The Center for Medical Missions' *e-Pistle* February 2007

Welcome to this month's e-Pistle. I have included more articles than usual this time. I hope you find them helpful and challenging.

Dr. Dave Stevens starts with a continuation of his Communication: The Essential Leadership Skill articles. I know you, too have found that you really have to work to make your communication effective. But being aware is not enough. We all have to consciously work on our communication skills.

Rev. Stan Key's Cura Animarum article this month is from the writing of Dr. Dietrich Bonhoeffer. I trust you will be blessed by it.

Barrabas, MD writes about a medical strategy for serving in creative access countries. You will learn how a hospice ministry can be an effective tool for ministry.

Dr. Daniel Tolan (Assistant Director of CMM) has lived his life prioritizing his family. This month he shares about something he and his wife have chosen to do to create family unity and family memories. I think you will enjoy learning what has worked for Daniel's family. Let us know if you have some traditions of your own you would like to share.

Nurse Practitioner Kris Diggins has some thoughts from her ministry to share. Her article is entitled, *Compassion or Pity*.

We have received multiple notices of the important role Faith Based Organizations are playing in the fight against HIV/AIDS. I have included the write-up of a couple of those reports. And as promised, I have included the notes on how you can nominate someone for next year's Dignity and Right to Health Award. I hope you are encouraged by these articles.

Finally, I have included a short announcement of a 5-day training course for hospital managers. It seems I have given you plenty to read about this month. Remember, we are always looking for articles to share. I do not have anyone in the pipeline for next month's e-Pistle, so if you have something to share that you think can benefit others, please let me know. We dream of being the conduit for sharing best practices, lessons learned, etc. Will you help? -Susan

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Communication: The Essential Leadership Skill **Section: VII, Useful Skills**

By David Stevens, MD (continued from last month)

#5 – More is communicated non-verbally than verbally.

Tone, volume, pacing and gestures communicate much more than the actual words. I can say, "I love you" with a tone of endearment, a question mark or even with an angry tone as I am pushing myself away from my mate.

I came back after furlough to a crises at our hospital. The staff was demanding the dismissal of the matron, pay increases and much more. The board had met, addressed the issues and communicated their decision to the staff. The doctor in charge had left, and that left me in charge. Three days later a hospital employee came to tell me the staff wanted to meet with me and pulled me away from dinner guests at 7:30 in the evening. When I arrived at the hospital meeting room it was packed with every seat full and several staff members were standing. I was presented with the same list of demands that the board had already dealt with on a slip of paper. I read just the first couple of demands and their threat to strike, folded the paper and put it in my pocket. I put my hand in my pants pocket to look relaxed (which I was not) and then in a calm but firm voice said, "If Tenwek Hospital is such a bad place to work, I encourage you to quit and go find another job." I then calmly walked out and went back to finish dinner. My words called their bluff and my attitude and gestures showed I was not concerned by their threat. As far as I was concerned, the matter was finished.

The next day everyone was at work and the issues were never raised again. (Whew!) In retrospect, I believe my non-verbal communication was more powerful than my words. Walking out sent a clear message that there was going to be no negotiating on what the board had already decided.

#6 – Develop the skill of listening and interpreting.

Most of my communication mistakes have been made because I did not listen well or take time to collect all the facts. Others have occurred because I spoke when I was angry or upset. After my second term, when I had been in charge of Tenwek, built a hydro plant, started a nursing school and a community development program, and generally burnt myself out, I got a letter from my field director. It said, "Dave, I was doing the yearly assessments on the missionaries at Tenwek and a good number of them felt like you were much more interested in getting things done than in the welfare of the people involved."

Whoa, was I angry! "He hadn't taken call every third or fourth night, seen 100 patients a day and managed a staff of 400," I mentally ranted. "No other missionary had come close to accomplishing what I had done in the last four years and this is my thanks?" By the grace of God, I did not write him back right away. The letter would have probably auto combusted! After venting to my wife, and reflection and prayer, God broke through my pride and emotional barriers and I admitted he was right. I had focused too much on the problems and not enough on the people. As we later communicated, I learned my lesson and changed my management style, hopefully for a lifetime.

It is impossible to take back things wrongly said. Learn to listen well, collect the facts from all those involved, and make an effort to learn to read non-verbal communication cues. As you master these disciplines, you will do a much better job of interpreting what is going on and communicating the right thing.

#7 – Use examples, stories, slogans and analogies to get your point across.

I teach doctors how to do media interviews twice a year. One of the most important things they learn is the power of a sound bite, example, story, or analogy. They are powerful communication tools, but are especially more so in many of the cultures where missionaries work. That is how the local people learn and understand.

One of the ways to motivate people is through competitions, and we had lots of them in our community health work. Using these non-financial incentives turbocharged the work efforts of our volunteers. In some competitions (Health Helper of the Month) only one person won. We also had competitions where everyone could win by meeting a minimum set of standards (home visits, revisits, new immunizations, etc.) One year, the prizes were bags of special seed corn. I had learned it was not what you give but how you give it, so we gave out the prizes at our big community health daylong event to the many that had succeeded. In front of the hundreds there, I told a story and drew the analogy between the work of planting, tilling and harvesting and what they were doing in their efforts to plant seeds of health in the community. Everyone went home with their prize, but more importantly went away telling everyone that they were "health seed planters" as they showed off their prize.

Get the idea? If I am communicating on physician-assisted suicide, I might tell a story challenging the listener to imagine going to the nursing home to see their mother or grandmother, only to find out that the doctor helped them kill themselves the night before. Or I might use the sound bite, "This is not about giving patients the right to die, but doctors the right to kill." I want to drive home the message, make it personal and memorable.

Testimony, stories, slogans, and analogies punch your message through mental barriers and get your point across.

#8 – Maintain a positive attitude.

Your attitude carries a lot of weight. You want to lead, not drive people through your communication if at all possible. Pick your words and tones carefully to convey a positive attitude, even in a negative situation. Let's say you have to lay people off. The number of patients has declined, so income is not meeting projections. Instead of saying you are downsizing, you may want to use a corporate term – "right sizing," which is more positive. Communicate the benefits that this move will bring for the future of the hospital, but more importantly for the staff that remain. "Once we right size, we are going be able to improve the benefits of all that remain. I know it is going to be difficult to let some of you go, but I am going to do all we can to ease the transition. God will see us through this time. He is still in control."

Even negative news can be couched in positive terms. When it is over, you want staff to think, "This was difficult for him. He cares about us and better days are ahead."

#9 – Be consistent.

Dr. Ernie Steury was the hospital founder and my mentor. He served as the Executive Director and I was the Medical Superintendent for a number of years when we were at Tenwek together. Like children do with parents, if staff did not like my answer, they would go to Ernie to try and get a different one, and vice versa. We learned that we needed to be in constant communication to make sure people did not conquer and divide us. We worked hard to speak with one voice – to be consistent.

The same is true even if the communication is only coming from you. You will get in a lot of trouble if you tell one group one thing and another group something different, or if you change your position without acknowledging that you have and do not explain why.

The other reason for being consistent is that studies show it can take up to seven different communications to get someone to change their habit. Stay on message and repeat it as necessary. It is one of the keys to good communication.

Without it you cannot…

#10 – Develop trust.

No matter how well you communicate, you have to have trust. The listener has to give you the benefit of the doubt.

If you have communicated with someone who does not trust you (and you know what I mean), that person filters everything through his or her misconceptions and puts everything you communicate in the worst light.

Remember the story above about the hospital staff about ready to go on strike. I unwittingly started the fracas when I wrote an orientation manual for visiting staff. In that manual, I advised that visitors not give gifts to staff members without checking with a missionary. They did not realize that an old pair of jeans was worth a month's salary or that some staff had the goal of getting close with visitors so they could milk each one for gifts. This was causing jealousy and hard feelings.

One of our visitors left their orientation manual in the surgery dressing room and an OR assistant with a chip on their shoulder took it. His interpretation of this section was that the missionaries wanted to oppress the nationals and he began to stir up things all over the hospital with his "evidence" in hand. Trust broke down and near anarchy followed.

Lack of trust is one of the main reasons interpersonal conflicts start and persist. Trust takes a long time to earn, but only seconds to lose. Consistency, sincerity, and actions that match your words will build trust over time. With hard cases, one on one communication, confrontation, and discipline may be necessary.

Remember that what you put in writing can come back to haunt you. It is "hard evidence," so be very careful when you put things in writing. If it is a sensitive communication, have one or two

other people read it and give you feedback. What you think you are saying may not be how others interpret it.

Communication is an art. Some innately are great communicators, but most of us have to learn to do it well. Take these principles and apply them. Realize that every communication is a learning experience on how to do it better. With effort, practice, and attention to detail, you can become a better communicator.

Cura Animarum

By Rev. Stan Key

Cheap grace is the deadly enemy of our Church. We are fighting today for costly grace…

Cheap grace means the justification of sin without the justification of the sinner. Grace alone does everything, they say, and so everything can remain as it was before…Cheap grace is the preaching of forgiveness without requiring repentance, baptism without church discipline, Communion without confession, absolution without personal confession. Cheap grace is grace without discipleship, grace without the cross, grace without Jesus Christ…

Costly grace is the treasure hidden in the field; for the sake of it a man will gladly go and sell all that he has…Costly grace is the gospel which must be *sought* again and again, the gift which must be asked for, the door at which a man must *knock.*

Such grace is costly because it calls us to follow, and it is *grace* because it calls us to follow *Jesus Christ*. It is costly because it costs a man his life, and it is grace because it gives a man the only true life. It is costly because it condemns sin, and grace because it justifies the sinner. Above all, it is costly because it cost God the life of his Son… Above all it is grace because God did not reckon his Son too dear a price to pay for our life, but delivered Him up for us…

The only man who has the right to say that he is justified by grace alone is the man who has left all to follow Christ.

The Cost of Discipleship. By Dietrich Bonhoeffer.

Medical Missions to Unreached People Groups: The Hospice Strategy

By Barabbas, M.D. chuche@nomadmail.net (secure email)

Last month we looked at "The Luke Ten Strategy," which was a means of empowering existing disciples to enter homes, care for the needy, and make more disciples. We called the Luke Ten Strategy a "health strategy" because it dealt with health issues, but the practitioners did not need medical training. This month, though, we will be looking at The Hospice Strategy, which is a

medical strategy. This means that the strategy requires a doctor or nurse to train the workers and to provide in-home evaluations.

In many cultures, terminal disease is never discussed with a patient or their family. Even if a patient is days from dying they may well be told that they are fine and that they are on the road to recovery. For this reason, we need to adjust our definition of Hospice care, for many cultures, and focus not just on the terminally ill, but anyone with a serious illness. It is also best to choose a label from the national language that does not imply care for the terminally ill; something like "Compassion Services."

Enter the community

In-home care for the chronically or seriously ill is virtually non-existent in most developing countries and can only be found in major cities in much of Asia. For this reason, a hospice strategy is a great way to enter a community. Country and community leaders should easily recognize the importance of this service and will welcome your team. At the same time, this strategy gives team members easy access into homes.

The first in-home visit should be done by a medical practitioner with a partner who will be the primary care giver and disciple-maker. This partner can be called a hospice technician. The medical worker should interview the family, make an evaluation, and tell the family about the kinds of services that will be provided. If you need to make some money for national workers, then you can charge a small amount for your services. Of course, this would necessitate getting the proper permissions and licenses for a health business.

From this point, the hospice technician would return regularly, perhaps twice each week, to care for the patient and family. Areas that can be addressed are:

1. Nutrition and exercise
2. Non-medical pain management
3. Organization and management of medications
4. Side effects of medicines and chemotherapy
5. Managing a bedridden patient
6. Emotional support
7. Spiritual counseling
8. Family counseling
9. Issues related to terminal illnesses

It is important that all workers realize that they are not doctors or nurses. They must remain within the area of their training, and should not give advice on medical issues. All questions that they cannot handle should be referred to the medical supervisor.

Make disciples

Because these disciple-makers are entering into national homes each day and are providing care for the needy, they are in a perfect position to present the gospel. They should not just concentrate on the patient, though, but should share Christ with the entire family. It is possible

that they could share the gospel with a family of five each day, resulting in as many as one hundred people hearing the gospel in one month.

If you are working in a very restricted country and your workers are sharing this frequently, then there will certainly be a backlash from religious leaders or other authorities. Each team, then, must adjust their strategy so that they postpone the day of scrutiny as long as possible, and will be able to survive the scrutiny when it comes. The numbers above are just given as an optimistic example.

Empower the church
New disciples must come together in small house fellowships. Elder leadership should be appointed and the new church should be taught how to baptize new disciples, how to take the Lord's Supper, and how to have Spirit-led worship together.

Another means of empowering the church is to take this strategy straight to a group of national disciples and train and mobilize them to be your hospice workers. Authentic disciples are longing to advance the gospel throughout their nation, but often do not have a way to enter into new communities or into the homes of the lost. If you champion a Hospice Strategy among them, then you could give them the means to meet these objectives.

Chronic or terminal illness is an enormous and lonely burden for any patient and their family. As disciples, we have the potential to take their awful situation and give eternal hope to the hurting. For more information on this, or other strategy ideas, feel free to write to me at the secure e-mail address above.

Family Traditions
By Daniel Tolan, MD

Traditions! Traditions! Whenever I hear this word, I picture Tevye, the father and village milkman in the movie *Fiddler on the Roof* in his struggle of maintaining old traditions and establishing new ones. No doubt we all have experienced traditions in our lives and know the value and impact they hold and can have.

I believe family traditions are important in raising children. Tevye makes this statement in *Fiddler on the Roof*: "Without tradition, our lives would be as insecure as the fiddler up there on the roof." He points to a man balancing himself on the peak of a steep roof while playing the fiddle. Each stroke of the bow could cause him to topple down one side of the roof or the other.

Is there a special place for traditions in family life while in missions? I believe so. Traditions should help promote a sense of identity and belonging. We live in a hectic and rapidly changing world. Family ties and bonds are easily weakened and dissolved if we allow this to happen. Maintaining important traditions helps promote feelings of safety and security within the family. Most of us do not like to think of ourselves as predictable, routine, or repetitive, but we all benefit by and in fact need the sense of assurance that effective family traditions provide. This is

especially true when we are in unfamiliar surroundings, cultures, or experiences. Family traditions can help provide this support for one another, but it takes intention and a sense of purpose.

I like what one author [Doherty] penned as the "entropic family." Entropy, in physical science, is a measure of the disorder or unavailability of energy within a system. Over time, systems tend to degenerate, causing entropy. More entropy means less energy available within that system. Traditions can help our families fight this tendency to lose energy and coherence over time.

In times of transition, our family traditions can be a solid rock to our children and even to ourselves. How often is the missionary family in a state of transition? Some have expressed missionary life as a perpetual state of transition. Furloughs, leaving home countries, boarding school, changes in place of ministry, cultural adjustments, colleagues leaving, political climates, kids leaving for college…these all place our families in periods of transition and cannot be avoided. But, certain traditions can be carried on throughout all of these times.

One tradition our family started during our first Christmas in Kenya was a Christmas Eve party. That first Christmas, in spite of the great joy of celebrating Jesus in Kenya, was a very lonely time for me. We decided to invite some people over to our house, and this evolved into a very important family tradition. We have carried on this tradition no matter where we found ourselves. As our family grew older and our kids started "coming home," it was just as important that we have this party and that they be able to participate in the candy making and preparations. A special memory I have is my father-in-law, on his last Christmas Eve in Kenya before he died, helping our children put out the Christmas candle luminaries lining our yard. One year, I had the brilliant idea of going on "safari" to a game park in southern Tanzania for Christmas, but that idea was nixed because we would miss out hosting our annual Christmas Eve party, which had become very important.

Another tradition was an annual camping trip with another family. Getting stuck, vehicle breakdowns, lions nearby the campsite, pulling our vehicles into a maize storage barn and sleeping out a storm all led to great memories from an established tradition.

Friday night pizza and games have always been a tradition. We have learned to make pizza wherever we are and I prefer my wife's pizza to anything New York or Chicago can offer to this day. There are other simple traditions we started while on the mission-field and still carry out today…the special plate that says "You are loved" used for all birthdays, a home-made advent calendar all our kids have grown up with, and the joy of even a few days of family vacation.

Take time to establish family traditions. Find something you can do no matter where life takes your family. Involve every member of your family and choose traditions with sensitivity to each one's needs. I was once invited to a traditional religious celebration by a Yemish family in rural Tanzania. They too were carrying out a tradition established years earlier.

Here are some suggestions.

1. Aim for a moderate number of simple traditions. Too many and you will not be consistent. Too elaborate or expensive and they will lose meaning.
2. Make sure you have spiritual traditions, but make sure these are not all you have.
3. Re-evaluate traditions as your family and circumstances change. This past Christmas we decided together it was time to put the Christmas Eve party to rest. If something does not meet the needs of your family any longer, do not be afraid to change.
4. Establish new traditions. This takes purposeful thought and action, but it is worth it. Each family is unique, so do what works for you.
5. Involve others from outside your family in some of your traditions. This is a great way to have fun and minister at the same time.

I think you will find, as we have, that missionary family life is exciting, challenging, and we would not trade our years in missions for anything. We have had long-standing traditions and others that lasted a short time. They have held our family together in the best of times and in times of difficulty, loss, and sorrow. They have provided security and helped us not slide off the fiddler's perch on the rooftop.

If you have any comments or suggestions to contribute, please write to us so we can share them with others.

And may God bless your family with deep and rich traditions for years to come.

Compassion or Pity?

By Kris Diggins, SIL Nurse Practitioner

Compassion is an emotion that motivates many of us to pursue a career in nursing. The desire to help others in physical need is at the heart of the art and science of nursing. I know for myself I have discovered an incredible joy and fulfillment in equipping others with improved health through the art of nursing. Compassion for the state of another person's suffering is a motivating force towards change. And yet, I have discovered for myself that there is a stark difference between compassion and pity. Compassion has its roots in respect for another human being. It implies seeing another person as an equal. On the other hand, pity demeans another's position. With pity there is a lack of respect for the person. When caring for another person's physical needs, we should focus on their needs and always strive to see them as equals - motivated by compassion.

Working in developing country medicine, the temptation is to focus only on the poverty, and the dire need of each one of my patients. Sometimes I notice that this focus tends to turn my compassion into pity. The danger is that I lose sight of the individuality of each patient. I remember vividly the first time this shift became obvious to me. I was caring for an illiterate elderly woman in the small city of Porto Velho, located in the heart of the Amazon jungle. As I sutured a wound on this woman's hand, I thought about the poverty she lived in, and I began to

pity the life that she lived. After she went home that day I thought a lot about the humble state of her existence.

A few days after that visit, she returned to the clinic with a beautiful basket in her hand. She told me she had weaved the basket as a gift of appreciation for what I had done for her. Holding that basket in my hand, I realized the delicate art her hands had weaved so skillfully. I was ashamed that I had only seen this woman in light of her need, and that my pity for her had nearly kept me from being able to appreciate the complexity of who she was.

I cannot help but wonder how often pity for a patient truly inhibits respect for the dynamic nature of human beings. How often in my nursing career has compassion turned to pity? I know from this experience that I miss out on the opportunity of seeing my patients as individuals whose identities are much greater than their circumstances. Patients are not defined by their physical need, and this is something that I hope to remember with each new patient. I cannot allow pity to guide me in my assistance. Only with compassion will I be able to offer my assistance in a manner that respects the individuality of my patients. This will be to my benefit, as well as to my patients'!

HIV / AIDS News
Dignity and Right to Health Award Nomination Process

The "Dignity and Right to Health Award" is an international symbol in the movement to address HIV. This is an activity of the International Christian Medical and Dental Association HIV Initiative. The award provides an essential opportunity to recognize, support and publicize the most outstanding role models and champions acting to stop this global epidemic. It is well positioned to become an important symbol for ensuring that voices from diverse communities and countries are acknowledged and championed.

The Dignity and Right to Health Award aims to model, mobilize and encourage creative and sustainable ways that enhance the dignity and human rights of people and communities affected by the epidemic and living with HIV/AIDS.

Process
Proposed Award Categories
Working in partnership with ICMDA and national bodies, the ICMDA HIV Initiative will seek nominations of individuals who demonstrate excellence, leadership, and compassion in HIV work in a field of prevention, treatment, research, care, support, and/or advocacy.

This award will be grounded in the provisions of the Merroo statement.

Each year on December 1, World AIDS Day, we will announce the winner of the "Dignity and Right to Health Award" of the ICMDA HIV Initiative. This will be awarded to an individual who has powerfully and compassionately engaged with the challenges of the HIV and AIDS epidemic.

Nomination Process
Nominations will be accepted each year online from June 1 until September 30. It will be important for all ICMDA partners and national bodies to ensure that information on the award is disseminated at national and local levels through their networks.

Nomination Criteria
The majority of awards will be granted to individuals in developing countries. Every effort has also been made to keep the nomination process easy and accessible, as it is important to allow for everyone, even those with limited resources and access to services, to be able to nominate.

Selection Criteria
The award will be given to individuals for excellence, outstanding leadership and compassion in responding to HIV/AIDS. The process will seek nominees who demonstrate the following:
- Significant impact at local and wider level;
- Empowers others in integrated community responses;
- Facilitates church integration and participation in best practice models of care;
- Demonstrates excellence in full community involvement and empowerment of People Living With HIV and AIDS (PLWHA);
- Works, facilitates, and advocates for gender equality in community participation and response to the epidemic;
- Links well with government and other actors in a comprehensive approach to the epidemic;
- Models creative and compassionate responses that inspire many to similarly enhance the dignity and human rights of people infected and affected by the epidemic.

Review Committee
The Review Committee will oversee the nominations and communicate during the time of October and November to conduct a review of the nominations and identify the winner(s). The committee will be reviewed at each subsequent ICMDA Congress. The proposed structure will seek diverse representation from ICMDA members.

For additional information please contact Dr. Michael Burke at njburke@bigpond.net.au.

Reports on Role of Faith-Based Services in Provision of HIV/AIDS Care

GALLUP NEWS SERVICE, in an article by Bob Tortora, Chief Methodologist reports: In 2006, the Gallup World Poll asked sub-Saharan Africans in 19 countries about their confidence in eight social and political institutions. Overall, across the continent, they were most likely to say they were confident in the religious organizations (76%) in their countries, followed by the military (61%), and financial institutions (55%).

As a general principle, channeling foreign aid through local religious organizations may be more likely to maximize optimism among African populations than if they perceive it to be directed through their governments, which could introduce an element of cynicism.

Full story: http://www.gallupworldpoll.com/content/?ci=26176

WHO Report Says Faith-Based Organizations Play a Major Role in HIV/AIDS Care and Treatment in Sub-Saharan Africa

According to an important study released on Feb 8 by the World Health Organization (WHO) at the National Cathedral in Washington, DC, efforts are needed to encourage greater collaboration between public health agencies and faith-based organizations (FBOs), if progress is to be made towards the goal of universal access towards HIV prevention, treatment, care, and support by 2010.

Full details of the report, "Appreciating assets: mapping, understanding, translating and engaging religious health assets in Zambia and Lesotho," can be found at http://www.who.int/mediacentre/news/notes/2007/np05/en/index.html.

Further information about Christian responses to HIV & AIDS can be found at the Christian HIV/AIDS Alliance [www.chaa.info] and ICMDA HIV Initiative [www.icmdahivinitiative.org] web sites.

For further information on the campaign to achieve universal access to HIV treatment, care and prevention, plus other campaigns to achieve the Millennium Development Goals, visit the Micah Challenge web site: www.micahchallenge.org.uk.

Training Opportunity

Health Development International offers a 5-day management course for hospital administrators. I haven not attended the course myself but I hear it is excellent. You can learn about it at: www.healthdevelopment.org/frames.htm. I believe Dr. Macagba will travel to your country if you can get such a conference organized.

The contact person is Dr. Rufi Macagba (rlmacagba@cox.net).

Center for Medical Missions
PO Box 7500
Bristol, TN 37621
423-844-1000
www.cmda.org