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of Christian Medicine & Dentistry

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Ageing Gracefully

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“As a medical student, I was challenged to see theological education as akin to secular education. Prior to this I had felt it was only for those considering full-time vocational ministry. We study and train for years to work as a doctor, but we are called to be followers of Jesus 24/7. I had intended to do a short stint of theological study after completing medicine but, with work, family and continued lay ministry, this decision was delayed until this year. As I became a father and more involved in church, I realised that studying the Bible in depth has value for every facet of life. As a doctor it will shape and mould the way I approach my work, but more importantly it will equip me to understand and teach the Bible better. Ultimately, it will allow me to serve God effectively wherever he places me. After proclaiming I'd had enough of study forever, this year has been the most rewarding, enjoyable and life-changing study I have done. It's never too late!” **SMBC student, Julian**

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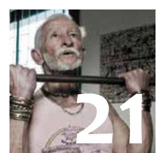
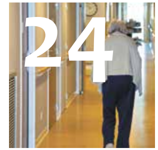
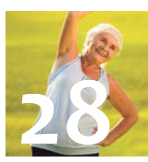

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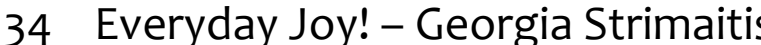

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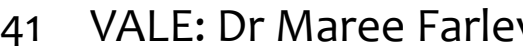

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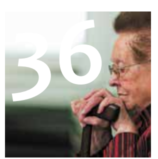
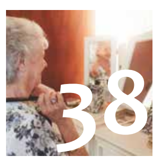
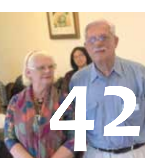

Themes for Next Editions:

Fire in the Belly
copy due 15 Dec 2020

Until the Very End: Dying and Palliative Care
copy due 30 Mar 2021

Dr Eleasa Sieh

Eleasa is a Canadian-born Chinese permanent resident of Australia, and works as a general practitioner on the Sunshine Coast, Queensland. This book was one she had on her always too-long to-read list but when it showed up on a list of book recommendations as part of a Biblical counselling course, she jumped at the chance to read it and write this for *Luke's Journal*.

EDITORIAL

Ageing Gracefully

"I would like everything to be immemorial – to have the same old horizons, the same garden, the same smells and sounds, always there, changeless. Autumn is really the best of the seasons: and I'm not sure that old age isn't the best part of life. But of course, like autumn, it doesn't last."
– C.S. Lewis

This issue of *Luke's Journal* comes at the end of a year that has shaken and sifted us all, with the SARS-CoV-2 virus and the COVID-19 pandemic having swept across the globe, crossing international boundaries, and affecting all cultures and ages, including the loss of nearly 1.2 million lives at the time of writing this editorial.[1] Among those who have lost their lives this year, the majority have, unsurprisingly, been those aged 70 and above.[2] It is this cohort in our societies who have been the focus of global public health guidelines on lockdowns of nursing home facilities. Facing strict no-visitor policies even at the end of life, and feeling the extent of suffering is aptly captured by the Italian word "*straziante*", defined as "a very acute physical or moral pain, beyond any capacity for tolerance".[3]

Closer to home, poor systems of care have been exposed with the recent Royal Commission into Aged Care Quality and Safety. The needs of the vulnerable and the frail continue to lie at the mercies of systems and institutions. These needs will exponentially increase, as the Australian Bureau of Statistics documents a rise over the last 20 years that is projected to exponentially continue over the next decade.[4]

There is a clear need for leadership, guidance, research, and thinking into the care of this growing populace. Deeper than the statistics, there is the existential question of whether there is truth to what C.S. Lewis calls the "best part of life" – is autumn truly the best of the seasons before winter's inevitable arrival?

The Christian doctrine of the *Imago Dei* – that each human being is born imprinted with the image of God – provides the unique undergirding exemplified in this issue's collection of articles and reflections. This issue is dedicated to this cohort of individuals who are part of us, whether ourselves, or those we daily interact with in our work, our spouses, our parents, our extended family members, our fellow church members, and our neighbours.

In this issue, you will read reflections on ageing and living with disabilities that arise from ageing, from medical professionals and aged-care pastoral care workers, as well as a registered nurse and priest and associate professor in theology. You will find a poem dedicated to the singular uniqueness of a farmer's wife, learn about Dignity Therapy, and enter into the realities of journeying with a spouse living with dementia as a medical professional.

My hope is that this issue would cause you to find meaning and purpose, or joy and peace, and even hope, for the autumn of ageing that we must all face, and discover that there is a practical and tangible reality to Ageing Gracefully.

In the grace of Christ,

Eleasa Sieh
On behalf of the Luke's Journal editorial team.

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4. https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release

Dr Paul Mercer

Dr Paul Mercer is an active General Practitioner in Brisbane. He is the former editor of *Luke's Journal* and enjoys his work in Aged Care Facilities.

Remembering (and being remembered)

Old Testament theologian, Walter Brueggemann, describes Psalm 77 as a "speech pilgrimage". While Protestants are modest about the concept of pilgrimage, walking the Camino in Spain has an enduring attraction. Christians have always been interested in visiting Israel. What about Bunyan's *Pilgrim's Progress*? Or hymns like *Guide Me O Thou Great Jehovah*? As health professionals, we share a privileged apprenticeship in life's journey with our patients. We have "walked a mile" on good, bad, and even ugly pathways.

This psalm is a pilgrimage that starts in despair, "I cry out loud to God". Here is the feel of the despair of an ageing body, the loss of social meaning and a threatening sense of loss of the memory of God. It is a psalm which captures echoes that could be generated from an aged care facility. There is a pathos even with and for the love of God. This worship leader speaks for anyone who will listen, from the place that senses God has forgotten us, that the strong right-hand of God has lost its grip on us (v10).

The psalm gathers all the groans of someone who senses they are spent. "I cry out loud to God – out loud to God so that he can hear me! During the day when I'm in trouble I look for my Lord. At night my hands are still outstretched and don't grow numb; my whole being refuses to be comforted. I remember God and I moan. I complain, and my spirit grows tired."

As our bodies and minds fail at the tail end of life, we can imagine that even the final moments themselves will be frustrating. "You've kept my eyelids from closing. I'm so upset I can't even speak" (v5). It is hard to imagine this pilgrimage is likely to bring us close to God.

> ***"The witness of God's story to us in the Scriptures is that we have permission to 'cry out', to complain to God no-holds-barred."***

Our speech pilgrimage then starts its journey as a classic lament. It is a challenge to be so honest with ourselves and God in this way. Have you ever been to such a dry well? That rock-bottom dungeon where even words fail you?

The witness of God's story to us in the Scriptures is that we have permission to "cry out", to complain to God no-holds-barred. Such cries don't have to be the end of life or at the bottom of despair either.

As medical doctors and healthcare professionals, we have the special honour to share the witness of crumpled faith at this unravelling and inelastic time in life's pilgrimage. Like Ezekiel, sometimes all I can do is sit with individuals; to be present as a sort of "cheer squad", when flickering memories of God's loving kindness re-emerge.

In verse 5 the psalm takes a turn, though without much confidence, away from moaning. Memory is the vehicle for change in this speech pilgrimage. Memory is an important part of faith. The liturgical call of the Christian life is to both share in and remember, with all the saints, the life, death, and resurrection of Jesus for us. In this faith-generated practice of communion we repeatedly recognise that God always remembers who we are. His love never ends.

Asaph, who has created the speech pilgrimage of Psalm 77, remembers in v5-9: "I think about days long past; I remember years that seem an eternity in the past. I meditate with my heart at night; I complain, and my spirit keeps searching: 'Will my

Lord reject me forever? Will he never be pleased again? Has his faithful love come to a complete end? Is his promise over for future generations? Has God forgotten how to be gracious? Has he angrily stopped up his compassion?'"

In this remembering, Asaph recognises for us that life can seem to stretch out. During this stage of his speech pilgrimage, he meditates, he questions, he searches his heart. All of these are robust components of the faith pilgrimage. They require patience, critical reasoning and honesty.

While this psalm has captured a speech pilgrimage, it has also given us a glimpse of the apophatic components of the journey of life – the "be still and know I am God" stages of the path, times when words fail us, when speaking no longer cuts through. "My spirit keeps on searching", the psalmist says.

One of the many benefits of a long life is to accept a slowing down and a recovery of stillness, of patience before God. Stillness and a seeking heart are genuine components of a normal spiritual life.

At the same time, empty uncluttered spaces in life can be misinterpreted. In our driven world, we may be tempted to interpret them as a waste of time. As Asaph takes us there, he becomes aware of painful questions: Has God's faithful love come to an end? Has God forgotten how to be gracious? Has God angrily stopped up his compassion? Memory can be wrapped in intense emotion.

What about you? Have you ever asked these pilgrimage questions? It takes courage, a Job-like defiance toward despair and the failures of ageing.

Let us consider memory for a few moments. Can we trust our memory? What does it mean if we reach a point when we forget the love of God is for us? Is despondent ageing, ageing with memory white-out, a strange prank that God plays on our lives?

Human beings exercise three different types of memory, as we live with the elusivity of time.

- Semantic memory relates to how we remember concepts and facts, such as names, places, formulas, and so on.

Art by Tracy Yu

- Procedural memory covers how we do things and develop skills. For instance, a person with no reliable short-term memory could play the piano.

- Episodic memory or the subjective experience of explicitly remembering past incidents is the type of memory that is deeply personal and is where dementia impacts memory most profoundly.

> ***"Honest pilgrims bear witness to grace in good times and bad – grace, even in times of pandemic lockdown and fear."***

Science gives us a range of other insights:

- Apparently, we remember interesting information that we process deeply, that we reflect on or mull over and so on.

- We remember visuospatial information better than verbal instructions.

- We remember information that is connected to things we already know.

- We remember information that we test ourselves on.

Science also can locate the brain structures involved in memory. The hippocampus is recognised as vital to episodic memory. Our left frontal cortex is vital to critical reasoning or how we make sense of the world and our memories.

In addition to long-term memory, we also have a short-term or working memory system. This memory helps us orientate, choose the next step, be socially appropriate, etc. Our working memory is in the order of 1-5 minutes. If distracted at the wrong moment, working memory will rapidly fade. Our working memory can almost instantaneously access stored memory capacity to make sense of the present.

Returning to our speech pilgrimage in Psalm 77, verses 5-10 draw on Asaph's episodic memory as he increasingly senses God's absence in the failing circumstance he finds himself in. He can exercise his memory to identify other times of his life when God's love was close, almost tenderly palpable, and yet so far away from where the pilgrimage has brought him in the present.

We often read the Bible and live the Christian life as if everything is stable, as if our lives are destined to remain happy and healthy, for our sanity and memory to remain intact. But are we aware that the life God calls each of us to never comes with such a guarantee? Prosperity gospels are a cruel hoax which simply ignore a psalm like this. Honest pilgrims bear witness to grace in good times and bad – grace, even in times of pandemic lockdown and fear.

Psalm 77 now takes a semantic twist. As Christians, we can remember the fact of the Cross, of Jesus' grace-scarred hands. As we do, we know our sins are forgiven. We know the shame and guilt of sin can be replaced by the hope of resurrection life. Our speech pilgrimage chooses these words in verses 11-15, "But I will remember the Lord's deeds; yes, I will remember your wondrous acts from times long past. I will meditate on all your works; I will ponder your deeds. God, your way is holiness! Who is as great a god as you, God? You are the God who works wonders; you have demonstrated your strength among all peoples. With your mighty arm you redeemed your people; redeemed the children of Jacob and Joseph."

By choosing to refocus and also actively meditate on the facts about God in Scripture – in the history of God's people, in the stories of miracles during the great Exodus event – the redemption of the children of Jacob and Joseph – the mood of this pilgrimage changes. A new type of question emerges, "Who is as great a god as you?" In the place of failing weakness that age may bring us, memory of God and for God's action from "time long past" are a source of rebalancing grace.

We Christians live with a double blessing of the memory of God's acts and qualities which are then consummated in the incarnation, in God becoming one of us through Jesus the Son. We also live with the blessing of God's presence in our own life pilgrimage as God's story intersects with our story.

And there is more. This speech pilgrimage invites us to ask all sorts of new questions. Questions like, "If God can bring His people out of slavery into the freedom of a land flowing in milk and honey, isn't there hope for new joy even in an aged care facility?" There is scope to dream, to imagine, to grasp new visions, to find the mind of Christ on any pilgrimage. Why? Because we can remember Jesus' promise to never leave or forsake us, we remember his promise to send the Spirit as a Comforter at any point of our life's calling.

In Asaph's speech pilgrimage, his words start to run wild with excitement. A Spirit-fired imagination gets him recreating the possibilities of God's action. "The waters saw you, God – the waters saw you and reeled! Even the deep depths shook! The clouds poured water; the skies cracked thunder; your arrows were flying all around! The crash of your thunder was in the swirling storm; lightning lit up the whole world; the earth shook and quaked. Your way went straight through the sea; your pathways went right through the mighty waters. But your footprints left no trace!" (v77:16-19)

Self-preoccupation hanging on for grim death has now transposed to delight, in the possibilities of any future moment. We have reached the "then sings my soul" moment in our pilgrimage here.

"If God can bring His people out of slavery into the freedom of a land flowing in milk and honey, isn't there hope for new joy even in an aged care facility?"

Our psalm started quite acceptably in self preoccupied despair. Remembering by the risk of faith has allowed a healing, a renewal, to take place. At the start of the pilgrimage, God seemed distressingly absent. Now through memory, we can speak imaginatively of God as a playful, active creator. It's chalk and cheese. It's moving from "I" to "you". "It is no longer I who live, but Christ [who] lives in me" (Gal 2:20)! The testimony of this psalm is that the smallest faith, the most tentative of faith as we look away from despair and diminishing capacity back toward God in whose image we are created, is a critical pastoral challenge in the pilgrimage of life.

At the start of this psalm, our pilgrim senses the absence of God. This breeds further despair. Now through the exercise of memory there is a revived sense of the vital presence of God. Ironically, there are still "no footprints" but memory has re-established a relationship.

I recently have been reading a book titled *Dementia: Living in the Memories of God*, by John Swinton. This author says, "It makes a world of difference to suggest that the memory loss we encounter in dementia happens to people who are loved by God, who are made in God's image and who reside within God's creation". The speech pilgrimage of Psalm 77 has orientated us to recognise this truth.

There are many types of dementia but the most common and well known is Alzheimer's type dementia. Swinton observes in his book that dementia is diagnosed by exclusion language. This is an illness of deficit in memory and, to some extent, thinking. Much of the description of dementia assumes a loss of the sense of self. Swinton argues that theology needs to work with science to defend the self in dementia. Our self is a reflection of being created in God's image. Here Swinton tells the story of a person wandering the corridors of a care facility repeating the word "God". Eventually, a nurse asked the question, "Are you afraid you will forget God?" The immediate response was, "Yes". Pastoral care at this point helped all the agitation to settle.

The "image of God" identifies not only the importance of vertical relationships, but also of horizontal. Our communities, our friendships, our human relationships all contribute to the sense of who we are. We are most clearly ourselves when we tell, or reflect on, the story of our lives in relationships.

Swinton has a word for the view of dementia which strips the self from a human being – "dementogenic cultures". Such cultures give permission to society to consider euthanasia rather than maximising relationships of care. Unsurprisingly, death anxiety is on the rise in our contemporary world.

Community surveys confirm that dementia or loss of memory is one of our greatest fears. The truth that God chooses not to forget any of us is of great comfort. Any honest speech pilgrimage will discover sooner or later that whether or not we remember, we can trust God remembers us. Isaiah 49:15-16 says, "I will not forget you! See I have engraved you on the palm of my hands". God's memory is of "yesterday, today and forevermore"

(Heb 13:8)! And yet, God can choose to forget – to forget our sins because of his great love for us. Now we can say of our lives, "we are not what we remember, we are remembered". Nothing can separate us from this truth, generated through the great love of God. God's memory informs the actions of God the Father, Son and Spirit.

Swinton's reflections about God's memory are rich. He says these things:

- God's memory is for the purpose of remembering; to bring together that which is fragmented.
- God remembers because God promises. Promises like, "I will be with you until the end of this age" (Matt 28:20).
- God's memory is not a recreation of the past, but a continuation of the self-same purpose.
- God's memory encompasses his entire relationship with his people (as this psalm acknowledges). His memory includes both great deeds of the past as well as his continued concern for his people in the future.
- Human memory is nothing more (and nothing less) than one mode of participation in the memory of God, which is our true memory and our only real source of identity and hope.

Swinton continues on with other profound reflections, but I think this picture is enough to carry us to the end of our speech pilgrimage.

Asaph has guided us from the despair of weakness, back to the playful presence of God. So how will his pilgrimage end? Verse 20 ends this psalm with the image of a faithful, open journey assisted by guides. Listen, "You lead your people like sheep under the care of Moses and Aaron". This verse reminds me of Israel's favourite psalm, number 23, "The Lord is my shepherd; I shall not want". Jesus speaks of sheep knowing his voice and following as he leads to "green pastures". Any memory we have of God's grace is a preparation for discovering new, fresh expressions of grace now and of God remembering us in the future.

Our calling at this point of the pilgrimage is trust, it is sweet surrender, again and again. While God doesn't leave footprints, he gives us leaders like Moses and Aaron who can support God's people in wilderness times, support when we are in the presence of enemies or even in the valley of the shadow of death. Indeed, Moses saw the day when the Spirit of God would be poured out on all the people, the day when we can all, in God's power, minister to and support each other.

As we come to the finishing line in our speech pilgrimage, you may be unsure about God's love. Is it because our bodies are failing, and we sense our memories are fading? The darkness of our doubts have a menacing quality, yet as we remember God's story, as we "eat the bread and drink the wine", the Spirit ministers God's memory of us, back to us. This is a wonderful blessing. We may have consigned God to "imaginary friend" status, only to discover the playful return of the most loyal of lovers.

Our speech pilgrimage has guided worship from the grip of despair to bring us to this place of enduring rest. Do you hear the voice of Jesus today, that most tender voice that knows you and your journey? Our life pilgrimage is naturally coming home, to rest. As we approach this day, let us confess that we are remembered.

This reflection is adapted from a sermon delivered at a Christian Aged Care facility in September 2019.

Resources:

- Bible – CEB
- Swinton, John. 2012. *Dementia: Living in the Memories of God*. Grand Rapids: Eerdmans Publishing Group.
- Brueggemann, Walter, 1995. *The Psalms and the Life of Faith.* Minneapolis: Fortress Press.
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LETTER TO THE EDITOR

Dear Editor,

All of us working in the healthcare sector are well aware of the increasing issues with the mental health of our patients. There is more awareness and focus about mental health in the public arena. The current pandemic is only making matters worse with an increase in the incidence of anxiety and depression. The Church is also beginning to accept that Christians are not immune to mental illness and there is an awakening of interest in the role that Christians can play in the healing ministry. This is a welcome change but Christians involved with mental health have faced theological conflicts and challenges over the years when it comes to mental illness.

In this regards I would like to share a couple of developments that might be of some interest to Christian health professionals who are involved in the area of mental health;

1. The Centre for Theology and Psychology (CTP) is a new initiative at the Melbourne School of Theology. For more information about the Centre and the activities, please visit the website of CTP at ctp.mst.edu.au CTP is organising webinars, workshops, a graduate diploma course and research in the interface of Theology and Psychology.
2. There has been a Christian Mental Health Fellowship functioning in Victoria for a few years with meetings 3-4 times a year with discussion of interesting topics to Christian mental health professionals. Following the pandemic this year, our meetings have been in the virtual space and we welcome anyone interested to join us from anywhere in Australia. It is a loose fellowship to support and encourage one another. Anyone interested please let me know and I will add you to our mailing list so that you can be kept informed of future meetings. My email id is drkgvilla@gmail.com

I trust that this information will be of some assistance to some of your readers involved in the metal health sector.

May God bless you
Kuruvilla George (KG)

Rev Prof Elizabeth MacKinlay AM, FACN, PhD

Elizabeth is both a registered nurse and a priest in the Anglican Church of Australia. She was the inaugural Director of the Centre for Ageing and Pastoral Studies at St Mark's National Theological Centre, Canberra 2001 to 2012. She is an Adjunct Research Professor, Public and Contextual Theology Research Centre, Charles Sturt University and Director, CAPS (Colloquium for Aging Perspectives and Spirituality) Australian Centre for Christianity and Culture, CSU.

Finding Meaning in Ageing

Ageing: what is longer life for?

Those of us living in twenty-first century Western countries for the most part, even in the time of COVID-19 pandemic, experience the gift of longer life. Yet, if we search the biblical record, we find that generally over the centuries, average life expectancy was much lower than it is now (MacKinlay & Cameron 2019). In terms of longevity, we have more years for living; but are these added years to be blessing or burden? The gift of added years of life raises questions of its own; what are these added years for? How are we to live these added years? Can we still find meaning in older age, in the midst of increasing disabilities, frailty, and/or dementia?

The answers to our questions depend at least to some extent on how we view life – do we see older age as burden? Do we expect to live our later years in the same ways our parents and grandparents did? Or, do we see these years as God's gift to us and perhaps as a bonus, where we may continue to grow spiritually, walking in God's love, having reason to live life to the full? As we were promised in Romans 8:19, we are co-creators with God; there must be meaning to be found in this revelation from God. However, it is only as we come to more deeply know our place in the whole of God's creation that we can begin to connect with the wondrous story of which we are a part.

> *"The gift of added years of life raises questions of its own; what are these added years for?"*

This relationship with God and our understanding of it goes to the depth of our being; it is tied with our identity in Christ and lies at the very essence of meaning. Paul wrote: "So if anyone is in Christ, there is a new creation: everything old has passed away; everything has become new" (2 Corinthians 5:17). However in a cautionary note, Paul wrote in his first letter to the Corinthians, "I fed you on milk, not solid food, for you were not ready for solid food. Even now you are still not ready" (1 Corinthians 3:2). Our growth in faith as Christians needs to come to maturity and this growth towards maturity may take a lifetime; coming to see meaning in our lives is a crucial component of this developing maturity.

The search for meaning

How do we find meaning in life? Some people would argue that meaning cannot be personal; 'it's something out there.' Still others search for meaning and find life to be meaningless. At least some of those who take their own lives do so because they struggle to find meaning and fail. The very narrative that they have used as a framework for life has failed them, yet personal narrative or story remains important for the life journey. The Christian Scriptures tell God's story through the millennia, and it is His story that is the vehicle carrying meaning for each of us. Each of us has a unique story that we may become more conscious of at particular times of our lives. In fact, it could be said that we do not just have a story, we *are* story (Kenyon, Clark & De Vries 2001). From the beginning, the Abrahamic faiths have affirmed story as the basis of faith and life, thus linking God's story with human story. Lash (1986, p120) wrote of the story of our own faiths, linked through the autobiographical nature of Christian and Jewish faith narrative.

Our story becomes the vehicle for knowing our identity in Christ. Our story, if it is authentic, is the conveyor of meaning and is deeply connected to meaning in our lives. However, meaning is not only personal. For Christians our stories are also connected to our families, our faith community, and ultimately to God. Meaning lies at the

very core of our being, and as Christians, meaning is encapsulated in our growing into Christ, as we increasingly come to see with God's eyes, rather than solely through human eyes.

There is a tendency to become more deeply concerned with life meaning as we grow older. In fact, Robert Butler (1995) wrote of the importance of reminiscence and review in later life:

> *As one's life nears an end, the opportunity to confront lifetime conflicts and acts of omission and commission, which warrant guilt as well as opportunities for atonement, resolution, and reconciliation, is precious because this is the last opportunity one had.' (p.xxi)*

Our story and God's story

When we search the Bible, we find that God has spread out so much of what He wants us to know in story. However, too often in recent years, story has been trivialised; it has become a popular activity in residential aged care to record each person's story. Once that is done, the task has been completed, set in stone. But what is important about story is not just the facts, dates, and places that are remembered, but the meaning of these to the person; this has often been neglected. It is through meaning that the Holy Spirit connects with each of us, and how we are drawn into God's story. But how do we learn to connect with that story, the story that is both yours and mine, the story that informs our identity as living human beings and children of God?

How do we learn to see and respond to God's story and our stories as God would want? In a very real sense, story is closely tied to our identity; it goes to the very core of who we are as human beings. All of us are conscious of having a story, in some way or another, even when we are children. However, it is in later life that the significance of who we are becomes more important to us, as we begin to seek answers to the important questions of life. As we grow older, we are able to revisit events of our earlier life, to review and sometimes to revise the way that we saw these events at the time they were experienced (MacKinlay 2017). This review of life, perhaps through the process of

spiritual reminiscence (MacKinlay 2018; MacKinlay & Trevitt 2015, 2010), may bring us, for the first time, to intentionally search for and realise the meaning of our lives. Viktor Frankl (2006) wrote that during our lives, we assign provisional meaning to situations as we experience them, but it is only as we become more aware of our mortality that we may become aware of a call from within to search for final life meaning. So, understood in this way, there is a distinct difference from what is sometimes called 'meaning-making' to merely searching for meaning.

> ***"How do we learn to see and respond to God's story and our stories as God would want?"***

Searching for meaning is not an activity or pastime, it is a deeply personal life journey. For Christians, this is our answer to the question of 'why am I here?' and 'what has been and is God's purpose for me in life?' Various situations can raise the importance of this final search for meaning. Perhaps it is the diagnosis of a terminal condition, or the loss through death of a loved life partner; perhaps it is increasing disability, or admission to residential aged care. Yet it is only as we acknowledge our vulnerability and our need of interdependence, rather than autonomy and independence, that we may at last discover our own transformation and the joy of living in God's love. Life is not just about material things, as Paul clearly articulated in 2 Corinthians: "So we do not lose heart. Even though our outer nature is wasting away, our inner nature is being renewed day by day" (2 Corinthians 4:16). In all situations we may search for and pray to find meaning and God's purpose in our lives.

A model of spiritual tasks and process of ageing

As we live longer it is relevant to ask whether there are changes in spirituality in these later years. Does ageing stimulate changes in meaning or the way it is perceived, or is simply more of the same? Often, we graduate young people out of the churches, with the expectation that as children, they have learnt all there is to being a Christian, and adults simply need to continue to live their lives with what they learned as children. But there are two possibilities that make this belief difficult. One is that often these days, children have not had the benefit of learning and committing to a faith; at least some of these, as adults in later life, come to search for faith, but lack the deposit of learning of faith that would provide the basis for spiritual growth.

The second possibility is that even growing up in a Christian community, we still have not learnt all we need to learn about living and being as Christians by the time we reach adulthood. More recent (secular) scholarship sees learning as a life-long pursuit. And shouldn't this be the same

for adult and ageing Christians? In fact, it seems that there are possibilities through decremental experiences of the ageing human body that may stimulate the person to ask the very questions that God wants us to ask, whether we have a faith or not.

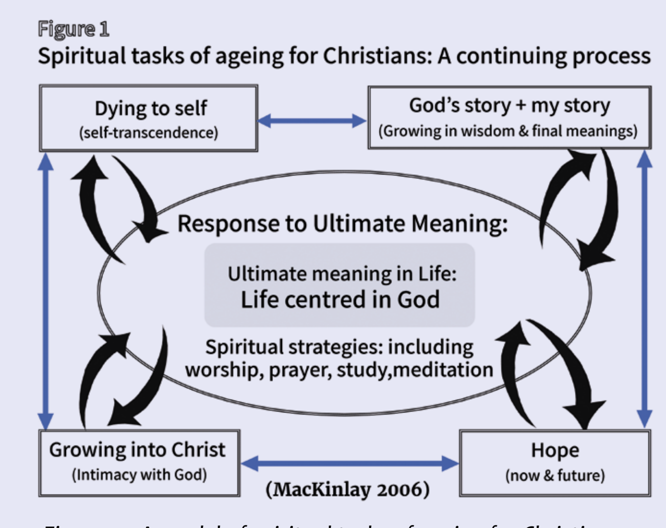
There are fundamental questions that come to most people, in mid- or later life, or earlier, if confronted by life crises. Importantly, 'Why am I here?' and 'Where do I find meaning in my life?' Clements (1990) wrote that potential crises of meaning may occur for young and old people which may result in some cases in conversion. Neugarten (1968) noted the change in perception of time in older people – a change from time since birth to time left to live. It was with these questions that I began a journey of discovery in the 1990s, to explore with older people where they found meaning in life. This exploration culminated in doctoral studies and the development of a model of spiritual tasks and process of ageing (MacKinlay 1998).

It is this model that I wish to write about now.

In my initial studies, being aware of the proportions of the Australian population holding a religious faith and those with no faith affiliation, I chose to include people of faith and with no religious faith in this study. This approach resulted in the construction of an initial generic model of the spiritual tasks and process of ageing and was followed by the construction of a model of spiritual tasks and process of ageing for those with a Christian faith. (See Figure 1)

This study sought to find whether there were specific developmental changes in a spirituality of later life. It was a mixed methods study using a survey of spiritual wellbeing in later life, and in-depth interviews of independent living older people. Factor analysis compared the survey and in-depth interview findings (MacKinlay 1998, 2017).

The interviews produced rich data on where participants found meaning.



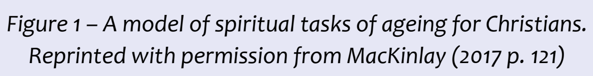


Figure 1 – A model of spiritual tasks of ageing for Christians. Reprinted with permission from MacKinlay (2017 p. 121)

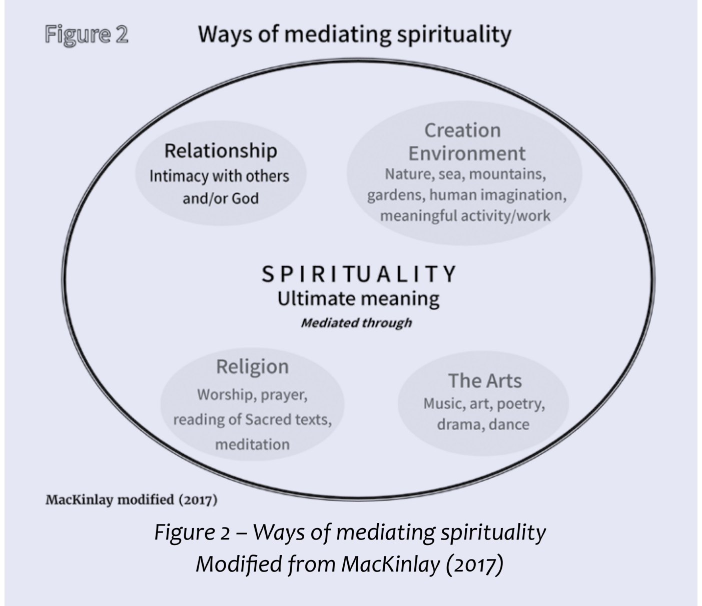


Figure 2 – Ways of mediating spirituality Modified from MacKinlay (2017)

This data corresponded with Frankl's perspective which found a progression from provisional meanings as people encounter situations through life, assigning meaning, but only later in life being able to see final meaning in their lives. Meaning was seen in two ways: provisional meaning, which in a sense was associated with their life process at the time of the event, and final or ultimate meaning being assigned, if at all, near the end of life. The model developed in this study (MacKinlay 1998) identified six main themes from the data – the first four are four continuums between self-sufficiency to vulnerability; provisional meaning and process of moving toward final meaning; relationship to isolation; hope to despair or fear; then response to meaning and final or ultimate meaning.

Meaning is found through relationship, with others and/or God; through creation/creativity, natural and human made; through the arts, including art, music, poetry, drama and dance; and religion through liturgy, religious services, symbols and rituals that carry meaning for the people and sacred texts (MacKinlay 2017).

These ways of connecting and conveying meaning remain important for frail older people. A recent study of the lived experience of frailty (MacKinlay, Mordike & Burns 2020) was valuable in finding how the frail participants were able to negotiate physical decrements and find meaning at this time in their lives. It was at this point that their very frailty brought opportunities for some, in terms of their self-awareness of increasing vulnerability, to be able to self-transcend their difficulties. Finding meaning and inner strength are ways towards self-transcendence. A number of these frail older people spoke of their inner strength, based on their certainty of God being present through the Holy Spirit in their lives.

Conclusion

At no time in life does meaning cease to exist, although it may be hard to find meaning in some situations. Finding meaning in life remains crucial for many in later life and is often accentuated as

people become more acutely aware of the nearness of end of life.

But, returning to a question I asked at the beginning of this article, can one still find meaning in dementia, when memory is failing, or recall dysfunction may exist? Helping people who have dementia to connect with meaning is one of the most important things we can do in support of these people, even as cognitive function declines. While cognitive abilities may continue to be lost, the search for meaning and sense of meaning at the very core of our being remains, and it is through the spiritual level of connecting with meaning that life can remain worth living for these people. This deep level of connection beyond language is profound and connects with the spiritual and ultimately, with God. Finding meaning in the final life career remains an important factor for many people (MacKinlay 2006, 2017), for meaning is closely connected with hope, peace and joy.

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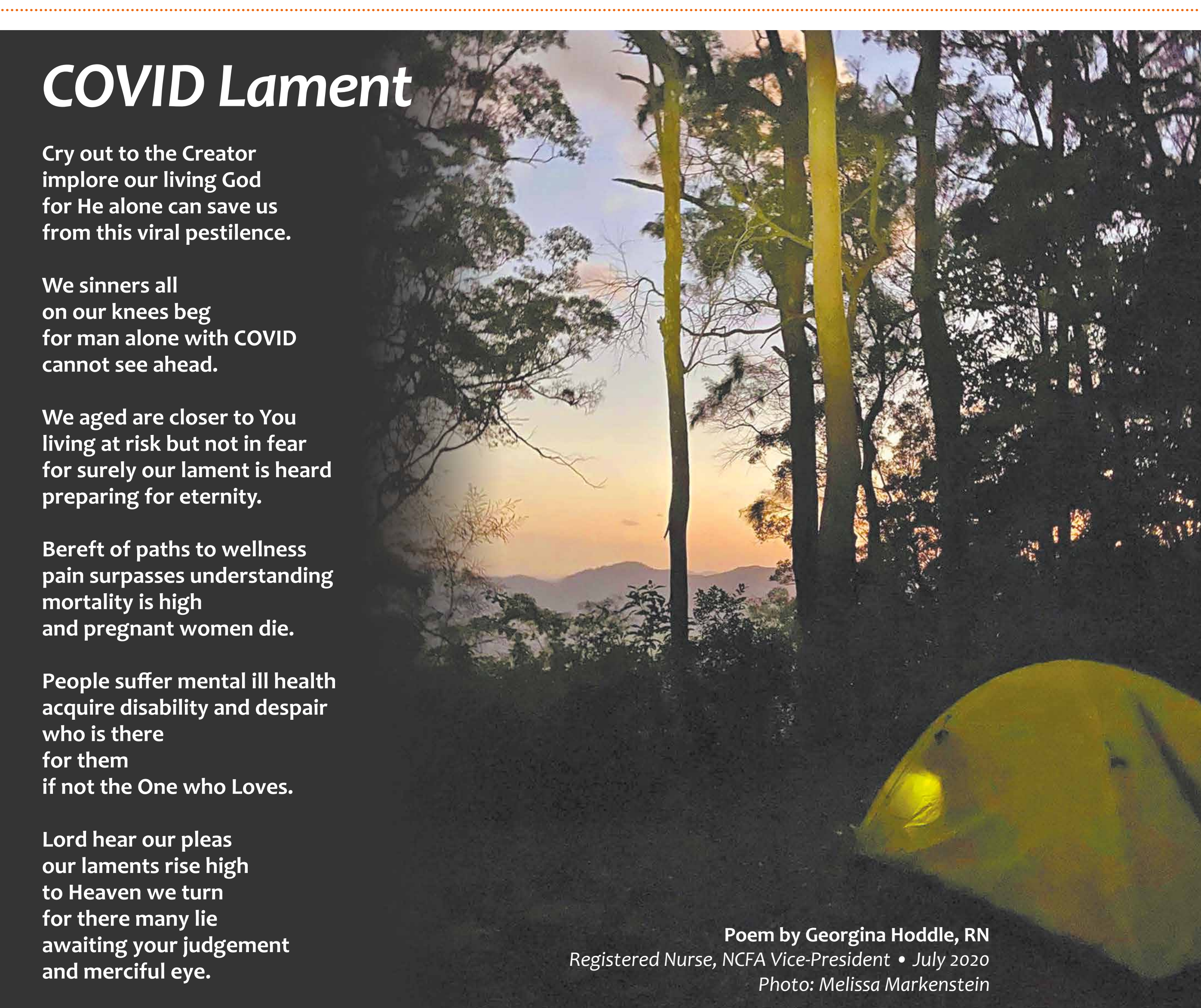
COVID Lament



Cry out to the Creator
implore our living God
for He alone can save us
from this viral pestilence.

We sinners all
on our knees beg
for man alone with COVID
cannot see ahead.

We aged are closer to You
living at risk but not in fear
for surely our lament is heard
preparing for eternity.

Bereft of paths to wellness
pain surpasses understanding
mortality is high
and pregnant women die.

People suffer mental ill health
acquire disability and despair
who is there
for them
if not the One who Loves.

Lord hear our pleas
our laments rise high
to Heaven we turn
for there many lie
awaiting your judgement
and merciful eye.

Poem by Georgina Hoddle, RN
Registered Nurse, NCFA Vice-President • July 2020
Photo: Melissa Markenstein

Viv Allanson
Viv is a Registered Nurse and has held the position of CEO of Maroba for over two decades. Viv has devoted herself to caring for people in need her entire career and has extensive experience in the Aged Care and the Business Sector. www.maroba.com.au

Is a Residential Aged Care Facility merely a Waiting Room for Death?

In my experience this is a question, a statement, and an entrenched belief for individuals and society as a whole.

My personal view is that the Aged Care service I lead is more like **God's Living Room** rather than God's waiting room. In fact, I frequently find myself gently challenging the many people who have formed the view that Aged Care is merely a waiting room for death, and that nothing of value happens there.

You see, when we even repeat that belief (some people say it as if it is funny) we are reinforcing the general societal view that older people have little value or have no contribution to make to their families, their community, and even to humanity. My expectation for older people is that they have the right to **live out the full number of their days – long and strong!**

Entry into an Aged Care service should not be the opportunity to give up on our life goals and aspirations or our contribution to society, or have others give up for us when we can no longer exercise our voice. Sadly, the federal government recently formalised the devaluing of older people by removing the Charter of Residents Rights and Responsibilities and replacing it with the 'Charter of Residents Rights'.

Yes, they removed 'Responsibilities' from the charter. What modern democracy has ever removed the basic human right for an individual to have both social rights and social responsibilities? I continue to be outraged by this demeaning gesture on the part of our political leaders, however I never miss the opportunity to step up and remind our residents that they continue to make a difference to our society, and indeed, humanity. I encourage each one that they have not finished the good works that they were created to do until their last breath.

> ***"Older people are spectacular human beings and long to make a difference to others … and they do!"***

After 28 years working in the Aged Care sector, I can say that Older people are spectacular human beings and long to make a difference to others … and they do!

In November 2013, I met a nun from South Africa at a conference in China. She was sent to work in a very poor Black (Sr Lucia's description, not mine) Rural Aged Care service in Kwazulu Natal and had no prior healthcare experience whatsoever. I made a commitment to bring her to Australia to experience Aged Care in another nation and to personally support her journey. As soon as I said it I thought: "How on earth will I raise the funds to bring her to Oz?" Upon my return, one of my staff asked me to give the Christmas message to our residents, so I began with: "Is there room in our inn for Jesus this Christmas?" then began to tell Sr Lucia's story and the life of older people in St Antonines Nursing Home in Kwazulu Natal – the poorest of the poor. I then asked: "Was there room in our inn for Sr Lucia this Christmas?" To my dismay, people started leaving the room. I immediately thought: "This isn't going down well… Was it that Sr Lucia is dark skinned? Is it that she is a nun? Is it that she is a foreigner, what could it be?" But wait, those same high care residents began to return waving $5, $10 and $20 notes at me. Noel, who was a retired missionary, came forward with his $2 coin that he had planned to spend on a cappuccino. They all had tears in their eyes as they just wanted to make room for Sr Lucia and her residents from St Antonines.

It didn't stop there. One lady who has been confined to a water chair for two decades

and can't even scratch her nose, sent for me and asked how much it would cost to bring Sr Lucia to Australia. I suggested about $5000 by the time we covered visas, transport, and bribes. She smiled and whispered: "I can afford that, let's make it happen." Over the following months, all the residents and staff continued to raise funds so that when Sr Lucia arrived in May 2014 on Maroba's red carpet we gave her a further $2000 so that she could purchase items needed for her nursing home upon her return. Sr Lucia and her understudy Sr Busi returned to Australia a couple of years ago and some residents continue to contribute from their pensions to support her. I love to remind our residents of their compassion, generosity and ongoing contribution to society and the difference they have made to humanity. They have truly touched the nations with the love of God.

Our residents were excited to send me off to St Antonines in 2015, where 2 of us spent 3 weeks working and living with the team there, nursing, painting, doing policies, food preparation, washing up, maintenance, training, doing activities and participating in their faith-filled services and even the privilege of preparing the deceased for burial at the back of the nursing home. Upon my return, everyone couldn't wait to learn of all that took place and what life was like. We connected our residents and theirs on Skype many times to learn more of each other's way of life. Yes, older people are interested in the plight of those across the globe.

Maroba residents continue to support many causes and continue to be generous with their time, their resources and their words – a great example to us all of being an effective global citizen. They continue to sign up for gym memberships, beauty therapy, and everything that is on offer, so don't believe for a minute that Aged Care is the beginning of the end.

When residents pass away, we honour them in death and remember their contribution to each of us that have shared our lives with theirs. As they leave the building we form a Guard of Honour at the front door so that they leave through the same door as they entered. The whole team participates: carers, admin, maintenance, housekeeping, laundry, catering, volunteers, and residents. We hold several memorial services throughout the year and we share stories with families and other residents about each one. I always love to remind families that their Mum or Dad or both at times were wonderful role models to us younger ones of what a faithful bond of marriage looks like in a world where marriage is disposable. I love to reflect on the way they taught us to be good friends to each other and how they led the way in sustainability in a wasteful world. Yes, they contributed to humanity until their last breath.

It is important for our residents that we demonstrate to them while they are well and active what the end will look like, so that when it gets close for them they too know they will be honored, talked about and remembered in positive ways.

So next time you think or even say that Aged Care facilities are God's Waiting Room … think again, change your thought, change your talk and raise the profile and value of older people by believing that being a contributor to the common good and engaging in humanitarian efforts should never depend on where you live or the means of mobility required, but more on the attitude of the people around you!

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In God's Waiting Room

Questions and Reflections on Memory, Death, and Aged Care in COVID-19 times

I try to remember all their names and faces, but there are so many.

- The retired pharmacist with dementia whose mild word-finding difficulties in English (unusually) disappeared when he spoke in the 6-7 other languages he knew. He was nevertheless declining cognitively after losing the mental stimulation from his wife's daily visits to play cards and backgammon. She only lived down the road - so near yet so far. She would come to stand in the garden below his "balcony" (window) for a chat – "We're like Romeo and Juliet, but in reverse!" he said.

- The frail 36kg Indonesian lady, bed and chair-bound, whose family could only wave at her through the glass doors of her RACF*. *Could she still recognise who they were anymore?* They wondered if she was eating, without them visiting to patiently spoon in her pureed diet. *She told me her favourite food was fried chicken.*

- The nth episode of recurrent aspiration pneumonia in as many months for the gentleman with advanced dementia. Back in hospital yet again (thankfully, COVID-negative) because his family would be unable to visit him at all if he remained in his RACF for treatment...

There are so many families who are unable to see their loved ones, our patients, for months – even as they might be approaching the end of life. Death seems so much more lonely and scary during COVID-19 times.[1-4] I helped to draft a local guidance sheet on the palliative management of COVID patients approaching end of life in RACFs, noting that the drug doses and up-titration rates were significantly higher than those we normally used in the frail elderly, because of how severe and distressing symptoms in a COVID death can be.[5] I spent hours with

> ***"Death seems so much more lonely and scary during COVID-19 times."***

my public health and outreach colleagues in Zoom meetings, poking holes through RACF outbreak management plans one by one. We watched events unfold south of the border, fearing the worst if our turn came, with 4500-odd residents across 60 RACFs in our district. And the cost of trying to keep them 'safe'? A deterioration in relationships, quality of life, oral intake, the early detection of subtle delirium and myriad other problems, person-centred BPSD* management, and increasing carer stress.

This pandemic has served to further highlight the cracks (chasms) in the aged care system that were already being brought to light by the Royal Commission. Chronic understaffing and underfunding, lack of adequate training, overuse of chemical and physical restraint, and the list goes on.[6,9] Yet Australia still has one of the highest proportions of elderly living in RACFs compared to other OECD* nations[7] – why is this the case? Alternative options are limited when care needs exceed the practicalities of what can be managed outside of institutionalised aged care. I spend a large portion of my time counselling families through the guilt, loss and anxiety surrounding this difficult decision with no good answers.[8] It is not our place to judge another's circumstances, only to allow them the dignity of risk, and support them through whatever choice they make. And true, there are some RACF residents who call their facilities 'home' and would rather stay there than be transferred to hospital, or to avoid feeling like a burden to their families. Not to mention the many RACF staff who genuinely care, but are restricted by the limitations of bureaucracy, funding and their own human strength.

So, how can we improve the parlous state of aged care in Australia? Where the frail elderly are hidden away in institutions and where their individuality becomes just another number? Perhaps it may help to view the older person (no matter their cognition, function, or social background) not as troublesome, irrelevant, a disease/problem to be solved or a burden on society, but as a person made in the image of God – beloved and deserving of dignity, respect and the best available evidence-based, person-centred care we can provide. They are someone's friend, parent, grandparent - but even if they weren't (I have met many "orphaned" elderly in RACFs) it shouldn't matter.[9]

Somewhere in the middle of the pandemic, my grandfather died at home in his sleep, aged 94. I remember the feeling of shock as I scrolled through the messages while walking down from the COVID ward after a post-take round (all turned out COVID negative, thankfully). My grandfather, the staunch Methodist whose last months were blunted by a progressive decline from vascular dementia, was finally released from the indignities of a crumbling body on the frailty trajectory into a wondrous eternity in the loving arms of Jesus. I had the strange thought that I'd probably been awake as he was taking his last breaths, having been woken at 2:30am by yet another call from ED. The rest of the day's routine unfolded numbly with its usual meetings, teaching and administrative duties. Perhaps it was the cumulative exhaustion from months of pandemic tension without a sign of reprieve on the horizon (or the pressure release of annual leave), but one of the last things one feels like doing is looking after other people's grandparents when one's own has just died. But I turned up to work the next day anyway (as you do too, so often). Focusing on other people's problems is such a great mental distraction. Besides, the team was understaffed due to sick leave (all turned out COVID negative, thankfully). It helps when you can hide half of your grieving face behind a surgical mask. And so, we soldier on – as my ever-pragmatic grandmother said, "That's just life."

Many told me it was a blessing to be able to die at home in his sleep – yet why is this much-envied outcome so difficult to

achieve? Most people don't wish to die alone, or surrounded by strangers, unable to communicate their needs and utterly dependent.[2-4] But most people also don't begin to talk about their goals of care until it's too late, and then the overlay of fear, denial and unrealistic expectation plays in. I've had countless discussions about advance care planning (even more in the era of COVID-19), with so many met by surprise at the mere notion. Age and multi-morbidity are key risk factors for increased

"How can we as clinicians better enable those who are at the ends of their earthly lives to face death with dignity, peace, and freedom from fear?"

mortality from COVID-19,[10] though there is still a proportion of the elderly who will have a minor illness and survive it, receiving supportive treatment that does not require hospitalisation. But inevitably, death is a reality that faces us all with rising probability as age increases. I have seen such vastly disparate perspectives on the appropriate management of frail, severely impaired older persons (ranging from doing "everything" including CPR and invasive life support, to considering euthanasia) that I begin to question the underlying views on the meaning or purpose of an individual's life and death that drive this. The Christian perspective suggests that the value of one's life does not depend on health, function, dependency, choice or the views of others, but on something more intrinsic and difficult to define: the worth of individuals as made in God's image, whose times are in His hands. And yet they are flawed by sin, their bodies subject to the disease of death (which an earthly physician can never cure), with the only certainty being the eternal life in Jesus which follows. How can we as clinicians better enable those who are at the ends of their earthly lives to face death with dignity, peace, and freedom from fear?

I don't claim to have the answers to any of the questions I've asked, and I'm not sure where they might exist. But just as the Lord does not forsake the elderly (Psalm 71), so should we not. The important thing is to keep asking the questions, fighting for better solutions, constantly reevaluating the individual's needs as their circumstances evolve – in spite of the uncertainty without a one-size-fits-all approach.

I often get asked why I chose to become a geriatrician – you might say we have a bit of a chip on our shoulders that many do not entirely understand what exactly it is that we do, as perhaps one of the less "desirable" and more "generalist" specialties. It is because of the *people*:

- the opportunity to spend time with and get to know my patients (and write 4-page CGAs* on them) and their families,
- taking a holistic and individualised approach to caring for a vulnerable population,
- and finding out what matters most to them as they reach the pointy end of life.

But it's also the people I get to work with – amazing multidisciplinary teams, the people in the sector who are all striving to provide the best possible care of the aged. No-one ever said it would be easy, and like all geriatric medicine, it's a team effort – a society effort, even.

And so to the aged and all those care for them, whether personally or professionally,

I would encourage you with this verse – which provided great comfort as I mourned my grandfather whom I will not see again in this life. I used it in the printouts for his funeral, only belatedly realising it was my Powerchart password at the time (this is my way of providing new reminders from God's word every 6 months or so – don't worry, I've changed it since then!). It speaks to the hope of eternity and the source of inner renewal that enables us to persevere:

> *"Therefore we do not lose heart.*
> *Though outwardly we are wasting away, yet inwardly we are being renewed day by day.*
> *For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all.*
> *So we fix our eyes not what is seen, but on what is unseen,*
> *since what is seen is temporary, but what is unseen is eternal."*
> *2 Corinthians 4:16-18*

***Abbreviations:**

RACF = residential aged care facility (i.e. nursing home)

BPSD = behavioural and psychological symptoms of dementia (e.g. wandering, aggression, agitation, apathy, depression, sleep-wake cycle disturbance)

OECD = Organisation for Economic Co-operation and Development

CGA = comprehensive geriatric assessment, the "black-box" core business of geriatricians, comprised of a multidimensional, usually interdisciplinary process of assessing an older person's medical, psychosocial, functional and cognitive status (often within the frameworks of geriatric syndromes), with the aim of developing patient-based interventions within an overall treatment plan aimed at optimising function (11)

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A/Prof Kuruvilla George (KG)
Kuruvilla is the Clinical Director of the Aged Persons Mental Health Service for Eastern Health, Melbourne. He is also the Director of Medical Services for the Peter James Centre. Prior to coming to Australia, KG was the first full time General Secretary of the Evangelical Medical Fellowship of India.

Depression in Ageing

Depression in the elderly is common and potentially disabling. Depression is the most common mental illness in old age. Due to the rise in our ageing population, the significance and impact of depression will also increase as a consequence. Depressive disorders in older people are often under-diagnosed and inadequately managed even after a diagnosis has been made. It is also associated with significant morbidity and high mortality rates. As part of the fallen human race, Christians and non-Christians are all vulnerable to depressive illness in ageing.

Causative and contributory factors for depression in ageing

- Physical ill health is a major risk factor for depression in old age. This is the single most important factor. The risk increases with both an increase in the number of illnesses as well as the severity of the illness.
- Age-related reduction in brain neuroamines (both serotonergic and dopaminergic).
- Genetic – Older people can have new onset depression or they can have a recurrent episode of depression from a pre-existing illness earlier in life. The genetic component plays a more important role in recurrent depression.
- Elevated homocysteine with associated folate deficiency and/or vitamin B-12 deficiency increases the risk of vascular disease and depression.
- Cerebrovascular lesions – atheromatous and ischaemic changes in the white matter of the brain.
- Neurological disorders (eg. CVA's, Parkinsonism and Motor Neurone Disease) are particularly important as risk factors for depression.
- Disability has been found to be more significant than the acuity of the illness. For example, disability from congestive cardiac failure would contribute more to depression than an acute myocardial infarction.
- Chronic pain is another important contributory factor.
- Loss of independence and the guilt of being a burden on family and others.
- Alcohol abuse.
- Prescribed medications – Around two dozen different drugs have been implicated and the elderly who have polypharmacy are more vulnerable.
- Psychosocial factors such as the death of a spouse or other recent losses including pets, living alone, loneliness, poor accommodation and financial stress.
- The "scrap heap phenomena" where an individual feels that they have outlived their usefulness and are now a burden on society (including to their family) can be an important factor. Ageism that is prevalent in society does not help this feeling.
- There is a higher incidence of depression in the residential care population.

Main features of depressive disorder

Core symptoms

- Depressed mood sustained for at least two weeks
- Loss of interest or pleasure in normal activities
- Decreased energy, increased fatigue

Additional symptoms

- Loss of confidence or self esteem
- Inappropriate and excessive guilt
- Recurrent thoughts of death, suicidal thoughts or behaviour
- Diminished evidence of ability to think or concentrate
- Change in psychomotor activity (agitation or retardation)
- Sleep disturbance
- Appetite change with corresponding weight change (mainly weight loss in older persons)

If the patient has at least five symptoms (including two core ones) from the list,

then by definition he or she has a "major depressive" disorder. If the patient has two to four symptoms (including at least one core symptom) then it would be considered as "minor depression".

Psalm 38 is an excellent description of someone suffering from depression:

A Psalm of David, for the memorial offering.
O LORD, rebuke me not in your anger,
nor discipline me in your wrath!
For your narrows have sunk into me,
and your hand has come down on me.
There is no soundness in my flesh
because of your indignation;
there is no health in my bones
because of my sin.
For my iniquities have gone over my head;
like a heavy burden, they are too heavy for me.
My wounds stink and fester
because of my foolishness,
I am utterly bowed down and prostrate;
all the day I go about mourning.
For my sides are filled with burning,
and there is no soundness in my flesh.
I am feeble and crushed;
I groan because of the tumult of my heart.
O Lord, all my longing is before you;
my sighing is not hidden from you.
My heart throbs; my strength fails me,
and the light of my eyes – it also has gone from me.
My friends and companions stand aloof from my plague,
and my nearest kin stand far off.
Those who seek my life clay their snares;
those who seek my hurt speak of ruin
and meditate treachery all day long.
But I am like a deaf man; I do not hear,
like a mute man who does not open his mouth.
I have become like a man who does not hear,
and in whose mouth are no rebukes.
But for you, O LORD, do I wait;
it is you, O Lord my God, who will answer.
For I said, "Only let them not rejoice over me,
who boast against me when my foot slips!"
For I am ready to fall,
and my pain is ever before me.
I confess my iniquity;
I am sorry for my sin.
But my foes are vigorous, they are mighty,
and many are those who hate me wrongfully.
Those who render me evil for good
accuse me because I follow after good.
Do not forsake me, O LORD!
O my God, be not far from me!
Make haste to help me,
O Lord, my salvation!

Under-detection of depression in older people

The clinical presentation of depression in older people can often be vague and non-specific. The elderly are less likely to complain of sadness or to identify depressive feelings. They have been brought up to be more "stoic" and are more likely to complain about physical problems rather than emotional problems when seeing a doctor. Their presentation may minimise depressed mood and focus instead on physical complaints, generalised anxiety, nervousness and irritability. Physical co-morbidities and cognitive deficits may also mask depression in older people. Ageism and the thinking that it is "normal to be old and depressed" could be a factor for underdetection. Social stigma about mental illness including depression is another factor. Christians are especially vulnerable due to the view that is wrongly held by many Christians that depression is due to lack of faith or due to a weak faith (Docetism).

> ***"The elderly are less likely to complain of sadness or to identify depressive feelings."***

Depression and Physical Illness

The interaction between physical illness and depression is complex and bidirectional.

- Depression is an independent risk factor for numerous medical conditions, including stroke.
- Depressive symptoms add to the disability experienced from physical illness in older people. These symptoms are also associated with physical decline and worsen the prognosis for co-existing physical disorders.
- Elderly people who have a physical disability are three times more likely to develop depression. Disability rather than acuity is the important contributory factor.
- Chronic ill health contributes to a poor prognosis in depressive disorders.
- Sensory impairment (hearing and visual) is associated with depression.
- Depressive symptoms are often masked by physical illness (examples include Parkinsonism, hypothyroidism, chronic pain disorders), resulting in low recognition rates of depression in the elderly.

Depression and Dementia

There is an interesting but complex relationship between depression and dementia in the elderly.

- Depression can be mistaken for dementia – depression may present as new-onset confusion or increased confusion. It can be difficult for non-psychiatrists to distinguish true dementia from depressive pseudodementia.
- Depression and dementia can co-exist in the same individual.
- Late-onset but recurrent depressive disorder in the elderly could be the precursor to a dementing illness.
- Some of the pharmacological interventions for depression, especially the tricyclic antidepressants, can give rise to cognitive deficits.

Depression and Psychosis

Sixty percent of women and fifty percent of men with late-onset major depression have psychotic symptoms. Psychotic symptoms are more common in late-onset depressive disorders. Common delusional themes include persecution, guilt, poverty, nihilism and somatic delusions.

Suicide in the elderly

Elderly people who have depression are a high risk group for suicide. Thirty percent of all suicides in Australia are accounted for by people over the age of 65 years. Risk factors for suicide include elderly men, living alone, social isolation, physical disability, recent bereavement and recent relocation. Symptoms that should cause concern include expressed risk of self-harm, anhedonia, guilty ruminations, weight loss, persistent physical complaints and alcohol abuse. Any deliberate self-harm in the elderly must be treated seriously as they are rarely attention-seeking and there is a high risk of completed suicide or a subsequent completed suicide.

Protective factors

Good physical health and physical fitness are protective factors. Those who are socially active and have well developed coping skills in early life are less vulnerable

for depression in older age. Marriage and adequate social supports have also been found to be protective factors. Spirituality and religiosity are also protective factors. As mentioned in the introduction, being a Christian does not make one less vulnerable to depression. However, research has repeatedly shown that the prognosis and recovery from depression is much better in one who has faith. It is spirituality rather than religiosity that is of significance. Having a faith creates hope, which aids recovery. As Christians, we know what, and more importantly Who, we believe in. The importance of taking a spiritual history is pertinent in this regard. In addition, undergoing Saline Process Witness training and being able to sensitively ask about and talk about faith issues would be particularly useful in our clinical work.

Management

Due to the role of multiple factors in late onset depression, the work-up of depression needs an extensive consideration of medical (including medication history), psychological and social issues. As comorbidities play an important role in the elderly, investigations for a first episode of major depression in later life needs to be comprehensive.

The choice of treatment will be influenced by the type of depression. Major depression (with melancholic and/or psychotic features) requires pharmacological treatment and sometimes Electro-Convulsive Treatment (ECT) with adjunct psychological therapies as the patient begins to recover. Minor depression is often best treated with psychological therapies but there may also be a role for pharmacological interventions. With pharmacological treatments, the dictum with the elderly is to "start low and go slow". There are no significant differences in speed of onset although older people generally have a longer recovery period. Cognitive Behaviour Therapy (CBT) and Interpersonal Therapy (IPT) have been proven to be useful in the elderly with mild to moderate depression. Other forms of therapy such as brief psychotherapy, problem-solving therapy and life review have also been found to have some benefit.

"Research has repeatedly shown that the prognosis and recovery from depression is much better in one who has faith."

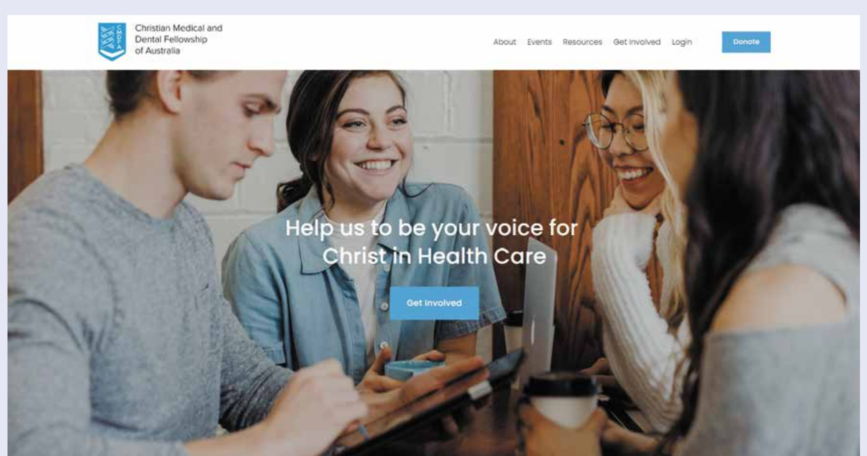
When to refer to a Specialist Mental Health Service

- When the diagnosis is in doubt
- Severe depression with melancholic/psychotic features
- Depression with suicidal risk
- Medical comorbidities that warrant specialist input
- Failure to respond to first-line therapies

Summary

- Depression is the most common mental health problem in the elderly.
- Depression is often unrecognised and untreated in older people.
- The main risk factor is poor physical health.
- Losses – of loved ones, independence, health, retirement are also important.
- The elderly, especially elderly men, are at high risk group for suicide.
- Depression treatments are effective but require appropriate management strategies to achieve and maintain remission.
- Christians are not immune to depression in ageing.
- Having a faith has been shown to facilitate recovery from depression.

Check out the newly refurbished CMDFA website!



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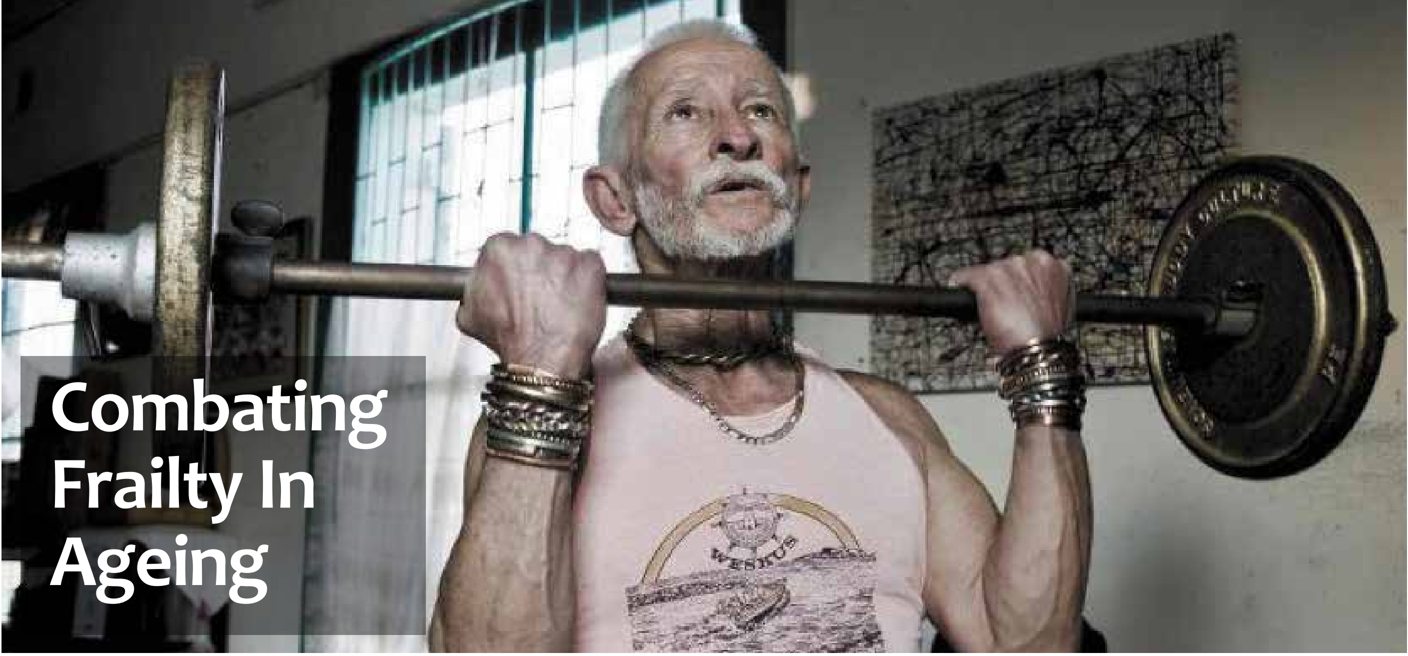

Combating Frailty In Ageing

Front-page headlines of the *Australian* Newspaper on the 17th of July 2020 read: "Age not an issue: Hospitals ordered to treat elderly".

In the midst of COVID-19, the fact that our elderly members are still loved and admired has been a refreshing reminder. This contrasts with the discrimination of ageism, which I believe has grown in our youth-obsessed and happiness-chasing culture.

This article is a reflection on these ideas in the context of combating frailty in ageing. It is about helping the elderly live well in their season of life.

The Biblical view on ageing

Seniority and old age are viewed very positively in the Bible. They are often considered to be part of a good life. Indeed, "long life" is a common blessing in the Jewish community. Many if not all of us are aware of the commandment to honour our parents as the commandment that comes with a promise.

> *"Honour your father and your mother, so that you may live long in the land that the Lord your God is giving you". (Exodus 20:12)*

The Bible additionally regards older people as wise and to be respected. The ageing community members in our society are vulnerable. The experience of losing independence, being taken advantage of and often disregarded is not uncommon. In this context, the Bible exhorts us to honour God by caring for the vulnerable and needy.

> ***"The Bible exhorts us to honour God by caring for the vulnerable and needy."***

> *"He who oppresses the poor shows contempt for their Maker, but whoever is kind to the needy honours God". (Proverbs 14:31)*

Meanwhile, "I'm getting old!" is a common reflection from individuals whose bodies are failing, whether it is osteoarthritis or lack of capacity. It highlights the negative view our society has on ageing, suggesting a despondent, defeatist attitude and a sense of worthlessness.

"Too old?": An introduction to Pam's story

As we consider this topic, meet Pam, aged 76 years. Her parents lived into their 90's. She has been widowed 7 years after enjoying a great marriage, Pam has also recovered from breast cancer treatment where she lost almost 10% of her lean muscle mass. An avid swimmer all her life, Pam participates in swim meets three times per week before having coffee with her squad. She also loves gardening.

In her post-cancer treatment Pam fell and tore her rotator cuff tendon in her shoulder. There was no improvement with non-operative treatment. She was advised by some doctors not to have surgery, as she is "too old". Her pain, movement restriction and weakness left her unable to swim and limited in her gardening. Let's keep her in mind as we look at frailty and ageing.

Defining frailty and ageing

The term "older" carries different connotations around the world. In developing countries it is associated with the inability to live independently and obtain gainful employment. The World Health Organisation (WHO) defines "older" as "age > 50 years", while the United Nations uses "> 60 years". In Western countries "older" is considered to be "> 65 years", which comprises 15% of the Australian population. Our older community is then sub-categorised into "young-old" (65-75 years), "old" (75-85 years) and "very old" (>85 years).[1]

The process of ageing is often associated with the syndrome of frailty. According to the British Geriatrics Society (BGS), 'Frailty describes a condition in which multiple body systems lose their built-in reserves'.[2] In general, people suffer from three or more out of five symptoms that co-exist. These include:

1. Unintentional weight loss
2. Muscle loss and weakness
3. A feeling of fatigue
4. Slow walking speed
5. Low levels of physical activity.

These symptoms will be expanded on, as we consider the physiological changes occurring with ageing.

The prevalence of frailty is 15-26% in those over 75 years, increasing with age.

The physiological changes and frailty symptoms in ageing

The physiological changes of ageing are well understood as affecting all systems of the human body. Understanding these changes allows us to tailor our interventions more effectively, in particular regarding physical activity.

a) Cardio-respiratory changes

From the age of 50, there is a 5-10% decline in VO2max (cardio-respiratory capacity) per decade. A VO_2max of 15-20ml/kg is required for independent community living. The sedentary (inactive) elderly often reach this around age 80-85.[3]

b) Musculoskeletal changes

The process of sarcopenia – loss of muscle mass, strength and endurance – commences at age 25. This becomes significant after 65 years when at least 25% of peak youth strength is lost. At 80 years, there is 50% loss of skeletal muscle due to muscle atrophy. Degenerative changes within most tissues occur, in particular the development of tendinopathy and articular cartilage degeneration.

c) Neurological changes

Proprioceptive, sensory and cognitive changes occur. The proprioceptive and sensory changes increase the risk of falls and therefore hospital admission for trauma care. The outcome from such admissions generally leaves older patients in a declining health state. Cognitive

changes, such as short-term memory loss, may affect compliance with exercises and also the ability to learn new movements.

d) Other factors

Sleep, hormonal changes, fatigue and adjusting to the changing seasons of life all have to be taken into account when considering the prescription of exercise. Relationally, many elderly people experience bouts of severe loneliness following the loss of a loved one, a "shrinking friendship circle" and social isolation from the community. In addition to the existing physical deficiencies, there are frequently deep social, emotional and spiritual needs.

> *"The health benefits of exercise for the elderly are profound."*

Assessing frailty

There are many tools available to assess for frailty. As a minimum the BGS include gait speed, a timed up and go test and the PRISMA 7 questionnaire. As the majority of frail patients have sarcopenia the "SARC-F" questionnaire is a helpful scoring tool. This tool combines capacity (e.g rising from a chair) with at-risk events (e.g. falls). It is also a predictor for falls and frailty.[4]

It is incumbent on all healthcare providers to be on the lookout for frailty in elderly people. Do approach this holistically considering physical, psycho-social and spiritual needs.

How to combat frailty in ageing

I must underpin all I say by endorsing the need for excellent General Practitioners (GPs) in this setting. A great GP stands out as gold.

A holistic approach is required, which is both highly satisfying and time consuming. Within formal geriatric care services there will be multi-disciplinary teams available to the patient. This is ideal but not always possible. In the setting of a general practice, where the patient may have good family and social support, gains can be made to conquer frailty and improve the health and wellbeing of the elderly.

Once any acute illness is excluded such as infection or metabolic disorder, the foundations of exercise prescription, dietary review and social support work together. Supervision to enhance compliance is needed more than that required in younger patients. To combat frailty the interventions include increased physical activity, dietary review and support to aid compliance.

a) The principles of prescribing exercise in the elderly

The health benefits of exercise for the elderly are profound.[5,6] The ability to improve aerobic performance, strength and balance still exists despite the ageing process. The results are impressive with even the most sedentary individuals.

Patients should be active and exercise for at least thirty minutes every day, i.e. > 150 minutes per week. Variety and safety is key with good supervision and support through family or health care professionals such as nurses, personal trainers, physiotherapists or exercise physiologists.

It should be noted that certain patients are fundamentally lazy and indeed may be proud of their inactivity. In a respectful way they need to be led to see that by choosing to be inactive and idle they will become a burden to loved ones and the community. Remember the sluggard in Proverbs 24:30-34. (Note: I am excluding those unmotivated due to mental illness.)

As a guideline, exercise prescription for the elderly[7] is similar to younger patients with the following adjustments:

i) Longer recovery, warm up and cool down periods required

ii) More variety and less repetition in training and activities
iii) Aerobic training: Moderate intensity for 150 minutes a week. Vigorous intensity for 60 minutes a week
iv) Resistance training twice weekly
v) Careful balance (proprioceptive) and flexibility training
vi) Consider group activities such as aqua-aerobics, chair based exercises and slow movement classes.

b) Nutritional review

Patients' weight, protein and caloric intake all need careful assessment. Supplements may be required. In patients who are motivated and otherwise well, the use of testosterone and other anabolic agents have been studied.

c) Care in other areas

Psychosocial and spiritual care is essential. I have found that the reality of being frail and needy usually makes older patients consider their life purpose and the trajectory of their life journeys.

This is very similar to what I have observed caring for elite athletes with career-ending/threatening injuries. I frequently take the opportunity to ask: "I know things are tough for you at the moment. How do you feel looking ahead?" I frequently offer to pray for them, noting that this has never been rejected and even may lead to gospel conversations. These experiences are a reminder of the command in 1 Peter 3:15-16 to "be ready and speak with gentleness and respect."

"Old, but not frail": Pam's story continues

Remember Pam, the swimmer and gardener? She did not improve with non-operative treatment and underwent arthroscopic rotator cuff repair surgery, rehabilitation and reconditioning. She returned to her friends swimming at 80% of her pre-injury levels. Gardening is fine and makes her happy. In her gratitude she became an effective swimming instructor for children with disabilities.

Summary

Combating frailty in ageing is satisfying, important and time consuming. A multi-disciplinary approach is best where the patient knows that the practitioner is a great support and offers hope.

Heroics are not expected, as most patients understand their season of life. From a platform of great care and trust it is an opportunity for the Christian healthcare worker to share the gospel hope of an eternal future where there is no more pain and suffering.

> *"There will be no more death or mourning or crying or pain, for the old order of things has passed away".*
> *(Revelation 21:4b)*

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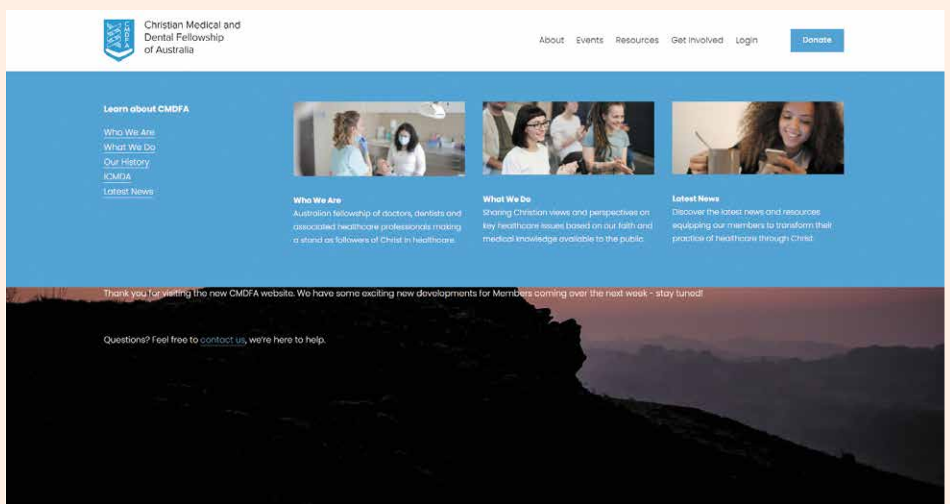
Have you explored the new CMDFA website yet?



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Dr Richard Chittleborough

Richard has worked for 17 years in suburban General Practice, 2 years in a rural district hospital in Tanzania, and spent his final 16 years in solo practice. These latter years were devoted to Aged Care and Palliative Care in hospital and domiciliary locations but mainly Residential Aged Care Facilities. He retired in 2014.

A Christian GP Reflects on Residential Aged Care

Ageing people come into Residential Aged Care Facilities (RACF) with – and sometimes because of – some established disabilities. Their admission often adds one or more unintended disabilities. Their new residence is usually foreign, with unfamiliar nurses and doctors providing care now. They are often transferred via an unfamiliar hospital because of a recent acute event, such as a stroke, fracture or worsening of chronic illness like dementia.

Consider the following **list of possible disabilities accompanying a new resident** into a Residential Aged Care Facility:

- Change – whether in location, food, neighbours, noises
- Pain – secondary to arthritis, recent trauma, angina, constipation
- Breathing difficulty – due to chronic COPD, asthma, recent pneumonia
- Impaired vision – necessitating the importance of keeping glasses clean and in place
- Impaired hearing – managed with the appropriate use of hearing aids, clearing the wax from the ear canal
- Deteriorating mobility – impacting transport for specialist or hospital follow-up
- Impaired speech
- Disturbed sleep
- Chronic tiredness – contributed by decreased exercise, burden of disease such as anaemia, hypothyroidism, drug effects
- Tremor – Parkinsonian or otherwise, or simply a general deterioration in fine or gross motor function
- Constipation – secondary to diet, fluid intake, reduced physical activity, drug effects

> ***"The nursing and care staff need access to good records from the GP, and vice versa."***

- Polypharmacy – Most of us doctors are relatively capable of and comfortable with starting medications, but we are not good at knowing when we should stop. Hence, with each new problem detected or a different doctor consulted, patients and nurses are burdened by yet another drug addition to their already long list of medications. We need to have good reasons for all our prescribing and need to keep clear records of the medications, indications and directions.
- Social isolation – Many Aged Care residents feel forgotten. They may forget that their daughter had already visited earlier that day. Or they may suffer the perception or reality of family, doctor, nurse, carer or allied health professional not visiting as promised or expected.
- Malnutrition – caused by dental problems or poor appetite
- Mental health issues - depression and anxiety
- Loss of independence

A welcomed or enjoyable priority?

Few doctors see nursing home residents as an interesting or enjoyable priority in their clinical practice. A senior geriatrician from the UK related his involvement in a regional team of about 14 geriatricians, of whom only two saw nursing home involvement as an enjoyable or important part of their practice. When I withdrew from involvement in wider areas of General Practice to focus on nursing homes, a couple of fellow GPs made comments such as, "Does that mean that I can dump all my nursing home patients on you?" GP involvement in caring for nursing home residents can be more time-consuming and less lucrative than seeing only patients who come to the doctor's rooms.

Verbal communication is important

Because of geographic change, the aged resident is often new to the GP and vice

versa, and likewise for families, nurses and carers. **Family conferences** involving doctor, resident, family and nurses can be enormously helpful, preferably as soon as possible after the resident's admission. They help to build relationships and establish mutually realistic expectations.

Written communication is also important

Sourcing the health history of a resident is a perennial problem. One doctor may prepare the hospital discharge summaries (sometimes a day before discharge), but another doctor may make additional medication changes without knowledge of the first. The copy of their hospital drug chart does not always arrive at the same time as the resident. Occasionally several pages of hospital record may arrive on time, but with some pages lacking dates or even names of the patient. All potentially disastrous if another new resident arrives from the same hospital at a similar time! We all need to take great care to **legibly name and date every page of health records.**

The nursing and care staff need access to good records from the GP, and vice versa. Over time it is possible to develop excellent mutually helpful relationships between GP and nurses. The GP can build a mental record of which staff members in the nursing home provide the most accurate and helpful information. This also facilitates the possibility of good telehealth advice after hours. A brief conversation with the relevant carer can often provide vital insight into the resident's needs. Site Director, Clinical Nurse, Registered Nurse, hands-on Carer, Domestic and Cleaning staff all have vital roles to play, as well as the GP. None should be discounted.

Asking questions that matter, gaining answers through stories

The elderly love to talk.

My own father spent his final years in a local RACF. If I asked him a general question such as "How are you today?" he would often launch into a lengthy description of his bowel habits. However, if I said, "Hi Dad, can you remember more about the uncle who used to ride his motorcycle from Melbourne to Adelaide?" he would expound all kinds of interesting family details.

My mother-in-law often asked for more fruit, mainly figs, for her bowels. The nursing staff said she always answered in the affirmative when asked if she had had her bowels open today. Her records indicated that she had "as required" orders for laxatives but never accepted or asked for them.

When I asked what her bowel actions were like, she said, "Like passing a brick." With further questions she admitted that she opened her bowels with considerable discomfort and difficulty, and only about once a week!

> ***"Always we can endeavour to accompany the patient on their journey and give them hope that we will not abandon them despite our inability to cure them."***

My father asked me to put new batteries in his torch.

"Why?" I asked.

"So I can read the clock in the night." He had had 5 timepieces in his room, but sometimes could see none of them because of low light or because someone had moved a clock or put another object in front of it!

Residents' stories are amazingly varied and informative and often repetitive, but also very interesting. Helpful therapeutic decisions sometimes arise from listening to long-winded stories!

Dealing with the acute on chronic

New or acute events can still be expected in those whose life and health are already dominated by chronic illness. For some diseases we can do very little but encourage patient and family acceptance of the chronicity. Fairly often we can do useful things to relieve symptoms.

A more severe example is the man with a long history of advanced prostatic carcinoma, numerous pathological fractures requiring insertion of several rods, plates or screws, who had been increasingly adamant about avoiding and refusing any more hospital admissions. He was already on significant doses of regular analgesia. He remained remarkably coherent in speech and in understanding of his predicament.

When the nursing staff contacted me one afternoon to say he was in agony because of a newly displaced pathological fracture of mid-femoral shaft, what should we do? We discussed the options again, and gave some intravenous diazepam and morphine and waited to see if he would physically relax. He did relax but also commenced a rather prolonged phase of not breathing during which nurses and I achieved significant correction of his femoral displacement. We waited anxiously for him to breathe again. He managed about two more weeks of reasonable comfort with the help of excellent nursing care and his usual analgesics.

Always we can endeavour to accompany the patient on their journey and give them hope that we will not abandon them despite our inability to cure them.

Feelings and Faith

It is rather common for nursing home residents to feel forgotten (by family, nurse, carer or doctor), burdensome or beyond their usefulness. A few see their nursing home admission as one of the best things that ever happened to them. Some are glad for the time to chat to others or to pray for others. Others may find everyone else a nuisance. Aged Care Chaplains do a great job, and we can be mutually supportive of all the other members of the team. Occasionally we might pray with and for the resident or the bereaved.

In summary, good care in nursing homes includes:

- Careful listening
- Accurate record keeping
- Clear conversations, and
- Lots of time!

Dr Richard Wong

Richard is a GP with city and rural experience, and does part-time hospital work. He serves as the CMDFA QLD (and formerly NSW) secretary, on the board of Healthserve, as a Saline trainer, and is interested in medical missions, both short and long term.

Conducting Christmas Outreach Services at Aged Care Facilities as a visiting GP

In the months before Christmas 2019, I started thinking about hosting a series of Christmas outreach services at the aged care facilities I regularly visit. I considered that this would be the one time of the year an evangelistic message would be acceptable. I had previously conducted such services in Sydney when I was working there so had a good idea of how to conduct them though here in Brisbane, when approaching the facility management for permission, it seemed novel and intriguing rather than something they were used to, so I realised I was on fertile soil if I ran them with discernment and sensitivity.

Thankfully all three facilities I approached enthusiastically granted permission and I would like to think it was because of the rapport and integrity I had developed with them as a Christian doctor honed by lessons learnt from years in CMDFA. The next step was to find a team that I could work together with to run these three consecutive Thursday afternoon half hour services.

I asked a young couple at the church I attend, Rayk and Christin Platzek, who are studying at Queensland Theological College and they were a delight to work with in implementing these services. Rayk and I alternated in delivering the messages, with him presenting two of them based on Mark 1:14-15, and Christin presented her well-received testimonies of her faith in Christ and what Christmas means to her. Altogether, these shaped essentially a full church service, consisting of me chairing the services with an opening prayer, singing a few well-known Christmas carols interspersed the testimony, a Bible reading followed by the main message, closing in prayer, and thanking the staff for their permission. The invitation to join in the singing of the carols was extended not only to my patients at each facility, but also to anyone else interested.

> ***"I considered that this would be the one time of the year an evangelistic message would be acceptable."***

I was blessed to have other church friends come and participate in the singing of the carols as well as talk to the elderly residents in the background, which freed me up to run it from the front.

Some logistical challenges I faced included an unexpected difficulty finding a pianist (ministers tell me it's a common issue in their congregations with not many younger ones playing the piano), but after a few attempts, we were blessed with the service of the daughter of a BSF (Bible Study Fellowship) leader as well as a member from another Presbyterian church who agreed literally the night before in answer to my prayer request for one.

Other difficulties included the "inaccurate" reporting from some staff who had advertised it as a carol service or sing-a-long rather than as including a Christmas message, so I had to gently rectify that. Also, given the high care needs of the residents, there needed to be dedicated staff who worked beyond their usual role duties to bring and supervise the residents in the halls we were using (which I scoped weeks beforehand for suitability), so I was conscious to thank them during this and after the service. For many of you reading this as medical professionals, treating the elderly either at facilities or in hospital is likely part of your everyday practice, but I think for some of my non-medical church friends who are young and fit, it was an eye-opener to the despair and morbidities that this section of the community live with. This is highlighted even more so now during the current climate in which I write this article, and for this I was very grateful they offered to serve.

As one of the team commented, "We were indeed out of our comfort zone because we hadn't expected to see that level of physical decline and mental impairment. It made us realise how cut-off we younger people generally are from the sick and dying in our community. So, seeing the pain and misery of these men and women was hard and yet, it spurred us on to share the gospel with them as clearly as possible. Perhaps it was the last time they heard about the love and peace of Christ, about God's offer of pardon and eternal life in His kingdom... So, we thank Richard for this ministry opportunity because it opened our eyes to the gospel urgency in such places and how vital Christian workers are to bringing light and hope to those in despair."

Feedback that I and my church friends received included that the residents found it a different way of serving, and refreshing for some to see parts of the body of Christ with our differing ages and personalities working together. For others, it was a break in their daily "boring" routine, as one put it. Others were appreciative of having an outside group visit. As for any feedback about the deeper aspect of the Gospel message convicting hearers, this will be knowledge in which the Holy Spirit will have to lead and for us to find out in eternity.

Across the three aged care facilities, I was excited that we could share the Christmas message to approximately one hundred people in north Brisbane, and that God could give me/us the opportunity to proclaim His Name! Looking back, it is a reminder to me that as Christian medicos, we are in a unique position to access areas of society and people's lives that many others are not (and I mean this respectfully and lovingly). Hopefully, this endeavour and reflection may be of encouragement for us to take the initiative in sharing the Gospel.

Ode to a Farmer's Wife

It was just after "Rest Time",
with patients still sleeping,
the nurses were busy updating
their notes.
I had "Out-of-Towners", brought in
from the Country,
and I wanted to see those
"Long Distant" ones first.

One of those patients was a little old lady,
a Farmer's wife, from way out "the Back"
She was a widow with no close relations,
no one to visit and take up the slack.

Almost engulfed in pillows and doonas,
the sides on her bed were raised
like a cot.
I nearly walked past that small
grey-haired lady,
so frail and alone, like they all had forgot.

So I put on my friendliest face
and mustered a heart-warming smile,
before announcing my mission,
to visit all the "Pressies" on file.

The Lady responded quite quickly,
when she realised I was one of her own,
"I used to teach Sunday School children,
when I lived with my parents at home."

Art by Emile Chou

Then I asked her how she was going –
what the hospital staff hoped to gain.
She shook her head with much sadness,
"My body is wracked with great pain!"

"Perhaps I could pray for that with you,"
I said with all the confidence I had.
But she buried her face in the pillow,
and told me, "I'm probably too bad."

"When I married, we moved
to the country,
to the Bush and onto a farm.
Then little by little things took over –
the fences, the shearing, the barn.

It was quite a long trip for groceries,
even further for mechanical parts.
When you factored in Church
on a Sunday,
it really challenged our hearts.

So I really don't think that I'm worthy,
to ask for your prayers for my pain,
For I left God and His house off my
"Do List",
and didn't go near Him again."

My heart ached for this suffering lady,
who had toiled many years on the land,
So I pulled out a tract about Jesus,
and the Hymn that says he's our friend.

I thought if I sang a few lines
of this wonderful faith-lifting hymn,
my suffering patient might remember,
and start putting her trust in Him.

But nothing like that even got started,
no memories with joy went on show,
until I launched into, "Jesus loves me",
the Bible, it does tell me so.

Her face was beginning to soften,
the memories brought deep humility.
I rejoiced as I heard her saying,
"Perhaps you could pray for me!"

I reached out my hand and asked her
if her hand I could hold for a while,
Just while I prayed to the Father,
for this daughter who needed His smile.

And when we had finished our praying,
and my visit had come to an end,
I offered a tract about Jesus,
and the Hymn which says he's our Friend.

The lady, unworthy no longer,
reached up with her outstretched hands,
and gladly read of the Saviour,
who saved her and taught her to dance.

Ian Johnston

Ian has been the Presbyterian chaplain at the John Hunter Hospital in Newcastle since 2012. He grew up in Coonamble, NSW, working as a computer programmer in Sydney till he was called to the ministry in 1973. He and his wife, Roseanne, served parishes in country NSW and northern Queensland till 2005, after which he lectured at Tahlee Bible College.

Dr Kenneth Ibe
Kenneth emigrated to Australia from Africa about twenty years ago. He is happily married to Sophia with four children and is a general practitioner in Dubbo, Western NSW. He eagerly looks forward to the soon return of our Lord Jesus Christ.

Ageing Gracefully and Living Well

Ageing is a universal part of life. We are born and pass through the natural stages of life, including old age, and then die. The World Health Organisation considers old age as beginning at 65 years of age, but at 55 years of age in Africa.

Old age is the stage of life characterised by declining regenerative abilities, diseases and sicknesses more than in the younger ages. As an individual transitions into old age, they undergo changes in physical and mental capacities that may lead to ill health. Sadly, Western culture does not esteem the aged. Old age is often thought of as an evil, an infirmity, and a dreary time of preparation for death. However, growing old does not have to mean developing disability and disease. Older adults can take action to reduce the risk of developing a chronic disease or minimise the impact of existing chronic diseases, so as to continue to live productive, purposeful and enjoyable lives. Ageing gracefully and living well is the art of living our best lives in our old age and having the physical and mental health to enjoy it. It is about being healthy and happy. Much can be done to age gracefully and live well.

Exercise

Foremost, exercise. Exercise improves our health and prevents chronic diseases. It is never too late to start. Exercising helps with weight control, lowers blood pressure, strengthens muscles and prevents falls. It decreases the risks of dementia, diabetes and certain types of arthritis. Older adults need not rigorously work out. Walking, gardening, or anything to keep moving is sufficient. In addition, stretching exercises are essential for maintaining and improving flexibility. About five minutes of stretching every day is beneficial.

> *"Being happy and having a generally sunny outlook on life is also linked to longer, healthier lives."*

Prevention

Preventive measures like annual vaccinations and screening tests for breast, cervical and colorectal cancers are important for growing old gracefully. Healthy diets nourish the body and also help to prevent the development of diseases. Quitting smoking and decreasing alcohol consumption prevent premature ageing and reduce the risk of developing lifestyle-related diseases. Good oral health and regular dental checkups prevent the risks of gum disease, heart disease, stroke, and pneumonia. Regular consults and checkups with your general practitioner or specialist may help prevent diseases through early diagnosis or timely risk assessments to mitigate onset.

Optimism

Being happy and having a generally sunny outlook on life is also linked to longer, healthier lives.

Studies indicate that optimistic people live longer and are less likely to develop certain chronic conditions such as heart disease. Being optimistic and maintaining a positive attitude is associated with longevity and better recovery from diseases. Being optimistic and lowering one's stress levels through relaxation techniques such as meditation, breathing exercises, adequate sleep, and talking to a friend helps much to prevent the development of diseases, including mental health conditions. Having a pet has been linked to lower stress and blood pressure, reduced loneliness and better mood. Finding new and meaningful hobbies can help with maintaining a sense of purpose and engagement throughout the course of life. Evidence shows that people who engage in hobbies, leisure and social activities are happier, experience less depression, and live longer.

What does the Bible say about ageing gracefully and living well?

The Bible has much to say about being born, growing old and dying. Ecclesiastes 12 talks about the infirmities of old age.

> ***Ecclesiastes 12***
> *Remember your Creator in the days of your youth,*
> *before the days of trouble come and the years approach when you will say,*
> *"I find no pleasure in them"–*
> *before the sun and the light*
> *and the moon and the stars grow dark,*
> *and the clouds return after the rain;*
> *when the keepers of the house tremble,*
> *and the strong men stoop,*
> *when the grinders cease because they are few,*
> *and those looking through the windows grow dim;*
> *when the doors to the street are closed*
> *and the sound of grinding fades;*
> *when people rise up at the sound of birds,*
> *but all their songs grow faint;*
> *when people are afraid of heights*
> *and of dangers in the streets;*
> *when the almond tree blossoms*
> *and the grasshopper drags itself along*
> *and desire no longer is stirred.*
> *Then people go to their eternal home*
> *and mourners go about the streets.*
> *Remember him – before the silver cord is severed,*
> *and the golden bowl is broken;*
> *before the pitcher is shattered at the spring,*
> *and the wheel broken at the well,*
> *and the dust returns to the ground it came from,*
> *and the spirit returns to God who gave it.*
> *"Meaningless! Meaningless!" says the Teacher.*
> *"Everything is meaningless!"*

By contrast, Psalm 71 is the psalm of God's way to grow old gracefully:

> ***Psalm 71:9-14***
> *Do not cast me away when I am old;*
> *do not forsake me when my strength is gone.*
> *For my enemies speak against me;*
> *those who wait to kill me conspire together.*
> *They say, "God has forsaken him;*
> *pursue him and seize him,*
> *for no one will rescue him."*
> *Do not be far from me, my God;*
> *come quickly, God, to help me.*
> *May my accusers perish in shame;*
> *may those who want to harm me*
> *be covered with scorn and disgrace.*
> *As for me, I will always have hope;*
> *I will praise you more and more.*

By developing a walk with God that involves a deep, personal, and experiential knowledge of God, that includes the habits of trust, praise, and hope, and a walk that involves a lifestyle and ministry for God, then as long as we have life, we can show and tell and sing of the greatness of our God to the next generation.[1]

What a way to live out our life!

Reference:

1. https://bible.org/seriespage/psalm-71-growing-old-god%E2%80%99s-way

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Instructions for contributors

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CMDFA

Dr Chris Poulos

Chris is a rehabilitation physician and Head of Research and Aged Care Clinical Services for independent Christian charity HammondCare. He is also a conjoint professor in the Medical Faculty at the University of NSW. Chris attends St Phillip's Anglican Church in Caringbah, Sydney.

Positive Ageing and Meaningful Life

"Even to your old age and grey hairs
I am He, I am He who will sustain you.
I have made you and I will carry you;
I will sustain you and I will rescue you."
(Isaiah 46:4 NIV)

To do the subject of 'Positive ageing and meaningful life' justice in only a few pages is an impossible task. We can only scratch the surface of this important topic. However, I will attempt to provide a framework in this article, divided into three sections.

- The first is a clinical approach to positive ageing, which focuses on functional ability as well as having purpose and meaning in life.
- The second section discusses how purpose and meaning is strengthened by a Christian worldview.
- The third draws both together.

The focus of the article is on someone who may be just entering, or is well into, older age (let's say late-50s – either fully retired, or retirement is on the horizon). One caveat – even though many of the principles still apply, I don't claim to cover some of the more complex needs of older people requiring high levels of supportive care, such as those with extreme frailty, or the more specialised needs of people living with dementia or those who are receiving palliative care.

Positive Ageing and Meaningful Life – a clinical approach

What is positive ageing?

A number of terms (such as *healthy, active, productive, successful*) have been used to describe what 'ideal' ageing might look like. While it's helpful to describe an ideal picture of older age, and to study the epidemiological determinants of ageing well (and hopefully raise the bar for all in the future) by identifying an ideal picture of older age, it is not particularly helpful for people who are already there.

> ***"Having meaning and purpose in life is also integral to positive ageing."***

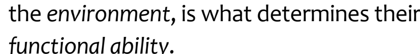
The ideal ageing journey usually requires a life-course approach, and many of the determinants of the ideal are out of a person's control – either because of genetics, or the environment in which they were raised, or because they have made poor decisions in the past that cannot be undone.

I prefer the term *positive ageing*, not necessarily confining its meaning to the realm of positive psychology. I use it in a more 'off-label' sense, such as: *there is usually something positive a person can do to improve their ageing journey.* This approach is more helpful to people who may not have aged particularly successfully, healthily, productively or actively.

Functional ability

Because I am a rehabilitation physician, I tend to view a patient in terms of their ability to function. People seek medical attention for many reasons, but declining function resulting in activity limitations is certainly one of the main ones. Activity limitations lead to a reduced ability for people to participate in life pursuits that are meaningful to them.

The World Health Organisation, in its 2015 World Report on Ageing and Health[1], introduced the term *intrinsic capacity*. Intrinsic capacity is defined as the "the composite of all the physical and mental capacities of an individual". A person's *intrinsic capacity*, along with



the *environment*, is what determines their *functional ability*.

The *environment*, in this context, consists of all the extrinsic factors that can influence function, such as the use of assistive technologies, the physical environment, social policy, or the formal and informal support available to the person.

The life-course view

Over the life-course, the aim is to maximise a person's intrinsic capacity, thereby creating a buffer, or reserve, against functional decline. The WHO Report provides a public health framework in which this can occur. From early in the life-course, the aim is to promote capacity enhancing behaviours. This is done by education, as well as public health and societal strategies (for example, minimising tobacco use through taxation and restrictions on supply, or creating environments which help promote physical activity). The health system also plays a role in helping people to build and maintain intrinsic capacity (for example, through identifying and managing risk factors for chronic disease).

An inevitable consequence of ageing is a decline in intrinsic capacity. The aim should be to slow the decline wherever possible, as well as take opportunities to reverse any declining capacity that occurs following illness or injury. Once again, the health system plays a large role in disease management, secondary prevention, and the provision of rehabilitation (and other restorative strategies). However, the environment surrounding the individual also plays a role and can help people maintain or maximise their functional ability by compensating for loss of capacity (for example, through the use of assistive technology and removing environmental barriers to participation).

The individual view

In a positive ageing approach, the same public health framework can be used at the individual patient level. A very truncated version of this approach follows[2]:

The starting point is to explore ways to maximise a person's intrinsic capacity through optimal disease management, including the management of pain, if present. Allied health therapies, especially exercise in its various forms (aerobic, strengthening and balance training), can also help a person maximise intrinsic capacity. Overcoming internal ageist attitudes about the benefits of exercise, and promoting self-efficacy is key. In the case of exercise, self-efficacy is a belief by the person that by exercising they can make a difference to their ability to function. Allied health practitioners are also very effective in looking at how the environment impacts function and they will be able to advise on assistive technologies as well as modifications to the environment.

If functional deficits remain, then further 'environmental' modifications in the form of community services are fortunately readily available in Australia. Providing supportive care might not seem to be a way of promoting functional ability, but it can do this when it allows someone to continue to undertake meaningful activities (for example, assistance with meals and cleaning to allow someone to live in their own home, or assistance with transport to allow continuation of shopping). Assistance with a task itself in the form of 'doing with', and not 'doing for', can also serve to promote the retention of functional ability.

Informal support through family carers is also very important, as is supporting those people in their caring role.

Ultimately, however, a change in accommodation, including to supported accommodation such as nursing home care, may be required. However, this too can positively impact a person's ability to continue to do some of the tasks that are meaningful to them.

Meaning and purpose as factors in positive ageing

Having meaning and purpose in life is also integral to positive ageing. Eudaimonia is a term for happiness or well-being. According to academic and psychologist, Carol Ryff[3], psychological well-being includes the following constructs: *self-acceptance; positive relationships with others; autonomy; environmental mastery; purpose in life*; and *personal growth*.

Having purpose includes having goals and a belief that life has a purpose.

Within HammondCare we run a program called *Arts on Prescription*, in which older people with unmet health and wellness needs work with professional artists to explore their own creativity in small group settings. An evaluation of the program suggests that this type of pursuit was able to create meaning and purpose and improve mental well-being.[4] (Note that *eudaimonia* can be contrasted with *hedonia*, which is happiness from short-term gratification and pleasure. Hedonistic pursuits are unlikely to create purpose and meaning – your football team may not always win!).

Volunteering is another pursuit that has been shown to promote positive ageing.[5] Volunteering and participatory arts both help to create purpose, connect people with others, develop new skills, and build confidence, all of which can lead to improved mental well-being. They can also be a means by which people increase their physical activity.

Meaningful life and the Christian worldview

Meaning and purpose

There are numerous self-help books that aim to help people age positively. Generally, they contain sensible suggestions that most people would agree with.

For example, in his book *Seven Strategies for Positive Ageing*[6], psychologist Robert Hill lists:

1. Finding meaning;
2. You're never too old to learn;
3. Using the past to cultivate wisdom;
4. Maintaining and enhancing meaningful relationships in older age;
5. The importance of giving (and receiving gratefully);
6. The power of forgiveness; and,
7. Having a grateful attitude.

While Hill's book is secular in nature, it does include a part of one Bible reference at the beginning of his chapter on forgiveness:

> *"Be kind and compassionate to one another, forgiving each other"*
> (Ephesians 4:32)

He then goes on to talk about the psychological, and some physical, benefits of forgiveness. There are clearly similarities

between Hill's *Seven Strategies* and the work of Ryff and others.

Meaning and purpose are Biblical precepts
We should expect that a secular view of positive ageing and the things that create meaning and purpose would be similar for both the Christian and non-Christian, because we all share the same Creator God. In fact, we can find Biblical precepts behind Hill's *Seven Strategies*:

1. **Our lives have meaning:**
   "I praise you because I am fearfully and wonderfully made;" (Psalm 139:14)

2. **God wants us to grow, especially within the Christian faith:**
   "For this very reason, make every effort to add to your faith goodness; and to goodness, knowledge; and to knowledge, self-control; and to self-control, perseverance; and to perseverance, godliness; and to godliness, mutual affection; and to mutual affection, love. For if you possess these qualities in increasing measure, they will keep you from being ineffective and unproductive in your knowledge of our Lord Jesus Christ." (2 Peter 1:5-8)

3. **We develop wisdom as we age:**
   "Is not wisdom found among the aged? Does not long life bring understanding?" (Job 12:12)

4. **God intended for us to value relationships:**
   "A new command I give you: Love one another. As I have loved you, so you must love one another." (John 13:34)

5. **We should be generous:**
   "In everything I did, I showed you that by this kind of hard work we must help the weak, remembering the words the Lord Jesus himself said: 'It is more blessed to give than to receive.' " (Acts 20:35)

6. **We should be forgiving:**
   "Therefore, as God's chosen people, holy and dearly loved, clothe yourselves with compassion, kindness, humility, gentleness and patience. Bear with each other and forgive one another if any of you has a grievance against someone. Forgive as the Lord forgave you." (Colossians 3:12-13)

7. **We are to be grateful and give thanks:**
   "Make sure that nobody pays back wrong for wrong, but always strive to do what is good for each other and for everyone else. Rejoice always, pray continually, give thanks in all circumstances; for this is God's will for you in Christ Jesus." (1 Thessalonians 5:15–18)

The added dimension
Within a Christian worldview, the things that create meaning and purpose in this life have an added dimension and greater depth:

We value relationships not only because strong relationships are inherently good, but because we are in relationship with God, and He with us:

> *"But when the set time had fully come, God sent his Son, born of a woman, born under the law, to redeem those under the law, that we might receive adoption to sonship. Because you are his sons, God sent the Spirit of his Son into our hearts, the Spirit who calls out, 'Abba, Father.' So, you are no longer a slave, but God's child; and since you are his child, God has made you also an heir."* (Galatians 4:4-7).

We can use our experiences as we age, including through suffering, to grow spiritually:

> *"Not only so, but we also glory in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope."* (Romans 5:3-4).

Ageing, with God's help, allows us to develop wisdom (i.e. a greater ability to discern, choose and encourage, see Proverbs 1 through 7). We are generous to others because God is generous to us. We are forgiving to others because, through Jesus, God has forgiven us. We are grateful to God for rescuing us.

And we have a future hope to help us through times of trouble – because, let's face it, ageing isn't always fun.

Positive ageing within a Christian worldview

When I contrast some of the Christian books written to provide practical advice about ageing, with the 'self-help' style secular books, I find that the former often take on a more contemplative approach, with a greater focus on dealing with loss, in its many facets: loss of loved ones; loss of status and meaning derived from work; loss of financial means; and loss of function – to name just a few.

While 'loss' is a theme that is especially prevalent in older age, given that our earthly life is fallen, fragile and fleeting, the Christian should be better placed to deal with loss, and able to maintain an eternal perspective. But I also wonder if some of these Christian books are written with these in focus so as to counterbalance the anti-ageing, "Let's not talk about death," mindset that is so pervasive in Western society today?

Christians who are ageing can still embrace life
There is every reason why the Christian should embrace older age to the extent that they are able. It is good to seek to maintain an active, meaningful life into older age, and it's good to look for ways to improve functional ability when declining function interferes with the ability to do so. Not to do this is both ageist and, I believe, not the view of ageing presented in the Bible.

Older age also presents many opportunities to strengthen one's faith and continue to play a role in advancing God's kingdom and imparting that faith to generations to come – particularly to grandchildren.

Within Australia there are a range of government-funded programs, including allied health services, to help people address functional decline.[2] There are also many opportunities for undertaking purposeful activities, such as volunteering. There are resources available now that were not available to previous generations that can assist older people to maintain an active faith life, despite functional loss.

- Audiobooks, podcasts and online sermons have opened up new opportunities for people who are visually impaired or otherwise isolated. David Suchet's complete reading of the Bible (NIV) is an excellent resource.

- The COVID-19 pandemic has fast-tracked the adoption of technology by many churches to bring church into the homes

of people, including the unchurched and people who are isolated and who may not have been able to attend in person, even before the current pandemic.

- Videoconferencing apps allow people to connect within home groups. Tablet devices allow visually impaired people much greater access to the written word. Within Australia, the purchase of these devices can even be done through home care package funds if it is deemed that the purchase improves the well-being of the person, and they cannot otherwise afford them.

Ageism

Finally, a word on ageism. Ageism can be both external (i.e. how society views older people, or how one person views another) and internal (i.e., how someone views themselves). Ageism is the enemy of positive ageing and living a meaningful life. Churches have an important role to play in combatting ageist attitudes (but this is a topic for another day).

A future hope

Inevitably there will come a time when ageing and functional decline does beat us. Until that time comes, there is opportunity to extract the most out of life. However, when the inevitable comes, the Christian has the comforting words of Isaiah 46:4 to rest on:

> *"Even to your old age and grey hairs*
> *I am he, I am he who will sustain you.*
> *I have made you and I will carry you;*
> *I will sustain you and I will rescue you."*

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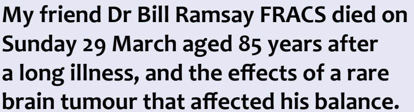
V A L E

Dr Bill Ramsay

29 March 2020 (85yrs)

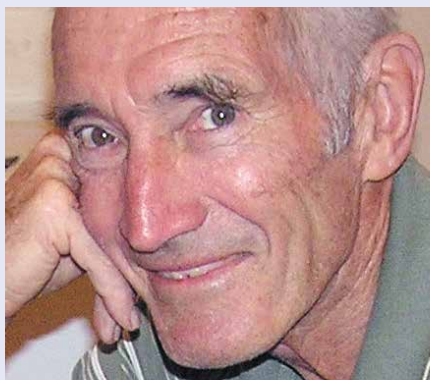


My friend Dr Bill Ramsay FRACS died on Sunday 29 March aged 85 years after a long illness, and the effects of a rare brain tumour that affected his balance.

Bill was a man one could never forget.

My earliest memories date back to the early fifties, where at Scotch College, Bill was my senior school hero – mainly because we all worshipped the demigods of the first division football and cricket teams; Bill was a champion in both.

His dear wife, Robyn, has confirmed that Bill came into the Crusader Group at school through the ministry of the *Bryan Green Echoes*. Crusaders was a precursor of the wider based Inter-School Christian Fellowship (ISCF) and Scripture Union. Bill was a keen young Christian in the mid-fifties when lots of school leaders found a vigorous Christian discipleship quite fashionable. He developed a close friendship with junior teacher David Scott, and then with the late Rev Lawrie Bartlett, who was Commandant at Camp Tallawalla at Toolangi. I can still remember Bill as a young leader at one Camp there, thumping a footy with his bare feet right out of the paddock! In fact, the all-purpose Hall at Toolangi site still bears the Ramsay name, but for more than his football prowess!



Bill was a big man, with a cheeky glint in his eye; he had a very strong faith in a very big God, which determined how he spent his time, his surgical skills, and his money. I believe his faith was fostered in his gracious family at their home in Templestowe, which has been preserved in the family for his son Peter.

Bill was a skilled surgeon of the old school, where a General Surgeon was trained to do generally everything. This was superb preparation for the life he felt called to live after an intentional early retirement so that he could work in a mission overseas where his skills were more needed. He became quite peripatetic, and with Robyn, worked with The Leprosy Mission in Papua New Guinea, then at Vellore CMC in Tamil Nadu, training in further leprosy techniques under Dr Paul Brand's successor.

Then followed 14 years back in Melbourne from 1973 at Box Hill Hospital; he then volunteered to work at Taksin in Nepal, then in Bhutan, then in the Cameroon for 12 months, before heading for Northern Iraq to serve among the Kurds - always aided and abetted by his best friend, and wife, Dr Robyn. What an incredible, adaptable and resilient couple.

Qualities like integrity, faithfulness and humble stamina were there in spades throughout Bill's extraordinary life, but deep down it was his personal faith in a personal God that shone through.

He always felt grateful to the members of the CMDFA, who were such a network of support for him, and he was a regular at most CMDFA Conferences. He is part of that heritage; on whose shoulders we see the future more clearly.

We are diminished by his loss, but inspired to serve and love our God generously, even wastefully, because Bill did it so naturally.

by David Price

Georgia Strimaitis

Georgia is an Occupational Therapist working in residential aged care in Perth. Georgia gave her life to Christ when she was six years old, and is passionate about showing His love and grace to those who are most vulnerable. Georgia grew up in Brisbane, and is currently living in Perth with her husband, who is studying medicine.

Everyday Joy!

Joy. A lot can be conveyed in only three letters. Joy is an emotion we all aspire too, yet is not one often associated with ageing and aged care. In an age of the Royal Commission and COVID-19, the pictures being painted of the aged care industry are often quite bleak, and it can be hard to imagine joy fitting in with the images we are fed of neglect, abuse and loneliness. As a professional, it can be disheartening to see your workplaces – and people's homes – viewed in this way. However, as an Occupational Therapist (OT) working in residential aged care, I am afforded the unique opportunity to not only witness, but to spark joy in the lives of the people I work with, and perhaps to even change their perspective on what it means to age.

Before I go any further, I want to look at just what joy is. The dictionary definition of the word joy is "to experience great pleasure or delight," (Merriam-Webster, 2020). According to Bill High (2017), Rick Warren defines joy as "the settled assurance that God is in control of all the details of my life, the quiet confidence that ultimately everything is going to be alright, and the determined choice to praise God in every situation."

It is both of these definitions that I am blessed to witness each and every day.

My job as an OT is a strange one. On the one hand I am one of the clinical staff, tasked with pain management and ensuring residents have equipment that is both appropriate and safe for them to use. On the other hand, however, I am there to ensure the men and women living in our facility are able to engage and participate in the activities and tasks they most want to. Whether it is working with our Therapy Assistants to plan the best activities program we can, going for a walk with a lady who is vision impaired, or engaging someone with advanced dementia in doll therapy, I am able to create pockets of joy that others may not ever witness.

> ***"I'm not worried about the future, because God has a plan."***

If there is one thing that working in aged care has taught me about joy, it is that something does not have to be a big, flashy event to bring you joy. Joy can be found in winning a round of bingo, eating the best ANZAC biscuit you've ever seen, or making decorations for the common area. As a staff member, I feel joy at watching my residents' faces light up with happiness during these moments.

Recently I witnessed a man watching his wife participate in a game with a giant balloon. This lady has advanced dementia, and is no longer independently mobile. She has recently been asleep when he visits, and watching him watch her face as she caught the balloon filled me with a joy that was not the "jump up and down" joy most people think of, but a warm, golden joy that sat in my chest. It is this kind of joy that I most want my residents to feel every day.

While I have been creating these moments of "great pleasure and delight" for my residents, they are the ones who have been teaching me about the joy that Rick Warren was talking about. Working in a Christian facility, I have been privileged to have many conversations with older Christians, many of whom have walked with the Lord for two or even three times my lifetime. Their quiet faith in their loving Father has been a stark contrast to my frenzied approach to each day. On the days where I am at my most stressed and panicked, God will send me a conversation that reminds me of what is most important – my faith in Him, and the blessings he has given me. Often, God sends me these moments coupled with one of my less-enjoyable roles – assessing

my residents for symptoms of anxiety and depression.

Given the high prevalence of mental ill-health in the elderly, it is to be expected that many of my residents – regardless of faith – struggle with some really difficult emotions and thoughts. It can be easy to be swept up in this, focusing only on the negatives. Many older people are struggling with the loss of their independence, and medical conditions that make each day a struggle against pain and illness. Many cannot see any hope, today or for the future.

However, not all of these assessments are negative. Every so often, I will ask a resident about how they see their future, and receive something like the following: "I'm not worried about the future, because God has a plan. I have my family and friends, and when it is my time, God will call me home."

Wow. What a different perspective on life. A perspective that only comes through a deep faith in the One who holds all of our lives in His hand. It is in conversations like these that I am reminded of Simeon and Anna, who knew that God had a plan for not only them, but all of humanity, and waited patiently for God to fulfil that promise. When I think about how I react to stressors and set-backs in my own life, the patient endurance of Simeon, Anna and the residents I am privileged to work with each day reminds me of God's sovereignty, and the joy that can be found in entrusting my situation to him.

Annetta Tsang art – One at a time flowers

In our current society, ageing is often seen as a negative experience, something to be feared. Many people whom I have spoken to also view ageing as a very lonely process, during which they watch their family and friends pass away, leaving them alone. Isaiah 46:3-4 reminds us that we are never alone, even in our old age.

> *"Listen to me, you descendants of Jacob,*
> *all the remnant of the people of Israel,*
> *you whom I have upheld since your birth,*
> *and have carried since you were born.*
> *Even to your old age and gray hairs*
> *I am he, I am he who will sustain you.*
> *I have made you and I will carry you;*
> *I will sustain you and I will rescue you."*

While I have the daily privilege of creating moments of joy in the lives of my residents, God reminds me that it is He that brings true joy, both now and for the rest of my life. I can rest assured knowing that my life – and the lives of my residents – are held securely in His hands, and He will sustain us until we are one day called home.

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Steve Calder

Steve is the Senior Pastoral Care Coordinator for HammondCare Health, a provider of inpatient and community services (including palliative care) in NSW. Originally working in Anglican ministry in Sydney, he is married to Sandra and has five sons.

Enhancing Dignity for Those Nearing the End of their Life

As I write this, I'm looking at a book on my desk. It's a book I had a hand in producing, and yet I didn't write it. It was written by Penny. It is Penny's story. How the book came about is a story in itself. But first let me introduce you to Penny.

Introducing Penny

Penny was a patient in the Palliative Care Ward where I work. She was 80 years old, suffering from metastatic endometrial cancer, and bed bound. When I met Penny she was sitting up in bed, her long silver hair pulled up into a tight bun. At first she eyed me with suspicion; after all, I was the "chaplain", and by her own admission she wasn't at all religious. Indeed, it became immediately obvious that she was very angry about her upbringing in a very religious household, which had turned her off anything... and anyone... who reminded her of that past.

Soon, though, as we began to talk, Penny softened and slowly told me her story. Penny had grown up in country NSW in a large and strict family, and at a young age had been sent away to boarding school. Tragically, she'd experienced physical abuse there. Later, as a young woman, she'd endured a broken engagement, had a child out of wedlock, and had suffered biting criticism from family members. She had been emotionally hurt by many people throughout her life. She knew little of the worth and value that she had, though she was made in the image of God and deeply loved by him (Genesis 1:26, Psalm 36:7).

Penny's book.

Her son, Adrian, was the light of her life. He was a gifted university academic, and Penny often spoke of how proud she was of him. Of course, Adrian knew most of his mother's stories, and yet it was clear that in the retelling of the account of her life, there were feelings that Penny had never shared with Adrian – her hopes and dreams for him, her love for him. She was also worried about him. He was single, and she longed for him to have a family of his own. But she found it difficult to talk to him face-to-face, and this was distressing to her, especially as she knew her time was short.

Introducing Dignity Therapy

It was then that I realised that Penny would be an excellent candidate for a specialised intervention to which I had been introduced only weeks before: Dignity Therapy. In short, Dignity Therapy is a way of capturing a person's story in writing so that hopes and wishes for loved ones can be expressed, and so "live on" after death, thereby conserving and enhancing dignity.

Dignity Therapy was developed by Canadian Palliative Care physician, Harvey Chochinov.[1] His research indicated that many people with a life-limiting illness have dignity-related concerns. In one study, over 87% of patients reported that their sense of dignity was most likely to be influenced by end-of-life worries, such as not being treated with respect or understanding, and feeling like they didn't matter anymore.[2]

Dignity Therapy *dignifies* the patient through the process of engaging in a directed and captured conversation. This conversation is built around a set of questions called the "Dignity Therapy Protocol Questions" (which are presented to the patient for review before the therapy begins). Questions include:

- Are there particular things that you would want your family to know about

you and are there particular things you would want them to remember?

- What do you take most pride in in your life?
- Are there particular things that you feel need to be said to your family (and others) or things that you would like to take the time to say once again?
- What are your hopes and dreams for your loved ones?

The directed conversation is recorded, transcribed, and, in an iterative process, the transcript is edited to form a final document which is then handed to the patient. It is this whole process which imbues the patient with dignity.

Penny's Book

As I went through this process with Penny, and she talked fondly about the rolling hills of the town in which she grew up, I saw an opportunity to further enhance the document I would hand her at the end. I sourced some beautiful recent photos of her town, and having obtained permission to use them, included them with her words in a book made using an online bookbinder. Penny graciously allowed me a make and keep a copy of the book myself.

I well remember the day I handed Penny her completed book. Her copious tears of joy were eloquent testimony that she knew that she had been dignified by this process. She had been able to express herself in a way that would have a lasting effect, especially upon Adrian. Later, when I visited her, the book was prominently displayed on her over-bed table, and she would beam when she recounted how she would show it to every visitor.

Final reflections

As I reflect back on participating in Dignity Therapy with Penny, I am reminded of what a privilege it is to spend time with older people, and to listen carefully to their stories. We mediate Christ's love by slowing down, attending to, reflecting, and seeking to understand what they say. Their stories always contain clues about their spiritual state. My conversations with Penny were deeper and more profound after Dignity Therapy, as we touched on her relationship with God in a way that would have been impossible before. Dignity Therapy is not for everyone, but when appropriate it is one tool that enhances the message that we want to convey as Christians: that each person has God-given worth and value, and indeed dignity, right to the last moment of their life.

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Dr Kristen Dang

Kristen is a family doctor who loves all things creative. She lives with her husband and daughter in Adelaide, and writes a regular blog (lostnowfoundk) on life with God. Her second blog (lilyofthevalleysk), aims to share her love for Jesus through the creative arts.

DEVOTION

Ageing Unhindered

People talk about ageing gracefully, embracing the gray hairs, appreciating what helped us grow, and investing in the next generation. Yet ageing often brings regrets, worries, fears and disability. "Don't get old!", people say as they smile through the weariness of physical decline. The years are inevitable, but there is a crown of glory that we can look forward to.

> *"Gray hair is a crown of glory;*
> *it is gained in a righteous life."*
> *(Proverbs 16:31)*

As I get older, I find I am much more aware of life's stages: childhood play, disciplined learning, milestones of family life, loss of loved ones and the day we ourselves take that final breath. Each stage of life has its own challenges and celebrations, and God remains our fortress through it all.

Never too old, never too weak

What an encouragement it is that God works through people of every age, nation, gifting and capacity. Many elderly and disabled people were used powerfully by God:

- *Moses* was 80 years old when he spoke to Pharaoh.
- The apostle *Paul* ministered to people despite having a "thorn in the flesh", commonly thought to reference a disease affecting his eyesight.
- The prophetess *Anna* was 84 years old at the time she recognised the young Jesus as Messiah and began to proclaim the good news.
- *Sarah* and *Elizabeth* were both older women well past child-bearing years. In their old age, Sarah became the mother of Isaac, patriarch of Israel, and Elizabeth the mother of John the Baptist.

There are also examples to be seen in more recent times:

- *Pastor Lee Jong Rak* continues to care for, and speak God's life over disabled children and abandoned babies despite his age and medical issues. "*The Dropbox*" is a documentary that covers some of his work and testimony.
- *Nick Vujicic* was born without properly formed arms or legs and shares his testimony through multiple platforms as an evangelist and motivational speaker.
- *George Matheson* went blind in his youth. His blindness caused his fiancée to leave him and he never married. Yet he knew God was faithful and composed the hymn *O Love That Wilt Not Let Me Go.*
- *Billy Graham* died in 2018, aged 99. He continued to share Christ with people right until the end of his earthly life. His book *Nearing Home*, was published in 2011, and addresses some of the challenges our faith may face in older years of life. He ends triumphantly, however, in reminding us that getting older on earth also means getting closer to our real home, eternity with Christ.

> ***"Each stage of life has its own challenges and celebrations, and God remains our fortress through it all."***

Lessons from Nonnas and Nonnos

When I "grow up" and grow old, I want to have the kind of seasoned, matured and steadfast faith I see in the nonnas and nonnos of my local church.

Age has not wearied their passion for

Christ, and it has not lessened their zeal for sharing the good news with strangers on the street. It has brought physical losses with reduced mobility, pain, hospital visits and the loss of spouses, but they have remained steadfast in praising God. These nonnas and nonnas are an inspiration to me. They show me what it looks like to love God wholeheartedly even when your physical condition means you need to sit down midway through the service.

They might not be on stage with a microphone in their hand, but the genuineness of their faith proclaims Christ to all they meet. They gladly worship Him despite their griefs on earth. They lovingly pray for and build up the younger members of the church, giving them opportunities to serve and grow and learn. They remember the testimonies of God throughout their life and joyfully share these powerful moments in everyday conversation. They see death approaching and are not afraid of it, but are confident that they will be with Christ that day.

"Ageing Unhindered - Gray Hairs a Crown"
by Kristen Dang

One way to grow old but not weary, is to keep refreshed daily with hope in Christ. This hope reminds us that there is a better day still to come, a day when we will be home with Christ. What a glorious day to look forward to!

Ageing Unhindered

Rather than letting the years hinder our faith, let us age gloriously, having the eternal perspective of knowing that life on earth is a journey towards our true home with Christ.

Let us celebrate the elderly, persevere through times of disability, lean on God our strength, and never cease to testify of what He has done for us. Age is no barrier to being used by God and who knows, perhaps the best is yet to come!

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Dr Monique Peris
Monique is a General Paediatric Advanced Trainee working in Melbourne, Victoria. She completed her medical training in NSW, joining the CMDFA community in her first year of medical school in 2007 through Transfusion camp.

Age: More Than A Number

"Hi, I'm the doctor in emergency. Do you want us to treat your grandmother aggressively or what? Your family can't decide so that's why you're on the phone."

"What's wrong with her?"

"I don't know but she's 96."

Sadly my grandmother's case is not isolated. Working in medicine it becomes apparent that the worth of the generation that lived through wars, drought and economic crisis can be boiled down to a number. Since when did everyone over the age of 80 automatically earn themselves a label of 'medical futility?' When did we give up on the generation that has given so much to us? When did these legends of the past lose the basic right to be informed of their options? The last of the 'doctor knows best' generation, elderly patients can be particularly vulnerable in healthcare encounters as they are more likely to accept the advice of treating medical professionals without question or complaint.

Even though the bedside manner of the physicians involved in Grandma's care improved, the attitude towards her treatment did not.

"You need to prepare yourself that this might be it for her. She may never recover."

I found myself wondering if we were talking about the same person as my grandma sat bolt upright in bed happily drinking her tea and talking about the ride in the ambulance.

> ***"When did we give up on the generation that has given so much to us?"***

My grandmother may have been 96, but she *loved* her life. She was certainly more frail and forgetful, but she still had her mind, for which we were grateful.

Thankfully my grandmother did live to fight another day. She returned to the nursing home excited to see everyone, regaling the adventure of the ambulance.

* * * * *

It has only been a few weeks since my grandmother passed. Every breath was on her own terms. She died with dignity and in peace surrounded by family.

The journey to that point has not been peaceful, but my family and I take comfort in the knowledge that she is now at complete peace with her Lord and savior, the ultimate physician and healer.

Several days before she passed we were once again faced with prejudice directed at grandma's age.

"You may want to discuss with the doctor about rationalising things."

At the time grandma had been sleeping for longer periods of time and eating less. Despite this she remained happy and well, eating and taking her tablets. Once again we were faced with changing her management while she appeared to be coping. Several days later she was reviewed by the GP having refused her medication that morning. We ran into the GP in the corridor who mentioned they may "change a few things". My mother didn't know what that meant but she trusted the medical team. I approached the doctor to clarify the plan. It seemed that she had ceased all of Grandma's medications and commenced her on regular oral morphine.

There was no explanation for us as a family. No discussion about a change to medications. No reasoning was given,

nor was there an explanation of the dying process or what we may expect over the next few days, weeks and months.

While the outcome would have been the same, the process was horrendous, stemming from an apparent disregard for the value of someone's life due to their age. As a family we constantly felt we were fighting for grandma to die with dignity in her own time.

We all have attitudes, experiences and beliefs that influence the way we practice. It is important to practice self-reflection and self-awareness as to what influences not only our attitude towards each patient but also what influences how we communicate with families and make decisions about a person's care.

The concept of Communication Accommodation Theory (CAT) was first described by Howard Giles.[1] CAT encompasses the concept that each person brings their own beliefs, experiences and perceptions to a conversation which influences how words are spoken and received.[2,3] In our communication we can be "accommodating" or "non-accommodating". Accommodating behaviors are when a practitioner adjusts their language, speech, tone and manner to meet the needs of a patient.[4] Accommodating communication may involve open-ended questions, listening, explaining, inviting input and expressing understanding which create a friendly, polite and compassionate atmosphere. This approach requires the practitioner to see the patient as an individual with their own story and unique needs and has been shown to be is perceived positively by the patients.[3] Non-accommodating communication commonly occurs in cases where the recipient is unable to communicate for themselves or is perceived to be of a different societal group. These encounters are more likely to occur when the patient is seen more as a member of a societal group as opposed to an individual with their own unique story and needs. Non-accommodating communication includes closed questions and use of medical jargon and subsequently leads to the perception of hostility and 'rudeness' by patients and families.[3] In my case, the doctor in ED had seen my grandmother not as an individual person who enjoyed a good quality of life. Instead they saw her as a member of the over-90s club in whom the discussion of medical investigation and management was futile.

> ***"In my case, the doctor in ED had seen my grandmother ... as a member of the over-90s club in whom the discussion of medical investigation and management was futile."***

Age is more than a number. It does not determine a person's worth. Capacity to make informed decision about one's own health can be influenced at any age. Patient centered care means looking at the person beyond the number.

Every patient needs our time, attention and compassion.

Every patient should have their medical management thoughtfully considered in light of their physical and mental health.

Every patient and their family has the right to hear all medical options in order to make an informed decision.

I want every one of my patients and their families to have the hope that I have. It is my belief that there will be a final day where there will be 'no more death or mourning or crying or pain, for the old order of things has passed away'. (Rev 21:4)

I've heard it said: "Few people will see a priest, but most will see a doctor. You may be the only Bible someone reads that day." We can be a witness, showing our belief through our work, ready to give an account to our collegues. We can be the difference and ensure every patient is treated with respect and dignity.

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VALE

CMDFA

Dr Maree Farley 21/12/33 - 8/4/20

With great regret I would like to inform you that Dr Maree Farley died in RNSH on the 8 April 2020 after a long illness.

Maree completed her final year at Abbotsleigh in the imposing role of a prefect. At the University her first year was spent in the Faculty of Science, until she saw the light and took up the "chosen profession". Since then she progressed steadily through Medicine, without a backward glance.

Maree was an active and enthusiastic member of the Evangelical Union, and showed a keen interest in her local church activities. Although a regular concert-goer, her interest in music was not merely passive, for her relaxation was to dabble in the works of Beethoven and Chopin. In the line of sport, tennis was her favourite.

She went onto a career in General Practice in Chatswood and also assisted the Church Missionary Society as their Registrar looking after missionaries around the world.

She was a member of St Pauls', Chatswood and then St Stephens, Willoughby after she moved to a nearby nursing home.

by Louise Holliday

Dr Michael Nicholson

Michael Nicholson has been a rural GP and VMO for most of his career. When Michael and Anne married in 1998, they established an olive grove in the hills above Mudgee in central west NSW. The years that followed produced many rewards as part-time farmers and full-time doctor. A period of reduced practice in the nearby town of Gulgong was followed by Michael's retirement in 2015.

Anne and I

A Journey with Alzheimer's Dementia

Michael and Anne Nicholson (standing on right) at a Newcastle CMDFA event.

Let's face it. When it comes to our nearest and dearest, sometimes dedication to our professional lives is not in their best interests. How true are the reflections of long ago 'the painter's house is the one in the street that needs painting' and 'It is only the doctor's children playing in the gutter in the dirt'?

And so, with shame, it took a while before I had one of those 'strike your forehead' moments.

The Awakening

It was 2013 and I had recently ceased full time practice at Mudgee in country NSW. I was working 3 days a week at the medical centre in the nearby old gold heritage town of Gulgong. We were living there, with an excellent Iraqi doctor whom I had supervised since his arrival in Australia.

At last there was more time for us both, but things with Anne were changing. I noticed subtle problems: a lack of confidence in tasks easily performed, a loss of interest in affairs generally, a hardening of attitudes and sometimes a coolness or unusual loss of consideration towards others.

Admittedly we are all prone to similar issues if over tired, stressed or anxious. And those factors had been there, but I felt they were less now. We could, and did, do more together.

I wonder if others ponder whether it is better not to know. This is, of course, essentially selfish, as having the diagnosis is essential to making adjustments to the inevitability of life from now. Not knowing encourages a sea of doubt while the relationship deteriorates and little events are magnified with recriminations and sometimes anger.

The pressure must be unbearable on someone, to struggle with the awareness of loss of memory and a lack of awareness from those around .

Col 3:13 comes to mind. "Bear with each other whatever grievances you may have against one another. Forgive as the Lord forgave you".

> ***"Not knowing encourages a sea of doubt while the relationship deteriorates and little events are magnified with recriminations and sometimes anger."***

The Reality

A number of physical issues meant trips to Anne's GP, a 200 km round trip. It is hard in country towns to see the doctor who may live all but next door. A wider delve into the whole picture led to the psycho-geriatric diagnosis and suspicions confirmed.

The need for lifestyle change was with us. A move to retirement from active practice became inevitable, to be closer to family and plan stimulating activities where there were good supports.

The Lake Macquarie, Newcastle area fitted perfectly with excellent medical facilities, an active "University of Third Age" (Anne signed up for almost daily courses!), various church denominations and a wonderful CMDFA group, which gave us those precious three years before deterioration set in.

Anne had travelled widely prior to our move and we tended to confine ourselves to local visits, only occasionally interstate. One cherished break in Norfolk Island involved flying internationally with NZ Airlines. Losing her within the terminal half an hour before boarding was a near

disaster but she had found her way to the right gate and queue, leaving me the shaken one.

How that slow loss of ability creeps up and saps the very essence of an extremely capable person. It is then so easy to try to help by taking over, but easy too to start to resent the extra time you have to spend, to ignore one's mounting exhaustion and shorter fuse – how very human we are!

Since then life has become more confining. Car trips are a welcome change of scenery and source of remembrance. However, leaving her and the keys in the car one chilly day, well after her licence had been handed in, resulted in an escapade involving some very understanding police. When neither she nor the vehicle could not be found and whilst we were all debating the next step at our home, she swept in, innocently unaware of the concerns, and parked the vehicle perfectly well in the garage. Some activities are better retained than others. More lessons are learnt.

The illness

A million words or more must have been written about dementia in all its disparity – the academic, seeking to unravel the scientific mystery, words of condolence, comfort, compassion, of hope, sitcom laughs at benign expense. Those in the early stages or recently diagnosed have written and spoken searingly of the inevitable agony.

Now that care is beyond our capacity at home, Anne is living in a dementia unit with Covid-19 visiting restrictions.

The Dreaming

I ponder and remember.

Sometimes you seemed so far from me. I see it when you sit immobile, eyes closed yet not asleep, listening, a Mozart concerto playing perhaps, or during a Mass. It is as if you are half-way to heaven and the rest of you longs for that other half. Your face smooths, you radiate a warmth to a world that knows it not, nor is it yet for me your earthly companion.

> ***" It is as if you are half-way to heaven and the rest of you longs for that other half. "***

Just maybe then we can relate to the forlorn cry in the Song of Songs 8:13,14 'You who dwell in the gardens, let me hear your voice' and still know that you long to respond 'Come away my lover and be like a gazelle'.

Or these words come to mind as I feel I am losing you:

"Are you a mere picture?
You came to me with the first
ray of dawn.
I lost you with the last gold of evening.
Ever since I am finding you
through the dark.
No, you are no mere picture".
(Rabindranath Tagore. *Lover's Gift*. XL11)

But you know better and instead extol the words of Henri Nouwen:

"We are not what we do. We are not what we are. We are not what others think of us.

Coming Home is claiming the Truth: I am a beloved child of the loving Creator. We no longer have to beg permission from the world to exist."

Can we ever enter that inner sanctum that can no longer speak our language? At times I feel you speak without words nor need translation:

'I close my eyes as the world confuses me and I dream dreams that only heaven understands. But They ask questions, sometimes They are out to get me.

Help me – I must resist;

No! let them do their worst, it must not disturb my dream.

Surely though the colours fade, a grey haze surrounds the meaning and the memory is vanishing in the gloom for ever.

Then They are back – do this, do that, we must clean you up, here's your tea, we want to help you.

But you cannot help because I need to find my dream again and you cannot enter it – I won't let you; it is all I have got.

So please understand, this is me now.'

B O O K R E V I E W

Second Forgetting by Dr Benjamin Mast – continued from p 44

My grandmother speaks little English, thus she hasn't and will never read this book. Yet I marvel at how God endowed her with His supernatural patience and perseverance in caring for my grandfather, who once served as a former general of the Nationalist army in China reduced to frailty by Alzheimer's dementia in his later years. My grandmother undoubtedly lived with providential hope and knowledge of God's redemptive grace during the physical toil of caring for him.

I am compelled now to live in light of this hope, by remembering God's faithfulness together with my grandmother through her retelling stories of her years caring for my grandfather. I hope to be able to pass on these stories of God's faithfulness to our family one day.

In our human finiteness we tend to forget God's grace and mercy, even during the best of times. This book has served as a touchstone to "number my days" and live wisely by taking the time now to remember, both who God is and what He has done for me and my family.

Dr Eleasa Sieh

Eleasa is a Canadian-born Chinese permanent resident of Australia, and works as a general practitioner on the Sunshine Coast, Queensland. This book was one she had on her always too-long to-read list but when it showed up on a list of book recommendations as part of a Biblical counselling course, she jumped at the chance to read it and write this for *Luke's Journal*.

BOOK REVIEW

Second Forgetting by Dr Benjamin Mast

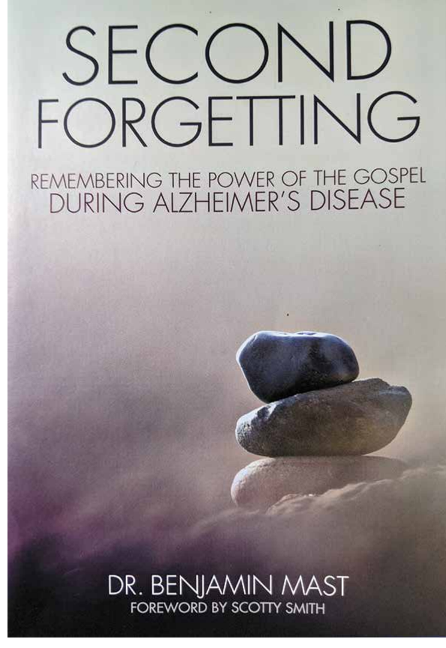
"This is a book about hope."

The opening sentence of the preface struck me. I first picked this book up out of curiosity at the meaning of its title and subtitle: "Remembering the power of the Gospel during Alzheimer's disease".

As a General Practitioner (GP) and granddaughter who watched her grandmother provide more than 10 years of care for my grandfather, who lived and eventually died with Alzheimer's dementia, the penny had never dropped on how hope played an important role in the life of someone living with dementia. Hope certainly wasn't considered when I conducted home visits on spouses and even couples living with dementia during my thus far short working experience in community geriatrics and general practice. These personal reasons made this book a pertinent read. And having done so, I heartily recommend this to anyone who is as intrigued by its title and content as I was.

> ***"[For me] the penny had never dropped on how hope played an important role in the life of someone living with dementia."***

Dr Benjamin Mast is a clinical psychologist and associate clinical professor in Geriatric Medicine at the University of Louisville, Kentucky. He has had extensive experience in clinical work and academic research with both those living with all stages of dementia, as well as their caregivers. It is also obvious that he has a clear and deep grasp of the redemptive story of God and His people, applying the Gospel to the book title's meaning and its implications for the sufferer, the carer and the local church.



The "first forgetting" is the hallmark of dementia, the predominant loss of declarative memory when a person develops one of the various types of dementia. The "second forgetting" is that of a spiritual amnesia, a temporary loss of memory of foundational Christian truths that is prevalent in people, including redeemed Christ-followers. This forgetting includes (but is not restricted to) that of God's faithfulness in the past, His presence in the midst of current trials and His promises for the future. As such, this is not just a book about dementia and caring for someone with dementia, but also "about how we respond to seemingly overwhelming situations of life and the weight of suffering".

It is no surprise that the suffering of dementia is largely silent, as functionality and declarative memory ebb away, robbed by the unrelenting disease. Dr Mast speaks the words of Scripture into this silence, giving voice to the grief and the groaning dementia causes to both its sufferers and their surrounding community.

The redemption of this groaning is seen through the lens of the Gospel, as well as the practical advice referenced from geriatric and psychiatric studies showing that emotional and procedural memory remain largely preserved in those living with dementia.

Furthermore, Dr Mast provides pastoral encouragement for caregivers in two specific chapters, as well as writing one chapter exhorting the body of Christ in how to more carefully and creatively care for the person living with dementia, their caregiver and family. There is helpful engagement with the reader through questions at the end of each chapter, addressing those who live with dementia, those who may be caring for and living with someone with dementia as well as a church member or pastoral care worker to this person.

> ***"It is Dr Mast's hope with this book to engage the sufferer and the carer with the God who never forgets, reminding both of them of this comforting truth."***

It is Dr Mast's hope with this book to engage the sufferer and the carer with the God who never forgets, reminding both of them of this comforting truth. This book is primarily addressed to the believer, who has redemptive freedom in their repentance and trust in God, for whom God's remembrance is a mercy and comfort. (On the other side of the coin and outside the scope of this book, God's remembrance is also the foundation of His justice, who because of Christ's redeeming blood shed on the cross, "remembers sins no more" as stated in Isaiah 43:25.)

to p43

CMDFA

Georgina Hoddle, RN

Georgie is a Registered Nurse, works as a NSW Health Authorised Nurse Immuniser in Aged Care. In 2010, while studying a master's degree in applied Linguistics (TESOL) at Macquarie University, Georgie received the Holy Spirit in a water baptism and has begun to age well on the shores of Port Stephens. Georgie is currently Vice-President of Nurses Christian Fellowship Australia.

BOOK REVIEW

Ageing, Disability and Spirituality

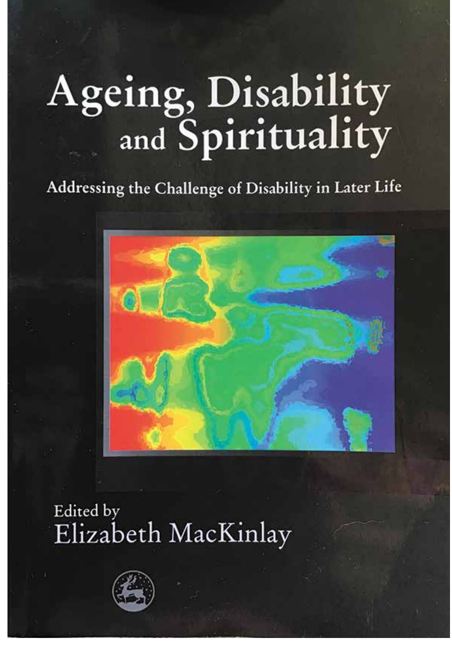
Ageing, Disability and Spirituality,
edited by Elizabeth MacKinlay, pp.7-271
Jessica Kingsley Publishers, ©2008 ISBN 978-1-84310-584-8

Through a collection of skilfully edited essays, this book illustrates how people with disabilities, whether life-long or secondary to the ageing process, can lead spiritually meaningful lives. MacKinlay's introduction to the book is ground-breaking, informative and questions our knowledge and understanding of the spiritual lives of people with disabilities.

For a book filled with so many different challenges, I struggled to find a good start to this book review. I eventually decided to start with the intriguing *Chapter 12: Bodhi, Karunā and Mettā: Buddhist perspectives for theology of pastoral care for the ageing and persons with disabilities (Ruwan Palapathwka)*. This chapter is relevant to my experience as an aged care and disability nurse. In this chapter, the author addresses issues that arise from the question **"What is holistic care for the ageing and persons with disabilities?"**. Having worked with both multi-cultural and Australian nurses who follow Buddhist philosophies and practices, I have witnessed first-hand their expression of compassion through person-centred care. Christians can establish common ground with Buddhists' beliefs and worldview by answering this question together. This will lead to better outcomes for their patients and residents in care homes. While Mahatma Gandhi said, "The way we treat the 'last person' is a measure of our humanity" (p.91), we can relate to a similar teaching with Jesus' words:

> *"I tell you the Truth, when you refused to help the least of these my brothers and sisters, you were refusing to help me."* (Matt. 25: 45b, NLT)

Next I ventured into the world of Christine Bryden in Chapter 11. Her experience of "dancing with dementia" by living optimistically with this progressive disease



touched my heart. Christine eloquently describes her journey to her inward spiritual self as dementia progressed; she was running out of time.

After that, I read *Chapter 2: Remembering the Person: Theological reflections on God, personhood and dementia*, by John Swinton of the University of Aberdeen, UK. I came across a contribution from my dear friend and long-serving colleague from Nurses Christian Fellowship Australia, Margaret Hutchison. She relayed a story of a fellow nurse whose patient, Mary, would repeatedly say "God, God, God", be pacing and displaying distressed behaviour. This situation was better understood and subsequently resolved by the nurse asking

Georgie Hoddle and author Elizabeth Mackinlay.

her an important question: "Are you afraid you will forget God?", to which Mary replied "Yes, yes!" (p.32). Swinton puts forward arguments for the personhood of people with dementia that are real and ever-present "even in the midst of the experience of severe dementia" (p.33).

In Chapter 8, Hallahan draws our attention to the fact that people with disability rarely participate "at the heart of congregational life". The perception one has of people with disabilities can create a difference in the nature of relationships one has with those who have disabilities. Hallahan introduces us to the Celtic concept "of thin places" where we are able to converge with deeper and more meaningful aspects of life (p.13). This is where she believes the marginalised live. It is a privilege for us to meet them in these "thin places" as we care for them physically and spiritually. Relationships and 'being connected' are the focal points of these chapters, and there are many more that will be of interest to not only nurses but other healthcare workers too.

As the Nursing and Midwifery Board of Australia's Standard for Practice N.1 focuses on nursing ethics, I then felt led to embrace a very difficult topic: Ethics. This is addressed in Chapters 6 and 7, by both Christopher Newell of the University of Tasmania and Rosalie Hudson from the University of Melbourne. However, such an important topic requires a *Luke's Journal* article of its own.

I recommend you source this volume and read it for yourself.

Footnote:
I bought this book at an international conference on Spirituality in Ageing, in Canberra October 2019. I heard of the work of Elizabeth MacKinlay and several other authors whose essays she edits in this volume, through my previous work as nurse educator in the field of intellectual and developmental disability.

Ageing and disability often go hand in hand, literally – we, as nurses, often ask for permission to take the hand of people who, in their fourth season of life, have acquired disability and cognitive/intellectual impairment.

CMDFA

Rev Jonathan (Jon) Phua

Jonathan is a Sydney Anglican Minister, currently working as Associate Pastor for the Evangelical Free Church of Australia (EFCA at East Lindfield). From 2016-2019, he was a Pastoral Care Coordinator (Aged Care Chaplain) for HammondCare. He is married with two children.

Pastoral Care in Aged Care Facilities

It is a privilege to spend time with people in Aged Care settings, as the interactions are often so rewarding and meaningful. When I was a Pastoral Care Coordinator (Aged Care Chaplain, from 2016-2019) for HammondCare in the residential Aged Care setting of Hammondville, there were many opportunities to serve and help residents there. Hammondville had multiple sections: independent living units (retirement village) and residential aged care, which was divided into low and high level care, and low and high level dementia-specific care.

Pastoral Care adopted a broad model of spirituality: that which gives people meaning and purpose – from where can they can gain some answers to life's questions? Religion is a subset of this as, naturally, faith in God gives people meaning and purpose. However, people who are not religious can still have other aspects of their lives that give them meaning and purpose – relationships, artistic expression, music, sports, being in natural settings, meditation.[1]

This inclusive approach allows Christians to provide care and support to any and everyone in Aged Care. It involves wanting to listen, asking interested questions, and engaging with them wherever they are in their spiritual journey. As most residents were of Anglo-Australian background, a natural question for me to ask was: 'Are you Catholic or Church of England?' These two affiliations covered over 90% of people, giving an opportunity to find out about attending Sunday School, Mass, Catholic School in the past. Sometimes people said that they were raised in church, but are not into it: not religious, not church attenders. For one man in our low level Dementia Cottage who was not religious but a past Snooker champion, this meant engaging him with Snooker videos giving him enjoyment with one of his loves, allowing him to express what made it a good part of his life.

Inclusion means including those of other faiths. I once cared for a Muslim man in his late forties, receiving palliative care in high level aged care, as there was no other under-65 facility available for him. He explained that for his faith he read the Koran on his mobile phone. When I asked him and his wife if he would like a visit from the local Imam (Muslim priest from the Mosque), they both declined, as they felt this was not his need. Pastoral care involves linking people with their faith communities if that is important to them, but may not necessarily require this.

Group Activities

A variety of group activities are vital for building friendships, relationships and a sense of belonging. Specifically, chapel services and Bible study group are essential for people's spiritual growth and relationships. Singing well-known, uplifting hymns such as *Amazing Grace*, and *Blessed Assurance* in a group is a reminder of one's faith, Christian upbringing, and reinforcement of Biblical truth. Singing lifts mood with cognitive benefits as participants make effort to stay in time and tune.[2] Hopefully, post-COVID-19 pandemic, singing of all sorts will resume in Aged Care Settings!

Large-print chapel service outlines with hymns, prayers, Bible readings and sermon messages allow people to read and follow the structures with familiar patterns, without getting lost. I print out my sermon message in full text, so people can follow on with me, and not lose concentration. Set prayers such as the Lord's Prayer, the Apostles' Creed, thanksgivings and confessions are meaningful, allowing people to continue or resume faith expressions, even if they have not been in church for years. Holy Communion gives visual, and experiential participation for believers to share in the benefits of Christ's sacrifice for our sins. The bread and cup are held up, are consumed, and each part of the service is explained.

Similarly, Bible study group has the chosen Bible passage, along with discussion questions, in large print for each participant. Discussion arises from basic comprehension and sharing of personal views, without complex exegetical debate, as might happen with young adult university Bible studies! One keen Christian lady with dementia would share her thoughts and though she was all too aware of her memory loss, she was encouraged and affirmed for her faith and wisdom, rather than scolded for any deficits.

Whole facility group activities are conducive for a whole village ethos. It was a great pleasure to be part of a Lawn Bowls group that had men and women from the different Hammondville sections: independent living, aged care and our dementia-specific cottages. Each resident was welcomed and helped to bowl regardless of skill and experience without competitive expectations! Residents enjoyed the outdoors, conversation, and company with it.

In summary, aged care ministry makes a significant difference in people's lives and is appreciated by residents, staff, and family.

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Georgina Hoddle

Georgina is a Registered Nurse with experience as clinical nurse educator in disability nursing; currently an Aged Care RN and NSW Health Authorised Nurse Immuniser. She studied General Nursing at St.Luke's Hospital (1971) and retrained at Royal North Shore Hospital (2005); Georgina studied at Macquarie University, gaining a Masters Degree in Applied Linguistics (TESOL,2011).

Hope and longer lives for Aboriginal and Torres Strait Islander people

Vaccines for a time such as this

Artwork by Esther/1721

Aboriginal and Torres Strait Islander (ATSI) people have a shorter life expectancy than the non-Indigenous Australian population.[1] We are living in very particular times. COVID-19 has brought about an awareness of the need to prevent illnesses from spreading and this year (2020) has seen uptake of the influenza vaccine at extraordinary rates. Commonwealth Public Health Orders directed all healthcare and aged care workers to have the influenza vaccine before 1st May, 2020 and recommended influenza vaccination for all "at risk" groups.

The pneumococcal vaccine schedule was also revised in 2020, as the incidence of pneumonia affecting adults between the ages of 65-70 years does not indicate that either Prevenar 13 or Pneumomax 23 are required in otherwise healthy people before the age of 70 years. An exception is where a person identifies as ATSI. In such a case, Prevenar 13 remains the first choice pneumococcal vaccine at the age of 50 years. (See *Table over page).*

It is not just a person's physical health that needs to be considered when introducing the topic of longevity[2]; there are spiritual, mental health, social and psychological needs that also need to be addressed when employing immunisation programs within the context of person-centred care. Some of these needs are acknowledged by public health departments when considering why and how to make essential vaccines available to ATSI people3-8.

Vaccination programs

Through vaccination, Australians have benefited from the elimination or substantial reduction in the rates of many vaccine-preventable diseases in recent decades. This has also substantially improved ATSI child mortality rates5. Successful vaccination programs among ATSI people have significantly reduced the incidence of diphtheria, poliomyelitis, tetanus hepatitis A and B, measles, mumps and rubella.

ATSI people have higher rates of some diseases, therefore some extra vaccines are recommended. Some vaccines indicated for non-Indigenous people may be recommended in a broader age range for Aboriginal and Torres Strait Islander people (*see table over page*).

Adult vaccine schedules

One example of a vaccine-preventable disease that has a disproportionately high burden of disease in ATSI people compared with non-Indigenous Australians is invasive pneumococcal disease. Vaccination has reduced the burden of disease caused by serotypes that are in the vaccines, but not all serotypes are included in the available vaccines. These other serotypes continue to cause disease among ATSI people.[6] Environmental factors mentioned beforehand may also contribute to increased exposure to the disease,[6-8] and untimely administration of vaccines may be another factor.[9,10]

Background

The ATSI people are a particularly vulnerable population. Since colonisation by the British and Europeans, these people have experienced very high morbidity and mortality from infectious disease epidemics with serious effects, such as smallpox (mortality rate >30%)[3], tuberculosis, annual influenza, measles (mortality rate >20%)[4], and syphilis. Lack of previous exposure[4] and high-density living in newly established settlements caused high rates of disease which, over the decades, have become associated with a higher burden of chronic disease (eg. diabetes, heart disease and chronic kidney disease). Additional factors include poorer access to water, housing and health care.[5] Some social determinants of health, such as poor standards of education, loss of control over life circumstances and lack of cultural safety[4] also contribute to their healthcare burden.

Extra vaccines recommended for Aboriginal and Torres Strait Islander adults

These are a few of the vaccines indicated for ATSI people, which are in addition to those recommended for all Australians, including those for particular medical, occupational, behavioural or other risk groups.

Vaccine	Recommendation for Aboriginal and Torres Strait Islander people
Hepatitis B	Non-vaccinated and non-immune adults
Influenza	All people aged ≥6 months – Annual vaccination
13vPCV (pneumococcal conjugate)	All adults aged ≥50 years (1 dose)
23vPPV (pneumococcal polysaccharide)	All adults aged ≥50 years – 2 doses (1 dose 12 months after the 13vPCV dose and 2nd dose at least 5 years later)

Vaccination services to ATSI people are important to the success of immunisation programs, and can be provided by:

- General Practitioners
- Aboriginal Community Controlled Health Services
- Aboriginal Medical Services
- Community Health Services
- The Royal Flying Doctor Service
- State and Territory Corrective Services

It is important to ascertain if people identify as being of Aboriginal and/or Torres Strait Islander background, in particular during presentations to urban mainstream health services. Patient information systems can be employed to record ATSI status, and preventive health services scheduled to increase opportunistic vaccination and enable patients to receive reminders.[11] These measures will help ensure increased quality of life and increase longevity[1] for this vulnerable patient group.

Improvements in coverage ensures that people receive their vaccines according to the relevant schedules.[12] ATSI status records also play a critical role in conveying changes to vaccine recommendations for these people. Culturally-appropriate service delivery and communication strategies are essential,[13] as well as the relevant Medicare items, to bring about improvements and access to health services for ATSI people.[14-16]

Providing ATSI people with preventive measures through vaccination will enable them to age well, and without the acquired disabilities procured by untreated risk factors17.

Acknowledgement

The Author acknowledges the Australian Government Immunisation Handbook (online, accessed 15 June 2020, as the source of the specific immunisation information contained in this article.)

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Image: Shutterstock

Dr Johanna Lynch

PhD MBBS FRACGP Grad Cert (Loss and Grief) FASPM – Johanna is a GP psychotherapist in Brisbane working with adults who have survived childhood trauma and neglect. She teaches medical students, GPs and mental health clinicians and completed a PhD through University of Queensland – recently turned into a book *A Whole Person Approach to Wellbeing: Building Sense of Safety.*

Sense of Safety During Covid

Abraham Maslow called humans 'safety seeking' organisms.[1] He named safety as a human meta-need. This echoes the wisdom literature of my Judeo-Christian faith as God repeatedly reminds us not to fear and draws attention to Himself as refuge, rock and hiding place. His promise to be our covering, a shield, and rampart, to bring peace in the midst of life's journey is a promise that not all people know.

I have felt called to translate my personal revelation of deep spiritual safety, in belonging to Jesus, into a wider invitation to our community. This has been a long journey that has been enacted in my own heart, clinical work, mentoring, and now my life as clinician-researcher!

As an Australian GP I shifted my practice to offer the first principle of trauma-informed care: Stabilisation[2] and found myself asking new questions – such as 'did you have anywhere in your childhood where you felt safe?' The answers to these questions led me to new understandings of vague and confusing somatic complaints; life stories that spoke of relational invasion, disconnection or confusion; the impact of finances and living conditions; as well as complicated patterns of physiological arousal and the addictive and obsessive ways that people defend against being overwhelmed. Safety became a priority of my care.

Canadian consultant liaison psychiatrists note: "Feeling secure in a frightening circumstance is often perceived as a more urgent goal than remaining healthy over a longer time".[3] The realisation of the potential physiological impacts of not feeling safe and its fundamental importance to healthcare[4] underpinned my doctoral research: *Sense of Safety: A whole person approach to distress.*[5] The wisdom culture of Aboriginal understanding, of the integrated whole in their concept of Social and Emotional Wellbeing, was also a lovely alignment. Along the way I also discovered the word *safe* derives from the Proto-Indo-European base word *solwos*, meaning "whole". So, I saw my doctoral research as a revelation, a sacred entrustment, a way to enfranchise whole person dignity and spiritual meaning-making as part of health, a way to describe key goals of healing.[1]

One night early in March 2020, I woke in the night with a desire to make my PhD useful to those who were facing the risks of COVID-19 in their day to day work. I integrated two key themes of my PhD research – *Whole Person Domains* (*the circles in the image over page*) with *Sense of Safety Dynamics* – the processes that build, protect and reveal a sense of safety, tailoring questions for this pandemic time. This image is shared with the consent of Routledge my book publisher – feel free to share these questions with others.

They prompt a direction of travel towards safety. They can prompt us to search for answers, new directions of growth, current resources, or new sources of help.

Perhaps we can emerge from this time of COVID-19 with new-found strengths, connections, and meaning: our whole person grounded in refuge with the One who offers us both comfort and courage. In a way this time of plague calls us to return to some of the deep truths about who we are and how we know our God… The One who the Psalmist reminds: "*He will cover you with his feathers, and under his wings you will find refuge; his faithfulness will be your shield and rampart*." Psalm 91:4

References

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2. Kezelman, C. and P. Stavropoulos, *Practice Guidelines for Treatment of Complex Trauma*. 2019, Sydney: Blue Knot Foundation
3. Maunder, R.G. and J.J. Hunter, *Can patients be 'attached'to healthcare providers? An observational study to measure attachment phenomena in patient–provider relationships*. BMJ open, 2016. 6(5): p. e011068.
4. Lynch, J.M. and A.L. Kirkengen, *Biology and Experience intertwined: trauma, neglect and physical health., in Humanising Mental Health Care in Australia: A Guide to Trauma-informed Approaches*, R. Benjamin, J. Haliburn, and S. King, Editors. 2019, CRC Press Taylor and Francis Group, Routledge: Sydney.
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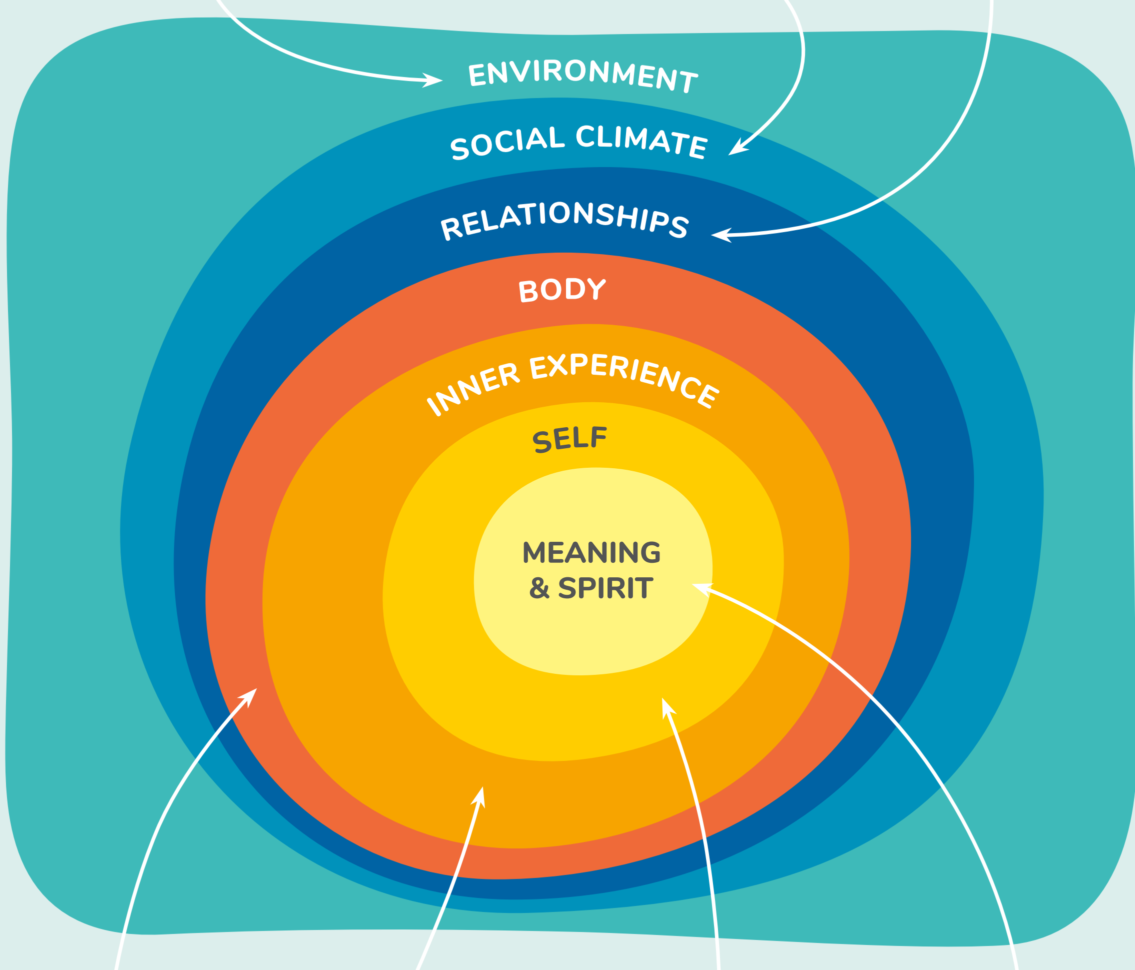
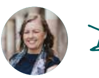
Sense of Safety During Covid





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This model of self-care is the outcome of a transdisciplinary project that integrates attachment, trauma-informed, psychophysiology and stress research in the context of whole person approaches to distress in primary care.

More on the sense of safety framework can be found in ***A Whole Person Approach to Wellbeing: Building Sense of Safety*** (2020 Routledge).

Lynch, J.M., Sense of Safety: a whole person approach to distress, in Primary Care Clinical Unit. 2019, University of Queensland: Brisbane. © Copyright 2020 Dr Johanna Lynch.

CMDFA Ethics Management Team
Any thoughts or comments can be directed to Kuruvilla George (KG)
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DISCUSSION PAPER

Discussion Paper on Moral Injury – CMDFA Ethics Management Team (EMT)

Moral injury has been defined as the *"ethical unease or disquiet resulting from a situation where a clinician believes they have contributed to avoidable patient or community harm through their involvement in an action, inaction, or decision that conflicts with their own values."*[1]

Moral distress is found to correlate with burnout, consideration or intention to leave a position or workplace and non-alignment with workplace ethical climate. Nurses score significantly higher on moral distress measures than doctors. The EMT is aware that the subject is always pertinent for Christian healthcare professionals, for example in the context of progressive legalization of abortion and euthanasia, but that it has greater significance at the moment because of the COVID-19 crisis. This is particularly the case in places where hard decisions are having to be made in a context of overwhelming need and allocation of finite health resources.

The EMT proposes to investigate Moral Injury as its initial project. A sub-committee has been appointed with this in view, to undertake the work and provide further reports. We would like to introduce the topic to our members and nurses to facilitate discussion and mutual support. Sometimes just a simple understanding of the issue can be helpful for coping. Moral injury has frequently been categorised as post-traumatic stress disorder, and this has not been helpful for dealing with it.

Moral injury is an event that violates deeply held moral beliefs or values. It can cause a profound psychological distress that results from actions, or lack of them, which deeply impacts one's moral code.[2] It may be something I have done, deeply personal and not necessarily known to any person other than myself. It may be something

I have done that involves others, even without them ever knowing. It may be something that has been done to me or I have witnessed done to others. It may be something that I have been compelled or obliged to do by others with the power to enforce it, or because they did not support me as they ought. It may at times simply be the failure or inability to give good bedside care. It is more than "just" a traumatic event. It is also something more than "just" guilt although this may be involved. Even when the event involves no actual physical describable trauma, it is still a violation and it needs to be recognised as such, as part of recovery.

Recognising/acknowledging the reality/truth of what happened, that it was more than just a traumatic or tragic event, that it ran in opposition to deeply held morals, that it was the result of a deliberate, non-accidental, course of action that was in conflict with those morals – even if it seemed there was no other course of action when it might have been the lesser of two evils – still requires defining for recovery to occur.

In view of the serious consequences of moral distress on the healthcare professional, it is important that it is addressed and support accessed. While it is not always possible to eliminate all situations that cause moral distress, there are ways to mitigate their impact. The EMT would like to help CMDFA members to understand moral distress and provide guidance to those who experience it.

Further reading:

Canadian Medical Association COVID-19 and moral distress
https://www.cma.ca/sites/default/files/pdf/Moral-Distress-E.pdf

Concerns raised about COVID-19 and moral distress
https://www.bioedge.org/bioethics/concerns-raised-about-covid-19-and-moral-distress/13482

COVID-19 patients need not die alone
https://www.bioedge.org/bioethics/covid-19-patients-need-not-die-alone/13483

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References

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2. Williamson, V., Murphy, D., & Greemberg, N. (2020). COVID-19 and experiences of moral injury in front-line key workers. Occupational medicine (Oxford, England), 70(5), 317-319. doi:10.1093/occmed/kqaa052

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I realised that God has not 'sent' me to work but in fact delights in co-labouring with me in the privileged path that each nursing shift provides me.

I am learning (and teaching) how to infuse my Christian faith into my workplace and can honestly say I am loving the opportunities this has brought to my journey. For me taking my faith to work is now second nature and I am so grateful for how gentle yet powerful is His presence through me."

- Gabrielle Macaulay

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