FOCUS MAGAZINE

WWW.CANADIANSFORCONSCIENCE.CA

Please direct your colleagues, family, friends and Church community to use the website to urge decision makers to protect conscience rights. The website now has over 25,000 people registered on it. The website is part of our overall conscience advocacy with the Coalition for HealthCARE and Conscience.

We have produced a series of resources for you to share with your Church community. Go to www.cmdscanada.org/PAS.aspx and download our newest resources, including a sample pulpit presentation, bulletin inserts, and a fact sheet on euthanasia and assisted suicide.

CMDS ON SOCIAL MEDIA

Our social media accounts have been busy with all the latest news on conscience rights. We’ve also been keeping our followers up to date with all the latest news articles relating to conscience protection and sharing messages of hope and faith.

www.facebook.com/CMDSCanada

WWW.CMDSCANADA.ORG

We launched our brand new website this year. It is sleek, user friendly, and allows members to log in to update their information with us. If you don’t have your password or user ID, simply contact us at office@cmdscanada.org

MONTHLY NEWSLETTER

We also launched a new monthly email newsletter to keep our members up to date on current events, student opportunities, and upcoming CMDS events like our student retreats, national conference, and local speaking engagements.

CALL FOR SUBMISSIONS

We are currently accepting submissions for our blog. Let us know what issues are affecting you as a medical professional or medical student. Contact Stephanie Potter at sjpotter@cmdscanada.org for more information.

GUEST EDITOR
Margaret Cottle, Vancouver, BC

EDITOR-IN-CHIEF
Larry Worthen, Dartmouth, NS

EDITORIAL ASSISTANT
Stephanie Potter, Dartmouth, NS

FOCUS MAGAZINE IS PUBLISHED BY
Christian Medical and Dental Society of Canada
9A-1000 Windmill Road
Dartmouth, NS B3B 1L7
Tel: 902.406.2955
Toll-free: 1.888.256.8653
Fax: 902.407.5313
Email: lworthen@cmdscanada.org
www.cmdscanada.org

PRODUCTION AND DESIGN
Megan Kamei, Winnipeg, MB

FOCUS is published three times per year. It is a national forum for students and graduates of medicine and dentistry to discuss topics related to the integration of Christian faith and practice across Canada. Contributions are welcome and should be directed to the Editor in chief (address above). We encourage readers to submit articles of personal or professional interest as well as those related to CMDS Canada activities at home and around the world. Subscriptions are available for $20/year. (Membership in CMDS Canada includes a subscription to FOCUS magazine)

Publications Mail Agreement
No. 40012641

ISSN 0925-8321 FOCUS (Steinbach, Print)

Return undeliverable mail to:
Christian Medical and Dental Society of Canada
9A-1000 Windmill Road
Dartmouth, NS B3B 1L7
Email: sjpotter@cmdscanada.org

FOCUS articles reflect the beliefs and opinions of the authors and do not necessarily reflect the official positions of CMDS Canada
Tell all the truth but tell it slant —
Success in Circuit lies
Too bright for our infirm Delight
The Truth’s superb surprise
As Lightning to the Children eased
With explanation kind
The Truth must dazzle gradually
Or every man be blind —
—Emily Dickinson.

Original copy reproduced with permission of Amherst College Archives and Special Collections.

As Emily Dickinson reminds us in her poem *Tell all the truth but tell it slant*, subtle, unexpected ways may communicate truth most effectively. Jesus taught by using stories and parables that engaged his listeners’ imaginations and elicited “Truth’s superb surprise.” Today, as his ambassadors, we encounter a cultural context that includes legal euthanasia, where killing is viewed as “compassionate” and death is seen as a “solution.” This is not only a grievous societal tragedy, but demonstrates a total failure to find creative, loving ways to address the complex issue of human suffering. Palliative care, the focus of this issue, was established as a result of Dr. Cicely Saunders’ Christian calling to work to alleviate every aspect of suffering for patients at the end of life and their loved ones. Following her example, can we help our colleagues, our church families and our fellow citizens to catch the vision that caring is a much greater adventure than killing? Perhaps we can heed Emily Dickinson’s advice and learn how to express these deep truths in artistic ways—to “tell it slant.”

Please join me in thanking our other volunteer authors for this issue. Dr. Michelle Korvemaker provides an excellent account of how she incorporates palliative care into her practice of family medicine. I hope that many will be inspired to follow her example. Dr. Anna Voeuk shares her unique experiences as part of the L’Arche community, with a special focus on palliative care in that setting. Our horizons will certainly be broadened by what Anna and the L’Arche community have to teach us. Dr. John Scott not only gives us a brief history of the development of palliative care in Canada, he beautifully articulates the sorrow and pain that we experience as *lament*, not only at the end of life, but also in light of the culture of death that is surrounding and threatening us all. May his exhortations and encouragement help us to lean into suffering and lament. It is interesting to note that all four of us who have written for this issue have identified the fundamental importance of accompaniment or presence, to “watch with” those who suffer, to be radically present. We also appreciate the dialogue between Dr. John Patrick and Dr. Dan Reilly on the Christian approach to suffering—they always leave us with much to contemplate. My own adventure into an artistic exploration of important issues can be found in the poetry published later in this issue.

These are difficult times for all of us in medicine, but especially for anyone involved in palliative care at any level. Those who have spent decades tirelessly working to improve the care we give to patients who are dying and to their loved ones, are facing devastating disappointment. For years we have been reassuring anyone who would listen that proper palliative care follows the World Health Organization definition and scope of treatment and seeks neither to hasten nor postpone natural death. All this has come crashing down, and health care workers and facilities are being bullied into being complicit with these practices. In time, we may have to relinquish the term “palliative care” if it becomes too contaminated by association with hastening the death of patients, but the Lord will never abandon us. He will always provide a way for us to follow him with integrity as we care for those he sends to us. Our mandate is to put on the full armour of God (Ephesians 6) and to continue to care for those who need our expertise and our presence at the end of life. Isaiah 43:19 (ESV) is very encouraging: “Behold, I am doing a new thing; now it springs forth, do you not perceive it? I will make a way in the wilderness and rivers in the desert.” May it be so, Lord Jesus! We thank you for helping us to find *your* way through this wilderness and for providing the unexpected abundance of rivers in this desert.

In conclusion, please consider seriously how you, too, can share your heart with others. A good beginning would be to tell your own remarkable stories with all their complexity and pain—just as the other authors in this issue of FOCUS have done so well. You also have other creative gifts—please do not think of them as small or insignificant, but offer them in his service and see where his breath of inspiration will lead! Paint a picture, write a song, tell a story, share a photo, build something beautiful and useful, knit something comforting, cook something sustaining, send a letter, write a poem or a prayer—however the Lord directs. We must keep speaking the truth in love at every opportunity the Lord provides, including presentations and teaching and media appearances, but let us also be open to how the Lord might inspire our creative efforts to “tell all the truth” in ways that “dazzle gradually” and communicate creatively. Our world is aching to hear his voice.
CONTRIBUTORS

Margaret Cottle is a Palliative Care physician in greater Vancouver, BC, working in Home Hospice Programs, and is a clinical assistant professor at the University of BC medical school. She speaks internationally about end of life issues and palliative care, and addressed members of the Canadian Parliament in 2006. Dr. Cottle serves on the boards for the Euthanasia Prevention Coalition and the Christian Advocacy Society of Greater Vancouver. Dr. Cottle and her husband, Dr. Robin Cottle, an ophthalmologist, sponsor the UBC student chapter of the Christian Medical and Dental Society of Canada, hosting the students weekly for dinner and discussions. Cara, their black Labrador retriever, accompanies Dr. Cottle on some of her home hospice visits.

Malcolm Guite is an English poet, singer-songwriter, Anglican priest, and academic. His research interests include the intersection of religion and the arts, and the examination of the works of Tolkein, Lewis and British Poets. He is currently a Bye-Fellow and Chaplain of Girton College, Cambridge and associate chaplain of St. Edward King and Martyr in Cambridge. On several occasions, he has taught as visiting faculty at several colleges and universities in England and North America.

Dan Hardock is the Associate Staff person at the University of Calgary serving that campus in two stints, 1998-2007, and currently since 2014. Dan has served in a variety of capacities with CMDS and worked as a professor for 16 years at a local theological college. He is married to Christin (MD) and together they have four children. Dan has recently been appointed as board member of CanMedSend.

Michelle Korvemaker lives in Woodstock, ON and works in the emergency department and in palliative care. She also does rural family medicine locums and emergency shifts in Wingham, ON.

John Patrick retired from the University of Ottawa in 2002. He now lectures throughout the world on moral issues in medicine and culture, and the integration of faith and science. John is the president of Augustine College in Ottawa. He is married to Sally, and resides part time in Ottawa, and part time on the farm.

Dan Reilly practices and teaches OB/GYN in small town Ontario and teaches ethics at McMaster University. Dan is a Past President of the CMDS Canada National Board, and provides leadership on many levels, including the annual Student Leadership Conference and the Eastern Student Retreat.

In 1975 John Scott assisted Dr. Balfour Mount in developing Canada’s first palliative care program at McGill University, Montreal. Trained in medicine, theology and clinical epidemiology, Dr. Scott was recruited to Ottawa in 1988 to establish Canada’s first university Division of Palliative Medicine. Presently, he is a staff physician in Palliative Care at The Ottawa Hospital and Associate Professor, Division of Palliative Medicine, University of Ottawa.

Anna Voek practiced as a rural family physician prior to completing a fellowship in palliative care medicine. She currently works as a palliative care physician in the Edmonton Zone Palliative Care Program. She is currently a member of the Board of Directors of the Canadian Society of Palliative Care Physicians and is also a member of the Board of Directors of L’Arche Edmonton. Her interests also include international and global health, with a particular interest in disaster responses.
I was a stranger and you invited me in. I was sick and you looked after me. Whatever you did for one of the least of these brothers and sisters of mine, you did for me.
Matthew 25: 35-36, 40
Associate Staff Update
University of Calgary

DAN HARDOCK

As one would expect, lots of activity is happening as the Medical School at the University of Calgary continues to push the boundaries of exhaustion and fatigue by starting its first year program at the beginning of August. The second year students (including our Leadership group) did not start until the third week of August so there were no CMDS regular activities for the first three weeks of the first year’s year. Confused? Hey – it wouldn’t be Calgary is something weird wasn’t happening!

Despite the disjointed start we have a strong and committed group who usually number 12 – 15 students each Thursday between 12:30 – 1:30 pm. If you include all students who would darken our door on a once a month or more basis the group is probably has around 20 regulars.

Despite the fact that meetings at the school started earlier our official kick off barbeque at Drs. David & Andrea Loewen’s was in the third week of August and was very well attended, probably attracting around 40 students, residents and local members. If you throw in kids, it probably numbered around three billion. The U of C program continues to attract a lot of families and this year alone we have seen two births and two marriages among our students.

September saw our first meeting that the entire school was invited to called “Meet the Docs” or colloquially called “Speed dating.” This year we used a panel format and eight CMDS docs were peppered with any question the students wanted to ask about life the universe and everything. I ended up getting an enthusiastic hug from one of the panelists who recognized me as her staff person from the mid-2000s. We had lost contact many years ago.

September also saw the first of our Noon Hour Speaking Series where the group invited CMDS docs to come and talk about some of their experiences. I will let Dr. Loewen who is the chief organizer describe this:

I wanted to share with the main office a new initiative we have started at the U of C this year. It is a lunch lecture series with the intent of highlighting the excellent health care our CMDS members are doing, and all students/staff of the med school are invited. The intent is to illustrate how people of faith do great health care and that having a faith and practicing medicine are not incompatible, and in a format that invites others into discussion with us. Kinda like tent making at the med school. We started today with Dr. Bill Bieber, who has done terrific work with his wife Sharon with Medical Ambassadors International developing Community Health Empowerment throughout south east Asia. It was an answer to prayer when one of the students attending (who happens to be on the exec of the med student global health club) stated she was amazed at the work that Bill was doing and wondered how he was able to do this respecting other people’s beliefs (she had declared herself an «atheist»). This was the exact sort of thing we had been hoping for!

Looking to the future we will be having more noon hour talks as well as a Missions Night in late October.

AN AREA OF CONCERN

One area of concern that has come up is that many of our student members are beginning to feel like they are under ethical siege. This does not come from the administration or the teaching faculty (who are quite supportive of our members’ ethical positions and their right to hold them) but their fellow students. There is a distinct stripe of intolerance that has appeared in the student body for anyone who would question issues of conscience. This appears primarily in the context of small groups but it is unclear as to whether it is going to remain there or start to appear in other settings. The hard line positions often taken in these discussions appear to be very un-reflected with little understanding that they undermine the very rights and freedoms that the critics enjoy. Because these discussions have happened with a great deal of passion I have recommended to the students that they get to know their ethical stuff and rather than try to argue their position start to ask questions that will reveal the weakness of the secular position. We will see how this plays out.
Love’s Welcome

MARGARET COTTLE

The thief comes only to steal and kill and destroy;
I have come that they may have life, and have it to the full.
John 10:10

No crowbar, knife or stealthy midnight raid
But welcomed guest, this thief, this Trojan horse.
False-gilded words, illusion, overlaid
On death, despair, depression and remorse.

“Just make your choice,” Fear croons, “and Death will free
You from your useless life – you have control!
No one need glimpse beneath your dignity,
Your loneliness, your hopeless, aching soul.”

But Love says, “Come! Stay close beneath My wings
Where darkness, sorrow, pain and weeping cease.
My Life poured out in all its fullness rings
Death’s knell and Comfort’s carillon of peace.”

O Mystery of Presence in our fear
Emmanuel, our true home, ever-near.

For a week in July 2016, I was privileged to study at Regent College with Dr. Malcolm Guite, a British poet and musician, an ordained Anglican chaplain at Girton College in Cambridge, England, and an excellent scholar. His spiritual biography of Samuel Taylor Coleridge is scheduled for publication in 2017. Dr. Guite has very generously allowed us to reprint his beautiful poem, “Descent” (see page 22) Please visit the excellent website which includes recordings of Dr. Guite’s music and poetry. https://malcolmguite.wordpress.com. In his course, “Parable and Paradox,” and we spent three hours each morning examining Jesus’ teachings through a poetic lens. My soul was fed in profound ways through Dr. Guite’s poetry and his insights into both scripture and our human condition. Part of our assignment for the course was to write our own poetry. Although a daunting task, I was inspired to try. Was there a way that poetry could reach hearts and minds unmoved by even the most eloquent, reasoned, evidence-based presentations? Might there be a poetic way to impart the richness we experience as we care for one another and as we allow the Lord and others to care for us? Could a poem expose the complete emptiness of the promises of autonomy and choice?

Our poetry was to be inspired by a passage of Scripture from the life and teachings of Jesus. At least one of the poems was to be a sonnet with the specific structural requirements that pertain to that poetic form. In brief, sonnets are written in iambic pentameter, a rhythm that mimics the human heartbeat. They contain 14 lines which are traditionally divided into two sections with the first 8 lines setting up the poem’s tension before the volta (turn) and the final 6 lines resolving the poem’s dilemma. In “Love’s Welcome,” I use John 10:10 as the foundation verse and try to communicate my distress that the illusion of “dignity” and the false promises of “choice” are robbing many of the true joy of love and belonging. The “Emmaus Triptych” was inspired by the encounter on the road to Emmaus recorded in Luke 24:13-35. I was struck by the many times in our lives when we are in the same position as those two people—in despair and thinking “we had hoped...” about our situation—completely unaware of the beautiful irony that Jesus himself is walking right beside us, eager to impart his wisdom and peace through the Holy Spirit. And for those who were living during Jesus’ earthly life, how they would have had their hopes raised and dashed over and over again! Reading the account, we share the joy of Jesus’ followers as they finally realize that the truth is so much more than anything they could have imagined. Jesus is with us, and that we, corporately, as his broken body can experience his presence and make him known in ways that lift him up, draw others to him, and are deeply satisfying for us as well.
Palliative Care in Primary Care Settings
MICHELLE KORVEMAKER

He lay on the bed, appearing to sleep comfortably. At times he had a racking cough but then he would settle again into a quiet tachypnea. When I took his hand, he roused, turned his head and gave me a weak smile and said, “I always liked you.” Then he closed his eyes and seemed to focus on breathing but kept my hand in his, though his grip was weak. One week earlier, I had seen him in the Emergency Department for urinary retention and he had needed an indwelling urinary catheter. He had told me good-bye that day because he seemed to think the catheter signified imminent death.

She sat in the chair with a non-rebreather mask on her face to receive the maximum amount of oxygen possible without using more invasive airway management. She had received strong antibiotics to attempt curative treatment but it had become apparent that her body was simply tiring out from her end stage COPD. On this day, she told me that she was done with interventions and said she was going to die that day. I told her I wasn’t sure about that but I assured her that we would help her to be comfortable. I ensured she had all the medications she would need on a regular and as needed basis to achieve comfort. She said goodbye to her family. She was gone the next morning.

“I don’t want to get addicted,” she said, as we discussed management of her pain. Her breast cancer had metastasized to her bones and her face was furrowed, wordlessly expressing her discomfort. She finally agreed to try hydromorphone at a small, regular dose as well as have that same dose for breakthrough pain every hour as needed. When I visited with her a few days later, it was gratifying to see her in a more relaxed position and her frowns replaced with smiles. Her palliative performance scale had improved dramatically just with controlling her pain. She would be able to continue living in her own home for many months to come.

The preceding vignettes describe some of my experiences in caring for people while providing palliative care. I am sure many family physicians and specialists can provide similar stories from their own practices.

I was primed to be involved in palliative care even before I entered medical school. My sister-in-law, Betty Ann, was a palliative care nurse and she had told me many stories about her work. I planned to have palliative care be part of my practice of medicine. I was able to do an elective in palliative care during my last year of medical school as well as during the second year of my family medicine residency. I did a post graduate year 3 called “Enhanced Skills in Rural Medicine” in which I had another 2 months of training in palliative care based on a palliative care floor in a city hospital. I was given a lot of autonomy and I had a great experience with the patients by applying all that I had learned and was learning about palliative care.

Now, over 10 years later, palliative care is regularly part of my practice of medicine. I am part of a local palliative care call group in Woodstock, ON, which covers community, hospice, and hospital inpatients. I also work part time in Emergency Rooms and I do locums in rural family medicine. I find that I am able to apply palliative care at some point in my daily work in whatever environment I may be at the time.
In Woodstock, we have a ten-bed hospice called Sakura House. We have five doctors who are part of the local palliative care team. All of us have family medicine training. We each take one week of call such that on weekdays, we are on call overnight from 6pm till 8am and on weekends, we are on call from Friday at 6pm till Monday at 8am. Family physicians in our community are being encouraged to be the primary provider of palliative care for their patients and to use the more focused palliative care physicians as consultants.

I am thankful for the opportunities to practice palliative medicine. It is rewarding to be able to sit and chat with the patients and hear their stories when they are still able to share them. It is a welcome change of pace compared to the Emergency room environment. It is also satisfying, and a challenge at times, to figure out what we need to do in order to get someone’s pain and symptoms controlled. It has always been my delight as a physician to be able to see the positive effect of a treatment on a patient. When someone is gasping for air and we are able to use various modalities to help them to be more comfortable, I am thankful to be part of that relief. It gives me a deep sense of accomplishment to see the person who is nearing their death resting comfortably in their bed with no appearance of distress in their body movements or facial expressions. I also enjoy being able to tell someone who is now receiving solely palliative care that they no longer need to worry about their caloric intake. They can eat when and as much as they want. Most of the time, they are no longer that interested in food and their appetite has waned secondary to their disease, but to allow them to have pleasure and control in some way, is gratifying. There are tough discussions at times to help patients and family members understand the reasoning behind food, or lack of it, as well as the reasoning behind which treatments do and don’t make sense in their current stage of illness. There are often many myths about palliative care and end of life care, which need to be addressed. There is also a satisfaction in being able to explain the situation to families and to give comfort when it is sought and welcomed.

There are rare times when we do need to use palliative sedation but my intent is always to relieve suffering. I am concerned that palliative sedation is being given a bad reputation in the current conversations about physician assisted suicide and euthanasia (ie Medical Assistance in Dying or MAiD). In my experience, I use palliative sedation when there is no other option for controlling someone’s pain other than to help them sleep. Also, I use it when the patient’s palliative performance scale has deteriorated to the point that although they are mostly comatose, at times they may get quite agitated, causing severe distress to their loved ones at the bedside. In some ways, palliative sedation in this setting can be likened to when we give medications like atropine or glycopyrrolate to dry up retained upper airway secretions because the gurgling is distressing to the family. The patients may not be aware of what is happening, but we are also striving to help their families to be in comfort as they “watch with them.” It is also important for family members to have peaceful memories of the hours and moments at the time of the death of their loved one.

In the Emergency Department, I have to manage pain regularly, as well as nausea and constipation and many of the other symptoms that are treated in palliative care. Often patients arrive for whom I can use curative treatment as well as palliative measures and there are those who clearly need palliative care only. It is a delicate situation when I have conversations with patients and their families about end of life planning which would have been better conducted in a family physician’s office or in the oncologist’s office prior to the crisis which has brought them into the emergency department. I am grateful for the training that I have received in this area as it makes these difficult situations easier to manage.

There are many opportunities for obtaining training in palliative care as a practicing physician. There is a course offered by Pallium Canada called LEAP - Learning Essential Approaches to Palliative and End of Life Care. The website for Pallium Canada is www.pallium.ca. There are also links to YouTube videos to help teach people about palliative care and help in broaching the topic of end of life care planning. The virtual hospice is also a great Canadian resource for lay people as well as health care professionals. The website for the virtual hospice is http://www.virtualhospice.ca.

There is a conference held in Montreal every two years called “The International Congress on Palliative Care” which is also an excellent opportunity to obtain palliative care education. The Clinical Master Class aimed at physicians, which is held on the first day of the Congress, has been a great help to my practice. The website for the congress is http://www.palliativemcare.ca. Every year, the Canadian Society of Palliative Care Physicians holds an annual conference called “Advanced Learning in Palliative Medicine.” You can find more information at their website http://www.cspcp.ca/.

Finally, universities which have strong palliative care medicine groups will also often present courses. For example, McMaster University offers a course called “3 days in Palliative Care.” There is also a hospice in Victoria, BC which offers a course at least once a year. Their website is the following; http://www.victoriahospice.org/courses/palliative-care-medical-intensive-course

Primary care is the optimal place for palliative care to be offered. Every family physician could (and, I would argue, should) have training in palliative care during their residency and be able to offer it to their patients. I have also noted many opportunities to obtain training once someone is in practice. Palliative care is part of caring for people across the age spectrum from birth to death. As Christian physicians, excellent palliative care is part of our calling. This is especially true now when we can provide a better way to deal with end of life care than to choose physician assisted suicide or euthanasia. I have enjoyed the opportunities to provide palliative care in my practice of medicine. I hope that others will be encouraged to consider adding or maintaining palliative care in their practice of medicine so that we can improve access to palliative care across Canada and provide a more hopeful approach to end of life.
Lamentation and the Roots of Palliative Care

JOHN SCOTT

My God, my God, why have you forsaken me?
Why are you so far from saving me, so far from the words of my groaning?
O my God I cry out by day but you do not answer. –Psalm 22

At the centre of the passion narrative stands a lament. Quoting Psalm 22, our Lord is fully participating in our humanity and our death, but also fulfilling the scriptures in a surprising way. The Lord hears the cry of the poor, but even more deeply He takes that cry unto His own lips. He suffers with us and for us. God’s lamentation is a critical element in the Gospel story.

HISTORY

As Christian physicians, we stand at the bedside of dying patients who struggle to find meaning in their suffering. We watch as our culture mindlessly throws itself headlong over the cliff of euthanasia. We too experience lamentation. Why, Lord?! As we offer palliative care to our patients, we participate in a deep mystery, moving us beyond our lament into a place of trust and praise. From Pentecost onwards, all palliative care, by whatever name, is the outpouring of the Lord’s love and mercy for those who anguish, physically or spiritually, with impending death. The Lord hears and responds to lamentation.

Prior to modern palliative care, there have been many precursors, intentional Christian ministries designed to care for those close to death: the early monastic pilgrim hospices, the early hospitals of Byzantium, Rome and medieval Europe, up to the ‘homes for incurables’ founded by protestants in the nineteenth century. The Church has always felt drawn, compelled by love, to care for Christ in disguise in the dying person. We recognize the bedside of the dying to be a holy place where the veil between this life and the eternal can be very thin.

The modern story of this field is rooted in the life of Cicely Saunders (1918-2005), a remarkable Christian woman trained in nursing, social work and finally in medicine. Dame Cicely began to sense the Lord’s call on her life in the 1940s, a call to address the needs of those for whom medicine believed they had nothing more to offer. Her rich biography1 demonstrates her trust and perseverance until the traditional neglect of terminal care was exposed and her new vision of ‘hospice care’ was demonstrated and acclaimed throughout the world. When she opened St. Christopher’s Hospice, near London, in 1967, she had recruited 3 senior Christian physicians – 2 evangelicals, Mary Baines and Tom West, and a Canadian-raised Catholic, Therese Vanier. Dr. Saunders appointed a Christian Matron (Director of Nursing) and many other staff who shared her vision of a Christian non-denominational foundation. Almost all the early UK hospices that followed were motivated by Christian mission and led by Christian physicians.

The transition from the hospice model to international palliative medicine was largely the result of Dr. Balfour Mount at McGill University,

Montreal, who was the first to coin the term ‘palliative care.’ Dr. Mount was an active Christian, as were the physicians who assisted him in the early years of the palliative care unit (Ina Cummings, Ken McKinnon and John Scott). From its origins, hospice and palliative care was consciously a Christian mission field. From the 1960s, the pioneers recognized, prayed and spoke out against the looming threat of euthanasia and saw this work as a way to demonstrate a Christian alternative.

Unlike the early UK hospices, the Canadian model consciously chose to imbed its work within mainstream medicine and its medical schools. In the 1970s and 1980s this led to an explosion of literature and global expansion of services. However, the secularism necessitated by this model left it vulnerable to losing its spiritual focus and vulnerable to having its vocabulary and services hijacked by pro-euthanasia forces. In facing the recent changes in Canadian palliative care, Christian physicians are invited to return to our roots – to return to the bedside.

**LAMENTATION**

At the bedside, we come face to face with a patient who cries out, “I wish I would die. Let me die. Help me to die.” In the midst of the “MAiD” disaster, there has been widespread failure to appreciate the role and function of lamentation in human experience and clinical practice.

Every socioeconomic group and all cultures of the ancient and modern world share the common phenomenon of lamentation. The lament is both an individual and a communal response to pain and death. It is both a literary motif and a psychological pattern. It is often triggered by varied forms of suffering: physical pain, impending death, bereavement, military defeat, broken relationships, humiliation. A passionate expression of total pain. A cry of the spirit. It issues forth with tears and urgent emotion, depending on cultural restrictions. The traditional lament begins as a repetitive description of the sources of suffering, including wounds of the past—unfulfilled dreams and relationships, regrets and guilt—and continues into the present—physical pain, loss of function and role—and anticipates the future—impending death, family’s future distress. This cry of fear and anger and despair may be addressed to God or family or doctor, but often it is simply a diffuse moan. This is powerful communication, but it is not neatly packaged, rational information that might be useful in decision making and negotiation with professionals. This is the verbal and emotional outpouring of an inner conflict. As we listen more deeply, we hear within the lament a compelling plea that begs for help, for relationship, for deliverance. Lament is not a single event but a process—a journey of searching for meaning in the midst of suffering. It is a cry that begs us to come closer, to engage, to share.

The Hebraic pattern of lamentation is seen in the book of Job and in one-third of the Psalter. Each passage begins in lament but gradually works through pain to a place of hope, reconciliation and peace. The lament commonly includes a cry for death, which may be expressed in many ways - “I would be better off dead,” “I wish I were dead,” “I can’t go on,” “Let me die,” “Help me to die.”

Lamentation may also be expressed less directly. The social demand to control emotion in Western cultures often leads to hidden forms of nonverbal or symbolic lament, such as withdrawal, increased physical pain or vomiting, dreams, exaggerated anger or grief. The MAiD debate and its philosophy of radical autonomy has re-shaped the traditional lament in Canada. When a patient requests hastened death using the cold rational vocabulary of law and human rights, we must listen deeply to hear the hidden lament inside. Very often, under several layers, is helplessness and hopelessness. The loss of control and loss of hope imposed by disease, disability and impending death is overwhelming, driving some to seek hastened death as a false form of control, not unlike the dynamics behind any suicide. But, if the emotional side of this struggle remains hidden to the observer or even to the sufferer, the lament may be missed. If the patient has given up all hope, she may not even be aware of her own lament. Whether hidden or expressed, the lament contains a cry for death in a complex mixture of fear and longing. Yet, beyond or inside the cry for death, we discover a cry for life.

Historically, suicide has been rare among patients with advanced disease, even when strength and means have been available. Despite the frequent repetition of the word or symbol of death and the apparent hopelessness within suicidal rumination, there is always evidence of ambivalence. The need to lament and the pattern of lament is embedded deeply in the human psyche. Its emotional content demands and invites human relationships. When death forms a central part of a lament (“I want to die”), the current health care environment provides the conditions where there is a serious danger of misinterpreting this cry. When a patient cries out for an end to suffering, that person is not requesting a euthanasia consent...
form. For us to interpret this cry as a legal request for death is to miss the mark entirely. In fact, the lament invites us to affirm life. It is interesting to note that all of us, and our health care system, understand this when “psychiatric” suicide is attempted. We work hard to prevent these suicides and respond to the lament and the underlying pain it reveals. We even go so far as to protect patients from self-harm until we have been able to intervene. Why should our actions be any different for patients lamenting at the end of life or living with a serious disability?

What about our own lament? As healers in the presence of suffering we, too, lament. When we hear and enter into our patients’ laments we may experience false guilt and view the suffering as our responsibility, to be resolved through clinical action. When drugs or surgery cannot relieve the complaint, some may be tempted to see death as a “treatment.” Instead, as doctors and caregivers, we must learn to listen to lament, resonate with its pain, and be truly present with the one who laments.

As educators of health care professionals, we must try to provide an opportunity and a safe milieu in which students can learn to listen. This learning process will include exposure to role models, opportunities to practise communication techniques under supervision, and frequent use of evaluation and feedback methods to highlight areas where growth and improvement are needed. Even more important, students in the health professions must learn to listen to their own lament, to attend to it carefully, and to process it fully as they explore the limits of their vocation. This may well be a fearful experience, bringing old griefs and insecurities to light. Resources and systems need to be firmly established so that all of us will be prepared to provide the same level of support to students and colleagues that we try to give to our patients.

Yes, we struggle. As we watch suffering and listen to lamentation, we may be tempted to cry out for death on our patient’s behalf. We should not suppress the urge to share our patient’s lament and to shout our own. Yes, we cry out, even cry out for death, but reject the temptation to kill. We hear the cry for life at the heart of the lament. We hear the cry for meaning hiding in the lament. We do not respond by silencing the one who issues the cry.

We respond in love, by learning to listen and to wait in the face of suffering. This is an active waiting during which we provide good pain relief and excellent palliative care. As we wait and truly abide, paradoxically we become a new source of hope and life for the ones who suffer – both the patient and loved ones, not only through our professional skill in comforting, but also in our personal commitment to enter into and to share the lament. In the face of imminent, irreversible death, our vocation is to wait and to watch in love – not only for death but until the lament of life has come to completion.

On August 27, 2016, CMDS Canada Associate Staff person for the University of Toronto, Jon Dykeman married his beautiful bride, Yenny. They were joined by several students and grad doctors from the local CMDS Toronto Chapter. Two students, Chris Hue and Marshall Kurniawan, led the worship. Yenny & Jon were married in their home Church, Christ Church St. James in Toronto. We rejoice in their joy and pray that they will share many years blessed by the Lord.

This November, CMDS Canada welcome a new Associate Staff person for the Memorial University of Newfoundland campus in St. John’s, Newfoundland. Stephen Dawe has been a Christian for about 24 years, coming to saving faith while an undergraduate at Memorial University of Newfoundland. Stephen Dawe has been a Christian for about 24 years, coming to saving faith while an undergraduate at Memorial University of Newfoundland. Since that time, he has worked as a volunteer in student ministries with InterVarsity Christian Fellowship, as a pastor in South Korea and in his native Newfoundland, and now as an elder and ministry assistant at Calvary Baptist Church in St. John’s, Newfoundland. He holds degrees in Philosophy (BA), Law (LLB) and ministry (M.Div), and is presently researching Secularization theory as part of a Master’s degree in Religious Studies at Memorial University. Convinced of the need for professionals to learn how to live their professional lives to the glory of God, he has strong interests in the intersection of ethics and work, as well as a desire to help people work through their relationship with Jesus Christ as it applies to every facet of their lives.
Living and Dying
Journeying Together in Community
ANNA VOEUK

WE NEED MORE PALLIATIVE CARE! You would be hard pressed to find many people who would disagree with this statement. More light has been shed on this need, given the current change in landscape in Canada, with the recent legislation of physician-hastened death. The difficulty, however, lies in how we can make universal access to high quality palliative care a reality. How can we ensure that everyone, particularly the more vulnerable in our society, is included?

Historically, hospice and palliative care were rooted in the Christian ethos. Churches and religious orders, along with families, friends, and neighbours were the ones to care for people who were dying, rather than medical institutions and health organizations. One’s community played an essential role in supporting people through death, dying, grief, and bereavement. The communities of L'Arche, through experience and wisdom gleaned from “accompanying people on the path of life, from fragility to strength and back to fragility,”¹ may offer insight into the journey at end-of-life.

L’ARCHE
I have had the privilege of living in L’Arche, and I have learned many lessons, personally and professionally as a physician. Founded by Jean Vanier, L’Arche is a faith-based organization that fosters an environment in which people with and without disabilities live together in community. French for the Ark, referring to Noah’s ark, L’Arche is meant to be a sign of hope for those living with developmental disabilities, known as core members, who live with assistants who support them. Living in community can be challenging, and yet at the same time rewarding and enriching.

My journey with L’Arche began as a summer assistant during my early university years. I relocated to Vancouver from rural Alberta and left behind a life of familiarity in my own established community. Feeling like a fish out of water, I tried to connect with people through various means. It wasn’t until I stumbled upon L’Arche that I found a new home away from home and a truly supportive community. Since then, I have assumed various roles in L’Arche, including assistant, house leader, volunteer, friend, and board member. The opportunity to experience L’Arche through various perspectives has deepened my appreciation for community and the value of each individual member. As Jean Vanier states:

One of the marvellous things about community is that it enables us to welcome and help people in a way we couldn’t as individuals. When we pool our strength and share the work and responsibility, we can welcome many people, even those in deep distress, and perhaps help them find self-confidence and inner healing.²

FACING DEATH & DYING IN COMMUNITY
Facing death and dying is not easy in any circumstances, but doing so in the presence of people who know you and are willing to walk with you through trying times makes it somewhat more endurable. Many of us seldom ask for assistance and try to manage on our own, especially during seasons of heartbreak. Authentic relationships and the invitation for us to be who we really are open the door for us to love and care for one another in a different, deeper way. Although

1 Vanier, Jean and Hollee Card. 2016. In assisted death, remember this: We all are fragile. The Globe and Mail. March 1.

it is simplistic to look at death and dying in three sections with a beginning, middle, and end, allow me to offer some reflections from my experiences in community following this basic outline.

ADVANCE CARE PLANNING
Due to the need for an increased level of care, Martha* moved into a long-term care facility, conveniently located within the L’Arche neighbourhood. Sometime later, after faithfully remaining connected to the community through regular visits to L’Arche and welcoming others to her new place, she died. We then began to realize that other core members were also ageing and becoming frail. It seemed timely for the community to begin conversations about advance care planning.

It was certainly something new to me, as I was in my early twenties. I was sitting cross-legged on the floor in the community meeting area known as the Big Living Room, when I was handed a package with the heading, “END OF LIFE PLANNING FOR…” followed by my name in big, capital letters. I wasn’t sure what to make of it, as I wasn’t expecting to die anytime soon. The invitation to participate in discussions around advance care planning was extended in such a grace filled and inclusive manner that it piqued almost everyone’s interest.

I attempted to protect people from having these discussions for fear they would not understand, but I soon realized that I was really trying to protect myself. When we did speak with them, some core members had more to say than I could have ever imagined; their thoughtful comments and insights were humbling. Although some people didn’t understand or have the capacity to make decisions around goals of care and the details surrounding a personal directive, they were able to guide their loved ones on making decisions about important issues.

ACCOMPANIMENT
In L’Arche, accompaniment is a term used to “express the reality of being alongside people as a companion and friend in order to help them grow.” The idea of coming alongside and walking with someone on his or her journey can be lived out in different ways. A key to accompanying someone is being fully present in that moment to which we are called. I have heard that the French word, “accompagner,” (to accompany) carries a deeper meaning, that is, the notion of being “radically present.” The significance of this is more apparent when accompanying those who are dying.

The thought of “just being” is terrifying to some, and yet, in a caring community, just being with someone is essential and fundamental. Often, nothing needs to be said or done except simply to be present. By being intentional, we manage somehow to turn the ordinary into something extraordinary. The weight of angst and distress experienced at the end-of-life seems to lighten. This has not gone unnoticed by medical teams who have witnessed and subsequently commented on the love and support the community has given to various core members who were admitted to acute care facilities or continuing care centres after their need for medical care exceeded that which could be given in the homes. As health care professionals, we have seen the positive difference it makes when patients have many visitors at the bedside compared to those who have none. Uncertainty can be frightening, especially when faced alone. When a community of caring people comes alongside someone, they can offer emotional and spiritual support that health care professionals often cannot.

Founded by Canadian humanitarian Jean Vanier in France in 1964, L’Arche has grown to be a worldwide network committed to creating a more just, inclusive and caring world. In L’Arche, people with and without intellectual disabilities live, work and learn together creating communities of friendship and belonging. L’Arche is a community within the wider community whose members are involved in the faith and cultural communities and social organizations of their choice. L’Arche is a unique model of support based on life-sharing and reciprocal relationships between those supported and those who support them. To learn more about L’Arche and a community near you go to larche.ca.
GRIEF AND BEREAVEMENT

The phone rang. I wasn’t expecting a call late that night. I picked up the receiver and tried to make some sense of what the voice at the end of the line was saying. All I heard was the word “expired.” In a daze, and after what must have seemed like an eternity for the caller who waited patiently for me to respond, I said thank you and hung up. Then, the proverbial light bulb over my head lit up. I realized what had happened. Hugo*, a core member, had died.

Grief and bereavement tend to get brushed aside. It is important to allow time and space for this and to give people permission to engage in it. This was our intention as we gathered together again in the Big Living Room for an opportunity to share feelings, memories, questions, and concerns after Hugo’s death. It offered an occasion for us to grieve and mourn together and more important, just to be together. As we spent time with people, we learned to pick up on nonverbal cues, we developed a sense of what was being articulated, and we tried to respond accordingly. Action and presence spoke louder than words. I was humbled by the purity of a gentle pat on the head from one core member to another and the comfort it provided. Prayers for one another served as a reminder and reassurance that we all would get through this difficult time. Through music, art, stories, and quiet reflection, we expressed our sorrow as best we could while relying on one another for support, not only that day but during the days to come.

When we reflect and reminisce, we don’t remember those who died for their disabilities but for who they are... His Beloved. Henri Nouwen describes this beautifully:

To be chosen as the Beloved of God is something radically different. Instead of excluding others, it includes others. Instead of rejecting others as less valuable, it accepts others in their own uniqueness. It is not a competitive, but a compassionate choice.

A LESSON FROM L’ARCHE

One of the most important lessons I have learned is this: we are all vulnerable. Jean Vanier writes, “We human beings are all fundamentally the same. We all belong to a common, broken humanity. We all have wounded, vulnerable hearts.” Dr. Balfour Mount, who coined the term palliative care, spoke with Jean Vanier at a L’Arche forum in Ottawa called Journey to Social and Personal Transformation, where he reminded us that “at best, we are all wounded healers. Our effectiveness comes from recognition of our own vulnerability.” When we can recognize that we are all fragile, we are somehow reminded of the need to protect those who are more vulnerable in our society, advocating for those who may not be able to speak for themselves, whether they are children or people with disabilities, mental health issues, or the frailty of ageing. We, as a caring society and community, have a shared responsibility to love and have compassion for those around us.

My journey with L’Arche is ongoing and, like all other journeys, is dynamic and ever-changing. Despite this, I take heart in knowing that when connected to community, we can choose to be fully present and walk alongside one another as we share in the sorrow and grief that accompanies death and also in the celebration and blessings that stem from the gift of life. Every person who has a life limiting illness, and their loved ones, can benefit from and has the right to high quality palliative care. In order for us to improve access to palliative care, we need to revisit the historical roots of hospice and palliative care that once relied heavily, if not solely, on community to provide compassionate care and comfort to those who were dying. Now is the time for the Church to return to a leadership role in this area and encourage people to support one another in community throughout all phases of life.

Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves have received from God. – 2 Corinthians 1:3-4 (NIV)

* Names and details have been modified.

Thinking about suffering and evil in the world

JOHN PATRICK

No problem confronts the Christian doctor more brutally than the question of what to say in the face of tragedy and apparent injustice, particularly with children. We never forget that feeling of utter impotence, the complete inadequacy of words. We manage to extricate ourselves from the situation and suppress the pain with another patient’s needs. Job, at least, had comforters who said nothing but simply sat with him for a week!

Our peace is further challenged by those who do not believe and use every opportunity to goad us with comments about our God and his malicious vindictiveness. But as CS Lewis realized as a student in Oxford the problem for the atheist is greater than for us. With the general acceptance of a rather naïve “survival of the fittest” evolutionary scientism, unbelievers ought not to be bothered by the problem because with their structure of meaning it is simply the price of evolutionary progress—but such dispassion goes against the deepest needs of our nature. We all, believer and unbeliever, want to be able to help, to have something to say, and we want it desperately.

This deep need for meaning became a turning point for Lewis who put the problem like this:

How had I got the idea of just and unjust? A man does not call a line crooked unless he has some idea of a straight line. What was I comparing this universe with when I called it unjust? If there is no God there is no possibility of individual meaning in suffering, neither is there any possibility of real justice only the will of the powerful. A reality we now face in the politics of blue collar alienation resentful of elite arrogance. Many more thoughtful atheists regret the loss of a philosophy of justice which comes with evolutionary theory but without, as yet, facing the spiritual realities. If our visceral horror at the cruelty of mankind has meaning there must be a God for it cannot be explained by evolution. Nature does not care.

When I was growing up in blue collar Birmingham, England, the dominant working class philosophy was stoicism, not that they could name it. Working people deserted the church after the 1914 -18 slaughter but retained the ideal that one did not moan about life but got on with one’s lot stoically. Feelings beyond everyday ups and downs were not expressed, and traditional Christian morality was accepted. Divorce was something to be ashamed of and it was very rare. English weather and post-war food needed such fortitude if one was not to be permanently miserable.

The alchemy of Darwinian reductionism was nevertheless brewing its consequences in the culture. Meaning and purpose were not discussed. The hard work of careful thought was steadily replaced by feelings. Principles derived from our Judeo-Christian past were replaced by crass utilitarian ideas. Solve the immediate problem and move on. I remember vividly a moment of truth when I asked a Boy’s Brigade class; what is wrong with stealing and immediately got the response – Getting caught, sir! It was not so great an insight as it should have been because I had become a reductionist, a behaviourist and a problem-solving utilitarian without truly understanding the implications of any of them. I had no twinge of conscience when I facilitated abortion for women with rubella early in their pregnancy. I felt it was a woman’s choice and didn’t think about it for 20 years. I didn’t even know that the much-maligned medievals had two words for conscience – conscientia–moral feeling known to be unreliable and synderesis–moral thought which is very reliable.

We now live in a world where politicians don’t know about moral argument, especially not the importance of the common good, but only look at polling data to see what voters want. “Ask not what your country can do for you but what you can do for your country,” would not lead to political victory today. Transfer these ideas into our world and what is happening especially at the end of life?

Never have we had more power over pain, yet never have we feared death and pain so much. We want human rights as long as I get what I want, but not human responsibilities. It is entirely logical that a truly secular, tacitly atheistic culture will want to legalize abortion and euthanasia because without hope in an eternal reality only present comfort remains. Paul’s desire to complete the sufferings of Christ sounds like psychotic masochism to the modern secularist. Our rather naïve and untaught faith does not prepare us to do battle in this context. Thus in the medical training process, in practice we become tacit atheists and start committing suicide in the face of existential pain (five of my friends and colleagues did so), using drugs, alcohol and mindless sex to suppress the pain. It is usually existential pain that leads to suicide, but we are not good at discussing this fact.

One of the most important reasons for existential pain is the loss of belief in objective moral truth, which in turn makes sin a meaningless concept and leaves no place for repentance, confession, restitution and forgiveness. Guilt is nevertheless real, and it gnaws at the modern soul despite denial. Every now and again the world at large is surprised by the capacity of a Christian community to forgive violence done to the innocent in their church, not recognizing that following Our Lord’s commandments is the only way to peace. The centrality of forgiveness in the teaching of Our Lord is undeniable, but forgiveness needs repentance and repentance is a gift which must be sought (cf the story of Cornelius in Acts 10). Sadly, particularly in non-liturgical churches, the practice of confession, forgiveness and celebrating the new life by forgiving others is noticeable by its absence. Similarly in medicine most patients are now bear at least partial responsibility for their medical problems. They know that those they love are suffering with them because of this behavior, so guilt is inevitable. The only solution is not pharmaceutical but spiritual; they need forgiveness. It is interesting that when I last looked I could not find the word guilt in the index of a textbook of internal medicine. Psychiatrists use it, but tend to treat guilt feelings as indicators of depression and usually with little basis in reality.

We must be able to make Lewis’s case that our need for meaning in the

cont’d p 15
Suffer Well

DAN REILLY

Suffering well is one of the most powerful ways Christians can be a witness for Christ and preach the gospel. This is increasingly true as our society becomes more secular since the Christian understanding of suffering contrasts sharply with the materialist’s.

Christians understand from the Genesis account of human origins that suffering is not good and was not part of God’s design for our world. Suffering exists in the world because of rebellion against God. We brought it into the world. Sin leads to suffering and suffering will disappear when all of creation is restored to right relationship with God. Submitting to God, we can participate with Christ in bringing that restoration to earth. Serving Christ in a fallen world will result in each of us enduring suffering and in our pursuing relief of suffering in others. Our Saviour’s suffering because of sin restored us to God and it is a privilege we don’t deserve to join Christ in suffering for others.

The materialist concludes that suffering exists because of physics and biology. Suffering may be good if it is chosen and serves a purpose. The Olympic athlete who has suffered for years in pursuit of human achievement is applauded. Suffering is bad if it is unbidden and purposeless. Physical and existential pain from terminal cancer must be eliminated at all cost since it was not consented to and serves only to frustrate human autonomy. The solution to suffering is the manipulation of physics and biology by autonomous humans imposing their will on nature.

As we become more like Christ, our instinct when we see suffering in others will be to move towards the other. We will ask God to remove their suffering. Then we will work to reduce their suffering and to share their burden as we journey with them on the path that God chooses. When we are the one suffering, we will ask for God to take the suffering away. Then we will share the suffering with the body of Christ and rely on God and the community to walk with us on our difficult path.

The materialist’s instinct when viewing suffering in others, or experiencing it himself, is to avoid the suffering. Our society provides a multitude of ways to diminish physical, emotional, and spiritual pain. Some of these are good things when pursued in submission to God, such as religious practices, medicine, counseling, community, or keeping your eye on the ultimate goal that suffering may bring us to. But these good things can become destructive when pursued with selfish motives. Some pain avoidance tools are always destructive. Suicide, pornography, substance abuse, and abusing those around us destroy both the person avoiding pain and the community.

For the Christian, suffering does not extinguish hope and joy. There is a wish to avoid suffering but no fear that it will overwhelm or destroy the good. That hope and joy is attractive to those who face suffering. A caring community that offers hope and joy to those who suffer will grow. The good news of Christ is on display in that community!

Do you have a Christian view of suffering? Do you and the Christian community you are part of suffer well?

cont’d context of pain, suffering and the sense of injustice actually means there must be a God and therefore there is hope. (As an aside Surprised by Hope by NT Wright has been one of the most encouraging books I have read.) We must also recognize that a secularist cannot comprehend our views and we can only argue for holding to traditional views on grounds of democracy, justice and demographics. As a secularist wants a doctor who will assist in hastening death or even ending life directly, a traditional theist wants the opposite. Subsidiarity appears to me to be the only way forward in the secular setting of our health care system.
The Emmaus Triptych
MARGARET COTTLE

NATIVITY

Undisturbed
even by a whisper
Dust of four hundred years
Suffocates
Hope

Momentary eddies scribe the surface
Zechariah
Elizabeth Mary
Joseph

Bethlehem–
Breath himself breathes earthly air
Emmanuel blows the dust into starlight and joy

Gloria in excelsis Deo!

Wonder!
Shepherds
Anna
Simeon
Magi

Ponder...
...Hope?

But the wind stirs, lifts and escapes to Egypt in a dream

Keening
In the settling dust
Rachel weeps for her children
And cannot be consoled.

We had hoped...

A VOICE IN THE WILDERNESS

John prepares the way,
A passionate sirocco
Churning the dust into irritating grit

Repent!

Humble hearts renewed
Stiff necks maddened

Jesus, too, comes to the Jordan
John hesitates
You should baptize me
then yields

God breathes—the Dove descends
This is my beloved Son, listen to him!

Clouds gather
I must decrease
A tempest threatens
Prison’s desolation gnaws at John’s certainty
Are you the One?

Foretelling by omission
no promise of captives released
Only...
Tell John, the blind see, the lame walk, the dead are raised,
good news is preached to the poor.

A malignant miasma of swirling veils, revenge and pride
Silences
John

We had hoped...
EMMAUS AND BEYOND

A maelstrom of holy anguish tears through Jerusalem
Grinds Hosannas to dust–
Rips open ancient graves, the temple veil
Swept home to Emmaus
Our steps and words in mournful cadence
...We had hoped...we had hoped...we had hoped
Eyes, throats, hearts
scoured raw with grief
The Stranger, joining us, wonders at our sorrow

Are you the only one who does not know?
The Teacher is dead
who fed, healed, forgave, performed miracles, raised the dead,
knew us...was with us...loved us
We had hoped that he was the one to redeem Israel...
Now, bewildering reports
an empty tomb...angels insisting he lives...

The stranger smiles
"And everlasting, relentless Love?
...the buried seed
...the tender blade from Jesse’s root
...the dry ground defied by Life?
As it was breathed...
...as it is written...
...just as he said...?"

Who is this one who sets our hearts ablaze??

The Stranger would travel on...
Please stay! You are welcome, yea needed, at our table.
He blesses and breaks the bread
And we know him...Teacher!

We had hoped...expected...
Might and spectacle
majesty and beauty
power and glory
Instead...his still, small voice,
The quiet crack of crust
of ordinary, daily bread
This bread of Presence
So robust it may wound our mouths
Revives, nourishes, sustains

We are this bread, his broken body
griefs borne
sorrows carried
Peace from his punishment
Healing from his wounds
Shalom and unfailling Love
our waybread for the journey
His companions
confronting the age-old dust of the world’s deepest pits
...nearest his heart in the most broken places
Borne along by the Breath
We are
More than conquerors
...awestruck through our tears
...and unafraid.

We have this hope as an anchor for the soul, firm and secure.
Conscience Protection Update

CPSO COURT CASE
Despite many attempts to contact the CPSO to have an open discussion about conscience rights, we have been unable to secure a meeting. Even the CMA came out strongly in favour of conscience rights, but the CPSO remained adamant that their policy had proper accommodations. We argue that freedom of conscience and religion is protected by section 2 of the Charter. The CPSO believes that effective referral is the only way to guarantee access and therefore fulfill the needs of patient care. However, nearly every other province in Canada has approved direct access (through websites or the local 811 line) and a patient initiated complete transfer of care. The CPSO has the burden to prove why the same model that works in Alberta, for example, won’t work in Ontario. The work that we do now is essential as it provides the legal groundwork for further appeals should they occur.

Early in 2017, the court case against the CPSO will be heard. We are currently in the process of going through the initial discovery for the case. The CPSO is pursuing the case aggressively. We have produced 16 supporting affidavits, our witnesses have been cross-examined by the CPSO, and now we are in the process of working through the CPSO’s affidavits and working on our next steps. As our legal costs began to rise, we reached out to our database of public supporters in the Coalition for HealthCARE and Conscience. Through that fundraising initiative we raised over $16,000. However, we will need another $45,000 to cover our full legal costs. Please consider donating to support the costs associated with the legal case. It is important that we take the necessary time to be thorough. The work done at this stage will ensure that our case is strong.

Please pray especially for the 5 doctors, Donato Gugliotta, Michelle Korvemaker, Isabel Sarides, Betty-Anne Story and Agnes Tanguay, who are at the heart of the legal case.

COALITION FOR HEALTHCARE AND CONSCIENCE
In January a decision was made to create the Coalition for HealthCARE and Conscience to advocate against legalization of assisted suicide and euthanasia and for increased services to the vulnerable, the disabled and those in palliative care. Conscience protection for health care workers and for facilities was also a key component of advocacy efforts.

The partners to the Coalition are as follows:
- Canadian Catholic Bioethics Institute
- Canadian Federation of Catholic Physicians’ Societies
- Catholic Archdiocese of Toronto
- Catholic Health Alliance of Canada
- Catholic Organization for Life and Family
- Christian Medical and Dental Society of Canada
- Canadian Physicians for Life
- Catholic Archdiocese of Vancouver
- Evangelical Fellowship of Canada
- Salvation Army

The Consultant firm we hired is Enterprise Canada and they are located in Toronto and Ottawa. Their services have included the development of a web site (www.CanadiansforConscience.ca), direction to the 25,000 people whose names are on the database, media relations, development of documents, and setting up meetings with key decision makers in government. Since January, Larry has travelled extensively and has been one of two main spokespersons for the Coalition. This has led to excellent exposure for CMDS Canada in the print and electronic media. We have had over 30 meetings with Federal Government representatives and another 45 meetings.

WHAT HAVE WE ACCOMPLISHED?
- Conscience protection wording in Bill C-14
- Raised awareness of conscience rights nationally
- Contacted government officials in every province
- Visited government officials in most provinces
- Contacted & visited key Federal government officials, elected representatives and Senators.
- Most Colleges (excluding Ontario/Quebec) have policies which respect our conscientious objection to effective referral for assisted suicide
- Gained support of OMA

The Consultant firm we hired is Enterprise Canada and they are located in Toronto and Ottawa. Their services have included the development of a web site (www.CanadiansforConscience.ca), direction to the 25,000 people whose names are on the database, media relations, development of documents, and setting up meetings with key decision makers in government. Since January, Larry has travelled extensively and has been one of two main spokespersons for the Coalition. This has led to excellent exposure for CMDS Canada in the print and electronic media. We have had over 30 meetings with Federal Government representatives and another 45 meetings.

CANADIANS SHOULDN’T HAVE TO COMPROMISE THEIR CONSCIENCE.
In Canada, everyone has the right to their faith and their conscience. The coming legalization of physician-assisted suicide will put healthcare practitioners and facilities in a compromised position.

Those who cannot support assisted suicide or euthanasia because of their conscience, faith and commitment to the Hippocratic Oath could be forced to compromise their convictions. They shouldn’t have to.

Our coalition stands opposed to assisted suicide.

We need your help to ensure Canadian’s faith and conscience rights are protected.

OUR CONSCIENCE RIGHTS MATTER.
www.CanadiansforConscience.ca
with Provincial Government representatives. Larry has travelled to each provincial capital to advocate on your behalf.

MEETINGS WITH ONTARIO MPPS
Teams of CMDS, CFCPS, and CPL Doctors, along with Dr. Janice Halpern, an observant Orthodox Jew, met with Ontario MPPs both in their own ridings and at Queen’s Park alongside CMDS Executive Director Larry Worthen, Cardinal Thomas Collins and representatives from the Salvation Army. Having well-informed conscientiously objecting Doctors in the meetings gave the nearly 40 MPPs we met an opportunity to hear witness from Doctors as to how required effective referral will personally affect them, their practice, and their relationship with God. Following that, Executive Director Larry Worthen would present the Coalition’s proposal for an acceptable accommodation.

MEETINGS WITH THE ONTARIO DEPARTMENT OF HEALTH & ATTORNEY GENERAL
These meetings with MPPs, paired with the emails sent through the Canadians for Conscience website, gained us a meeting first with Dr. Robert Bell, the Ontario Deputy Minister of Health, and then later with Minister Eric Hoskins, Ontario Minister of Health and Attorney General Yasir Naqvi. We arrived at both of these meetings with carefully prepared briefing binders with relevant documents, which helped support our argument and informed the discussion. The meeting itself went well, and while no accommodation was reached, we believe that some of the groundwork was laid. We proposed, with the support of Patrick Dicerni, Assistant Deputy Minister of Health Policy, to form a committee with the government to create a proposal for an acceptable accommodation for their consideration. The Minister and Attorney General are considering this idea.

WHAT CAN YOU DO?
Invite your friends, family, colleagues and Church to visit www.CanadiansForConscience.ca to write to decision makers. Our ability to advocate on your behalf is vastly increased by decision makers seeing the number of active supporters who are contacting them about conscience rights.

PRAYER SUPPORT
If you want to join our prayer chain for conscience protection, email Sandra at prayer@cmdscanada.org Your prayers are making a difference!

Singing the Lord’s Song in a Foreign Land  Ps. 137:4
Working with the Great Physician in a Darkening World

May 4-7, 2017 • Double Tree by Hilton • Toronto, ON
Keynote Speakers
Rev. Dan MacDonald, Senior Pastor Grace Toronto Church
Ewan Goligher, MD, PhD Intensivist, Mt. Sinai Hospital

2017 CMDS NATIONAL CONFERENCE
Singing the Lord’s Song in a Foreign Land

STEPHANIE POTTER

Stephanie is the Communications Manager for CMDS Canada and is serving as staff liaison within the local organizing committee.

The recent struggles with conscience rights have highlighted that we as Christians have become strangers in our own culture. All around us are people gleefully celebrating assisted suicide, another milestone of “progress,” while we mourn that not all progress is positive. We would never say a speeding Freight train veering far off track is progress. Rather we’d call it movement in the wrong direction. We see the trajectory towards an all-encompassing culture of death and selfishness. The culture we live in has lost sight of the value of life and the true meaning of dignity. Yet, even though parts of our culture are so adversarial to our Christian views, we are not called to leave those lost to this culture. We are called to reach out, preaching the truth in love. As the theme for our 2017 CMDS National Conference announces, we are called to sing the Lord’s song in this foreign land.

But how can we reach out and evangelize a culture that doesn’t even seem to use language the same way we do? The culture around us has absorbed the trappings of our faith and abandoned the depth of meaning behind them. Christian language populates the public sphere, but is robbed of its meaning. Our desire to use these familiar terms fall flat as they have taken on public baggage. Words like dignity have opposite meanings for those who believe in God and those who don’t. Dignity has become a buzzword of the pro-euthanasia advocates, which they imply can only be applied to those people who are in complete control of their life and death. When we think of dignity, we know it’s meaning relates far more to the innate, God-given dignity we have from being made in the image and likeness of God. To say that our dignity could be reduced, challenged or even lost by declining ability or illness is dissonant to our Christian vocabulary. Even when we are at our most vulnerable, our dignity remains, a hallmark of God’s endless love for us.

When the culture fails to see the dignity of the vulnerable, medical professionals have the unique opportunity to give care that recognizes and respects that dignity. Through the mission work dentists do, both abroad and in their own community, and the very way they treat their patients, they are showing their patients that they recognize their immeasurable value. Each specialty has their own way to care for their patients in a way that recognizes their dignity: how an obstetrician treats a birthing mother and her newborn child; how an anesthesiologist watches carefully over their patient; how a palliative care physician works with the patient and family to ensure comfort; how a family doctor journeys with their patients through minor and major illnesses and life events; how a neurologist helps uncover and treat the unseen burdens of their patients; and so on. Medical and dental professionals take the view of the whole person and have access to some of the most vulnerable moments in their patients’ lives. Without even saying the name of Christ, they can be salt and light by being an instrument of God’s fatherly care for His children. They are given special opportunities for service which can fly in the face of the current culture. We are called to give more to a world that is increasingly broken, but doesn’t see its own brokenness.

This is in many ways a thankless task, but when we keep our eyes on Christ, we are reminded we were not promised an earthly inheritance, but an eternal inheritance as the adopted children of God. As we work diligently to serve the vulnerable placed in our lives by God, we are like the early Church. We are seen as an alien and unwanted presence by some within our culture, which tries through all allowable means to indoctrinate us. If we are to persevere, we must look to the early days of the Church for inspiration. To live biblically as a Church is first and foremost to seek the community of our brothers and sisters in Christ. This community gives us solace, respite and inspiration for our mission. The sharing of a meal, the sharing of witness, the confession of our weaknesses and thanksgiving for God’s gifts in our lives are all hallmarks of the early Church. CMDS Canada does this locally through the Chapters, and on a national scale through our annual Conference. We come together in fellowship and praise of God and restore our spirits before we go back into the world. We educate ourselves because evangelization is not simply proposing Christ, but deconstructing the falsehoods of the current culture so that we can build a new culture, focused on the mission...
CMDS Canada has had a busy year full of growth and innovation. Our membership continues to grow, the public’s awareness of our organization has increased dramatically, our advocacy work for conscience rights continued with focus and intensity, while at the same time we held another successful annual Conference, Western and Eastern Student Retreats, and our Student Leadership Conference. Chapters across the country have been looking for innovative ways to connect, support and serve and our Associate Staff continue their essential ministry with medical and dental students. Our accomplishments and events this year show a clear sign that CMDS Canada continues to be blessed to participate with the mission of Christ. The 2017 Operating Budget shows our dedication to fiscal responsibility as a Society while also showing our renewed dedication to our mission and ministry to the Body of Christ and the world.

We seek to propose and promote a new culture which does not simply have the external languages and symbols of Christianity, but one that truly values all creation and is moved to serve God. This is not the task of just our pastors or of individual missionaries. This is the joint work of the entire Body of Christ, which is not limited by denomination, career, education, or capabilities. When we come together, we can discern how best to unite our own individual efforts in our joint mission.

We are called to be salt and light to our culture. When we hear salt, we may remember the old adage of “rubbing salt into the wound” and recall it being a negative thing. However, salt was used as an anti-bacterial and drying agent in ancient wound care. It helps wounds heal faster, but not without a cost. The salt stings. So too light is not always perceived as a positive. When you’re fast asleep in bed and someone throws open the curtains, the sudden burst of sunlight stings your eyes and causes you to recoil. But just as the salt, which initially stings, helps heal wounds, so too light stings at first, but then helps us to better see what’s around us.

Our 2017 National Conference in Toronto plenary speakers will be wrestling with the themes of witness, the role of Gospel-centered medical and dental practice, our role in the current culture, and the value of and need for fellowship. Our workshops will take up the more specific issues that arise from those themes. These workshops, divided between teach-ins and symposia, invite attendees to engage on the topics that interest them and deeply affect their lived experience as a Christian in medical and dental practice. A full list is available on the CMDS Website.

CMDS Canada has had a busy year full of growth and innovation. Our membership continues to grow, the public’s awareness of our organization has increased dramatically, our advocacy work for conscience rights continued with focus and intensity, while at the same time we held another successful annual Conference, Western and Eastern Student Retreats, and our Student Leadership Conference. Chapters across the country have been looking for innovative ways to connect, support and serve and our Associate Staff continue their essential ministry with medical and dental students. Our accomplishments and events this year show a clear sign that CMDS Canada continues to be blessed to participate with the mission of Christ. The 2017 Operating Budget shows our dedication to fiscal responsibility as a Society while also showing our renewed dedication to our mission and ministry to the Body of Christ and the world.
Descent

MALCOLM GUITE

From ‘The Singing Bowl’ Canterbury Press 2013, reprinted with the permission of the poet

They sought to soar into the skies
Those classic gods of high renown
For lofty pride aspires to rise
But you came down.

You dropped down from the mountains sheer
Forsook the eagle for the dove
The other Gods demanded fear
But you gave love

Where chiselled marble seemed to freeze
Their abstract and perfected form
Compassion brought you to your knees
Your blood was warm

They called for blood in sacrifice
Their victims on an altar bled
When no one else could pay the price
You died instead

They towered above our mortal plain,
Dismissed this restless flesh with scorn,
Aloof from birth and death and pain,
But you were born.

Born to these burdens, borne by all
Born with us all ‘astride the grave’
Weak, to be with us when we fall,
And strong to save.
ICMDA South Sudan Health Sciences Institute in Jonglei Update

After an urgent appeal from Anil Cherian, the Director of the ICMDA South Sudan Health Sciences Institute in Jonglei, for funds to keep the Institute operational, organizations around the world reached out in support. CMDS Canada had already designated the Institute as a recipient of special donations from our banquet at the annual National Conference. At the Conference, CMDS Canada raised $16,708 which was sent to support the important work of the Institute. After Anil Cherian's appeal, our members donated another $51,862, totaling $68,570 in 2016. We were astounded by the swift responses to their request for support. Thank you to all of our members who were so incredibly generous!

STUDENT TESTIMONIAL
Abraham Wol Kiir Machok is a final year student at the institute studying a Diploma in Registered Nursing. He comes from Gogrial East in South Sudan. He comes from a huge family where his father has 3 wives, and he has 5 siblings. Previously he had planned to study engineering at a government institute but later changed his mind and opted for nursing, despite not having good knowledge in medical field. He says he was advised by a friend to go into the medical field. Abraham says he loves his course because it deals with people's lives and he would love to be a part of saving the lives of his fellow countrymen.

With the training, he hopes he and his other fellow students can go back to South Sudan and change the health situation. He says the health situation is quite poor with many cases of Malaria. This situation is made worse by a lack of trained professionals and with the people trusting more in traditional methods rather than going to health centres. “The training I have had here is very important,” Abraham says. “Hopefully when I go back to South Sudan, I will be able to educate my people with time, maybe there will be a change in the health situation.”

He says the funding and all that the students are provided with is very helpful and has made it possible for them to come this far. “For most of us, we come from huge families and most times providing an education is not easy, so being sponsored and getting scholastic materials has helped many of us. Most of our parents or relatives cannot be able to afford to give us all this.” He adds that he is appreciative and feels blessed that he has an opportunity to be funded as not many of his fellow South Sudanese have this opportunity.
As we enter into the Christmas season, all of us have our eyes turned to Bethlehem. The name Bethlehem translates to “house of bread.” How fitting that the Bread of Life should become flesh in such a place. This small town, also called Ephrath and Ephrata, in the hill country of Judah, was the site of many Biblical stories. Matriarchs and patriarchs, Kings, Queens and prophets once walked the streets of this town. By the time of the birth of Christ, this town was past its prime as the center of Biblical history, long eclipsed by Jerusalem. However, in the birth of Christ, Bethlehem is forever remembered as the site of the moment God became flesh was born into this world. God, who makes all things new (Rev 21:5), re-made Bethlehem itself as not just the City of David, but as the birthplace of the Rod of Jesse, the Bread of Life, the Messiah, the Christ.

This is a beautiful reminder that God does not forget us, even when the world has forgotten us. When we allow ourselves, like Bethlehem, to become a cradle for Christ, He comes and makes us new. But we cannot just be a place of welcome for Christ. We are called to take Christ to the world. We are called to be our brother’s keeper. As we have reflected on palliative care in this issue of FOCUS, we are reminded of the unique role palliative care has of caring for people when they are at their most vulnerable. The cradle and the cross are close together here. Just as we usher our children into the world as gently as we can, surrounding them with love, so too we are called to help usher our brothers and sisters gently through the end of their earthly journey until the time of God’s choosing.

Those who work in palliative care know the value of the journey itself. There is time for healing of the spirit, connection with loved ones, and the opportunity to leave a legacy of joyful faith. Just as Mary and Joseph had to journey to Bethlehem, a difficult and even perilous journey, so too are some called to journey with their final destination in sight. As caregivers, we have the opportunity to ease their sufferings. By caring for their bodies, a precious gift from God, who Himself chose to take on human flesh, we recognize the dignity of their entire person. Their body is not something to be cast off as they race home, but a treasure to be respected and cared for gently. Death is not an end, or an obstacle. It is simply the next step on our journey home. So, let us remember, especially in the Christmas season, to be aware of our journey, and that we are called to be Bethlehem. We are called to both be a cradle to the vulnerable in their immense dignity and also to be a place that can be made new by Christ’s presence.

Merry Christmas!

Larry Worthen, Stephanie Potter, Shannon Friesen & Cynthia Irving

One short sleep past, we wake eternally
And death shall be no more; Death, thou shalt die.
Death be not Proud - John Donne
Reach out to your colleagues
Invite them to join the CMDS Canada fellowship

The issues have never been so serious, the need for a Christian voice in healthcare has never been more apparent.

“I would like to express my thanks to all the members of your society who are involved in this [CPSO] case. If Christians do not stand up to discrimination and the violation of our rights, we will only have more and more of them taken away.”
– member of the public

If you know someone you think might be interested in becoming a member, send us their name and we will mail them a complimentary copy of FOCUS and invite them to join our fellowship!

office@cmdscanada.org

CMDS
Christian Medical and Dental Society
Singing the Lord’s Song in a Foreign Land  Ps. 137:4

Working with the Great Physician in a Darkening World

Christian Medical and Dental Society of Canada
9A-1000 Windmill Road
Dartmouth, NS B3B 1L7