The Center for Medical Missions' *e-Pistle* March 2010

Can you believe it is almost Easter? It doesn't seem possible that 2010 is almost a quarter passed. But how wonderful that spring is coming and with it the blooming of trees and flowers reminding us of our resurrected Son. In chapel this morning, we were encouraged to look at our hurts through the frame of the suffering the Son on the cross. We are taught that it is by His stripes we are healed. What comfort to know that He understands. What encouragement to know, through His death the sacrifice for our sin has been paid. How glorious to know His resurrection gives us eternal life. May you rejoice in Him this Easter.

I need your help. Well really it is a new missionary in Nepal that needs your help. He asks: "Can you help me identify the most useful medical references to get started in my ministry in rural western Nepal? This would include on line databases and websites along with textbooks and journals that developing world medical missionaries have found they refer to most frequently in their practice." I can't answer that for him, but do you have a few minutes to tell me what medical references are most helpful to you? He did mention that references for training would also be useful. I will be sure to forward them to the doctor who has asked. You can respond to susan.carter@cmda.org. Thanks so very much.

In this Month's Edition

Dissociative Thinking - Section V: Finances

by David Stevens, MD

In my carnality, I hate money! Okay, I know that sounds weird so let me break it down.

The love of money is the root of all evil, the Bible clearly teaches, and I believe that. Christine Snead slyly made that point when she said,

> *If all the rich people in the world divided up their money among themselves there wouldn't be enough to go around.*

People will pursue wealth and the feeling of power it gives to the detriment of everything that has real value.

George Bernard Shaw overstated his point when he quipped,

The lack of money is the root of all evil, but he gets a lot closer to the reason for my love/hate relationship with "filthy lucre." I hate money because there are so many good things in ministry I can not do for the lack of it!

I bet you battle the same feelings. Your life is full of, "If we just had the money, we could …." I bet lots of words would fit into that blank space – build a nursing school, start a residency program, improve our immunization coverage, hire more nurses or a national doctor – and many more.

The lists I would write to fill that vacate space would be different, but just as long as yours. That's why of late I have been mulling about money. This past weekend I think I made some progress on this issue that you might find helpful.

I serve as the vice chair of the board of my alma mater, Asbury University that was called Asbury College until this last weekend. Commissioner Israel Gaither, the national commander for the Salvation Army gave a rousing challenge at chapel inaugurating the name change noting that the name change was not a celebration of past accomplishments but a new start – an opportunity for greater ministry and influence than ever before. Everyone, including me, jumped to our feet in a standing ovation as he concluded.

Afterwards I went to my meeting of the board development committee that I serve on. You know, that committee who is supposed to help the administration find the funding needed to start the new construction on the buildings and develop the new programs. After we heard reports, we moved into a brainstorming session. The bottom line was like your ministry; the college did not have a constituency with enough wealth to accomplish all it needed to do.

As someone said, the definition of lunacy is doing the same thing over and over again and thinking you will get a different result. What we usually do is spend our brainstorming time tweaking what we have been doing in the past which if anything marginally increases our financial support.

And then a board member, a retired businessman from a large corporation, related they did the same thing at his company until a new leader decided they needed to change their whole pattern of thinking. They should not spend all their effort on figuring out how to increase sells 5-10% the next year. They needed to disassociate themselves from the progress curve they were on with all its focus on incremental improvement. They needed to step outside that "boxed-in" approach and instead ask, "What could we do to take us to a whole new level of success?" What could dramatically change the company's future and move their growth curve to a much steeper slope?

You know the kind of dissociative thinking that Thomas Edison did. He didn't spend all of his time trying to figure out how to make gas lights work more efficiently or burn brighter. He

stepped away from the concept of improvement and created the light bulb, then the first phonograph and the first movie projector.

Get the picture? (Pun intended)

So let's go back to money issues and do a little dissociative thinking and consider some examples. I suspect you have major things that need to be done and a list of donors that don't have the resources to do very many of them. How can you find a better source of income?

Indiana Wesleyan University use to be the small-unknown Marion Bible College with great financial needs. Their dissociative thinking led them outside their box to begin to provide distance learning via the Internet and satellite campuses. Someone smartly noted that the profit margins were much higher when you didn't have to build dormitories, cafeterias and run sports programs for students. They now have 12,000-day students all over the Midwest and have grown their residential student body to 4,000 with the proceeds on their state of the art campus. Now, they have much more impact.

Perhaps your ministry could reorganize to do the same thing, not stopping what you are now doing, but expanding its based on a total new income generation outreach.

In our development meeting, we realized we weren't going to get dramatically different fund raising results by going to the same supporters of the college. In large part, they were supporting the school to the best of their ability. Dissociative thinking led us to the conclusion if we could find one or two very wealthy donors who would not just support a particular project but become a champion for the whole University, we would reach a "hinge point". Wealthy people have friends who are wealthy that they can recruit to help. I saw at another small college where they recruited a very wealthy board member who then recruited two or three more. That school with only 600 students successfully completed a $50 million dollar capital campaign, more than they had ever dreamed possible just a few years before. The vast majority of the money came from those wealthy board members and their friends.

So here is my challenge to you. I want you to become a dissociative thinker! No, I'm not talking about the medical disorder of depersonalization. I want you to get together with some of your most creative thinkers and ask yourself, "What could we do that would take us to a whole new level of financial support or ministry effectiveness?" While you are brainstorming forget those things that are behind and press forward to what God has in store.

Get outside the limits of what your mind says is possible, seek God's wisdom and pray. Do some "dissociative thinking." Who knows what may happen?

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Cura Animarum
by Rev. Stan Key

C. S. Lewis gives us a wonderful picture of the meaning of the resurrection in his classic book *The Lion, the Witch and the Wardrobe*. The lion Aslan (the Christ figure in Narnia) has been killed but then raised miraculously to life again. Immediately, death begins to start working backwards. Wherever the risen Aslan goes, things come to life. The most dramatic illustration of this comes when Aslan enters the palace courtyard of the witch. Her evil had put a spell over a multitude of Narnian creatures, turning them into lifeless stone statues. When the risen Aslan bounded into that courtyard, he began to breathe on those stony statues one at a time. His breath caused a miracle to occur.

> *I expect you've seen someone put a lighted match to a bit of newspaper which is propped up in a grate against an unlit fire. And for a second nothing seems to have happened; and then, you notice a tiny streak of flame creeping along the edge of the newspaper. It was like that now. For a second after Aslan had breathed upon him the stone lion looked just the same. Then a tiny streak of gold began to run along his white marble back – then it spread – then the color seemed to lick all over him as the flame licks all over a bit of paper – then, while his hindquarters were still obviously stone, the lion shook his mane and all the heavy, stone folds rippled into living hair. Then he opened a great red mouth, warm and living, and gave a prodigious yawn. And now his hind legs had come to life. He lifted one of them and scratched himself. Then, having caught sight of Aslan, he went bounding after him and frisking round him whimpering with delight and jumping up to lick his face.*
>
> *… Everywhere the statues were coming to life. The courtyard looked no longer like a museum; it looked more like a zoo. … the whole place rang with the sound of happy roarings, brayings, yelpings, barkings, squealings, cooings, neighings, stampings, shouts, hurrahs, songs and laughter… (The Lion, the Witch and the Wardrobe, Pages 167ff.)*

Anybody feel dead this morning? Anyone feel trapped and frozen in a stony condition that cannot be changed? Anyone feel like a relic in a museum? Anyone wishing they could really come alive? I have incredible news: Jesus is alive! And this is no children's fantasy. This is fact. In time and space, Jesus of Nazareth has destroyed the power of death and brought life and immortality to light! The meaning of Easter can be summed up in one pregnant statement of Jesus: Because I live, you shall live also (John 14:19).

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Announcements

Preparing for the Future: An Orientation to Medical Missions

Our annual conference for medical missionaries preparing to leave for the field is only a month away, April 23 – 25. We have 16 registered so far and would love to welcome more. If you know someone preparing to come to the field, please let them know about this helpful opportunity.

According to participants the conference gets better each year. To learn more and register: click here.

CMDA National Convention

A Time for Renewal…….
April 29 – May 2, 2010
Ridgecrest Conference Center, Ridgecrest, NC (near Asheville)

Speakers include: David Thompson, MD, missionary surgeon in Gabon; Os Guiness, author, social critic and Senior Fellow of the EastWest Institute in New York; John Patrick. MD, retired associate professor in clinical nutrition; Teresa Collett, JD, Professor of Law at the University of St. Thomas School of Law in Minneapolis where she is the director of the Prolife Advocacy Center; David Stevens, MD, CEO Christian Medical & Dental Associations.

For more information and to register, click here.

XIV ICMDA World Congress

South America, Punta del Este, Uruguay
1 - 4 July 2010: Student/Junior Grads conference
4 - 8 July 2010 Main Congress

Speakers at the world congress:
Dr David Stevens, CEO of CMDA US, will be a keynote speaker on Tuesday 6 July and his topic will be "Your profession - Career or Calling"
Dr Aldo Fontao, will be the keynote speaker on Monday 5 July on "For whom are you working?"
Dr Pablo Martinez, - will be doing the 4 Bible readings on "A new set of values for a New Life: The Priorities of a Christian"
Philip Yancey, will be the keynote speaker on Wednesday 7 July.

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A Cool Drink of Water

by Michael Soderling, MD

Short term health-related missions outreaches (STHRM) have exploded in number these past 30 years. Exact statistics are hard to come by, since the agencies which send out such teams vary so greatly. Some are sent by established agencies with a long track record of doing STHRM's and some go out through their local church, while others go as a part of a medical school outreach. In any case, there are thousands of health care professionals who take part in STHRM's each year. Much suffering is alleviated by these compassionate health care providers. But during a recent visit I had with a team working in Central America, I heard a very common refrain having to do with the nature of what some call "storm clinics": coming into a poor community with a team of

health care providers to do mostly primary health-type work. These efforts are often linked to some form of evangelism and even community health-related education.

The refrain I refer to is usually in response to a question I always pose: what long term impact will the team have on the health of the people they seek to serve? The refrain goes something like this: “We know what we are doing will likely not have a long term impact on the health of the people, but what we are doing is like giving the people a cool drink of water in the desert.” The other explanation I often hear is this: “We know what we are doing isn’t addressing the deeper needs of the community and those who live here, but we are at least able to put a band-aid on the problem that will help in some small way.”

I have used this reasoning myself when explaining my previous involvement with such teams. But after this most recent encounter, I had to ask myself if this rationale is valid. Would Jesus have given someone He encountered in the desert a cool drink of water and then walked away leaving the person still in the desert? What came to mind immediately was the parable of the Good Samaritan.

Let's examine briefly this parable in Luke 10. We read in the 10th chapter of Luke that a man falls prey to robbers who strip and beat him to within an inch of his life and leave him for dead. Anyone who has done cross-cultural ministry in the majority world can probably relate to the scene as it unfolds. The religious authorities pass by, not being allowed to help because of the rigidity of their traditions. I think it is very much like what we find in many cultures around the world. The poor may not be literally beaten by the non-poor, but the systems that are in place and which maintain the status quo give the poor the same feeling as if they were physically beaten and left for dead. This is the background into which many of our medical teams are parachuted, with the hope of doing as much as they can in a limited amount of time.

But along comes the Good Samaritan, right? He sees the crumpled figure on the side of the road looking little better than road kill. I imagine that Roman chariots produced a bit of that back in those days. The chariot race scene in Ben Hur comes to mind. The Good Samaritan has a huge heart and stops to help. Luke relates the scene to us in verse 34a: ***"When he saw him, he was moved with compassion, came to him, and bound up his wounds, pouring on oil and wine."*** Now, doesn't that describe what so many are about when it comes to STMM's? Compassion. Healing. Ministering to the suffering. How many of us have looked into the eyes of the hopeless and physically beaten down, whom God loves with all His heart, and felt moved to action? And for many health-related professionals, this takes the form of a short term, maybe one or two week, medical mission trip. But how many of us, myself included, have felt at the end of the trip that what we did was somehow so inadequate? Then comes that reassurance that what we did was like offering someone suffering in the desert a cool drink of water.

But let's return to our parable. Does it end with the Good Samaritan treating the wounds and maybe giving a drink of water and then leaving the man at the side of the road (still in the desert)? Let's read the text from 34b through 35; ***“He set him on his own animal, and brought him to an inn, and took care of him. On the next day, when he departed, he took out two denarii, and gave them to the host, and said to him, ‘Take care of him. Whatever you spend beyond that, I will repay you when I return.’"***

First we see our good friend the Samaritan putting this weak and still suffering individual on his own animal in order to take him to an inn for further care. And he didn't just drop him on the doorstep to let the innkeeper deal with the situation. He stayed with the man all night while continually caring for the man's wounds and tending to his other needs. How many times have we found ourselves with very difficult medical challenges, such as a patient with a blood sugar of 400, during a STMM trip, with no knowledge of what to do for them? Many groups I have seen work with no local healthcare providers and have no plan for follow-up of difficult patients, because they have not taken the time to develop the necessary relationships in the communities in which they are going to work. It's just short term after all. Who has the time or resources to do that kind of partnership development?

After caring for this person all night, the Good Samaritan pays for the man to be cared for by the innkeeper. Now, I don't know to what level innkeepers were trained in caring for injured travelers, but maybe it was more than we would imagine. After all, in the early history of the West in the US, it was the barbers who often worked as doctors, as I recall. In any case, he made plans for long term follow-up. And whatever needs came up, he would pay the innkeeper accordingly UPON HIS RETURN!!

This makes a good case, I believe, for not thinking only with a short term mentality concerning our STHRM's. There is much power in the "both/and" approach, as Jim Collins has written about in his book, Built to Last. Why does it have to be that one is involved either in short term work or long term initiatives? Can you imagine the results we would see if we took a coordinated approach to our work in the health-related fields of ministry? And I am not speaking only of how Christian health-related ministries could more effectively work together. I am also urging a greater coordination with local governmental and non-governmental agencies that may not have a spiritual basis for their work. I know there are those who are actively involved in these kinds of efforts already, and I applaud these efforts. But many, probably the majority, are not doing so and should carefully assess what they are getting into. I believe that if we are to truly see our vast resources used to effectively improve the health of the poor around the world while also strengthening the local church, it must be the health care professionals who are being asked to help in these efforts (with their time, talents and treasures) who begin to ask important questions about the nature and conduct of such short term health-related missions.

Let's pretend for a moment we are that Good Samaritan. Our group of highly trained healthcare professionals does a fantastic job of caring for the man's wounds with the basic meds that were acquired in-country, based on the WHO recommendations for developing nations. Because our team took the time to partner with the local church and a local Christian health worker, we are aware that there is no nearby Christian clinic or hospital which can care for this person's ongoing needs. But there is a local government-run hospital, though it is chronically short of most basic medications. But the bed is available, and because our local contacts have an ongoing relationship with the director of the hospital, we are able to secure a bed and nursing care. We invite the local hospital administrator to share dinner with us to further build our relationship for the future and to find out about the needs of the hospital he serves. Also attending the dinner are the local mayor and some of the people who are part of the local community development committee. We find out more about the community and its desperate need for a clean water supply. Someone on our team has a contact in his local Rotary Club back home who is interested

in doing a water project for a poor community in a developing nation. The local pastor has always wanted to develop a hospital ministry outreach, and a nurse on the team has access to teaching materials that will help him achieve this goal. The list of ideas could go on and on. For example, after finding out about the chronic shortages at the hospital, the team decides to donate the medications that remain at the end of the week to the hospital and its outpatient clinic. This of course would best be done in the presence of many witnesses.

Well, you see then where this beautiful parable has taken us. It would certainly not be a parable Jesus would have turned to if it had ended with the Good Samaritan simply tending to the man's wounds but leaving him at the side of the road (in the desert, as it were). No. The power of the parable lies as much in what the Good Samaritan did after meeting the most immediate need. He helped meet the longer-term needs as well.

In the 2010 Winter Olympics, the bronze medal in the 1500 m short track skating event went to J.R. Celski of the United States. Celski injured his right leg when he crashed during the final race of Olympic trials on Sept. 12 in Marquette, Michigan, five months to the day from the 2010 Olympics Opening Ceremony. Celski's left skate blade punctured his right thigh, slicing completely through his quadriceps muscle. He had to pull the skate blade from his leg as blood poured onto the ice. It left a 6-inch-wide gash. Fortunately for him, he received quick professional medical attention that included something more than just a band-aid. J.R. Celski's life represents the lives and communities of many living in the majority world. We, the Church of Christ on this earth, have the necessary resources to meet these needs. But we will continue to see these needs go unmet if we do not begin to ask of the agencies with which we work, be they our local church or a well-established mission agency, how the work we do is going to have long-term impact on the health of the people. We can no longer be content with merely giving a cool drink of water in the desert.

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Nepotism

by Dr. Ron Koteskey

Your field director's nephew is coming to serve at the hospital for a year. Knowing that a long-term family will be returning to their passport country for that year, the field director assigns his nephew's family to their beautiful, large home for that year. If he does this, no one else will have to move unnecessarily.

About a month later another family serving with you is really angry that the field director showed so much favoritism to his nephew. This family had already served three years of their four-year term, and they had hoped they could move into that beautiful home which was so much larger—and it had a pool as well. They start complaining about the blatant nepotism shown by the field director.

What is nepotism?

Nepotism is the showing of favoritism toward relatives based on that relationship rather than on objective factors such as ability or merit. For example, nepotism would be hiring a person with a master's degree in fashion design as an elementary principal because she is the niece of the school board chairman rather than hiring an applicant with a doctoral degree in education who has taught elementary school for a decade.

This family-based favoritism over competence often leads to low morale, low productivity, and a seeming lack of integrity to some.

Did it occur in Bible times?

Of course, it did. It was part of the Jewish culture in the Old Testament. In fact, it was the major factor in people becoming priests or kings.

The whole book of Leviticus details the system of laws governing the Levites. Priests had to be descendants of Aaron, brother of Moses, and of the tribe of Levi. Sometimes the children of priests were good, and at other times they were bad, unfit to be priests. The sons of Eli the priest (1 Samuel 1-4) were also serving as priests, but they treated the Lord's offering with contempt and seduced the women serving at the entrance to God's house. Nepotism did not lead to good.

After Israel began being ruled by kings, the king's oldest son became the next king unless there was a coup. After division of the kingdom, the Northern Kingdom (Israel) had all evil kings. Nepotism did not lead to good. Sometimes a good king in the Southern Kingdom (Judah) had a good son, but other times the son was evil. Here are some examples from over 200 years of successive rulers of Judah.

Did it occur in the church?

Of course it did. In fact, that is where the term "nepotism" originated. The Latin word nepos means "nephew" or "grandchild." The suffix –ism comes from the favoritism popes showed to their relatives in appointing them to positions in the church.

Since the popes had taken vows of chastity and had no children of their own, they most often appointed their nephews (nepos) to become cardinals. The cardinals then chose a new pope when one died, and it was often another cardinal in the family—thus papal "dynasties."

This practice began shortly after 1000 AD and continued until Pope Paul III appointed two nephews (one 14 years old and the other 16 years old) as cardinals. A papal bull in 1692 finally prohibited appointing more than one qualified relative as cardinal. The practice of promoting family members continues to some extent in many churches today.

Did it occur in missions?

It has been happening in missions since the second term of Christian missionary service (Acts 15:36-41). Paul proposed a second term to Barnabas, a teammate on their first term. Barnabas wanted to take his cousin, John Mark. Paul did not think it was wise to take someone who had

deserted them during their first term. Paul and Barnabas parted company, and Barnabas took John Mark with him to a different place of service.

Nepotism still occurs in missions today, probably most often when third culture kids (TCKs) want to return to the culture where they grew up—it is home to them! Of course, their parents (and perhaps other relatives) are often still there and are likely to be in leadership roles since they are more mature and have had more experience there than most others on the field. When the TCKs arrive, they often find that being a missionary on that field is quite different from being a TCK. Many of them are rather disappointed. Their parents may then favor them in attempt to make the experience better for their TCKs.

Is it only perceived as nepotism?

Giving a family a larger house with a pool so that others will not have to move is not nepotism. It is a matter of trying to help by causing as little disruption in people's lives as possible.

Nepotism is not involved in hiring family members who are the persons with the best qualifications, even if they are family members. If family members are excluded from the pool of applicants, one may be excluding the people best qualified for the job, and people often know more about their relatives' talents than others know.

However, everyone must realize that it is best to avoid even the appearance of evil. What people perceive becomes the "reality" to which they react. If the situation leads to low morale, low productivity, or a seeming lack of integrity, it should be evaluated for its effects.

What is the solution?

This is a very difficult problem because we want to avoid favoritism toward family members on the one hand and discrimination against family members on the other. About 40% of the states in the USA have nepotism laws against hiring people for state positions. The other 60% do not have such laws because they want to avoid discrimination.

Some corporations, educational institutions, and agencies have nepotism rules, but others do not. Treating people fairly is difficult when those making the decisions are obviously biased. Walking the fine line between favoritism and discrimination is never easy, but here are some suggestions.

- The best "solution" is to not be in a position where nepotism can occur. That is, do not serve where you are supervising a family member or one is supervising you. However, since that is not always possible, the following may help.
- Acknowledge to yourself that nepotism does happen and that you could be guilty of it yourself. It is only "natural" for people to want the best for their own family members.
- Bring up to the group the possibility of nepotism happening. This brings it out into the open where it can be discussed by everyone.
- Talk with people on all sides of the question. Tell them that you want to be fair, guilty neither of favoritism toward family members nor of discriminating against them. Ask if they think you are doing either.

- Treat everyone applying exactly the same. Openly announce that positions, housing, and so forth are available and ask people to apply for them.

These may not prevent accusations of nepotism, but at least you have a record of your attempts to avoid it.

For a more complete treatment of this topic as well as other topics please visit www.missionarycare.com. Also please let your non-medical colleagues know about these free resources.

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The fastest and most secure way to give to CMDA is through our secure online giving site. Your gifts will be used to continue and expand the critical work of CMDA as we minister to doctors, students and patients.

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