INNOVATION & LEADERSHIP

In November, we launched our brand new website at our new URL: www.cmdacanada.org. This new website is modern and highly functional. Enjoy our members only features, including an updated membership directory. The goal of this website is to witness to all the good that God has done and continues to do through CMDA Canada. Expect new content there regularly featuring the activities and ministries of our members. To log in, simply use your email address on file and the password from our previous website. If you don’t know your password, you can reset it using your email address by following the prompts on the member login page.

MILESTONES

CMDA Canada is now accepting submissions from members for the Milestones regular feature. Submissions should be 150 words or less and include a relevant picture. Appropriate Milestones can include weddings, births, awards, and in memoriam of members.

CALL FOR SUBMISSIONS

We are currently accepting submissions for FOCUS Magazine. Let us know what issues are affecting you as a medical professional or medical student. Contact Stephanie Potter at communications@cmdacanada.org for more information.

STRATEGIC PLANNING

CMDA Canada has launched a strategic planning process which will culminate in a 5 year plan to be presented at the 2020 Conference in Vaudreuil-Doiron, QC. Please participate in this process by filling out the member survey at www.surveymonkey.com/r/SPFOCUS.

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 is part of our overall conscience advocacy with the Coalition for HealthCARE and Conscience. There will be more Call for Conscience campaigns in 2020. Keep watch on our website and the Coalition Social Media accounts.

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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 at sjpotter@cmdacanada.org.

We encourage readers to submit articles of personal or professional interest as well as those related to CMDA Canada activities at home and around the world. Subscriptions are available for $20/year. (Membership in CMDA Canada includes a subscription to FOCUS magazine.)

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FOCUS articles reflect the beliefs and opinions of the authors and do not necessarily reflect the official positions of CMDA Canada.

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Christian Medical and Dental Association of Canada

Drs. Vincent and Fenton both refer to Dr. Wilder Penfield’s essay “The Second Career” (also the name of a book of his essay). We were unable to get permission to reprint the essay in FOCUS. If you can find the essay or the book on-line or in a library, it is good advice.

The issue of what to do with old patient records is raised by Dr. Gagnon. This is a very important issue. Storing old records in your basement is no longer acceptable. Issues may vary province to province, so check with your local medical association, local College, and the CMPA to ensure proper compliance with current regulations.

The cover photo shows a road heading towards a grand mountain – but note there is a curve in the distance and where it leads is not apparent. My experience of God’s leading over my years as a physician is that an opportunity or path is presented and common sense assessment and prayer suggests a way forward though there may be many uncertainties. As the path is followed, there comes the certainty that it is God’s leading. Inevitably, there are curves to be followed and fresh leading for the new direction is provided.

Some words for living and travelling your path well (1 Peter 1: 17b & 15,16 from The Message):

Your life is a journey you must travel with a deep consciousness of God … let yourselves be pulled into a way of life shaped by God’s life, a life energetic and blazing with holiness. God said, “I am holy; you be holy.”
Dr. W James Fenton retired from Dental practice after 35 years of service in Toronto, although he maintains his license. Dr. Fenton and his wife Sandra have been active in dental missions in the Caribbean, Central America, Asia and Africa. Dr. Fenton has also served on the Boards of EMAS as President and CMDA Canada as Interim President.

Dr. Winston Dykeman was born in New Brunswick and grew up in Sackville, NB. He graduated from Dalhousie University Medical School in 1972 and retired in 2014 after 42 years of family practice in Moncton, NB. He and his wife Doreen (now deceased) carried on a ministry to new immigrants in over 30 years of home bible studies. He has a special interest in privacy, confidentiality and security of personal health information. He represented the CCFP in a presentation of concerns regarding Federal Privacy Bill C6 to the Canadian Senate in 2000.

Dr. Theodore K Fenske is a Clinical Professor with the Division of Cardiology at the University of Alberta, Staff Cardiologist at the C.K. Hui Heart Centre, and Director of Cardiac Rehabilitation for the Northern Alberta Program. Dr. Fenske is an executive member of the CMDA Edmonton Chapter is the proud father of three sons, Oliver, Cameron, and Joel. He and his wife Tanya are content to call Edmonton “home” where they are actively involved in the Christian community and Young Adult ministry.

Dr. W James Fenton practiced Internal Medicine in Saskatoon for 40 years, retiring in 2012. He served as national CMDA Canada president for five years.

Dr. Linda Gagnon practiced as a family physician for 33 years in Dartmouth, NS, doing cradle-to-grave patient care. She developed an interest in occupational medicine about 12 years ago and became a Medical Advisor for WCBNS five years ago and continues to work there now. She has also continued her work at a long term care facility. On a personal note, she is married to Larry Worthen and has two married, adult children and 5 grandchildren.

Dr. Robert Clark has more than 30 years of progressive experience which includes pastoral ministry and serving clients as a financial advisor. Lorne presently serves as the National Director for Kingdom Advisors in Canada. His qualifications include a Bachelor of Theology, CFP® (Certified Financial Planner), CLU (Chartered Life Underwriter), and CKA® (Certified Kingdom Advisor), which equip him to communicate stewardship more effectively.

Dr. Robert Clark

Dr. Merville O. Vincent earned his medical degree from Dalhousie University in 1955. His medical career began in the United States before he returned to Canada where he worked first in Ontario and later opened a private practice in BC. He retired from medical practice in 1998. Dr. Vincent published the book, God, Sex and You, and over 120 articles, chapters and essays in both medical and religious publications. In addition to other various honours, Dr. Vincent was awarded the Queen’s Jubilee Medal and was a member of the Royal College of Psychiatrists.

Dr. Merville O. Vincent

Dr. Lisa Gagnon

Dr. W James Fenton

Dr. Theodore K Fenske

Dr. W James Fenton

Lorne Robinson

Samantha Rossi

Linda Gagnon

Lorne Robinson

Samantha Rossi

Carolyn Watts

Merville Vincent

W James Fenton

William & Sharon Bieber

Winston Dykeman

Dr. Lisa Gagnon

Lorne Robinson

Samantha Rossi

Carolyn Watts

Merville Vincent

Therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything I have commanded you. And surely I am with you always, to the very end of the age. Matthew 28:19-20
The Physician’s Retirement

MERVILLE VINCENT

Editor’s note: This is a condensed version of an address Dr. Vincent gave to the Ontario Medical Association Scientific Session May 12, 1977. The issues addressed are as pertinent today as then. Dr. Vincent, a long time member of CMDA Canada, has had a life long interest in issues of physician well-being which has very recently been discovered as an issue by the profession at Large. - W James Fenton MD FRCP.

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FEATURE

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I would like to define retirement not as resigning from life, but as that period of life when you are free to do things you want to do. This may even be practicing medicine with greater freedom.

If a number of current trends persist, I believe that we shall see an increase in the number of physicians retiring. Some of these trends are:

1. Malpractice insurance is becoming more expensive. This may make slowing down a practice less affordable.
2. More physicians are in salaried positions often producing pressure to retire as well as providing pensions that make it practical.
3. It is increasingly difficult to keep up with the technical advances of medicine.
4. Peer review is here. Added to this is the need to document learning.
5. Perhaps physicians have always grumbled, but it is my impression that I hear physicians increasingly express their disenchantment with medical practice, saying that they are getting tired of red-tape, filling out forms, seeing their autonomy disappearing, all while the risk of being sued increases.

THE PHYSICIAN’S FEAR OF RETIREMENT

People do not look forward to retirement, and physicians share this view. Most of us are prepared to admit that we do not like the idea of getting older. We accept growing older because there is only one alternative? In not wanting to grow older, we often avoid sensible planning for it. Physicians tend to share the public’s negative view of retirement that sees retirement as a very stressful transition, often followed by serious maladjustment, physical and emotional deterioration, decreased life satisfaction and expectancy.

However, studies in recent years point in a more positive direction. Poor health is much more commonly a cause of retirement than as a consequence of retirement. Studies suggest that retirement improves physical health and do not confirm that retirement brings about a decrease in "generally life satisfaction".

The most important variable in adjustment to retirement is not retirement itself, but rather the individual personality and life patterns of the individual. Further, these are cultivated early in life and are not subject to change suddenly at the moment of retirement.

A recently retired physician considering reasons offered for not retiring, wrote: “the really important reason that doctors are loath to admit, is that they know little and can do little outside of their own little worlds. Doctors as a class are very poorly educated except in medicine.”

Dr. A. D. Kelly (General Secretary of the CMA from 1954 to 1966) said: “We have been accustomed to hard, responsible work for long hours and most of us have been so immersed in professional activities that avocations have been neglected.

THE BASIS OF A SATISFYING RETIREMENT

A philosophy of life or belief-system is needed that permits you to see yourself as valuable, gives you self-esteem and a sense of identity which is not based solely on your work output or production. If our self-esteem is based solely on our productivity both are likely to decline with the years. To be useful, our philosophy and faith must help us live with the inevitable losses of advancing years.

Good physical health certainly adds satisfaction at all ages. Much ill-health results from "diseases of choice" and should I add "procrastination"? Tomorrow I start my diet/exercise/quit smoking, etc.

A positive attitude towards retirement is also vital. A healthy attitude views retirement, not as a crisis event, but rather as one of life’s expected transitions. Retirement is best

The sooner we begin to plan the better – like today. Life is unpredictable and full of the unexpected. If you plan, you must be prepared to modify your plans.

Assuming a satisfying philosophy of life, reasonable health, finances, and a positive attitude, what next?

1. Start now to notice things having to do with retirement. How do you wish to spend your time in retirement? What are the activities you enjoy? Make a list of interests and activities that you would like to develop, but don’t have time for now. Try out some of these ideas. Seek to develop or maintain non-medical interest throughout your life.
2. As the years go by, try to make time to develop these interests, hobbies, avocations or skills.
3. If possible, ease into your second career by progressively arranging more leisure time to try out the things you think you are interested in.

W. James Fenton MD FRCPC

I am suggesting we should all plan for the possibility of retirement. The sooner we were aware of the need, the better. We were aware of the need, the better.

Wider Penfield "The Second Career",

W. James Fenton MD FRCPC

The Physician’s Retirement

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There is a better way.

In such a mission trip and had similar questions. He continued: “The first patient I saw had high blood pressure, not in my specialty area, but I was eager to try out the skills they are teaching, pastors at the other end waiting to have their churches chosen to facilitate the medical mission. Along with our two teenage children, we were part of one such organized trip some years back with about twenty others—medical practitioners and their families. After the thrill of the experience wore off, discomfort with the whole process told us that we could not do this again.

We could see that by treating patients and dispensing medicine without cost, we were unwittingly undermining the local health care facilities and workers. Our own experience of working with the Department of Health in Papua New Guinea for eight years when our children were younger was enough to tell us that. Not only were the medications free, but they were often not available or too expensive in the country for ongoing treatment. And did our translators understand enough to adequately explain to the patients when and how to take the medication? Did the treatments prescribed meet local protocol? Did the Canadian and US doctors who had spent years in other specialties really understand the tropical diseases they were treating? Was our well-intentioned help really helping at all, or were we hurting their long-term health? Their need for better health care and living conditions was obvious. But did our one-week foray into curative medicine—in this rural area do anything to better their future community or family health status? Perhaps it was simply a great experience for our kids, as an enthusiastic team incorporated them into the program by letting them weigh babies, take blood pressures and assist the dentist. But at what expense, if there was damage control needed after we went home or if we had somehow tampered the confidence of the people in their own healthcare system?

Best Practices for Medical Missions

In his excellent book Where Healthcare Hurts, Greg Seager has thoroughly researched the complications of such short-term medical missions. The four interweaving categories of best practices Seager outlines are:

1. Patient safety
2. Integration and collaboration with the national healthcare system.
3. Facilitating health development.

He starts with similar questions that our specialist colleagues and ourselves had asked after reflecting on our trips. He concludes that short-term healthcare workers could bring improvements to healthcare quality and empower communities to help themselves by working alongside the government system and providers who would like to upgrade to international standards. Knowing how to do that, taking time to research the local government systems as well as international initiatives, and then making connections with the appropriate authorities is essential.

Fitting in with the country’s health objectives rather than our own agendas is the first step in dropping the paternalism that usually characterizes our efforts. Most of us tend to be skeptical of systems that are different from what we are used to, every country assuming its own is best! Researching the current Health Plan of the country where we are going is a good place to start. We must first of all be learners if we are to leave our paternalism at home. MEDICAL AMBASSADORS CANADA

Our own learning experience has evolved over the course of a long career. A few years of full-time medical practice in Canada was followed by eight years in Papua New Guinea both in clinical teaching and as a Provincial Health Officer within the Government system. What we learned there was applicable as we returned home to help found a Calgary street clinic called CUPS and a full service community family health clinic.

Encountering Medical Ambassadors International (MAI) at a conference led us into early semi-retirement. For the better part of twenty years, we have been volunteering part-time (upwards to eight months a year and now much less) for MAI and the Canadian counterpart, Medical Ambassadors Canada (MACA). Here the focus is on empowering communities to lift themselves out of poverty by addressing health from the broad WHO definition—health is a state of complete physical, mental, social (and some areas add spiritual), not just the absence of disease or infirmity.

The strategy, called CHE—Community Health Education/Evangelism—Empowerment depending on the region of the world, has taught us that we must address the whole person and whole community in order to see health status change long-term. CHE equips national trainers to work in their own communities by giving training in using prepared lesson plans, booklets, and ongoing workshops on topics relevant to human flourishing, as well as facilitating skills for engaging adult learners.

In many countries, early interventions and The First 1000 Days initiative is a current focus, while in others social or economic issues are at the top of community agendas.

BOTTOM UP, TOP DOWN, OUTSIDE IN

This idea of working with communities to take ownership of their own health issues using peer-to-peer teaching, is arguably the way to see long-lasting change. In their book Just and Lasting Change, Drs. Carl Taylor and Daniel Taylor-Ide, (Carl founded the International School of Public Health at Johns Hopkins University in 1965), propose a model that makes sense to us. They talk about a “bottom-up, top-down, outside in” three-way partnership. The “bottom-up” initiatives at the community level are the base of the pyramid in all regards and must take the lead. But if the “top-down” support from the appropriate government agencies and the “outside-in” objectivity and expertise are not lending their support, the bottom will soon find they cannot move beyond a certain level. The “outside-in” may be people like us Western physicians who can advocate for the community, support the local specialists and bring an international perspective.

Often, as here at home, we find a disconnect between the top levels of the medical system, for example specialists in the referral hospitals, and the rural health centres with staff that feel isolated and unsupported. Here we think, is another “outside-in” niche—we in Medical Ambassadors approach health from the bottom while connecting at the top, so are able to make contributions at both levels while at the same time advocating for the needs of community health. In this way we take our role as ambassadors’ seriously.

The Short Term Medical Mission Dilemma

“...there has to be a better way...” he said. We had to agree. This was not the first time we were part of one such organized trip some years back with about twenty others—medical practitioners and their families. After the thrill of the experience wore off, discomfort with the whole process told us that we could not do this again. We could see that by treating patients and dispensing medicine without cost, we were unwittingly undermining the local health care facilities and workers. Our own experience of working with the Department of Health in Papua New Guinea for eight years when our children were younger was enough to tell us that. Not only were the medications free, but they were often not available or too expensive in the country for ongoing treatment. And did our translators understand enough to adequately explain to the patients when and how to take the medication? Did the treatments prescribed meet local protocol? Did the Canadian and US doctors who had spent years in other specialties really understand the tropical diseases they were treating? Was our well-intentioned help really helping at all, or were we hurting their long-term health? Their need for better health care and living conditions was obvious. But did our one-week foray into curative medicine—in this rural area do anything to better their future community or family health status? Perhaps it was simply a great experience for our kids, as an enthusiastic team incorporated them into the program by letting them weigh babies, take blood pressures and assist the dentist. But at what expense, if there was damage control needed after we went home or if we had somehow tampered the confidence of the people in their own healthcare system? BEST PRACTICES FOR MEDICAL MISSIONS

In his excellent book Where Healthcare Hurts, Greg Seager has thoroughly researched the complications of such short-term medical
The Royal College of Physicians and Surgeons of Canada, in an attempt to encourage Canadian Specialists to be involved internationally, has created a non-profit arm called the Royal College International Incorporated (RCI). Their stated goal is to “improve medical education and practice globally and to build capacity internationally in specialty medical education and professional development.” They work “alongside peers within government departments and ministries.” By cooperating with the local health departments to build capacity with specialty peers in the receiving country, RCI believes this will “demonstrate positive impact within targeted stakeholders organizations/regions as a result of their direct collaborations [...] for sustainable long term success.”

Medical Ambassadors have seen the value of this strategy and believe that both CME and advocating for integration between the “top-down” and the “bottom-up” will accomplish our goal to see human flourishing. And as Christians, we know that when we integrate the spiritual with our efforts to see transformation happen at the individual and community level we are modeling Jesus as the Great Physician.

For many years MAI and MACA have supported a very effective Philippine NGO to train Community Health Education organizers/regions as a result of their direct positive impact within targeted stakeholders. They work “alongside peers within government departments and ministries.” By cooperating with the local health departments to build capacity with specialty peers in the receiving country, RCI believes this will “demonstrate positive impact within targeted stakeholders organizations/regions as a result of their direct collaborations [...] for sustainable long term success.”

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THE TACLOBAN STORY

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Many of the Filipino specialists from the regional hospital discussed their issues. This was a first for the community CHE trainers. They validated his work. I have seen that even this is from God’s behind me, but I was encouraged to realize that when you have the most influence, have the most experience and gained the most wisdom.

Mitch Anthony, in his book, The New Retirementality says, “Without question, for the retired it is a life where the focus and motivation of our work should not be all-consuming. Allow me to offer just a few thoughts on the source of income. If work provides no more than a means of living and not to be all-consuming. Allow me to offer just a few thoughts on the source of income. If work provides no more than a means of living and not to be all-consuming. Allow me to offer just a few thoughts on the source of income. If work provides no more than a means of living and not to be all-consuming. Allow me to offer just a few thoughts on the source of income. If work provides no more than a means of living and not to be all-consuming. Allow me to offer just a few thoughts on the source of income. If work provides no more than a means of living and not to be all-consuming. Allow me to offer just a few thoughts on the source of income. 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PLANNING

The term “calling” has often been reserved for a religious setting, a form of public ministry, such as a member of the clergy or an overseas missionary. However, becoming a politician, lawyer, doctor, fire fighter, police officer, mechanic etc. has been considered more of a career choice and not typically connected to calling at all. It seems that calling is “sacred” while the other careers listed are more “secular” and we tend to separate the two.

In his book, Conformed to His Image, Dr. Ken Boa says, “Our primary calling is to know and love God. Our secondary calling is to express this relationship in everything we do and with everyone we encounter.”

As a teenager, I felt a “call” on my life and the best way I could interpret it at the time was to become a pastor. My response was to attend Bible College and during my first year, my Bible was open to 2 Timothy 4 where I was reminded daily, “Preach the word; be in season or out of season.” Due to unforeseen circumstances however, I entered the financial services industry and therefore, felt more “out of season” in regards to my calling. My perspective was that my work as a financial advisor was not necessarily a “calling” but just a job (secular). I felt my “calling” as pastor was my true work (sacred). Had I missed my “calling” or was it possible that I could actually live it out by being a financial professional? Maybe I had the wrong perspective to start with.

My problem was that my secondary calling (as a financial advisor) was somehow disconnected from my primary calling. Dr. Ken Boa explains, “If the secondary is not related to the primary, we slip into the error of dichotomizing the ‘spiritual’ and the ‘secular’ when they should really be integrated. When this happens, our relationship with the Lord is disconnected from the everyday activities of our lives.”

Boa also points out, “the opposite error occurs when secondary calling replaces primary calling. When this occurs, work becomes an end in itself by turning into our personal ‘vocation’ (from the Latin word for “calling”.) I wonder if “work becoming an end in itself” is the reason we desire to retire from it, especially when work lacks fulfillment. When I recognized the opportunity to bring glory to God (primary) through my practice (secondary), my work was transformed and took on new meaning.

My level of fulfillment reached new heights because a secular and sacred were merged after many years. Dr. Boa sums this up perfectly: “When we keep our primary calling first and seek to express it in and through our secondary calling, we become more holistic in our thinking and actions.”

For many years, as my focus was on building the business, which included developing relationships and serving clients. While my focus was good (and typical of this industry), this sometimes lacking lack of perspective that only comes by incorporating the primary calling. Dr. Ken Boa explains it this way: “Secular work becomes spiritual when done to the glory of God. Spiritual work becomes secular when done to please and impress men.” When I recognized the opportunity to bring glory to God (primary) through my practice (secondary) my work was transformed and took on new meaning.

Eric Liddell was a devout Christian and missionary to China, who felt it a priority to run in the Olympic games. His sister felt that his training for the 1924 Olympics deterred him from returning to China. He said, “I believe the Lord made me for a purpose – China. But he also made me fast! And when I run I feel His pleasure. To give up would be to hold Him in contempt. It’s not just fun. It was to honour Him.” We usually would not class running or involvement in a sporting activity as spiritual, or God-glorifying. For Liddell, running wasn’t just a fun activity; it was where he sensed God’s pleasure. That ought to be our goal in work and life when it comes time to pay them off. Large debts are a ball and chain on your life when it comes time to pay them off. Large debts are a ball and chain on your life.

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Jean Watson stresses the importance of “extracting the most meaning from the means you possess.”

When work lacks fulfillment, we become a financial professional? Maybe I had the problem was that my secondary calling (as a financial advisor) was somehow disconnected from my primary calling. Dr. Ken Boa explains, “If the secondary is not related to the primary, we slip into the error of dichotomizing the ‘spiritual’ and the ‘secular’ when they should really be integrated. When this happens, our relationship with the Lord is disconnected from the everyday activities of our lives.”

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he has enough money to complete it” (Luke 14:28)

PRACTICAL TIPS TO CONSIDER IN OR LEADING UP TO RETIREMENT

Below is a list that all Certified Kingdom Advisors need to commit to annually, which is something everyone can certainly be applicable to any Christian who is serious about their role as a steward – whether working, approaching retirement, or in retirement. This is in no way meant to be exhaustive advice. For advice tailored to your particular needs, I suggest you contact a Certified Kingdom Advisor to find specific answers and personal advice that aligns with their Christian values: https://kingdomadvisors.com/find-a-professional/directory-search

1. Lifestyle is adjusted in Retirement (Income & Work)

Plan your ideal week in Retirement: Consider what you will do each morning, afternoon and evening for everyday of the week.

“When your most valuable asset is time, not money. A rich life is about spending that time well.” (Mitch Anthony)

One adviser has said fewer clients now seek a complete break from their professional lives. Instead, they are looking for ways to use their expertise gained over a life time of working. Steam Rempel (from Calgary) says this could mean working 24/7 (24 hours per week/7 months of the year). In other words, work when you want, if you want. Ask the question: What brings fulfillment? Retirement is a unique opportunity to focus on what makes you feel His pleasure.

2. Provision & Taxes Diversify your retirement income

The RRSP/RRIF: Take advantage of Spousal RSP’s, as it can be a great way for couples to split retirement income.

TFSA: Maximize this option since it can be an income source that will not increase your annual tax payable.

Non-Registered Funds: Utilize Return of Capital. As an investor you can receive a percentage of your RRSP/RRIF, and these payments are not considered income or capital gains from the investment. Note that a return of capital reduces an investor’s adjusted cost basis. When the ACB is reduced to zero, the entire remaining balance is taxable when sold. One strategy is to give this taxable other amount (or a portion of this) directly to charity to reduce taxes. Eliminate Debt: Less income is required when there are no repayment obligations.

4. Give from the highest taxed sources: Registered funds are fully taxable; you can use T1213 form to receive CRA permission to donate 100% of RRSP withdrawal (no taxes withheld), if the amount is to be donated to Canadian charities. Also consider donating stock or funds with an appreciated gain to reduce the tax. This can be accomplished by transferring the value directly to the charity for donations.

Financial Planning for Retirement

W J FENTON

Your finances in retirement are affected by your financial decisions over many years, including many years when you are not even thinking about retirement. The entire way you approach how you spend, invest, and save can change the future value of your wealth in retirement. The time to start planning for retirement is now. Here are some practical tips to keep in mind.

MEDICAL PRACTICE YEARS

1. Right at the beginning, you need a good Chattered Accountant to get your financial affairs properly organized and to prepare your tax returns. The tax act is complex and you will pay heavily for not doing it yourself and not consultizing an expert.

2. As early as you can, start contributing to your RRSP. Small contributions become quite sizable when compounded over a long time and sheltered from taxation.

3. You need good investment advice. Look for someone who is paid by charging for his or her advice or by a small percentage of the value of your investments (an incentive to have their advice cause your funds to do well) rather than someone who makes their living selling investment products. As a group, physicians have a reputation of being poor financial managers and of being suckers for investments that are “too good to be true” (they usually are bunk).

4. You need insurance, so get a good agent. Get a good disability insurance when you are healthy. If you want to wait until you need it, the need will be prorated or not covered. If you are married and especially if you have children you need life insurance to protect them should you meet an untimely end.

5. Once in practice you will be making a much better income than most people. Avoid the need to spend it all and catch up on “adult toys.” Deal with your debts. If you are married and especially if you have children you need life insurance to protect them should you meet an untimely end.

6. Buy a house means debt acquisition but it is a good form of deple provided you are reasonable about what kind of house you buy. Buy a house that meets your family needs, not one that strokes your ego or need to impress others. Same thinking applies to the car you buy.

FINANCIAL PRACTICE YEARS

1. Minimize debts as much as possible. Large debts are a ball and chain on your life when it comes time to pay them off.

2. Live modestly according to your means and not what borrowed money might provide.

3. Eliminate Debt: Less income is required when there are no repayment obligations.

4. Give from the highest taxed sources: Registered funds are fully taxable; you can use T1213 form to receive CRA permission to donate 100% of RRSP withdrawal (no taxes withheld), if the amount is to be donated to Canadian charities. Also consider donating stock or funds with an appreciated gain to reduce the tax. This can be accomplished by transferring the value directly to the charity for donations.

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As a practicing physician, parent of three children, and long-time member of the Christian Medical and Dental Association of Canada, I strongly endorse the film, Unplanned, and commend its viewing to everyone (regnaged and older). This also includes those who are against abortion, those who are committed to promoting this so-called “reproductive health choice,” as well as those who are either ambivalent on the issue or, if pressed, feel abortion should be permitted. For the former group, my hope is that the film would encourage active ambivalence on the issue or, if pressed, feel abortion should be permitted. The film unashamedly brings attention to the reality of the abortion procedure. While “pro-choice” activists might prefer this information be kept behind closed doors, the bottom line of abortion is that babies are killed. There’s no denying this. After it’s all said and done, innocent lives are lost, and in unfathomable numbers. Rhetorical claims to freedom of choice can’t hide this truth. The producer of the film had a pro-life life mission one of pro-life activism. The film doesn’t limit its emphasis to the surgical suite and the abortion procedure, but thoughtfully delves into a full array of the subject’s complexities. There are recurring scenes which take place at the Planned Parenthood Clinic’s parking lot fence, for example, depicting the communications that employees and patients have with various groups of protesters. Some of these interactions, such as the angry accusations shouted by clinic staff to those at the fence and their immature use of the sprinkler system to purposely soak them, or the protesters decked in Guin Reaper costumes yelling vulgarities at arriving patients, expose ugly aspects of the abortion debate. However, there are also numerous tender scenes that take place at the fence, as well, depicting pro-life groups praying over the clinic, holding vigil for the unborn, and making tireless attempts to engage patients and staff in relational conversation. This is important because although this is a hyper-polarized, emotionally-supercharged topic, if an end to abortion is to be realized, it won’t be from argumentation alone, but will require the development of genuine caring relationships. The film portrays well the inner turmoil and anguish experienced by expectant mothers who are struggling with an unwanted pregnancy, and underscores their vulnerability and need for compassionate care. In addition, the film emphasizes not only the need for life-giving alternatives to pregnancy termination, but the importance of extending compassion to those involved in abortion clinic work and pro-abortion activism.

Despite the negative media coverage of the film and the imposed limited theatre run, Unplanned has swept the nation, selling out in theatres from coast to coast, even on weeknight viewings. Supplemented by numerous private buy-outs across the country, the film has even reached the number one position for per screen average in North America, and is positioned for an extensive global expansion. The timing of the film is critical because lives are hanging in the balance, and momentum is building to help counter our current abortion-on-demand status. With the growing number of American states passing “heartbeat” bills in the US, which will ban abortions as early as six weeks into pregnancy, the day may be drawing near when the landmark 1973 Supreme Court case of Roe v Wade gets overturned. This would be welcome news for pro-life advocacy groups worldwide, particularly in our nation, where abortion is without legal restriction and remains lawful at all stages of pregnancy. Advocacy and resolve will be needed to stop this killing. Make sure to take an important step in this direction and plan to see Unplanned.
Retiring from Family Practice

LINDA GAGNON

I retired from family practice December 14, 2018 at the age of 61 years old. I loved my career in family and did everything — cradle to grave. I ran an office in a big clinic with a walk-in clinic as well as our offices. I delivered babies for 22 years, participated in sexual assault call, acute care inpatient, surgical assists, OPD procedures, LTC, housecalls, etc. It was exactly as I had planned. So why did I retire at such an early age? I spent my career paid by fee for service and by the time I was accepted for an ACP, my decision to retire was already made.

There are a number of influences that affected my decision to retire. The cost of running a medical office is expensive and always has been. The addition of electronic medical records created two problems: escalating cost and the increase of the time needed to spend on each individual visit for documentation. Most nights I was not leaving the office until between 6:30 and 8:00 PM. This in itself wouldn’t be such a problem, except getting a focus was difficult to impossible, therefore vacation time became quite expensive. With the lack of rest from taking less vacation time, stress levels go up.

On top of that, there were external pressures from patient expectations, pressure to know every clinical practice guideline on every topic, and increasing college complaints. Complaints alone have increased 10 fold in the past 10 years alongside College policies that don’t allow for people of conscience to avoid what they consider unethical practices.

What this did was to affect how I felt when I would open the door each day to my office. It got to the point where I was at first anxious and later on actually dreading the best way to deal with them. I have spoken to colleagues who retired around the same time as me and they confirmed that lost sleep over this issue is common. My medical/business partner and I had practices that were over 30 years old. We only started to use an electronic medical record in the last eight years of our practice and as such we had a substantial store of paper records to tackle.

My medical/business partner and I paid for the staff to hang on for 2 1/2 months after we closed the office to scan all of the paper charts into the electronic medical record. This had to be done by a certain date as the clinic that we worked at was switching to a different electronic medical record system and the clinic was going to be migrated to that new system.

Both of us incurred approximately $10,000 each to digitize our charts, but it did allow for the clinic (and thus our patients) to have access to the patient charts.

I don’t think I would’ve done anything different in closing the practice, because there were too many things out of my control. I would suggest that anybody who has paper charts to start scanning them into their electronic medical records gradually to decrease the financial and emotional burdens at retirement.

In my last years in practice, I had already been transitioning to more occupational medicine and insurance medicine. The four years before I retired from family practice I was doing two days per week as a medical advisor at the Worker’s Compensation Board. I had become certified as an independent medical examiner so when I retired, I increased the amount of impairment assessments that I did for the WCB. Not wanting to go out of my patient contacts completely, I also continued on working at the long-term care facility as a Care by Design doctor. I still wanted to work and be productive and I was not ready to say goodbye to all patient care. There is no overhead to either of these jobs therefore there are no ongoing expenses when I am not there. There are fewer chances of moral/ethical issues.

It’s been almost a year and I still have some residual anxiety regarding work, but it is continuing to quiet down. I sleep well. I work three days a week, so I now have time to spend pursuing other interests in my life and taking care of my own well-being. I have more time to spend with my grandchildren and taking vacation is no longer a major stressor.

This is a solution for someone at the end of their career, but what about all the young Christian family doctors? I wonder how they will cope with these changes, which will be soon the norm. There really is only one way to survive and that is to speak up and demand the protections that all Canadians should have, including when you do not agree with the anti-Christian policies of our colleges and the decisions of the courts. Our government should be protecting us from these non-elected groups; the court judges and boards of the medical colleges (half are not elected). Some suggestions—make sure the voted members of the provincial medical colleges are those who would support your positions, vote for candidates that will at least protect your right to conscience, speak up to your colleagues and support groups like CMDA Canada and EFC who are in the courts battling with governments over these issues. We of the older generations will support you.

When I graduated from dental school in 1977, there was the furthest idea in my mind. I was setting sail on a new career the end of which was so, so many years away. We were told in school to start preparing early in our career for retirement and financially I did. I really never gave much thought about giving it all up until my last year in practice.

The last two weeks in July were my traditional time to take vacation. Year after year, I blocked that time off as soon as the schedule for the next year was available. It was a time for me to enjoy family vacations and recharge. I always felt relaxed and after a two week break ready to get right back to the office. After 35 years in practice and at the end of my two-week break, I did not have that feeling that I was ready to head back into the office. I had a sense that change was coming.

My initial reaction was to kick the can down the road a bit. I told my wife Sandra that, if this feeling did not go away, then I think it was time to look into a change. I enjoyed dentistry and working in my practice. Things were going very well. I had great patients and a great staff, yet I was considering giving it all up.

My life verse is Proverbs 3:5-6, and I have always felt His calling, and now I applied to get into dentistry and subsequent to this, I have always felt His calling, and now I felt a calling to change.

I started to investigate how to transition out of practice. I hired a company to evaluate my practice and then to find a dentist to take it over. Everything went smoothly and a buyer was found. All within the course of 2 months, I went from full time practice to full time retirement.

I was excited by the prospect this new chapter in life was bringing. It was different to wake up each day without having to go to the office. I missed the staff and the patients, but there is something refreshing knowing that there is no rush to get to the office each morning. I have found that our days are full with other things. In fact, with more time to babyvisit grandchildren, and visit aging parents, I sometimes wonder how I had time for running a practice.

I still have my toe in the dentistry pool. Sandra and I have always been involved in short term dental missions throughout my career. I first went on as a dental student with CMDA Canada and I continued over the years to participate on and lead some dental missions. In our first year of retirement, we went on a medical mission to Honduras.

We were staying at a mission run school in the country and visited the local villages with the medical and dental team. One day was dedicated to seeing the 100 plus students enrolled in the school. Needles to say, even with the two dentists on the team, we were able to do a little more than handle a few dental emergencies. I asked the school if next year I could come a week earlier than the team and just see the students and assess their dental needs. We have been doing this for 5 years now. We are going for over 3 weeks each time to examine all of the children and treat their dental needs. For many it is their first time ever to visit the dentist and treating their dental needs at the start of the school year allows them to be free of any dental needs during the year.

I asked the Lord in my undergrad year, allow me to serve where you call me. Retirement is the next chapter in my life and I still feel the Lord’s leading and my serving. I am thankful for the career that I had in dentistry and I am now enjoying the next phase of that career, retirement.

When I first started in practice, a gentleman in our church had just retired. I asked him how he was enjoying retirement and he said, “I highly recommend it” and I do too!
The Arete Medical Ethics Summer Seminar is a ministry of CMDA US. Thanks to networking by our Associate Staff/Networkeer Jen Dykeman, Samantha was invited to attend. The cost of tuition and accommodations were provided by CMDA US.

During the last week of June, I had the opportunity to attend the Arete Medical Ethics Summer Seminar at Duke University in North Carolina; a five-day intensive course that was unforgettable and life-changing for me as a medical learner. The seminar was facilitated by Dr. Faye Curlin, a palliative care physician at Duke University, and Dr. Christopher Tollefsen, a philosophy professor at The University of South Carolina. At the seminar, we were invited to examine central ethical questions that arise in medical practice and to interpret those questions through a moral framework drawn from both natural law and medicine’s traditional orientation toward patient health. Furthermore, we were tasked with considering what sort of practice medicine is and whether it has a rational end or goal. The seminar’s emphasis on natural law attracted a predominantly Christian group of learners. Nonetheless, nearly 20 medical learners from various ethnic backgrounds, and with differing belief systems and levels of medical training, came together to engage in intimate, thought-provoking sessions guided by Dr. Curlin and Dr. Tollefsen. We represented schools from all across the USA and Canada, and even Europe! The fruits of my week at Duke were manifold. Most fundamentally, the seminar served as a crash course in bioethics. We discussed the definition of health, and examined topics including the beginning of life, reproductive health, the end-of-life, and conscience/freedom of belief in medical practice. We were also introduced to a variety of moral frameworks, including principism and consequentialism, as well as a natural law-informed approach coined The Way of Medicine by Curlin and Tollefsen. We used critical thinking to put the various ethical frameworks to the test in our discussions of bioethical issues. As pre meds, most of us are introduced to principism through books like Heber’s Doing Right, which has essentially become prerequisite reading for medical school interview preparation. The principism framework is one that we, as medical learners in Canada, accept as the framework of choice even before our training begins, and which continues to be reinforced throughout medical school. Principism calls us to make ethically challenging decisions according to four very noble principles loosely grounded in the Hippocratic tradition: autonomy, beneficence, non-maleficence, and justice. In many cases, these principles serve as appropriate, sensible criteria for making ethically sound medical decisions. However, in cases where two or more principles are found to be at odds, we are often tasked with prioritizing which principle will take precedence over the other(s). And this is precisely where things get murky.

Take end-of-life care, for example. It would be both just and beneficial for a physician to intervene in some way to help a suffering patient feel less pain, so to improve their quality of life. Should a patient want to end their own life because they are suffering immensely, respecting a person’s autonomy might see a physician participate in assisted suicide to help the patient fulfill their request. However, the principle of non-maleficence would suggest that autonomy – intentionally ending the life of another person – is morally wrong, as it is an intrinsically immoral act. Here we can see the clashing of principles, and a decision must be made to prioritize one over the other. Four years ago, Canadian law would have held that the principle of non-maleficence should outweigh autonomy, condemning euthanasia as a morally impermissible act of killing. However, with the introduction of Medical Aid in Dying (MAID) legislation in 2016, the ordering of the principles has been reversed such that autonomy triumphs non-maleficence and even tours MAID as an act of beneficence by allowing someone the ‘right to die.’

Through principism can and does help us to make decisions regarding ethical dilemmas by weighing all of the principles when making a decision, in today’s post-Enlightenment individualistic society, it often gives the principle of autonomy veto power over the other three principles. As demonstrated above, principism has the potential to introduce a slippery slope where virtually any patient request can be deemed morally acceptable if it is autonomous, and provided that the other principles are being respected (or at least can be portrayed in such a way that they seem to be respected.) This glorification of autonomy has led to what Curlin and Tollefsen have called the Provider of Services Model, wherein physicians are asked to respond to patient requests for ‘health’ services that may or may not actually be oriented toward a patient’s health.

Throughout the week, Curlin and Tollefsen exposed us to The Way of Medicine as an alternative to the Provider of Services Model. In The Way of Medicine, all treatments a physician prescribes are oriented toward the basic human good of health and serve to restore the well-working of the human organism and lead to its flourishing. I could spend days applying this framework to various biotechnical issues — and believe me, we did — but suffice it to say that the physician is not merely a provider of services under this framework, but also a desirer as a Christian. From a Christian perspective, physicians under The Way of Medicine act to restore the patient back to their well-working state, in accordance with the natural law as God has designed it. What I take away from the seminar is that physicians today have a profound deficit in knowledge and understanding regarding the historical and philosophical underpinnings of modern-day medical practice and the implications of the notion that our values are extreme and irrationally held. After this conference, I am willing and ready to defend them. In a conversation with hard feelings, but instead with a thirst to keep learning more and to grow in faith. Through the week, some of us Christian medical students in the group went out to worship events on campus, and even some of the non-Christian friends came along for the ride. I did become clear to grow in faith. As Christians, we are often ignored because of the notion has running, it’s extreme and irrational hold. After this conference, I have become even more fully convinced that a biotechnical perspective consistent with Christian values is grounded in sound, logical, and irrationally held. After this conference, I am willing and ready to defend them. In a conversation with the first person, to that speaking up with an unpopular opinion is futile. There are many Luke-warm people out there just waiting to hear a message that resonates with them. As St. Augustine of Hippo said, “The truth is like a lion; you don’t have to defend it. Let it loose; it will defend itself!”
I'm Retired: How Did I Get Here? How Am I Doing?

W James Fenton

When I graduated from U of T Medicine in June 1966, my vision was to start interning in June and get married in September after a seven year courtship. I anticipated going to the Arctic for a couple of years (I had been there the summer between 3rd and 4th med and loved it) and then join my brother in general practice in Saskatoon (he had taken over my late father's practice). The internship and marriage happened; the rest did not!

I started my internship with three months on the medical wards. I enjoyed it but had a strong sense that I needed to learn so much more. I thought an additional year of internal medicine was needed. Good relationships and good times with my sons plus the added benefit of daughters-in-law and four grandchildren. And we are now more available to them in our retirement years.

Keeping my medical career within certain boundaries has helped me pay attention to Dr. Penfield's Second Career model. I've made time for other interests, prime among them enjoying God's wild creation and photography.

Importantly, it has also helped protect and nourish my marriage relationship. She "ooked" my heart when I was 17. A small plaque in our home reads: "Here lives an old fisherman with the catch of his life." It's true! I must confess I didn't do as good a job of limiting the demands of church leadership. In all of this we have tried to be sensitive to God's leading as we made the decisions. In retirement, observers continue to ask us leading the decisions that need to be made.

In retirement, as in life, the unexpected happens. My vision for retirement did not include having coronary bypass surgery. Fortunately, it came about in a way that the diseased pipes were bypassed before any muscle damage had occurred. I also developed fairly severe hearing loss. Expensive hearing aids certainly help but they make music sound off key and music has been an important and enjoyable part of our lives.

These are issues of aging and lifestyle. We can and should live in ways that slow such processes down, but we should not be surprised when they occur or let them discourage us from living well.

By sharing my personal story, I hope I have illustrated how important ideas and concepts that came to my attention early on have helped me to practice medicine better, live better and retire better than if I had not become aware of them.

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As part of our 50th anniversary celebrations, we have been reprinting articles from our last 40 years of producing FOCUS Magazine. In 1966, Dr. Dykeman was asked to prepare a presidential lecture for CMDA Canada: "How Secularism has Corrupted Medicine". This lecture was given at the Annual Meeting in Saint John, NB in May 1997 and published in Focus in two parts, in February and May of 1998. Below is a sequel to those articles.

The theme and content of the lecture was timeless. A recent review of the subject reveals the processes of secularism are relentless and persistent. Not only has it affected medicine, but also law and justice, religion, and rights and freedoms. The core problem of secularism is a faulty view of God, man, and the physical material world. There is an irreverent tension between reason and revelation. The predictable outcome is what we are seeing around us today: combating voices in the public space. Voices becoming more shrill and demanding, conversations becoming a shouting match. Just tune in to TV newscasts for examples.

This present article reflects on core issues that are evolving: What is a Person? What is Truth? What are the Absolutes? Are they knowable? Where do I find them? How do I live a Godly life in a Pagan Society? (1 Peter 2: 11-17)

THE PERSON

The Oxford Universal Dictionary defines a person as a human being, alive, and having rights or duties recognized by law, but who intercedes for the fetus and acts as their defense lawyer? The fetus is a person made in the image of God and loved by God. Jeremiah 1: 5 declares, "The word of the Lord came to me saying, 'Before I formed you in the womb I known you, before you were born I set you apart; I appointed you as a prophet to the nations.'" The secular definition of "the person" is like evolving: What is a Person? What are the Absolutes? Are they knowable? Where do I find them? How do I live a Godly life in a Pagan Society? (1 Peter 2: 11-17)

ABORTION

The Canadian Institute of Health Information tables of reports "reported the total number of reported abortions that took place between 1997-2010 in Canada was 5,193,362." This does not include data from private clinics and Quebec. P.E.I. has no abortion facilities. See AbortionInCanada.ca for a breakdown by province and by year. Abortion issues surfaced in Canada's last Federal Election, but no party leaders wanted to pursue it. The media seemed convinced that someone wanted to change current laws. Roe v Wade in the United States has come under attack. Some states dropped funding for planned parenthood clinics if they were providing abortion services. President Trump has done the same thing federally in the U.S. autonomous, my right to define my own meaning and purpose in the universe as the fetus plays no role in these decisions.

Abortion is legal in Canada, but different provinces have different requirements for physicians. In Ontario, if the physician cannot provide the service, they are told to make an effective referral, which is defined as taking positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, health-care provider or agency. The implication here is that failure to follow this policy makes the doctor an unethical physician and liable to censure from the licensing body. Here is where a clash of values occurs. The woman insists she has a right to have an abortion, "My Body. My Choice." The fetus is helpless and has no rights before 3 months. The physician is caught in a dilemma and feels a referral implicitly involves him/her in killing a human life.

Secularism has a defective or anesthetized conscience and hence the average person sees no problem with doing something against their natural instincts. The structure of the Canadian Medical Association to Nursing and Medical School in some jurisdictions are being asked to affirm they would be prepared to assist in an abortion or euthanasia case. But the secularist observation is that we neglect to see the weakest and most vulnerable person is the fetus in utero. Their life began at conception. All the body parts and functions are there embedded in the DNA Code. It is heaven sent for us to see that 3.1 million fetuses were aborted from 1974 to 2010. This is more than enough to populate the Atlantic Provinces and still have some left over. Who represents these people and who cries out for Justice for the brutality they suffer? The "rule of Law" is of no help to these people. They are on the wrong side of the equation! "Canadians Values" are of no use to the fetus. However we believe that "The Supremacy of God, now removed from the Charter."

In future, it will be a stressful task for all. Services will be further stressed in the future as the baby-boomers age to 70+ and access to resources will be challenged. Everyone's last will and testament should clearly provide a family member with the authority to determine what forms of terminal care to pursue. Once again the secularist sees no problem in dispensing a person with a terminal illness. The issue here is motive. Compassionate terminal care respects the wishes of the patient and family and directs treatment to relieve discomfort. It does not prescribe doses of medications to hasten death. We don't have a license to kill.

The reference to the "Supremacy of God" in the preamble of our Constitution was of no legal significance in our laws. It failed to see that they too are responsible to a higher power and will be responsible for the cases they adjudicate.

A personal request to the Governor General of the day for his understanding of the "Supremacy of God" phrase elicited the response: "His excellency considers it unenlightening."

CMDA Canada is strategically positioned to offer that kind of healing environment and share our walk with God enables us to do one day at a time living godly lives in a pagan society.

EUTHANASIA/ASSISTED SUICIDE

Just as Canadian Physicians have been compelled to participate in the abortion scenario, so now they are expected to follow suit with euthanasia. Why has the profession that is dedicated to helping people live, suddenly saddled with the task of becoming "State Executioners"? The Euthanasia Bill was passed into law and it is already getting challenges and questions of interpretation. The EFC is monitoring this carefully at their website www.TheEFC.ca, as is CMDA Canada. The Federal Law currently requires that in order to be eligible for MAID (Medical Assistance in Dying), a person's natural death must be "reasonably foreseeable." Quebec's Act Respecting End-of-Life Care also requires that a person be at the end of life in order to be eligible for euthanasia. Justice Christine Baudouin of the Quebec Superior Court recently found that the "reasonably foreseeable" clause of the federal legislation "to be unconstitutional, violating the equality provisions of the Charter."

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Will the generation that sowed the seeds of abortion reap the whirlwind of euthanasia?

JUSTICE AND LAW

The Canadian Secular State has a defective view of reality. God is not in the picture. Concepts of rights, freedom, and justice are defective because the view of man is defective. This structure that support these are also defective. We see this daily in the public square.

The Supreme Court of Canada ruled that reference to the "Supremacy of God" in the preamble of our Constitution was of no legal significance in our laws. It failed to see that they too are responsible to a higher power and will be responsible for the cases they adjudicate.

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The Corruption of Medicine by Secularism – A Sequel

WINSTON DYKEMAN

The Preamble to the International Declaration of Human Rights states: "Whereas recognition of the inherent dignity and the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." Then 30 rights follow in the text.

It is a good test for motives in how we interact with each other. A good question to start with is before we embark on any project involving people: "Does what I am doing reflect respect and dignity for the human person?"

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Abortion issues surfaced in Canada's last Federal Election, but no party leaders wanted to pursue it. The media seemed convinced that someone wanted to change current laws. Roe v Wade in the United States has come under attack. Some states dropped funding for planned parenthood clinics if they were providing abortion services. President Trump has done the same thing federally in the U.S.

The theme and content of the lecture was timeless. A recent review of the subject reveals the processes of secularism are relentless and persistent. Not only has it affected medicine, but also law and justice, religion, and rights and freedoms. The core problem of secularism is a faulty view of God, man, and the physical material world. There is an irreverent tension between reason and revelation. The predictable outcome is what we are seeing around us today: combating voices in the public space. Voices becoming more shrill and demanding, conversations becoming a shouting match. Just tune in to TV newscasts for examples.

This present article reflects on core issues that are evolving: What is a Person? What is Truth? What are the Absolutes? Are they knowable? Where do I find them? How do I live a Godly life in a Pagan Society? (1 Peter 2: 11-17)

THE PERSON

The Oxford Universal Dictionary defines a person as a human being, alive, and having rights or duties recognized by law, but who intercedes for the fetus and acts as their defense lawyer? The fetus is a person made in the image of God and loved by God. Jeremiah 1: 5 declares: "The word of the Lord came to me saying, 'Before I formed you in the womb I knew you, before you were born I set you apart; I appointed you as a prophet to the nations.'"

The secular definition of "the person" is like a moving target with changing parameters depending on the latest opinion polls or political needs. The definition is arbitrary. Since God is not in the picture it lacks stability and endurance. This leaves it wide open to abuse and manipulation. What Parliament gives today, it can take away tomorrow!

1 cf. CIHI Health Statistics; AbortionsInCanada.ca.
Fifteen years ago, if someone had suggested to me the possibility of living gently, or suggested to me that limitations might be a gift, I would have thought, “Living gently? What’s that? Then, “Isn’t that selfish and lazy?” Then, “Don’t I wish! But it’s just not possible in my situation.”

But slowly, over the past decade or two, I’ve been learning what it means to live gently, that it’s not selfish but faithful stewardship, and that the barriers to living gently are a lot more internal than I thought. I might not be able to change the whole situation, but I can make small choices that make a difference.

I grew up believing that a good Christian life meant always meeting the needs of others, even when it meant persistently disregarding my own needs. I wanted to love God and others, and to share the gifts I had been given in order to serve. I discovered that I was an obstetrician and went off to a little village in the mountains of Afghanistan where 1 in 8 women died giving birth. Picture a hospital made out of mud-brick, with no running water, limited solar electricity, no x-ray machine or blood bank, and lines of beautiful and needy people waiting to be served. My work there felt important. Many days I could see how God had used me to help save someone’s life. And so I kept pushing, becoming more and more exhausted as I forced myself to keep trying to meet the endless needs. If I didn’t meet them, who would?

The consequence of my constant pushing was illness. I fought the need to rest. Even when I was so weak that it took two tries to drag myself on hands and knees to the outhouse, I kept working lying down in bed, writing protocols to write, emails to answer. My life was a command to push without ceasing—until I couldn’t push anymore and my life fell apart and God began to teach me that even hard labor can and must be lived gently.

Living gently, then, means respecting the limits and rhythms built into me as part of creation, and learning to push and rest, push and rest, rather than to push all the time. This entails remembering that I am human and not God, and that is good. God remembers that I am dust, and has compassion on me (Psalm 103:13-14). Can I let myself, in my limited humanness, receive God’s compassion and learn to be gentle with myself as he is with me? Can I live with hands open rather than clenched, attentive and responsive to God rather than focused on control.

What does it mean to live gently?

I was still in training when I saw a first-time mom try to push without ceasing. The baby’s descending head was stretching her pelvic floor, and feeling the unrelenting burn, she pushed through the contractions and kept on pushing long after the contraction had eased.

The contraction is “over. Take a breath,” I’d urge, my hand on her abdomen. She would feel it as a contraction rose and when it waned. But she kept pushing, trying to bring the pain to an end. The baby’s head, descending when its mother pushed with the help of the uterus, had scarcely budged when she pushed on her own, and in a moment or two, she was exhausted.

As a midwife, it seemed so obvious to me that her constant pushing was not helpful. If she would just follow the rhythm that her uterus was setting for her and push with contractions and breathe between, then we’d maybe get somewhere.

But she was a classic case of trying to take the speck out of my sister’s eye while I had a log in my own—a log that I thought was essential and something to be valued. I was a hard worker. I could keep pushing. I had to keep pushing even when everything in me was crying out for rest. There were always more patients to see, protocols to write, emails to answer. My pattern, wired into me by personality and upbringing, and strengthened by my medical training, was to push without ceasing—until I couldn’t push anymore and my life fell apart and God began to teach me that even hard labor can and must be lived gently.

This is what the Sovereign Lord, the Holy One of Israel, says: “In repentance and rest you shall be saved, in quietness and trust is your strength, but you would have none of it. “No, we will push on, and we will not rest.” Therefore you will flee! You will say, “We will ride on swift horses.” Therefore: your pursuers will be swift. A thousand will flee at the threat of one; at the threat of five you will flee away, tayo you are like a flappist on a mountaintop, like a banner on a hill.” Yet the LORD longs to be gracious to you, and he longs to show you compassion. The LORD does not abandon those who on him trust. I noticed two things: First, we are offered rest. In reality, it’s more of a command than an offer, because there are serious consequences if we don’t accept it. This scared me and made me think, “I’d better not ignore this. I’d rather learn it when it’s offered than when I’m forced to learn it the hard way.”

Second, God longs to be gracious to us. He wants us to learn to rest and will do what it takes to teach us this important lesson. My productivity does not come from God. He is compassionate, gentle, and kind—which should explain why he has limits, as outlined in the fruit of the Spirit, is marked by love, kindness, and gentleness.

God not only commands rest, he actively involves himself in providing rest for his people. “The LORD replied, “My Presence will go with you, and I will give you rest.” (Ex. 33:14-15; Deut. 33:12; Num 10:33).

I knew we are human and we need rest to function well - physically, emotionally, mentally, spiritually. And he loves us and cares about our well-being (Mark 6:31-32). Rest is also a reminder that God is our God and He is the One who keeps the earth in orbit and makes us holy (Ex 31:13-16, 17; Ezek 20:12, 20). And finding a favorite reason for learning to rest: it brings God glory. “Like a cattle that go down to the plain, they were given rest by the Spirit of the LORD. This is how you guided your people to make for yourself a glorious name” (lsa 64:14 NIV). Rest, for me, has seemed necessary to be able to have enough strength to get on with doing the things through which God could use me. And I could see that God cloths me not just with the ability to do the work that He does in and through us, but through the rest that He provides for us—because it shows that He is a good and kind God who cares for His people.

The Gift of Limitations

Even with this combination of permission to rest and commands to rest and warnings about the consequences of not resting that I received in my pre-Afghanistan days, I couldn’t manage to rest. Not deeply. Not in the way that I needed. The external and internal barriers were too strong. So I finally, my favorite reason for learning to rest: it brings God glory. The Lord said: “And you shall observe my Sabbath, for it is a sign between me and you, so that you might know that I am the Lord your God” (Ex 31:13-17). In the past, I’ve blamed primarily the external factors. But when I got beyond three hundred times in Scripture, and that there are many other verses that speak of limitations and learning to live gently, or wrestling with a situation in which living gently feels impossible, we are accompanied by Someone who knows what it’s like to struggle and suffer, and who loves us with great compassion.

As doctors, it is hard for us of acceptance to limit our limitations as a potential gift because we’re used to pushing past our limitations and being in control. But is it possible to step back from those limits and set aside our own needs in order to survive. I remember one night in my residency as we scrambled for yet another middle-of-the-night cesarean section we joked about needing an indentation catheterer so we could set aside even the most insistent of our personal needs. Sometimes we lamented that, why can’t we change the systems, the rules, our own limitations, but put others first. In a culture that applauds driveness, it is hard for us to acknowledge that what we’d prefer to see as unadulterated strength can be a spiritual liability. But when it was all taken away, I realized how much my identity and my hope were in my work, my role, my competence rather than in God.

How do we learn to live gently?

It’s all very well to recognize our need to learn to live gently. That’s a huge first step, and one that took me a long time to acknowledge. But then what?

It has been almost eleven years since I crashed and was sent home from Afghanistan and began the journey of learning to live gently, and though I’ve come far, I still recognize the tendencies to driveness in myself. Each person’s journey will be different. But here are a few things I’ve found helpful along the way:

Recognize that as long as many of the barriers to living gently are internal rather than external, and work through these barriers, with help if needed.

Celebrate your smallness – We have a Father who loves and is gentle with us (Ps 105) and who promises to carry us right through our old age (Isa 63:9).

Learn in close to Jesus. He knows what it is like to live in a body that gets tired and sick (John 4:6; Luke 8:23; Hebrews 2:18-20, 14-16). He knows what it is like to face crowds and to make the choice to disappear for a while and be alone with his Father even when people were looking for him.

Instead of resisting or resisting a limitation, consider asking Jesus how he wants to be with you in it.

Keep listening to the invitation to live gently wherever you can find it: in God’s own example of working and resting and the gracious command that we do likewise; in Jesus’ example in Scripture and his call to come and find me more of him than I can see, touch, or feel it in, and to walk alongside him, going at his pace (Matt 11:28-30); in other people who do this well, and in the rhythms in nature and in our own bodies.

Pay attention to what things feel like they’re crowding or oppressing you, and look for places under your control where you could make small changes to live a little more gently and spaciously and with a bit more respect for your limitations.

Begin making choices to live more gently. Choose one small step and notice the difference it makes for you and then after that has become habit, choose another small step. Some ideas of places to start? Don’t check your email after supper. Sit daily for 5 or 20 minutes in stillness before God, open to him, giving him room to speak. Try keeping Sabbath on your off-call weekends.

And, finally, remember that wherever we are in this process of facing our barriers to living gently and learning to live gently, or wrestling with a situation in which living gently feels impossible, we are accompanied by Someone who knows what it’s like to struggle and suffer, and who loves us with great compassion.
CMDA Canada’s Board of Directors has called for a year of discernment—of prayer and listening to the Lord to ask him to reveal to us his plan for our organization. The first stage of this strategic planning process is to take a survey of our membership to understand where you feel the Lord is moving us. Please take our online member survey at www.surveymonkey.com/r/SPFOCUS or by scanning the QR code below with an app that reads QR codes.

Last weekend I preached on religious freedom. I spoke from the heart saying exactly what I really believe Christ wanted me to say. My dear wife even helped me develop the message and confirmed it was from the Lord.

I’ve never received such a warm response from the congregation—one of the 70 year olds came up and fist bumped me! I talked about how our behaviour as Christians needs to be consistent with our theology. “This generation honours me with their lips but their hearts are far from me.” I went on to say that secularist forces within society are trying to force us not to act as Christians in the public square. They are ok with our “eccentric” behaviour within the walls of the church on Sunday mornings but it is not ok to allow that behaviour to spill out on the weekdays.

At our annual national conference in Vancouver this year, we were treated to a series of presentations by Dr. Sarah Williams. At the end of her comments, she said that she had a vision of the physicians of CMDA Canada—that they were like birds trapped in a cage and then suddenly the door was opened and they flew out. I think this was prophetic. We often feel that we are trapped into leading another life that is more restricted than the one God wants for us. If you want to see what freedom looks like turn to page 18 and take a good look at James Fenton. He is a man at peace.

Samantha Rossi (page 16) is also at peace. She is not retired, but she has found a way to answer the call of her heart to live her medical career as a moral and ethical pursuit. Stay true to your heart Samantha and you will experience the fruits of your convictions. Bob Clark (page 15) is also a man at peace having given of his personal time to service to the poor in short term medical missions.

These are happy people who have found peace in serving the Lord. They have found satisfaction in being the people God has called them to be. This has helped overcome the fears that make us all conform to the cookie cutter model of secular existence.

The first message of the angels to the shepherds in the fields outside of Bethlehem was “Fear Not!”

And there were in the same country shepherds abiding in the field, keeping watch over their flock by night.

And, lo, the angel of the Lord came upon them, and the glory of the Lord shone round about them: and they were sore afraid. And the angel said unto them, Fear not: for, behold, I bring you good tidings of great joy, which shall be to all people. For unto you is born this day in the city of David a Saviour, which is Christ the Lord. And this shall be a sign unto you: Ye shall find the babe wrapped in swaddling clothes, lying in a manger.
Un Avenir Plein d’Espérance
Hope for the Future
Ésaïe/Isaiah 30:15

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