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

Welcome to this issue of the e-Pistle. I hope you find the articles useful.

Are you going to be in the States and attending the Global Mission Health Conference in November. If so, I hope you will plan to participate in a focus group with Suzanne Boswell who is conducting research for us. Suzanne is trying to define success in medical missions and also identify factors of success and longevity. Please put this in your mind if you are going to be at the GMHC in Louisville. And please stop by our CMM booth in the lower exhibit hall. I'd like to put faces to some of the names I find in our e-Pistle database.

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Here are the links to this month's articles:

Short-Term Ethics

by David Stevens, MD

Aren't vacations great! I'm just back from a week off, and I have returned restored and renewed for a very busy fall schedule.

I'm sure my title caught your attention. Rest easy. I'm not suggesting your ethics should be short-term! The title actually was prompted by a longer one in the September 23, 2008 issue of JAMA, Vol 300, No. 12 that a missionary friend drew my attention too. It is entitled "Ethical Considerations for Short-term Experiences by Trainees in Global Health."

The article is well worth a read but unfortunately costs $30 to download. It is not worth that much money but it does raise some issues that are worth thinking about that I want to address.

It notes that almost two out of three US medical schools have established global health initiatives with the goal of reducing disparities through research, education and service. Often due to student demand, these medical schools are now providing rotations in "resource limited

settings." The article lauds these as noble goals but raises ethical cautions about when schools go beyond classroom teaching to providing field experience.

My first medical mission experience occurred after my junior year in college. I had no clinical skills or knowledge but in a bush hospital setting with but a hand full of trained staff learned how to pass instruments in surgery and delivered my first baby. Of course, the baby was from a grand multiparous woman so the only skill needed under the watchful eye of a midwife was to make sure that I didn't let the baby hit the floor!

Things had changed by the time I came back as a fourth year medical student. The hospital wasn't much better staffed but I had a good bit of knowledge and some experience. There were only two doctors in the 125-bed hospital that summer and it was averaging way over 100% occupancy. The few nurses made rounds on the wards most days and doctors saw the most problematic patients and did surgeries. I remember when I arrived I made rounds with one of the doctors on the men's and women's medical wards. He tried to get around to see those patients once a week. When we finished seeing the 40 patients he informed me that these would be my wards, where the medical library was and to feel free to seek him out with any questions that I had.

The authors of this article would frown on that since I obviously lacked experience in "recognizing serious or unfamiliar conditions" and "performing particular procedures." They would also be concerned that I had "inflated ideas about the value of " my skills and lacked knowledge to work in a "limited laboratory" environment. They also point out that I was disadvantaged by language, cultural and other barriers. I'm sure they would have thought I had been given responsibilities beyond my capability.

In fact, most of the article has this tone. They admit that being thrust into these situations "can be exciting" but go on to say that "it can result in considerable stress and guilt in actions taken." The authors warn that the trainees also can get sick or be involved in a motor accident.

They point out that local staff and host institutions may have issues as well. They can neglect patients because they are spending time with visiting students or residents. It takes time to secure translators, provide orientations and insure supervision. It may cost more than is paid to provide food, lodging and transport. Visiting students may spend too much time in experiencing their exotic locations or being tourists and not enough on their duties.

If you have been overseas long and hosted students, residents and graduate docs, you probably could go through the above paragraphs and attach some visitor's name to each problem they raise! I can from the hundreds of visiting staff during my time overseas.

The article unfortunately is too negative by not giving full value to the benefits of visiting staff and they don't offer solutions or principles to guide sending or receiving institutions in these matters. Instead they call for more research to address the problems they raise.

I guess we should not be surprised since secular institutions are relatively new to the ethical and other issues raised in short term service whereas mission facilities have been providing these opportunities for 40-50 years.

Here are some of the principles I employed in dealing with 50 or more short-termers each year when I was overseas. Some will be a review for you and others may give you some new ideas.

- Training Involves Greater Patient Risk - All of us are in agreement that we want to do the best we can to insure competent and safe healthcare for our patients but that understanding has to include both a short and long-term view. To train new doctors and nurses, there is always some risk for patients. We allow that because if we don't we will have less competent doctors in the future.

  As I work with thousands of students in my role at CMDA, I sense the pendulum in the USA has swung too far over to the side of safety. Increasingly students don't have the procedural experience nor the training in patient care they need to be competently trained. More and more is done with "standardized patients" (actors) in role play situations and procedures are done with simulators. Some of these and other methods have their place but an overemphasis on this versus actual patient care makes an inferior physician. That is one reason students are so eager to get overseas.

- Where You Are is Not the USA – Transplanting what is the norm in the USA to your mission facility won't work. It would have been better when I was a student if the long-term mission doctor could make rounds on every patient. He couldn't. The missionary nurse, who had no formal diagnostic training, couldn't see everyone and if she did, wouldn't have time to improve the inadequate nursing services patients experienced. Yes, I wasn't ideal. Yes, I was stretched and scared to death but I did see every patient every day. I read and learned and asked questions and got consults and learned procedures. Was I as good as the missionary doctor? No, but I would estimate the patients overall were better off just because they got more attention. I was the best that could be done for them.
- Utilitarian Ethics – There is a place for them if there is no absolute principle that is being ignored. In your service spot you need to look at your situation, weigh the good and bad and make a decision on getting the most good for the most people with the resources you have.
- Build Good Systems – Take the time to create good orientation for short-termers. Put up the appropriate fences for them to work within based on your patient load and the number of trained staff you have to meet them. Provide the best clinical supervision and training that is possible in your ministry realizing that it may fall far short of the ideal.
- Improve – You have a moral obligation to make things better than they are. Usually the biggest issue is not enough physicians and nurses. Investing your time in visitors is your best hope of getting new staff to join you. As they come, move the fences in to the appropriate place. Use these new people and newly developed methods to make your orientation, training and mentoring better. Wherever possible let visiting staff be part of what you are doing. Much more than new skills or knowledge is transmitted then. You will instill values, behavior and beliefs into those that follow you around.

- Address Outliers Quickly and Appropriately – With the checks and balances you put in place you should be able to see who is breaking down the fences and straying. Rope them quickly. Bring them back inside the fences, admonish them and watch them more closely. Deepen your relationship with them. If they continue to stray, don't hesitate to throw them off the ranch.
- Its' More Than Medicine – Sometimes visitors can be more trouble than they are worth. Make sure that you require them to stay long enough that you get some return on your investment as they gain knowledge and abilities and truly can help carry your load. But the bottom line to remember is this; your visitors are part of your mission field. For most, spending time working with you will have a profound and long lasting effect on them as they are drawn closer to Christ and become more compassionate whether they practice overseas or not.

I'm out of time and space. This list is not complete so feel free to share your insights in a note to the Center for Medical Mission and we will share some of your ideas in future issues.

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Cura Animarum

by Rev. Stan Key

There is much we do not know about Jesus. We meet Him as a baby at His birth. Again at age twelve we catch a glimpse of Him in Jerusalem at the Temple. We don't meet Him again, however, until age 30 at His baptism which marked the beginning of His public ministry.

What was Jesus doing between age 12 and 30? The answer may surprise you. The Son of God was working as a manual laborer (Mark 6:3).

Jesus spent 18 years as a carpenter. He spent three years as a preacher. In other words, Jesus Christ spent six times more of His life sawing lumber, planning boards, and sweeping sawdust than preaching, teaching and healing.

Go figure.

I am not sure I know the full theological implication of this fact, but in this month of Labor Day, I want to challenge you to ponder it deeply.

- Were those 18 years as a manual laborer wasted?
- Was Jesus less spiritual when He was making a cabinet than when He was preaching a sermon?
- When Jesus made a table, did it wobble? When He made a yoke, did it chafe?
- Did Jesus enjoy talking for hours about the difference between the quality of cedar and acacia?
- When Jesus' hands skillfully crafted a chair, did He have a flashback to when those hands had shaped the Milky Way?

- Did Jesus feel the pressure and stress of deadlines?
- Was He ever late for work?
- Did He sweat and get dirt under His fingernails?
- How did Jesus respond when a customer was late paying his bill?
- How did Jesus treat the hired help in Joseph & Sons Carpentry?
- Was God as much glorified in the cabinets Jesus made as in the sermons He preached?

Labor Day is not just a last fling before summer ends. It is also an invitation to think deeply about the meaning of work. This week as you work, think about those 18 years Jesus spent in the shop… and let His life transform your workplace into a place of worship and praise!

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Training Opportunity

You are invited to a fast paced, high quality, exciting, inexpensive global health volunteerism preparatory course called "A Taste of Tropical Medicine, 2010".

A Taste of Tropical Medicine is 1 1/2 day conference at Mayo Clinic on October 29 - 30, 2010 which purposes to prepare consultants, NP/PA's, residents, and medical students to participate more intelligently in global health volunteerism. Mayo and University of Minnesota Global Health faculty with expertise in the care of patients suffering from tropical diseases and diseases of poverty in resource-limited areas are partnering together to teach this course. Most of them have medical missions experience or are currently serving overseas. This year we are offering 9.25 Hrs of Cat 1 CME credit and expect 300-350 attendees from across the US at the course. For more information contact Steve Merry at merry.stephen@mayo.edu. Cost of course is $79.

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Short-Term Medical Sorting

Many mission hospitals are so short-staffed that day-to-day priorities leave no time for sorting incoming medical supplies, as much as they are needed. We know this from friends, as well as our own short-term medical experiences in several countries. Having recently returned from a six week "sorting sortee," we'd like to encourage mission hospitals that there may indeed be hope--recruitment of specific-task short-term help.

A bit of history. This sorting business definitely wasn't our area of expertise. I'm a has-been nurse and Al a retired surgeon. We didn't so much plan the trip as we were cajoled and prayed into it. In six weeks of sweltering heat, we sorted through nine storerooms of over 200 barrels, innumerable cartons and countless garbage bags full of medical supplies. We left behind cleared storerooms for other usage, easily accessible supplies and a more orderly storage system facilitating future incoming shipments.

Each hospital will have different levels of backlog or disorganization, as well as storage capacity. We began with a fairly sizeable, essentially empty area. In addition to primary sorting and setting up an orderly storage-retrieval system, we integrated other smaller storerooms.

Our unique barrel storage racks were devised by the mission surgeon after his small child was nearly crushed by shifting horizontally-stacked barrels. Welded metal angle-bars hold emptied shipping barrels at a forward slant. Racks can be quickly constructed to fit existing spaces, three or four barrels high and of nearly infinite length (one measured 21 ft long). The empty shipping barrels were sanded, a small "lip" welded to retain stock, then spray-painted inside and out. These barrels were not only stable, but more accessible, easily seen, inventory-able and cost-effective. We lined the barrels with heavy-duty garbage bags, allowing bags of supplies to be more easily rearranged than shifting heavy barrels.

Note: By request and time constraints, no inventory system was established but could have been done simply with strikes on paper attached to shelving or even a simple computer data system. However, with this new storage system, a basic visual assessment of supplies could be made. Anecdote: With no prior means of checking such supplies, an urgent order for ace bandages was placed just after we had sorted out an entire garbage bag full of that size.

This information addresses short-term teams, with starting-points for the more backlogged facilities. No ideas are unique but might serve as a checklist. Some items will seem self-evident but could be easily overlooked by an overworked hospital staff. For example, #6 might actually prove crucial for successful completion of tasks by a short-term team.

1. For recruitment, determine specific type of assistance needed. Possibilities:
    A. mass sorting of totally unsorted supplies (our situation)
    B. re-organization of sorted supplies on existing shelving
    C. construction of a more efficient storage system
    D. assistance with inventory and retrieval systems
        1. 1) primary set-up
        2. 2) update existing inventory
        3. 3) switch from manual to computer system
        4. 3) upgrade software
    E. e. shelving construction and painting
2. Select area(s) of most urgent need
3. Estimate a realistic time the team will be needed
4. Solicit short-term teams based on analysis of needs, e.g.:
    A. surgeons and OR nurses for identifying instruments, equipment, medications
    B. central supply personnel for primary inventory set-up or updating
    C. computer expertise for software installation
5. Determine pre-arrival preparation (for efficient use of short-term help):
    A. clean, paint, upgrade lighting, air circulation, minor construction
    B. assess existing shelving vs. more efficient type of storage
    C. clear work areas for pre-sorting and sorting tables
    D. provide convenient space for stacking of incoming boxes, bags
    E. obtain materials (wood, metal, paint, sprayers)

F. list supplies for team to bring (labels, tape, marking pens, laptops, software)
G. identify workshop personnel for on-call assistance (lift, move, construct, repair)
H. arrange for non-technical pre-sorting (baby, school supplies from medical items)
I. plan for dealing with culled, outdated, overstocked supplies for disposal or sharing

6. Establish structure and chain of command to work with short-term team

   individual with primary responsibility for the project

   A. key personnel for consultation about supply placement (RN, ortho, surgeon, CS)
   B. communication mode between team and hospital staff (cell, runner, written notes) (to assess manufacturer to existing equipment, usability, over-supply)
   C. plan for quick diversion of workshop personnel for immediate team needs (disposal of trash, bring in more unsorted barrels, boxes, etc)
   D. identification, authorization and disposal of unusable, outdated or excess supplies
      1. to another mission hospital
      2. share with local hospital
      3. fund-raising sale for community
      4. trash disposal, where and by whom
   E. schedule prompt on-arrival meeting of team with all involved personnel

OUR OWN PROCESS (as it developed):

1. Superb pre-arrival preparations: painting, lighting, ceiling fans, some pre-sorting
2. group meeting, establishing:
   A. priorities—empty old ortho, basic sorting from other storerooms; no inventories
   B. supply placement--nursing forefront, physician separate, less-accessed supplies identified for rear (stocks of unsterile packs, gowns, booties)
   C. shelving decisions--traditional shelving for most nursing supplies (sutures, IV solutions & supplies); majority of supplies in barrels on slanted racks
   D. rough diagram of storeroom with general storage locations (IV, dressings, OB, ortho, anesthesia, general surgery, gloves, needles, foley catheters)
3. non-medical person assigned to pre-sort daily (essential time-saver)
4. tables set up for sorting
5. table for items needing consultation re: usability, manufacturer match, what-is-this?
6. nearby area designated for delivery of unsorted supplies, as requested
7. reorganization and culling of outdated or rarely-used items from existing shelves
8. system to deliver full barrels & collect empty for sanding, welding, spray-painting
9. time determined for welding barrel frames, as we established length and height
10. first barrel-storage rack set up
11. general category sorting into barrels (no sizing of oxygen masks, tubing, gloves)
12. temporary content labels taped to barrels (on scrap paper)
13. realization of need for continual resorting and shuffling (no concept of amount, type, usability or condition of supplies to be sorted)
14. decision to line barrels with heavy plastic bags (vs shifting heavy barrels) to facilitate constant re-organizing

15. frequent consultations with designated doctor and nurse re:
    A. average usage of supplies (e.g. ace bandage sizes)
    B. excess-supply disposal (secondary storage area, share with other hospitals)
    C. usability (ortho pins, plates)
    D. supplies lacking same-maker equipment (lap ports, surgical staples)
    E. possibly outmoded equipment
16. rack measurements sent to workshop as needed
17. continual re-sorting into new or sub-categories and sizes
18. shifting of plastic bags between barrels to accommodate new sub-categories
19. surplus and non-matching supplies repacked in empty barrels and boxes to forward to another in-country mission hospital
20. semi-permanent labels affixed to barrels
21. orientation of long-term sorters to location and organization of supplies
22. good laughs with personnel about outdated, unusable items unearthed (hardened leather OR booties with anti-static tails, WWII field X-ray kit)
23. praise-filled Project Completed Tea with involved staff and workshop crew

If you would like to ask questions regarding this article, please contact Nancee Dickson at forjoyfull@yahoo.com.

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Reentry: Entering Well

by Dr. Ron Koteskey

Last month we considered the importance of leaving well by building a good RAFT and of giving yourself some time to transition on the way home if possible. This month we consider how to enter (really re-enter well).

Entering Well

Of course, the first steps to re-entering well are to build a good RAFT and give yourself some time to transition on the way home. Now you find out if your expectations are realistic or not. Your expectations form the basis for evaluating everything back home, and everyone has expectations even if they deny them.

Unfortunately expectations may be based on what was true one, two or four years ago. However, during that time everything has changed—you, your friends and family, your church, and your culture.

- You have changed. Before you left, you drove your car to the corner store, threw away food, and discarded plastic bags without thinking. Now you walk half a mile, take food home from the restaurant, and hoard bags. Paul had changed, and he told the people in his passport country about persecuting followers of the Way, being struck blind on the road, and then being sent to the Gentiles (Acts 22) Your friends and family have changed. You used to belong to the group, know where you fit with everyone, and friends confided in

you and listened to you. While you were gone, new people came into the group, and your friends are involved in different activities. You now feel like a marginal person, do not understand the jokes others laugh at, and misinterpret some of the things they say and do.

- Your church has changed. When you left, it may have seemed to be such a mission-minded church, but now no one seems very interested in missions. When you try to talk about your mission experience, people may listen politely for a few minutes, then launch into an excited conversation about how the local football team is doing. When Paul came home from his first term (Acts 15) of missionary service, people from the church maintained that his converts were not saved. At the end of Paul's third term (Acts 22) people in his own denomination were excited. However, when he went to the big church in town, the people basically listened politely until he mentioned his missionary call; then they called for his death.
- Your culture has changed. Alvin Toffler wrote Future Shock to point out that cultures now change so fast that even the people living in them can barely keep up with the changes. People gone for several years often return to a culture quite different from the one they left. Something as simple as walking into a store and buying something can be overwhelming.

Pitfalls to avoid

You will face many difficult situations. Here are some of the most common.

- Frustration. Things will be different, and some of those differences will be very frustrating. For example, while overseas, your family may have been closer because there was no TV and you home-schooled your children. Back home TV, school activities, many church activities, sporting events, club activities, etc. will separate family members.
- Disillusionment. You return home all excited about what you have been doing, but everyone at home seems so apathetic. As one person put it, "They are comatose and don't even know it."
- Judgmental. It is very easy to become critical, condemning others in the face of their apparent apathy. You may confuse the narrower functions of the mission agency (outreach and training for most) with the very broad functions of your local church.
- Bitterness and Hostility. If you let these things progress far enough, you may become bitter inside and let that express itself in hostility toward the very people who supported you financially and with prayer.

Suggestions for avoiding pitfalls

Pitfalls can be avoided, or at least made less disruptive to your life and witness. Here are some suggestions.

- Grieve your losses. If you have not taken time to grieve during leaving or traveling, take some time to do so after you arrive. Although time will be at a premium, set aside a few minutes each day (perhaps during your devotional time) to fully grieve what you have left behind.

- Be honest. Do not let pride (spirituality?) keep you from sharing your struggle with someone. Find someone(another missionary, a close friend who will keep a confidence, a counselor who understands missionaries, etc.) who will mentor you in adjusting to life back home.
- Adjust to changes in ministry. Most likely you will not be doing the same kind of ministry that you were on the mission field. What you do may seem quite mundane in comparison. However, all avenues of service are pleasing to God, and you can find a way to be a servant in any local church.
- Thank your supporters. Even if you are not given the chance to speak to all the people in your church during a service, find some way to thank those who have helped you. Perhaps you can invite them over for a meal you learned to prepare while in another culture and share what God did in and through you.
- Reach out to people. Whatever you do, continue to reach out to people as you did on the field. As you reach out, people will see how you have changed and perhaps want to experience the same changes in their lives.

The following E-books about reentry are available on-line free of charge.

- Ron & Bonnie Koteskey (posted November 2003). Coming "home": The reentry transition. http://www.missionarycare.com/ebook.htm. This book is written to be used by people after they reach their passport country, but it contains relevant information in Chapters 5-6.
- Ron Koteskey (posted May 2010). Reentry after short-term missionary service. http://www.missionarycare.com/ebook.htm. This book is written for short-term people, and contains relevant information in Chapters 5-6.
- Ron & Bonnie Koteskey (posted February 2007). We're going home: Reentry for elementary children. http://www.missionarycare.com/ebook.htm. This book is written for children 6-12 years of age with relevant information in Chapters 8-11.
- Ron Koteskey (posted February 2007). I don't want to go home: Parent's guide for reentry for elementary children. http://www.missionarycare.com/ebook.htm. This book is for the parents of children 6-12 years of age with relevant information in Chapters 8-11.

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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