittent and followed by remorse and excuses. In other cases violence can occur nightly. Alcohol and drug abuse or mental health issues may be a factor in the build up to explosive episodes of DV, but should not be regarded as the sole cause.

"While domestic violence can occur to anyone... it is more common in situations of poverty and unemployment and among people previously exposed to childhood trauma or adult trauma including war or refugee experience."

Diagram 2 (page 68) demonstrates a recognised cycle of violence. The periods of calm and enmeshment, presenting as closeness and repentance, can deceive persons experiencing domestic violence and

health professionals, (and persons perpetrating domestic violence) into thinking that everything is now resolved and harmonious.

There are cases of domestic violence where the abuser displays no anger but instead remains calm, and any physical violence is calculated and planned.

There may be no violence but instead fear is created by spoken or implied threats. Reported threats of serious violence should be taken seriously by health workers.

Family dislocation can increase the significance of a threat. Abusers may have codes for serious physical acts which only the victim understands. In some contexts threats to deprive the children, for example by 'losing' their pet, may be powerfully used by an individual to sexually control their ex-partner.

There is an elevated risk of violence by a partner or ex-partner around the time of separation.[6]

Community responsibility for domestic violence

While DV can occur to anyone, however wealthy and accomplished, it is more common in situations of poverty and unemployment[7] and among people previously exposed to childhood trauma or adult trauma including war or refugee experience.[8] If change is to occur, an individual perpetrator must have a genuine desire to stop and to take responsibility for his or her own behaviour. From a society perspective we share a responsibility to create a more aware and respectful community with resources to help people bearing burdens of post-traumatic stress disorder and other adult stressors and to avoid social experiences of devaluation such as chronic unemployment.

Domestic violence as a health issue

The World Health Organisation (WHO) describes violence against women as a major public health issue affecting physical, mental and reproductive health. Any chronic illness is adversely affected by emotional or physical battery. The WHO highlights the following conditions as common presentations of the results of DV: post-traumatic stress and other anxiety disorders, sleep difficulties, eating disorders, suicide attempts, depression, problem drinking, headaches, back pain, abdominal pain, gastrointestinal disorders, limited mobility and poor overall health.

Recent research has revealed the extent of Acquired Brain Injury among women who experience physical violence as a result of blows to the head or strangulation.[9]

The victim experience

People experiencing DV often feel deeply ashamed about their situation and are likely to find it difficult to disclose domestic violence to a health professional or, indeed, to a friend or church leader. However Australian research indicates that women who have been abused want to be asked about DV and are more likely to disclose if asked. It seems reasonable to the author to extrapolate this to the church situation provided the question is asked with sensitivity, empathy and adequate confidentiality.[10]

Common misunderstandings

- If a disclosure of DV is later withdrawn many people may think that the initial disclosure was false. This is usually not so. Retraction may result from fear of further violence or other fears such as losing the children, compounded by lack of family or community support.

- A second common error is to disbelieve the victim because she is showing signs of her life spinning out of control, such as

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deteriorating mental health. Police may arrive at a DV situation to find a weeping fragile woman who appears neurotic, and a calm, controlled, alleged perpetrator who states that it has all been a misunderstanding. Victims who are in pain or fear, or have had a recent anoxic event, may be disbelieved.

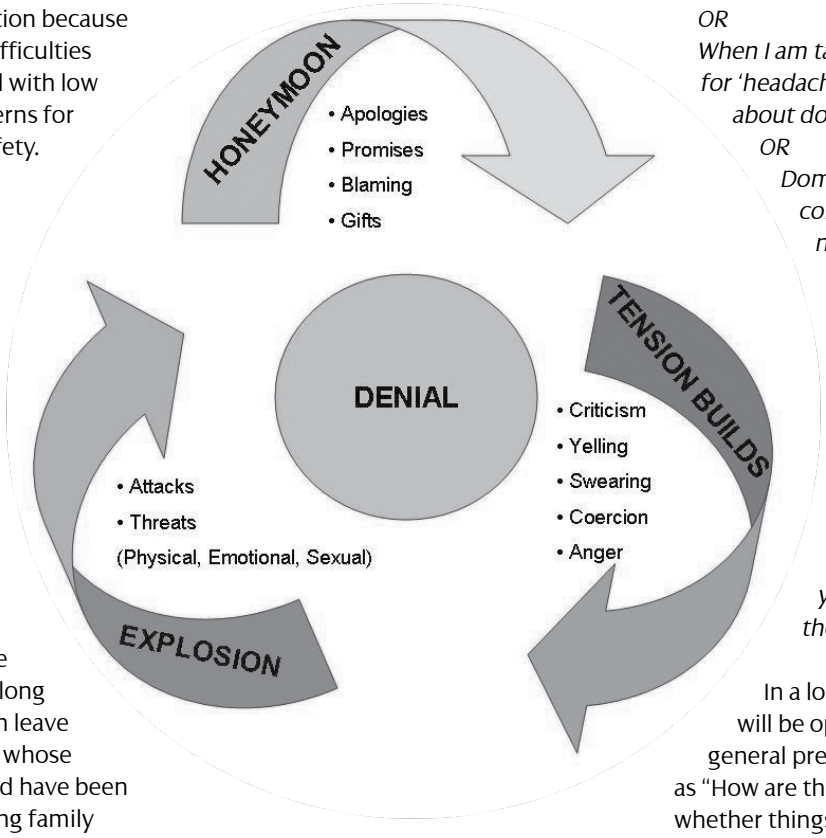
- There is a myth that the sensible victim would always leave immediately. However, victims may stay in a DV situation because of a complex mix of difficulties which may be coupled with low self-esteem and concerns for family stability and safety. Many victims become expert in protecting their children and hiding the abuse from wider family and others by managing the behaviours of a violent partner. Leaving is often dangerous and may precipitate homelessness and other losses. Many women will work and plan for a better future for their family over a long period so that they can leave at a safer time. Those, whose preferred option would have been an intact and flourishing family may retain a degree of hope for the violence to stop through a change in their partner's behaviour.

- Domestic violence may be wrongly categorised as a 'relationship problem'. Tension may have built up before the explosion of violence as a result of behaviour that either or both parties regret, but this is not the cause of the violent behaviour.

- Someone may state that the perpetrator could not control his behaviour. A useful thought experiment to challenge this statement is to ask if the perpetrator would have behaved in the same way if a police officer or his boss had been present.

Domestic violence presenting as injuries in a health setting

Recognising that considerable physical violence can occur without causing visible injury, doctors need to be alert to opportunities to identify injuries caused by DV. Perpetrators will often direct the assault to parts of the body which are hidden and soft and hence less likely show bruising. Victims may hide visible injuries at work, or in the health setting such as the antenatal clinic, by wearing covering clothing such as long sleeves and scarves and by fabricating an explanation for the cause of symptoms. Patients suffering DV may appear unreliable or inconsiderate as they postpone appointments to hide injuries. Strangulation, suffocation and brain injury may result in vague or nil physical signs.



HOW TO ASK
about domestic violence

Privacy is essential and may require some creativity and effort to achieve in an Emergency Department. Avoid asking in front of children. The child may be later questioned by the perpetrator "What did Mummy say at the doctor, today?"

Direct questions are needed. Some victims will not yet recognise that the pushing or punching they have experienced is domestic violence. I offer the following simple and direct approach:

First normalise asking the question by giving some context or reason. Here are examples:

When I see a patient with an injury like this I always ask …
OR
When I am taking a medical history for 'headache' I ask my patients about domestic violence…
OR
Domestic violence is very common in Australia so I need to ask you…

Then ask:

Did anyone hurt you?
OR
Did anything else happen? Has anyone hurt you?
OR
Have you been hurt by your partner, now or in the past?

In a longer consultation there will be opportunity for more general preliminary questions such as "How are things at home?" and whether things get "out of hand".[11]

HOW TO RESPOND
if a patient discloses domestic violence

1. Validate the person who has disclosed the domestic violence to you. It may have required considerable courage. Show you heard what they said and believe them:
   "It is good that you told me", or
   "I am very sorry to hear that".

2. Say something that indicates that domestic violence is not acceptable and not the victim's fault
   "That's domestic violence. Domestic violence is never acceptable/OK" or
   "You are not to blame. No-one deserves to be treated like that"

3. Offer help.
   For a chance conversation (on a bus for example) a phone number can be provided for a DV Support service (1800 RESPECT). This can make a significant difference. In medical practice there is usually the opportunity to offer a more comprehensive medical response to domestic violence.

The medical response to domestic violence.

• Documentation of history and examination is good medicine.
Document the allegation and take further history of the violence without pressuring the patient to talk. Documentation of injuries such as bruising may prove important years later, in a legal context such as when Police seek to protect the victim by taking any action to restrain the perpetrator, or there are family court proceedings. Ideally, injuries should be drawn on body diagrams[12] and documented by medical photography. Patients may be fearful to have this information visible to other staff members in the medical record of a group practice. If software settings are not available to protect the information, a supplementary paper file which is indexed to the computer-based health record may be a solution.

• Ask about pressure on the neck, choking or difficulty breathing.
Patients often do not realise the seriousness of strangulation and may not report it. In 50% of cases there may be no visible external injuries to head and neck. It is possible to kill a person with the pressure from one hand. Pressure to the carotids with a forearm in a skilful choke-hold will render a person unconscious in 8 seconds. Unfortunately it is easy to acquire this skill from a YouTube tutorial. Acute or long term brain damage from strangulation or head injury is being increasingly recognised as a significant health issue.[13]

• Ask if children were present at the time of the assault, or are otherwise at risk, and consider whether a report to the child protection authorities, or any other referrals for the children's health,

"The most helpful response to a patient revealing abuse is to listen supportively and offer information, resources and a commitment to follow-up."

are necessary. Consider frail elderly, the disabled and other vulnerable persons in the household. What you are permitted to do, or mandated to do, to protect vulnerable people varies in each State. Medico-legal insurers and local professional organisations should be able to provide detailed advice.

• Provide information and resources.
Generally, the most helpful response to a patient revealing abuse is to listen supportively and offer information, resources and a commitment to follow-up. This non-directive response assists a victim with her own decision-making and to build on her own strengths.

This includes:
- A DV support and counselling service or social work service so a victim can work through and explore her options. They will know how best to find safe accommodation.
- Local police can provide information on protection, including how to apply for orders given by a magistrate to restrain the perpetrator from certain actions, such as restricting him from entering the street where the victim lives.
- Phone services available Australia-wide. Can you find a space in your practice for a patient to talk with a phone counsellor before she leaves?

Useful numbers include:

1. 1800 RESPECT. This phone or web service offers advice, information and counselling to anyone impacted by domestic or sexual violence. This could include victims, worried family members, or you or your staff impacted by a harrowing experience with a patient experiencing DV.

2. Men's Referral Service (NSW, Victoria and Tasmania) 1800 766 491. This includes a counselling service for men concerned about their own violent or abusive behaviour.

3. Men's Line 1300 78 99 78. This is an Australia wide men's counselling service and can provide an immediate counselling response and referrals and information to local programs.

4. Lifeline 13 1114, Headspace (for persons 14-24) and Kids Help Line 1800 55 1800

5. Safety Assessments and Planning. There are practical resources to guide health workers in assisting victims to develop a safety plan. (Chapter 3 RACGP White Book https://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-3-safety-and-risk-assessment/).

In most cases DV is a chronic condition, but in some cases a victim may present in crisis when there is immediate serious risk and the victim has nowhere safe to go. This may be indicated by serious injury, escalating injuries and threats, isolation from help and the presence of weapons in the home, such as a gun or knife. A traumatised

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victim may be incapable of making a safe decision. If attempts to persuade a victim who is in imminent danger to immediately involve the police fail, then it may be necessary for the health worker to inform the police without victim consent.[14] State laws vary. Medicolegal defence services can provide advice.

Family violence as a Chronic Condition

It is important to recognise that responding to DV can be a long process, and a particular interaction with a health worker may be a step on the way. It can be traumatic for health workers to know that their patients are returning to a dysfunctional and abusive situation. A non-judgemental and respectful stance in listening will leave the door open for victims to return for further discussion and practical help.

Uncounted women across the world endure long term violence because they live in counties with no laws or systems to protect their rights. In these cases, the choice to leave the marriage would likely involve permanent isolation from their children, or perhaps involve their children being put out with them to starve on the streets. Aid services that provide education and economic empowerment for women have been shown to improve the health of women and children and reduce the incidence of DV.

Warnings for health care workers

It can be tempting for a doctor to think it might be helpful to call in the perpetrator and tell him to stop. This is ineffective and dangerous: the perpetrator may go home and punish the victim.[15]

Couple counselling is contraindicated in domestic violence situations. The perpetrator can punish the victim at home for what she said during counselling.

When a victim discloses domestic violence it may be a natural reaction for the health worker to express their shock and strong criticism of the perpetrator. Expressing this to the victim tends to have the effect of making her feel more ashamed and disempowered, and may provoke her to come to his defence. Concentrate on condemning the unacceptable behaviours rather than condemning the perpetrator.

Other forms of family violence

In this article I have not addressed the important areas of child abuse and elder abuse. There are many other patterns of violence. I list here three that are common and not well recognised.

- **Family violence by teenage children.** An overwrought and worked up teenager may hit out at a parent, usually their mother. The teenager may have recognised anxiety or depression, or other mental illness, but there needs to be a clear message that violence is completely unacceptable and must stop. It can help for both the family and the doctor to clearly state to the teenager that a push can lead to a chain of events where the police are called and the teenager is charged. Anyone, including a neighbour or health worker, might call the police. Enquire about other patterns of abusive family behaviour.

- **Violence from an adult child living at home.** A case example would be a middle-aged woman who has an adult child with a serious mental health problem living with her, and the adult child becomes violent to her. The mother is worried that if she puts her adult child out of the home they may get deeper into a drug culture or become a victim of homelessness and violence. These are complex situations and the health worker may need to advocate to find a service that will respond with the detailed support and information needed.

- **The exhausted carer.** There are people without adequate support taking on enormous caring burdens, such as the care of a very troubled autistic child or an angry cognitively-impaired adult. A carer doing a heroic job may "snap" and push or thump. The carer may present very troubled and remorseful. These carers need relief and help.

The medical response to the perpetrator as a patient

There is hope when a patient admits that things "get out of control", admits to perpetrating violence and asks for help to change their own behaviour. It is vital to reinforce that abuse is not acceptable. It is also helpful to non-judgmentally provide information about the health harms to victim and children. Reinforce that only the perpetrator can take the steps to change. Medical history will involve an assessment of risk for other family members and a history of suicidality, weapons availability, mental health and drug and alcohol issues. Evidence-based "Men's behaviour change" programs and similar programs can be effective. These require long-term commitment. Men may be motivated by wanting to be good dads.[16] It is not possible for the one practitioner to provide ongoing counselling to the victim and to the abuser separately as there will be a perceived breach of confidentiality and impartiality, even if none occurs. If it is necessary for a couple to separate, it is preferable for the perpetrator, rather than the victim, to leave the family home.

Special concerns for Christians.

Christians affirm the nurture of healthy relationships, and that special care is needed for vulnerable persons in our communities.

Conversely, bullying at home, church, school or work makes for a violence-prone society. Christian health workers could prepare information for their local church or community from the excellent resources freely available, such as 1800 Respect https://www.1800respect.org.au about domestic violence or www.joinonelove.org about identifying unhealthy relationships and building healthy relationships. Resources produced for Christian organisations include www.saferresource.org.au. The RACGP has an excellent publication titled, "Abuse and Violence: Working with our Patients in General Practice" at https://www.racgp.org.au/whitebook/ and this is suitable for all health professionals to develop their knowledge and skills.

Christians offering pastoral care to persons affected by domestic violence need to recognise that 'worldly' remorse and sorrow about violence are not the same as repentance (2 Cor 7:10). Repentance will be seen in long-term difficult and sacrificial actions, such as commitment to specialised behaviour-change programs, and the willingness to move out of the family home for a period of time, or perhaps forever. Church members can provide practical assistance such as transporting children to events, or providing a safe place to live. A marriage may end in divorce. It is vital for those providing pastoral care to recognise how hard it is to speak up about DV and to realise that when there are no reports of ongoing violence this does not mean that the situation is solved for that family.

To conclude, each case of domestic violence impoverishes all within the community - not just the silent victims such as children and grandparents.

In addition, we all bear some responsibility for the perpetration of violence: words of anger or impatience on anyone's part may add to the burden a stressed perpetrator takes home or diminish the confidence of a victim of DV. We also collectively bear some responsibility for poverty and war which increase stress and violence.

I am grateful for those who have gone before, and campaigned for resources and laws to protect the weak and vulnerable, and for training for police, counsellors and other professionals. I am grateful for those who continue this work and those victims who have bravely spoken out. ●

by Dr Rosemary Isaacs

Rosemary works for a major Sydney hospital in forensic and medical care for victims of sexual abuse, domestic violence and child abuse. Rosemary is currently involved in domestic violence education for health workers and also in speaking on this topic in churches.

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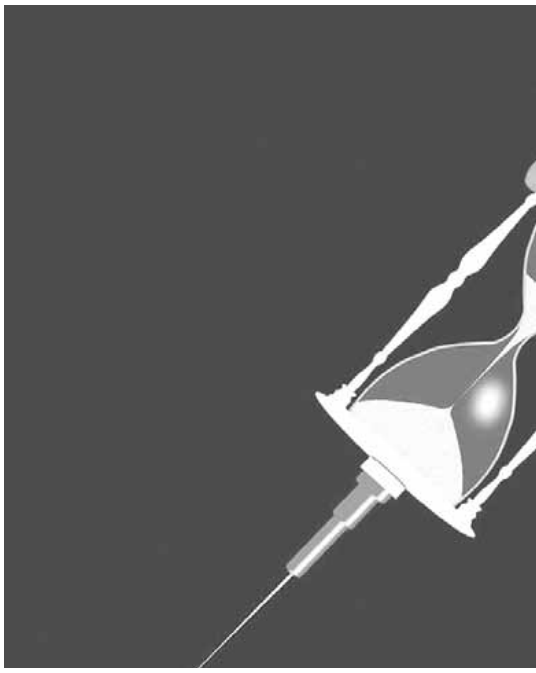
Euthanasia Legislation in Australia

How did we get here?



As I look back over the last twenty-five years of euthanasia debate in Australia, I remember why I became involved in bioethical debate in this country.

In the 1990's, as a palliative care registrar, I remember thinking that the public debate about end of life (EOL) care did not reflect what really happened, nor what was possible, in our care for dying patients. The bill before the Northern Territory (NT) parliament was not seriously considered a threat by its opponents due to problems in its construction, and it was a rude shock when it passed.

Australia became the first country in the world to legalise euthanasia when the *Rights of the Terminally Ill (ROTI) Act* was passed in 1995. Never underestimate the power of the champion, in this case Chief Minister of NT, Marshall Peron, who was deeply affected by the suffering experienced by a close relative before death. The Act became law in 1996 and its troubled path has been documented.[1] The ROTI Act was subsequently overturned by Federal Parliament in 1997.

Apparently, one factor contributing to the overturning of the legislation was its impact on Aboriginal people, who make up 25% of the population in the NT. A report of a euthanasia education program commissioned by the NT government after the ROTI Act commenced, said that 'the level of fear and of hostility to the legislation is far more widespread than originally envisaged… which makes one wonder about the public opinion polling that suggests high support among the NT public for the legislation. One imagines that phone polling doesn't get to too many Aboriginal people.'[2]

Since then, at least 30 bills have been debated and defeated across the country. One outcome of the brief legalisation of euthanasia in the Northern Territory was an increase in palliative care funding (palliative care provision had been particularly poor in NT). The arguments for legalisation of euthanasia and physician-assisted suicide (EPAS) gradually focussed less on suffering as the potential of palliative care became known, and the need to allow mentally competent adults to choose the timing and manner of their own death became the focus. Meanwhile public support was documented consistently at levels above 50%.

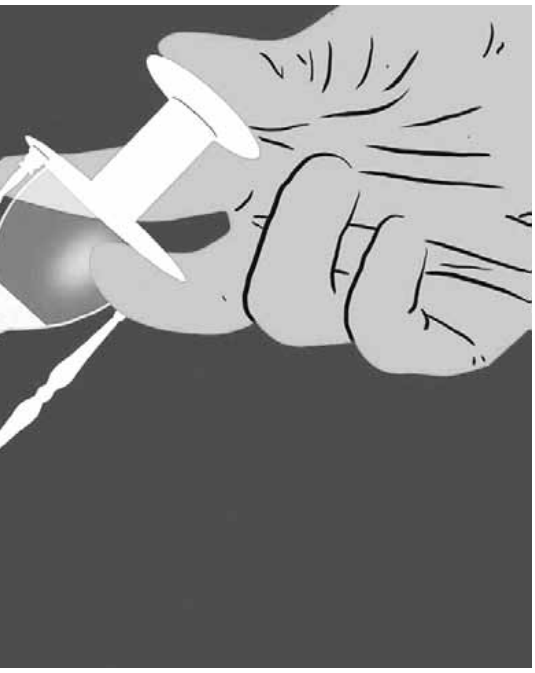
"If you need to spend so much time talking about 'safeguards', there must be something inherently unsafe about the practice."

The polls which elicited the overwhelming public support for euthanasia tended to ask loaded questions. Take, for example, the single question in a 2009 Newspoll commissioned by Dying with Dignity: 'If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to provide a lethal dose, or not?'[3] Note the leading and emotive wording, underlying presumptions and limited options of responding. 85% Australians, on this occasion, answered, 'Yes'. Magelsen and colleagues found that framing effects, that is, effects on the respondents' stated attitudes caused by question wording and context, do impact responses to public surveys on assisted dying.[4] They concluded that survey results should be interpreted with caution.

It is obvious that parliamentarians have resisted many attempts to legalise EPAS in Australia. The main reason for this, according to my research, is that EPAS is difficult to regulate. Really, you can't help feeling that if you need to spend so much time talking about 'safeguards', there must be something inherently unsafe about the practice. Five wide-ranging, government-sponsored inquiries in four different countries were held investigating the consequences of legalising euthanasia. Despite the inclusion of pro-euthanasia members, all reports concluded that such law could never be made safe from the possibility, if not the likelihood, of abuse.[5] So, for the next decade, pro-euthanasia societies produced polls showing public support in Australia, bills were presented to parliament, and parliamentarians refused to pass them.

Then suddenly, things changed. A Federal Senate Inquiry into the Medical Services (Dying with Dignity) Exposure

Draft Bill 2014 asked for submissions not on whether EPAS should be legalised, but how it should be legalised, describing assisted dying as a 'medical service' requiring regulation.



This approach was similar to that taken by the Victorian government, whose Ministerial Advisory Panel on Assisted Dying asking for submissions suggesting how to implement legal EPAS specifically stated that submissions arguing against legalisation would not be read.[6]

The Victorian Government modelled a new approach to end of life (EOL) care by holding an extensive Inquiry into EOL Choices in 2015. The report of the Legal and Social Issues Committee was published in 2016. It made 49 Recommendations for improvement of EOL care, and the final recommendation, that the Victorian government introduce a legal framework providing for assisted dying, was enthusiastically taken up.

As the Victorian government looked increasingly keen to legalise EPAS, a ruling in the Victorian Civil and Administrative Tribunal (VCAT) sounded an ominous warning. Euthanasia advocate and urologist Dr Rodney Syme had been found guilty by the Medical Board of Australia of breaching his legal and professional duties by assisting people to kill themselves, citing a case where he provided Nembutal to a patient with tongue and throat cancer. Syme argued his intention in providing Nembutal was solely to provide relief from distress to a patient who wanted to control his own death. Even though his means of providing that relief was to provide the means by which the patient could kill himself, Syme denied he had any intention of assisting the patient to commit suicide. While not many people would argue that providing the means of suicide to a suicidal patient does not constitute assisting suicide, VCAT decided that Dr Syme did not pose a serious risk to persons and did not uphold the Board's decision. They accepted Dr Syme's suggestion that his action constituted palliative care, though I personally do not know any palliative care physicians who prescribe Nembutal to their patients.[7]

One of the troubling claims of Syme and the tribunal is that, by providing Nembutal to his patient with the information that it would end his life – that is, to relieve the patient's existential suffering, foreseeing that it may have the unintended effect of assisting him to commit suicide – is analogous to that found in the administration of "terminal sedation", as accepted in routine palliative care practice.

But this ignores the fact that the term terminal sedation, or palliative sedation, is used by different doctors for different practices. Some doctors use the term to describe their practice of relieving the patient's symptoms (eg severe dyspnoea) at the very end of life, with no impact on survival. Other doctors use the same term to describe their practice of deliberately hastening the patient's death with an overdose of opioids or sedatives (yes, sadly I know this happens). The former can be perfectly good clinical practice and is perfectly legal. The latter is neither and should be reported to the Health Care Complaints Commission. The situation is further complicated by the fact that many people, including doctors, think that therapeutic doses of drugs such as morphine inevitably shorten life, therefore reasoning that if the patient is receiving regular morphine at the end of life, it inevitably has contributed to the death. This kind of practice has been labelled by pro-euthanasia advocates as 'passive euthanasia', who then argue that if we practice *that* kind of euthanasia, we should be able to use the *other* type of euthanasia – lethal injection, which they call 'active euthanasia'. You see the problem. But it is all based on a myth that morphine shortens the life of the patient. In fact, there is a significant body of research showing that this is *not* the case, and that regular (appropriate) therapeutic doses of morphine and sedatives at the EOL may in fact increase survival.[8]

Around this time medical associations started to come under attack from minorities within their organisations who tried to lobby for official pro- or at least neutral stances towards EPAS. Confusion about position statements from the AMA, and other organisations ensued. The Australian and New Zealand Society of Palliative Medicine (ANZSPM) was challenged by a small number of individuals who objected to the anti-EPAS position statement, and the Australasian College of Physicians has been successfully challenged for trying to move from its opposition position without consultation with the membership. Watch this space.

"The suffering angle had resurfaced in the public debate, with the attempted demolition of palliative care as a viable alternative to EPAS legislation in view of the impotence of palliative care staff in the face of suffering at the end of life."

The Victorian Government's Ministerial Advisory Panel put forward a bill, and the debate was nasty. For example, medical practitioners working in Catholic organisations were attacked by a prominent journalist for intentionally withholding analgesia from patients in pain on the grounds that they thought that suffering was 'good for them'.

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Palliative care services were criticised for inadequately caring for the terminally ill. The suffering angle had resurfaced in the public debate, with the attempted demolition of palliative care as a viable alternative to EPAS legislation in view of the impotence of palliative care staff in the face of suffering at the end of life.

Let me be very clear. This debate was not about suffering. If it was about suffering it would not be occurring now, when we have more medical cures than ever before in human history. If it were about suffering, it would not be a debate that occurs primarily in western countries. If it were about suffering, we would not have had Victorian politicians calling for a cut in funding for Catholic hospitals, major providers of palliative care in that state, because they publicly stated that they would not cooperate with EPAS if a law were passed.

This debate is about autonomy – the right to make self-determining choices, in this case the right to choose the timing and manner of one's own death. Coming face-to-face with one's own death raises existential questions which many people in our society are ill-equipped to answer. They are afraid and want to control death – and the only way it can be controlled is by determining its manner and timing. In a society which has lost touch with the meaning of suffering, there is, understandably, a loss of the willingness to endure it. So many people now want to avoid the process of dying altogether. And if you thought this world was all there is, why wouldn't you?

But, disturbingly, there are other factors driving the euthanasia debate. In my conversations with politicians it is obvious that there is a lot of unhappiness in Australian society regarding how doctors manage their dying patients. I know what they mean. Unnecessary treatment because no-one diagnosed impending death. Inability to care for the patient in the dying phase. (I know of one medical school where there is more time in the curriculum given to delivering babies than palliative care. How much training did you have?) There are the blatant EPAS advocates who are known to provide the means if the patient is so inclined. I don't know the details but some of my patients do. Then there's that 'morphine reflex', where as soon as a patient *is* recognised to be dying, the morphine drip goes up. I used to ask on palliative care consults where the pain was, trying to understand this response. Families are concerned, and I don't blame them. One politician told me that, even if he disagreed with EPAS, his constituents were demanding that something be done to regulate care at the end of life. In some ways we have only ourselves to blame.

"I know of one medical school where there is more time in the curriculum given to delivering babies than palliative care."

Meanwhile the Victorian law passed after a marathon 28-hour debate in parliament at the end of 2017. At present, a committee is working out the details for the enactment of the legislation. It is due to become active on June 19, 2019. From that time, patients who have a life expectancy of less than six months, whose illness is incurable and causes intolerable suffering, are over 18 and live in Victoria will be able to request "voluntary assisted dying". Mental illness is excluded as grounds for access to the law.

Victorian Premier Daniel Andrews consistently argued through his campaign that the new law is the safest and most conservative scheme in the world. The law is modelled on that in Oregon, USA, about which, supporters note, there is no evidence of abuse. That is true. But there is also no evidence that it is practiced safely. Because there is virtually no data collected by the Oregon authorities and what is collected comes from the prescribing doctor who may have met the patient only once, over a year before. There are medical journal articles, though, that record studies of patients who are depressed and not sent for psychiatric evaluation, as recommended by the legislation. One of the first patients to die under the legislation asked her own doctor for a lethal prescription and was refused. A second doctor also refused, saying she was depressed. At that point she contacted a pro-EPAS society who organised a referral to a co-operating doctor. A review of this case raises deep concerns about the 'safeguards' in place.[10] Earlier this year, the Oregon Health Authority confirmed that it would allow a person who is not dying, but who has a chronic disease such as diabetes, to refuse treatment for the disease and thereby become eligible to be prescribed a lethal substance for the purpose of committing suicide on the

"What will happen if palliative care units start hosting the local euthanasia practice?"

grounds of a six-month prognosis.[11] And this is the *safe* model?

Whatever safeguards are in place now, they can always be watered down in the future. This was clearly stated by pro-euthanasia advocates during the Victorian campaign. And it may not take all that long. At the time the law passed, Dr Philip Nitschke, probably Australia's most notorious euthanasia activist, had already complained that the law was too conservative.

I have been told that EPAS laws are inevitable. I don't see why. Internationally, most countries don't allow it. And of those who do allow it, not all use doctors. Look at the capital punishment system in the USA – that doesn't involve doctors. Particularly if this is all about autonomy, why do doctors have to be involved? Lawyers would do a better job working out who is legally eligible. And anyone can learn to give an injection. Personally, I am greatly in favour of separating EPAS from medicine, not only because it conflicts with traditional medical ethics, but also because by labelling it as a form of medical care, it is given a veneer of medical legitimacy that it doesn't deserve. And besides, it's hard enough getting people to accept a palliative care referral – what will happen if palliative care units start hosting the local euthanasia practice?

What can you do? If you feel you do not really understand what this debate involves, I urge you to read through the CMDFA's position statement on euthanasia.[12] If you would like extra and/or up-to-date information, please go to a website for medical professionals opposed to legalisation of euthanasia, *Health Professionals Say No.*[13] You will also have the opportunity to publicly register your support of the position statement.

Euthanasia campaigns are active in Western Australia, Queensland, ACT and NSW at the time of writing. If you are a doctor, legal EPAS changes what is viewed as 'standard practice' for a registered medical practitioner in this country. If you object to killing your patients, consider getting educated and contact your local member and other parliamentarians in your state to register your objection. Educate your congregations, talk to your friends and family. There is so much misinformation in this debate that it is possible EPAS will enter our lives through sheer ignorance.

Lastly, I would just like to add on a personal note that I did not join the medical profession to kill my patients. It is not a goal of medicine. I object to being told by the government that my profession now includes this practice. To adapt a quote from one of my favourite papers on euthanasia: 'What if politicians were the ones who were suddenly told they had to administer EPAS? There is a difference between thinking it best that something should happen and thinking that you should do it - between thinking that it would be best if a person were to die and thinking that you ought to kill him or her. The latter involves questions of personal moral responsibility for ending a human life that politicians may be reluctant to take on. Euthanasia has not traditionally been a major focus of medical education. So, then perhaps we should reconsider the implications of asking a profession to take on a duty for which it feels ill-equipped, about which at least some of its members have deep moral reservations, and which carries such potentially grave consequences for those to whom that duty might be directed.' ●

by Dr Megan Best

Megan is a bioethicist, palliative care doctor and psycho-oncology researcher at the University of Sydney and the University of Notre Dame Australia. She has been involved with the national euthanasia debate for nearly 30 years.

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A Broad Ethical Approach to Screening for Prenatal Genetic Defects

I'm not sure who it was that decided it was more empowering for women to:

a) have the opportunity to screen their unborn child for genetic abnormality and abort those found wanting, rather than

b) provide adequate support after the birth to care for a child with special needs.

However, the practice of prenatal screening, diagnosis and termination is a well-established practice in our society and something with which registered medical practitioners have to deal. This creates a dilemma for those of us who value human life before birth.

Contemporary medical curricula propose 'Principlism' as the basis of bioethics. Principlism is the term used to describe an approach to biomedical ethics advocated by Tom Beauchamp and James Childress. They suggested that respect for autonomy (the right for an individual to make self-governing choices), nonmaleficence (above all, do no harm), beneficence (act in the best interests of the patient) and justice (treat all persons fairly and equally) should guide ethical thinking in health care. In their defence, they never intended the principles to play the part of an independent ethical theory, but nonetheless, these principles frame the ethical thinking of many healthcare workers.

So when we come to the question of an ethical approach to prenatal genetic screening, it is easy to be confused. For example, beneficence for whom? I do not commend Principlism to Christians as a helpful way to make ethical decisions in healthcare but, in view of its popularity, let us consider the principles in this situation.

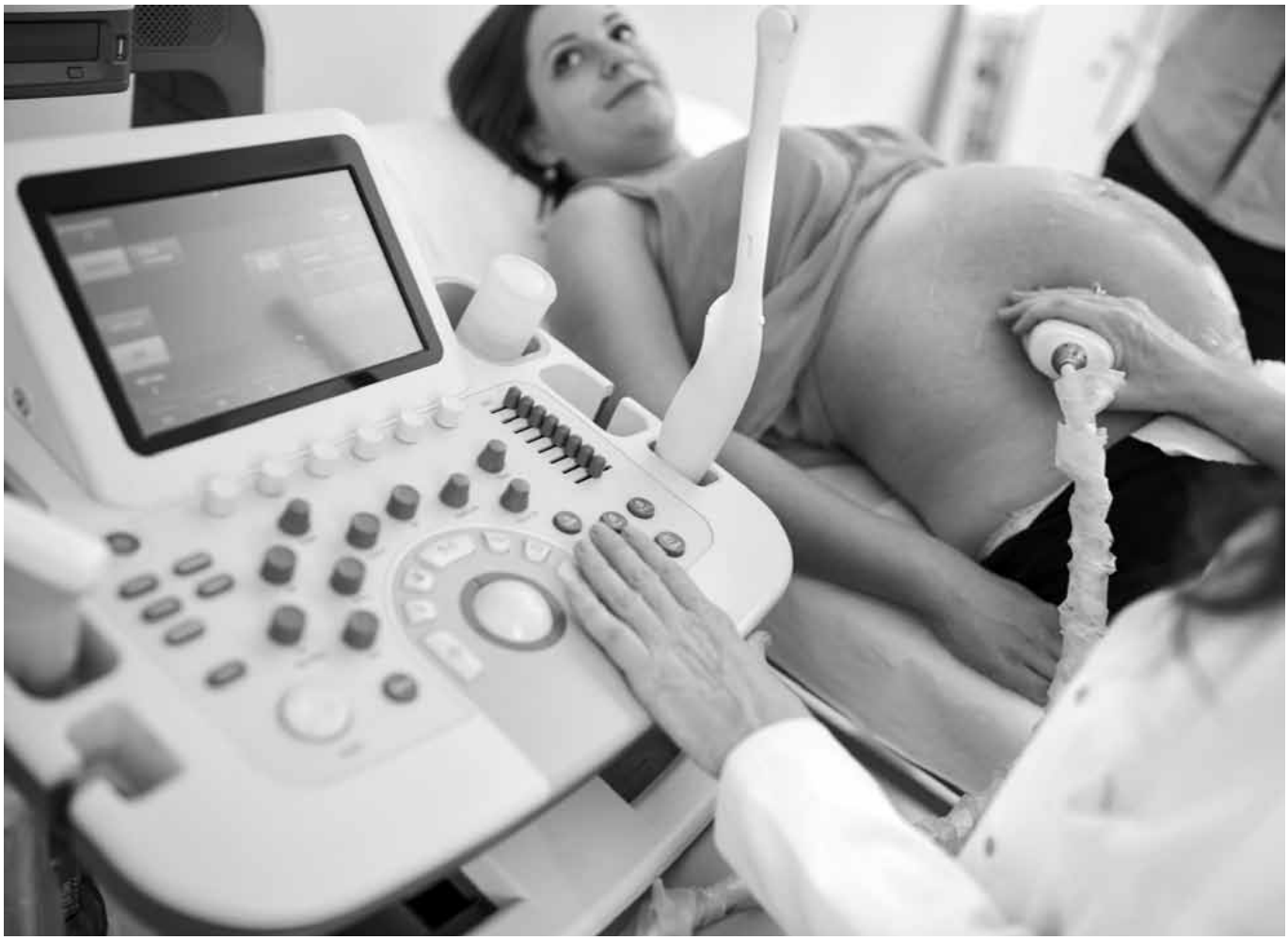
"In our democratic society, we cannot stop people from making decisions we disagree with, but we can reduce the number of people that make uninformed decisions."

An unborn child cannot exert autonomy. It is not capable of making decisions. Therefore, it is the autonomy of the mother that is regarded when it comes to prenatal screening. It would be possible to attribute beneficence to the child, but in practice this can be done only with the agreement of the (autonomous) mother. A problem arises when termination is considered, since what is often seen by the mother as beneficence (relieving her of the burden of a genetically defective child), can hardly be considered to be in the best interests of the child. Likewise, attribution of maleficence and justice will result in opposition between the two. This is one of the weaknesses of Principlism – it doesn't give us guidance in a situation where the principles conflict.

However, it is easy to see that the key person regarding the outcome of prenatal screening will be the mother. Hence it is absolutely necessary to make sure she understands what it's all about. In our democratic society, we cannot stop people from making decisions we disagree with, but we can reduce the number of people that make uninformed decisions.

As Christians, we worship a God who has a special concern for the vulnerable and the weak. As we love our God and our neighbour, we will seek to protect those unborn humans who cannot protect themselves. This is not forcing our ideas onto a non-Christian public. This is showing concern for fellow human beings.

The medical practitioner who is in a situation where she is legally obliged to offer prenatal genetic screening to a pregnant woman is in a privileged, but challenging position. Privileged, because she has the opportunity to help the woman involved to realise her choices in a society where testing is often routine. Challenging, because this comes at a cost. It takes time to explain to a newly-pregnant woman that some of the tests she is being offered are to see if the child has a genetic abnormality. And, as many conditions screened for do not have treatment available, that termination



"Often families benefit from visiting those who are living with a child with the same condition as that diagnosed in the fetus."

is one of the options available in the case of a positive result. Add to that explaining the concepts of risk, partial and full penetrability of genes, genotype and phenotype, and (once genomic screening is available) incidental findings or those of unknown significance – most of us doctors need to have it explained to us first!

So what are we to do? Obviously we need to educate ourselves so we can explain the basics of the tests, and/or know who you can refer to for more counselling. Also, remember that the decision doesn't have to be made on the spot – in fact, many people advocate a 'cooling off' period before going ahead with tests like these.

The father and other members of the family may want to discuss the options as well.

Whatever your own views on prenatal screening, remember that tests such as ultrasound give valuable information for managing a pregnancy, such as locating placental position, as well as looking for fetal anomalies. Furthermore, many couples opposed to termination will benefit from knowing in advance the need to prepare for a child who will need extra care. Don't discard the notion of screening altogether. If you and your patient want to limit what is sought in a scan, talk to the local sonographer and radiologist. Find someone who will cooperate with limiting the scope of the examination. It's not all-or-nothing.

In the event of a high-risk or abnormal result, many women will struggle to know what is the right response. Once again, it is vital that they understand there is a choice and that there is no rush in making it. Often families benefit from visiting those who are living with a child with the same condition as that diagnosed in the fetus. Seeing someone affected by the condition diagnosed is known to reduce the incidence of decisions to terminate the pregnancy.

Often termination is chosen because the mother feels unable to cope. Once again, knowing the local resources available locally to help those who are in need of emotional, physical, or spiritual support will make a difference.

It seems that within the current system, who should live and who should die is dependent on the genes and the wantedness of the child. Let's do all we can to help our patients make the best decision possible. ●

by Megan Best

Megan is a bioethicist, palliative care doctor and psycho-oncology researcher at the University of Sydney and the University of Notre Dame Australia. She is the author of *Fearfully and Wonderfully Made* (2012), a comprehensive, Biblically-based ethical handbook about issues at the beginning of life.

Moral Reflections on Conscience in Medicine

There's a growing sense that the role of a doctor's conscience in their practice of medicine is under threat.

There are concerns about the implications of clauses in the proposed new AHPRA Code of Conduct.[1] More substantively, there has been a vigorous debate in the literature on medical ethics and law on whether it is ever appropriate for a doctor's 'private' (religious and) moral opinions to impinge on the provision of patient care.[2]

There are many issues at stake here: justified rejection of medical paternalism; concerns about subjective private morality compromising good patient care; questions about appropriate engagement in a state or socially-sanctioned service. Whilst I wouldn't say that they all have one thing in common, arguments for *excluding* conscientious objection from medical practice do presume a problematic understanding of medicine and other health care professions: namely, that they are morally neutral practices. The presumption is that whilst medicine may be undertaken by good people for what they see as morally good reasons, and that those motivations might prompt them to go to work each day, their private morality needs to be parked at the door of the clinic. This presumed moral neutrality of medicine is simply mistaken.

Any reasonable construal of medicine requires the recognition of its inherent morality, such that all medical practice is an exercise of the clinician's moral agency – in which assessments of the actual, rather than the perceived, good of the patient are paramount. A simple analysis of power and its use makes that plain. What prompts a patient to go to their doctor is a perceived need: a weakness or vulnerability that the doctor's expertise can meet. The knowledge, expertise, skills, access to resources denied to others (medication, surgical procedures and the like), and even such basic practices as history-taking and physical examination, all place the doctor in a position of power. And with power comes responsibility – moral responsibility. Morality is not an imposition on (supposedly neutral) medicine; it is part of its very substance. Moral questions are an inevitable feature of good medical practice.

EDITOR'S NOTE:
The request by AHPRA mid-2018 to comment on its intended changes to the medical code of conduct sparked a widespread flurry of debate, letters and petitions via email and social media. Many of these conversations involved participation by CMDFA members. Here are some of them.

"Morality is not an imposition on (supposedly neutral) medicine... Moral questions are an inevitable feature of good medical practice."

The question must then be not *whether* but *how ought* a doctor's moral judgements influence their clinical practice? In what circumstances might a doctor rightly object to a medical or surgical procedure on grounds of conscience? And what form should that objection take? I would suggest that there are important questions about the scope and limits of such objection.

It needs to be a properly moral objection that is relevant to this particular person's condition of need. To refuse treatment to someone with an STD on the grounds of their (presumed) sexual immorality is as unwarranted as refusing to treat someone with lung cancer. Perhaps unwise or ungodly choices have led to them being in this situation of need, or perhaps not – it may be their spouse's fault they have an STD, or just bad genetics that they have lung cancer. Furthermore, the harms – moral harms – that denying treatment would cause for them and others, outweighs any presumed concerns we might have about our treatment tacitly approving their behaviour. I cannot see a case for conscientious objection in such circumstances, and know of no one who would seriously suggest it. It would be equally unconscionable to refuse to treat someone with pneumonia because they identify as LGBTQI+, or Muslim, or secular humanist. While we may question the legitimacy of their lifestyle and other choices, I fail to see how that is relevant to how we ought to treat them as a person in need. Conscientious objection gives us no right to morally objectionable judgementalism or bigotry, or to punitive refusals to treat.

But there are legitimate objections that may be made to some kinds of treatment that do not pick out morally irrelevant qualities of that person. Many – perhaps most – doctors who object to euthanasia believe that it is wrong for doctors to take the lives of their patients, or to assist them in doing so themselves, and that to do so would be both wrong and harmful.[3] Many – perhaps most – doctors who object to abortions on demand believe that there is another person's life at stake, and that terminating the pregnancy both harms that developing person and wrongs them. Many – perhaps most – doctors who object to some cosmetic

procedures believe that it is wrong for doctors to allow culturally determined 'body fashions' and unrealistic perceptions of bodies and ageing to be inscribed on the bodies of their patients. (Which is not to say that all cosmetic and reconstructive surgery is wrong; it is to suggest that there are important questions to be raised about the cosmetic surgery industry and its role, product, and perpetrator, of unhealthy body image in late modern capitalism. Dare I say, questions of this kind deserve more attention in Christian reflections on medicine than they generally receive. But I digress...). These may all be contested claims, but they are morally relevant.

These are non-trivial questions of moral substance that have direct bearing on treatment decisions.[4] They are questions that can rightly be asked about the deploying of medical power and knowledge in these circumstances. They are questions that do not intrude illegitimately on a morally neutral social service, but which arise out of the fundamentally and inescapably moral nature of an enterprise such as medicine. They are questions – big questions – about the nature and goals of medicine, and its role in a well-ordered society.[5] Simply ruling such questions out of court does not invalidate them. Equally, stridently asserting the right of conscientious objection without addressing them will win us no friends and gain no traction. We ought to continue to *raise questions* about what medicine is, what it's for, and what role medicine and medical practitioners ought to play in our evolving society.

We need to learn how to ask – and answer – those questions well, for the sake of both our patients and our profession. ●

by Dr Andrew Sloane

Andrew practiced briefly as a doctor before training for Baptist ministry. He is Senior Lecturer in Old Testament and Christian Thought, and Director of Postgraduate Studies at Morling College in Sydney. His current research is focused on philosophy and theology of medicine and related questions.

References

1. See https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx and the draft of proposed changes file:///C:/Users/andrews/Downloads/Medical-Board – Consultation – Draft-revised-Good-medical-practice – A-code-of-conduct-for-doctors-in-Australia.PDF. CMDFA has raised concerns about the wording of the provisions regarding compliance with the law, public comment and cultural sensitivity and the ways this might impact on a clinician's exercise of moral and clinical judgement.
2. See Julian Savulescu's criticism of the notion, "Conscientious objection in medicine." BMJ 332 (2006): 294-97; https://www.doctorportal.com.au/mjainsight/2011/42/julian-savulescu-beliefs-can-do-harm/, and Trevor Stammers' defense of the notion, http://www.cmq.org.uk/CMQ/2013/Aug/nhs_no_place_for_conscience.html
3. It is important to distinguish between harms and wrongs. A harm is an injury done to a person which may or may not wrong them (punishment, of whatever form, is a case in point of a harm without a wrong). A wrong is viewing or treating a person in such a way as to ignore or deny or pervert their unique moral worth, which may or may not entail harm (lust is sinful not just because of the way it both expresses and fosters disordered desires, but because it wrongs another in treating them as an object of desire rather than a person). For this important distinction, see Nicholas Wolterstorff, *Justice: Rights and Wrongs*. Princeton: Princeton University Press, 2008.
4. There are many others, but they lie outside the scope of this piece – questions such as whether a doctor who refers or directs a patient to such treatment is morally complicit in their decision (open to question in my view), or whether their long-term interests are better served by such a referral and the ongoing caring relationship that this may foster (as I suspect is often the case).
5. I address these larger questions in Andrew Sloane, *Vulnerability and Care: Christian Reflections on the Philosophy of Medicine*. London: Bloomsbury T&T Clark, 2016.

Dear AHPRA

Thank you for the opportunity to send in a submission regarding the Medical Code of Conduct.

"Good medical practice" being 'patient-centred' would benefit even more by taking into account our patients' beliefs and spiritual understanding. The Code of Conduct for Doctors in Australia 2009 states that "this includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor-patient relationship and on the delivery of health services". Often in my twenty-odd years of medical practice, the patient benefits more when we treat the patient as a whole person rather than merely a scientific object devoid of feeling, belief or hope.

Faith, therefore, is important in health care, as shown by various articles and research papers correlating this with good health outcomes. Furthermore it has been shown that many patients are open and keen to discuss their religious beliefs in the context of their health. In addition to this, in a number of jurisdictions around the world, it is a desired element of best medical practice.[1]

The Scottish patients' charter expresses this sentiment reasonably well, "All patients can expect NHS staff to acknowledge their spiritual needs and aspirations and be sensitive to the wide variation in values and cultural backgrounds of their patients. In support of this, the NHS is expected to make every effort to provide for the spiritual needs of patients and staff".

Of course this is all the context of general good medical practice – of treating the patient with sensitivity, permission and respect.

Thank you for reading and considering my submission to the revised code of conduct. I am happy to correspond further. ●

Yours sincerely,

Dr Richard Wong
MB BS BSc(Med)
FRACGP DCH DRANZCOG
CTh DCH rural locum doctor
CMDFA /Healthserve

Reference:

1. The UK GMC ethical guidance point 15: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-1---knowledge-skills-and-performance#paragraph-14
New Brunswick College of physicians and surgeons code of ethics: https://cpsnb.org/en/medical-act-regulations-and-guidelines/code-of-ethics
Since I wrote the submission only about two months ago, ANZCA seems to have replaced its own code of conduct with the Australian medical code of conduct (hence all the more reason we keep up the good fight of submissions !) http://www.anzca.edu.au/resources/professional-documents

Is Clinical Medicine a Science?

I have encountered two sociologists recently who argue that clinical medicine is a science.

They then argue that, as a science, clinical medicine is hostile to religion. The Balbonis[1], a minister/sociologist husband and a palliative radiation oncologist wife, argue that medicine has increasingly focussed on the physical aspects of illness to the detriment of the non-physical, or transcendent aspect of the human condition. They argue that clinical medicine, by ignoring the human soul, has become hostile to religious/spiritual inputs. They believe that clinical medicine has become dehumanised by focusing on three dimensions of hospital care – science and technology, the legal and bureaucratic, and the economic and market dimensions. Clinical medicine has neglected the fourth dimension of hospitality and caring, a dimension enhanced by spiritual and religious considerations. The Balbonis regard religion as the physical and outward manifestation of spirituality, and claim that spirituality is expressed through religion, and that this affects hospitality and compassion. The other sociologist is Dr Paul Tyson[2], who describes modern clinicians as value-free scientists practising a utilitarian ethic and unable to develop a theistic ethic based on the intellective, qualitative and transcendent nature of Christian ethics. The clinician as a scientist is to blame.

But what if they are mistaken in regarding clinical medicine as a science? What if it is not based on the quantitative measurement, immanence, and rationalistic foundations these two sociologists believe clinical medicine are placed on? What is clinical medicine anyway?

Clinicians are primarily not scientists, although we try to base what we do on a number of very different sciences, eclectically picking up bits that are useful and dropping bits that are not. We are primarily pragmatists, solving whatever health problems patients present to us, and doing so with the best that the profession has to offer. The aphorism: "Cure seldom, relieve often and comfort always," summarises the messiness of what we do. Where we can, we cure – whether it be a cut, or a fracture, or a bacterial infection – always bearing in mind the healing power of the human body to aid the healing of a cut, or the fracture, or the infection. If there is no immune system, curing infection is much more difficult, although these days we have ways of enhancing the immune response. While the healing takes place, caring clinicians aim to relieve pain and suffering with appropriate support. Good clinicians also seek to provide the patient the comfort of an adequate understanding of their disease, their prognosis and the way in which they can best deal with the challenge of time off from work, sickness benefits and so on. In the comfort area particularly, the holistic clinician sees herself as part of a team of carers committed to the cure, relief and comfort of patients. The Christian clinician will seek to help a patient work through the spiritual issues sickness has raised, and provide appropriate help or referral to bring help to the sufferer spiritually.

"The Christian clinician will seek to help a patient work through the spiritual issues sickness has raised, and provide appropriate help or referral to bring help to the sufferer spiritually."

Central to this is to perceive the presenting problem as it truly is – from a mild skin lesion which can be left alone, to an urgent problem like central crushing chest pain which will require immediate and skilled attention. We use whatever strategies work, and try to protect our patients from quackeries that do not work. We work hard, sometimes too hard, to meet the demands the public make on us. We practice humanely and ethically, conscious of the trust the public have in us, and socialising our students to develop the same professionalism that we were taught. We have ethical boards with expectations from the profession. Those who abuse the trust that patients have in our profession are sanctioned by that board, even to the extent of deregistering the doctor. There are imperfections in the system, and those damaged by the profession believe we have not been transparent enough. Thus we now have lay representatives on our professional boards to give an external perspective on our deliberations. For example, the Victorian Government has set up a Health Services Commission to process complaints against those in our profession who are perceived as having abused their power as professionals. The Health Services Commission in turn has set up patient advocates in each of the major hospitals to speak up on behalf of patients who feel abused by the system.

Does that mean there is no science to clinical care? By no means! There are many sciences – from basic anatomy, physiology, biochemistry, pathology, pharmacology and microbiology to the softer sciences of psychology, sociology, and even economics. Further, there are the public health

sciences of epidemiology and ecology. These in turn are usually based on the even more fundamental sciences of physics, chemistry, biology, botany and zoology. There are even the sciences of clinical medicine: nosology, clinical epidemiology, evidence based medicine, clinical economics and health economics and we call on the help of the professions of law and business administration. But each of these sciences, and there are others, are subsumed to the basic aim of providing competent complete patient care.

Clinicians come from all walks of life and all religious persuasions (or none), and are united in the common purpose of doing the best that we can. That is the ideal. We recognise, however, that there are some colleagues among us who are driven by other motives – be they profit, or political power, or scientific prestige. These days, if we desire to embark on clinical research, we are asked to submit our research to clinical ethics committees. These have been constructed following disastrous paternalistic and compassionless approaches to patients – not just of the Nazis during World War II, but also the post-war unethical behaviour in the US and other places.[3] So research ethics committees have been developed to ensure that any experiments done on patients are done ethically with fully informed consent.

"I believe that my being a Christian makes a considerable difference to my clinical care."

I believe that my being a Christian makes a considerable difference to my clinical care. I want to model the compassion of the Master, to bring the hope and peace that he brings. His love shapes my ethics, and well as my practice. However, some of the best and most caring clinicians I have had the privilege of working with do not have the same faith commitment. However, they still share my commitment to excellent and compassionate clinical care. None of us have developed a coherent philosophy of what we do. In fact, we share a suspicion of those who, with the best of intentions, have tried to develop such a theoretical framework of what we do. We simply get on with it.

Most of my non-Christian colleagues are not hostile to my faith. Not only do they respect it, but they even admire it, even when they do not share such a faith with me. They do not see the need for such a faith, they simply get on with what they know how to do best, to cure where we can (which is seldom), to relieve often and to comfort always.

Is there a biblical justification for such an eclectic approach? I believe there is. Interestingly the Wisdom literature of the First Testament describes wisdom as encapsulated, not in large, rationally-argued theses (like this article!), but in proverbs, parables, sayings and riddles of the wise (Proverbs 1:1-7). It seems that the modern ambition of one single, complete, comprehensive theory-of-everything needs to be replaced by a post-modern, far more fragmented, particular view of single issues without an overarching framework. For all its attractions, Biblical theology is not systematic, it is fragmentary, found in a selection of stories about the Master from the early church and followed by a series of ad hoc letters to churches addressing particular situations. As Christian doctors we draw on these stories for information and inspiration for what we do. ●

A/Prof Alan Gijsbers
MBBS FRACP FAChAM DTM&H PGDipEpi University of Melbourne, Head Addiction Medicine Royal Melbourne Hospital Medical Director Substance Withdrawal Unit, The Melbourne Clinic. President of ISCAST.

Alan has a particular interest in studying neuroscience and theology, the philosophy of the self, and spirituality, topics which underpin his approach to addiction care. He has won an award for clinical teaching in the Master of Psychiatry course 2017 at the University of Melbourne. He is married to Lois, has three children and seven grandchildren.

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Petition Regarding Freedom of Speech

Submitted to AHPRA July 31. By anonymous member CMDFA and signed by over 500 people.

The proposed changes to the Medical Board's Code of conduct amounts to essentially a gag order, threatening those who speak out with disciplinary action and deregistration.

The relevant section is 2.1:

> *"You need to acknowledge and consider the effect of your comments and actions outside work, including online, on your professional standing and on the reputation of the profession. If making public comment, you should acknowledge the profession's generally accepted views and indicate when your personal opinion differs. Behaviour which could undermine community trust in the profession… may be considered unprofessional."*

This vaguely worded paragraph could be used to stifle free speech and debate on contentious topics.

Australia is a pluralistic society with many different worldviews. This is one of the great strengths of our democracy. This is also a strength in the medical community.

The medical community is a broad church of widely dissenting views, as we would expect. However, it is this very practice of questioning the status quo that has been so invaluable in the progress of both the science and the politics of medicine.

Let's say you have two excellent doctors, who both recognise their role in treating addiction as an illness.

EDITOR'S NOTE:
The request by AHPRA mid-2018 to comment on its intended changes to the medical code of conduct sparked a widespread flurry of debate, letters and petitions via email and social media. Many of these conversations involved participation by CMDFA members. Here are some of them.

Let's say Doctor A publically advocates for decriminalisation of recreational drugs and increased injecting rooms.

Let's say Doctor B publically advocates for the state to continue to criminalise recreational drugs and opposes injecting rooms.

Let's say you have 2 excellent doctors who work in a state where abortion on demand is not legal after a certain gestation.

Let's say Doctor A publically advocates for abortion on demand up until term.

Let's say Doctor B publically advocates the law remain as is and late-term abortions only be conducted under highly regulated conditions.

Let's say you have 2 excellent doctors who both practice refugee health.

Let's say Doctor A publically advocates for the government to reform its refugee policy for the sake of refugee welfare.

Let's say Doctor B publicly supports the government's approach in trying to "stop the boats" to indirectly improve refugee welfare.

Gagged

This threat of disciplinary action clearly impinges on the ability of Doctors to comment and advocate for some of the most disadvantaged people in our society.

It limits their right to participate in the discussion of the most important social and medical issues such as asylum seeker policy, abortion, euthanasia, drug policy, public health, gender, even myHR.

Now let's go back 50 years. At the time the commonly and medically held view was that homosexuality was a psychiatric disorder. Which doctor would have threatened with deregistration then – the one who publicly promoted the commonly held view, or the one who publicly dissented against it?

Medicine and its associated topics are not always clear cut. Social reform and medicine progress on respectful free thought, speech and debate. As both a doctor and a private citizen I would oppose any moves from AHPRA to limit that.

Sign and share…

If you feel that medical professionals should not be threatened with deregistration for discussing difficult topics then please sign, share and also submit personally to:

medboardconsultation@ahpra.gov.au with 'Public consultation on Good medical practice' as the subject

or by express mail to:
Executive Officer, Medical, AHPRA,
GPO Box 9958, Melbourne 3001

Draft code here:http://www.medicalboard.gov.au/documents/default.aspx?record=WD18%2f25522&dbid=AP&chksum=a8i6jtK%2fa%2bYFGb%2f%2fL%2fxZ%2fw%3d%3d ●

Dear Medical Board of Australia

We thank you for this opportunity to contribute to the public consultation on the draft revised code of conduct, *Good medical practice: A code of conduct for doctors in Australia.*

We congratulate you on the many improvements noted in the new draft. We are particularly grateful for clearer guidance on safety in the workplace related to violations of discrimination, bullying and sexual harassment. We also appreciate the efforts to increase consistency with the codes of conducts for nurses and midwives.

We would like to highlight a few areas that provide opportunities to strengthen items and address omissions.

In section 3, 'Providing good care', we note the use of the phrase "good patient care" and in section 4, 'Working with patients' we note the use of the phrase "good doctor-patient partnership". In both these sections there is no explicit reference to "person-centred care" nor "holistic healthcare" but these concepts are clearly implicit in each of the listed items in these sections. We note the statement "Good medical practice is patient-centred" in section 2.1, but this appears to be the only explicit use of this phrase. "Person-centred care' and 'holistic healthcare' are powerful concepts underpinning good patient care and the good doctor-patient partnership.[1] They provide valuable frameworks to understanding the health needs of individual Australians and Australian communities. We suggest they should be made more explicit in sections 3 and 4 as well.

For instance, item 3.1.1 currently states:

> *3.1.1 Assessing the patient, taking into account the history, the patient's views, and an appropriate physical examination. The history includes relevant psychological, social and cultural aspects.*

We suggest strengthening this item by phrasing it as:

> ***3.1.1 <u>Holistically</u> assessing the patient, taking into account the history, the patient's views, and an appropriate physical examination. The history includes relevant psychological, social, cultural and <u>spiritual</u> aspects.***

Further, item 4.2, 'Doctor-patient partnership' currently opens with:

> *A good doctor–patient partnership requires high standards of professional conduct.*

We suggest strengthening this opening by phrasing it as:

> ***A good doctor–patient partnership requires high standards of professional conduct and <u>person- (or patient-) centred care.</u>***

In addition, item 4.3, 'Effective communication', currently states:

> *4.3.8 Taking all practical steps to ensure that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect patients' understanding.*

We suggest strengthening this item by phrasing it as:

> ***4.3.8 Taking all practical steps to ensure that arrangements are made to <u>provide holistic care that meets</u> patients' specific language, cultural and communication needs, and being aware of how these needs affect patients' understanding.***

Holistic health care and person-centred care acknowledge that spiritual belief is a key determinant of health.[1,2,3,4,5] Although the World Health Organisation (WHO) are yet to amend their 1946 definition of health that endorses the three dimensions of "physical, mental and social well-being" 6, there have been many calls for 'spiritual well-being' to also be officially recognised as a legitimate "4th dimension" in the definition of health.[7,8,9]

In the draft revised code of conduct, there is no explicit reference to this spiritual dimension of a person's health. Whilst it may be implicit in references to "cultural" and "social" aspects, we recommend that it be made explicit as well. Our colleagues in the General Medical Council (GMC) of the United Kingdom (UK) have done so in their ethical guidance for doctors.[10] Our suggestion to re-phrase item 3.1.1. above reflects this.

We recommend that taking a spiritual history must be conducted with **permission, sensitivity and respect** and we endorse and appreciate that the items in section 4.2 and 4.3 already address this.

We also endorse and appreciate the several explicit notations to "cultural" aspects to healthcare, even though it is not currently explicit in the WHO definition of health.

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EDITOR'S NOTE:
The request by AHPRA mid-2018 to comment on its intended changes to the medical code of conduct sparked a widespread flurry of debate, letters and petitions via email and social media. Many of these conversations involved participation by CMDFA members. Here are some of them.

Finally, we note with concern the absence of a reference to individual "conscience" in the revised code of conduct. As our colleagues in the GMC note, medical practice according to conscience is important.[10]

In section 2 on 'Professionalism', item 2.1 'Professional values and qualities of doctors' currently opens with:

> *While individual doctors have their own personal beliefs and values, there are certain professional values that underpin good medical practice.*

This subsection goes on to cogently and appropriately emphasise the duty of doctors to maintain patient and community trust.

We suggest strengthening this subsection by including a paragraph regarding the doctor's right to practice according to their conscience. We recommend similar phrasing to that provided by the GMC for UK doctors:[10]

> ***The right of a doctor to practice according to their conscience is valued by the profession. You may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients. This means you must not refuse to treat a particular patient or group of patients because of your personal beliefs or views about them. Also, you must not refuse to treat the health consequences of lifestyle choices to which you object because of your beliefs.***

We thank you for your sincere consideration of our suggestions and recommendations for improvements to the revised code of conduct. Once again, we commend the work that you are doing on this important task. Please do not hesitate to contact us should you require any further information or clarification.

Yours sincerely,

Dr Michael Burke
MBBS, BSc, MA, MPH&TM, MSc (Clin Epi), PhD, DCH DRANZCOF, FRACGP, FACTM, FAICD
General Practitioner, Blacktown, Western Sydney
Conjoint Associate Professor,
University of Western Sydney

Dr Sneha Kirubakaran
BComp, BAppSc (Hons), BMBS,
Grad Dip Clinical Education, FRACGP
General Practitioner (Adelaide),
Lecturer & PhD student (Flinders University)

Georgie Hoddle (RN)
Clinical Nurse Educator, Vice-President
Nurses Christian Fellowship Australia

On behalf of the Saline Australia Network ●

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BOOK REVIEW

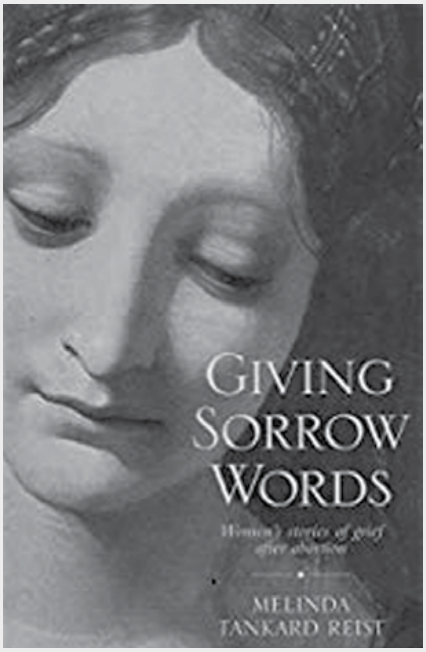
Giving Sorrow Words

Melinda Tankard Reist

These are the stories you were never supposed to hear. These are the women kept hidden from view, whose feelings have been invalidated and whose experiences have been belittled. *Giving Sorrow Words* by Melinda Tankard Reist is an important collation of women's true stories of grief after their abortion.

The stories in this book were gathered in a response to a small advertisement in a newspaper inviting women to tell the story of their abortion. Two hundred and fifty women responded, taking up the opportunity to open up their grief. The eighteen stories that appear in the final edition are from women ageing from teenagers to seventy-year-olds, from students to professionals, both unmarried and married, both atheist and religious – demonstrating that the tragedy of abortion is not limited to one particular stereotype.

As well as the stories from forgotten women, Tankard Reist also includes a helpful introduction and afterword which takes an academic look at the phenomenon of post-abortion grief. This research was never presented at university and the common refrain has



been that the only emotion women feel after abortion is relief. This is important information for doctors to have when counselling women who are seeking advice regarding what to do with an unwanted pregnancy. One woman is quoted as saying, "Looking back now, if I had known then what emotional torment I would go through as a result of having the abortion, I would never have gone through with it."

Common themes in these stories are pressure from family members or partners, insufficient counselling, paternalistic medical professionals and low-standard medical care. Whilst abortion has been heralded as a woman's choice, these stories demonstrate that it was, in fact, the opposite. Tankard Reist – a politically incorrect feminist – provides a platform for voiceless women to be heard. In doing so, she validates the lives of their unborn children.

This book should be essential reading for all medical professionals. Not only does it debunk the myth that abortion is pro-woman, it will also enable the reader to be more compassionate to those patients who have gone through the trauma of abortion. Our patients need to know that "there will be losses having a baby, but don't underestimate the loss of having an abortion." ●

by Dr Jacki Dunning

Jacki is a paediatric trainee at the Children's Hospital at Westmead, Sydney. She is wife to Joseph and mother to Joey (3 years old) and Idelette (11 months). She also serves as the student worker in CMDFA.

CMDFA

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This Journal is published three times a year by the **Christian Medical and Dental Fellowship of Australia Inc. (CMDFA)**.

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Indonesian Earthquake-Tsunami Emergency Appeal

Since the devastating earthquake and tsunami in Indonesia in September, our Indonesian partner *The Nation's Torch of Love Foundation* (in Indonesian: *Yayasan Suluh Kasih Bangsa*) has been putting together a plan to train community health-workers to serve the Lombok/Sulawesi Island region.

The Foundation is expecting between three to six months of ongoing healthcare issues in these devastated communities.

Healthserve Australia is partnering with *The Nation's Torch of Love Foundation* and asking our donors to be generous and give to this HealthServe Australia Emergency Appeal.

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Further information is at the HSA Website: ***www.healthserve.org.au***

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