The Center for Medical Mission's
e-Pistle
September 2011

Thanks so much for your prayers for our Medical Mission Summit with representatives of your various sending agencies. There were 17 in attendance and the consensus was that this was the best Summit yet. We are excited about the three working groups that will develop papers on the topics of medical mission training, advocacy for medical missions in the sending agencies and developing a theology for medical missions. The groups will do their work and then share it with all other participants. The expectation is that there will be significant work to present during the next Summit.

We agreed together that we need to have better representation at the next Summit. If you want to be sure your agency is represented, please encourage the appropriate person to participate. We are no longer asking for the CEOs as many organizations have a different position that is better suited to discussing medical missions. Please send me the name and contact information for the specific individual you would like to be invited to the 2012 Summit. susan.carter@cmda.org

In this issue, Dr. Mark Strand shares the results of the PRISM survey that many of you completed. I think you will find it very interesting. The mission representatives at the Summit did. It was this work that took the group to the three follow-up issues. At the conclusion of the article, you will find a link to the results booklet that was shared at the Summit.

Don't forget about this year's Global Missions Health Conference. It will take place at Southeast Christian Church on November 10- 12 in Louisville, Kentucky. Hope to see many of you there!

Included in this month's e-Pistle are:

The Noble Pursuit of Medicine - cont'd from July

by David Stevens, MD, MA (Ethics)

(Introduction – I recently gave an academic plenary talk at the Center for Bioethics and Human Dignity in Chicago on "The Noble Pursuit of Medicine." As I researched and thought extensively about this topic, I gained new insights into what God has called me to do. I trust sharing some excerpts from that talk over the net few issues will do the same for you. DS)

The Second C - Character

For the pursuit of medicine to be noble, it is not enough to have convictions or beliefs. The practitioner must have a virtuous character, the second C.

The following virtues of the medical practitioner have been well articulated by Edmund D. Pellegrino and David C. Thomasma in *The Virtues of Medical Practice*.

- Trustworthiness
- Compassion
- Prognosis (practical wisdom)
- Justice
- Fortitude
- Temperance
- Integrity
- Self-Effacement
- Faith
- Hope
- Charity

Healthcare professionals face an ever expanding medical knowledge, the motivation of money, their own personal tiredness, insurance company directives, time limitations, government intrusion into the doctor/patient relationship and a host of other factors. The best insurance that the clinician will act for the patient's good despite these extensive influences is that the healthcare professional is inherently good. No code or convictions can cover all contingencies. There are too many variables in the practice of medicine.

Let's focus on just a few of the most important character qualities that are the most essential in the noble pursuit of medicine.

In a 2010 Gallup poll, survey takers were asked to "tell me how you would rate the honesty and ethical standards of people in these different fields." The highest trust was put in nurses (81 percent), military officers (73 percent) and pharmacists (71 percent). Physicians had dropped to fourth at 66 percent and were followed by police officers (57 percent) and clergy (53 percent). The three last places were congressman (9 percent), used car salesman (7 percent) and lobbyists (7 percent).

As a physician, I'm concerned that only two out of every three potential patients find us to be honest and ethical, because the foundation of the doctor-patient relationship is trust. If doctors continue to be not considered trustworthy, our medical system will be fatally wounded. That is one of the reasons I fight so hard against the legalization of physician-assisted suicide. You

cannot trust a doctor who can both cure you and kill you. We've seen that in the Netherlands where fearful elderly citizens carry cards saying, "Please don't euthanize me," out of fear a doctor will kill them if they are seriously ill and taken to a hospital.

Another essential characteristic is reliability. Reliability is the willingness to be there for your patients just like in the marriage covenant "in sickness and in health." It is ironic that today's younger physicians idealize a practice style of very limited availability – no night call, no weekends, etc. – at the same time when patients are demanding more availability. Patients want to be able to tweet or post a status update with their questions and their concerns to their doctor at any time. We have gained more convenience with same-day appointments, walk-in clinics and 24/7 emergency rooms; at the same time, you lose the personal relationship you would normally encounter when seeing a doctor who knows you.

I'm not advocating a 24/7 medical practice without boundaries, but noble medicine is not a "9 to 5" job. I fear the pendulum is swinging too far from unlimited commitment to unreliableness in the U.S.

Another essential characteristic in the noble pursuit of medicine is that the healthcare professional must be responsible and conscientious. When patients put their health and even their life into your hands, they want someone who is obsessive-compulsive and will pay attention to even the smallest details.

Dr. Sam Molind, the oral surgeon who previously headed CMDA's Global Health Outreach, related a story to me of his work in Hanoi, Vietnam, where he has traveled to train doctors and residents annually for more than 15 years. The chair of oral surgery at the medical school tapped him on the shoulder as he was scrubbing for a case and asked, "Are you a Christian?" Not knowing his motives, Sam said, "Why do you ask?"

The chair said, "I've noticed you always talk to the patient's family before and after a surgery. We only talk to the family if there are unexpected problems. We go home on weekends and don't come into the hospital to even see our post-op patients, but you come in every day and check on each one. Your conscientiousness makes me think you may be a Christian."

Sam told the chair that he was a Christian, and the chair went on to say, "We want to train our doctors to be like you."

Another noble principle of medicine is truthfulness. When a physician or nurse communicates with patients, honesty fosters confidence and shows respect. Truthfulness is a prerequisite to engender trust. If a patient discovers or perceives a lack of honesty and candor by the physician, trust is destroyed.

In 1961, only 10 percent of physicians surveyed believed it was correct to tell a patient of a fatal cancer diagnosis. By 1979, 97 percent felt that such disclosure was correct. Without being told their diagnosis, prognosis and treatment options, patients cannot fully participate in healthcare decision-making. Of course there can be some inconsequential information that does not need to be shared and some information that needs to be shared in a sensitive and tactful way.

Can being truthful be harmful at times? Rarely, and then it is often due to the patient's culture. If the physician has some compelling reason to think that disclosure would create a real and predictable harmful effect on the patient, it may be justified to withhold truthful information. For example, sharing a terminal diagnosis with a suicidal patient may cause that patient to act upon impulse.

At times, a patient may request to not be informed but rather have the information be discussed with his or her family. Complete disclosure may also be hampered by the patient's mental capacity to understand and process the doctor's information.

No list of essential character traits that healthcare professionals must demonstrate to nobly pursue medicine would be complete without mentioning competence. Competence is a blend of knowledge and experience that leads to good judgment or what many of us would call wisdom.

Competence is not just knowledge. All of us know healthcare professionals who have near photographic memories but lack the common sense and insight in how to apply that knowledge. Having competence requires the virtues of self-discipline to continually learn. Unfortunately, educational institutions and professional bodies increasingly use coercion to persuade professionals to maintain competency with ever-increasing certification and recertification requirements. It would seem better to inspire continual learning through the character virtue of self-discipline.

-To be continued

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Cura Animarum
by Rev. Stan Key

THE GAP

I'd almost given up all hope
Of finding ways to help me cope
With this great chasm, broad and deep,
That breaks my heart and makes me weep;
This gap that's there for all to see
Between what is… and ought to be.

On one side, Lord, I see Your power,
That gives me grace for every hour:
Your blood that cleanses from all sin,
Your Spirit giving strength within,
Your Word that guides me in the way,
And feeds my soul for each new day.

But here on this side, Lord, I see
An opposite reality.
For when I try to do what's right
I find the will… but not the might.
This inner turmoil makes me sore,
I am a walking civil war!
Is this gap forever there?
Mocking me with empty air?
If Your Gospel, Lord, is true,
Is this all that grace can do?
Humbly now, I must confess;
Though I'm Yours, I'm still a mess!
Then You turned to me and said,
"Victory comes when you are dead.
You will never be set free
Till you're crucified with Me.
Then My power you'll understand,
And this cursed gap be spanned."
The gap today is still a part
Of truths that often break my heart;
But now its breadth is not so wide,
And crossing to the other side,
Is simpler; for I've found the key:
"More of Him and less of me."

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Can You Help?

Resources for Training Hospital Chaplains?

I've had a question from a ministry in Africa asking where he might find resources for training hospital chaplains. Do any of you know of books, online courses, websites or other resources that chaplains might use to improve their services? This individual already knows about the chaplain training course at Tenwek Hospital in Kenya, but he wants something less costly in time and money but will still help chaplains serve more effectively. If you have any ideas, please write me at susan.carter@cmda.org. Thanks so much!

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Taking to Heart the Results of the PRISM Survey (Patterns and Responses in Intercultural Service in Medicine)

By Mark Strand, PhD

In recent years, there has been a sense that skilled medical personnel are being under-utilized in cross-cultural Christian medical work. While we would hope to be willing to change our expectations in our serving, we also have an area of expertise which we hope to use for the Lord, and should strive to do so as best as we are able. Christian hospitals are being closed or turned over to national leadership, and some organizations are focusing their attention on cheaper, simpler methods of engaging the community. It leads one to ask, is it possible that…

- …the world economy and global medical systems have grown past the day when small medical missionaries have anything of value to offer?
- …medicine is too technical and specialized for multifaceted mission organizations?
- …medical work is too tedious to be an efficient form of ministry and witness?

If so, then perhaps we should resort to the cheapest, lowest technology means by which to get the maximum spiritual output from our mission efforts.

In search of answers to these questions, we recently completed a global survey of 393 cross-cultural medical workers from 18 countries serving in 68 countries (average age 48 and average term of service 10.8 years, respectively). Many (37.7 percent) of the respondents consider their organizations to be moving away from clinical medicine and hospital-based work. And yet, 83.6 percent consider their medical work to be an essential or important part of their purpose in being there, and 64 percent are still working in hospitals and clinics doing clinical medicine (in Asian countries it is a bit lower at 56.8 percent). A total of 61.5 percent agree that their organizations have a clear strategy, but comments suggest that such strategies are not designed with the medical work in mind or they are arbitrarily enforced. In either case, it is leaving medical workers and their work dangling in an uncertain world.

Of the respondents, 32.3 percent agree that getting permission to initiate effective long-term medical work for expatriate medical workers is getting harder when compared to when they first arrived. One reason is that the local healthcare systems are improving, as agreed upon by 58.9 percent of respondents (rising to 83.3 percent in Asian countries). How should we move forward in the face of improving national healthcare systems? More than twice the percentage of non-American respondents compared to Americans is working in government hospitals or clinics. So maybe we need to learn from their experience bringing value to those settings.

The biggest perceived challenge in cross-cultural medical work was reported to be not enough qualified workers, while the biggest opportunity was considered to be mentoring national like-minded medical workers or training nationals. (This was despite the fact that the majority are primarily involved in patient care.) 42.1 percent feel that short-term medical work is not having a significant positive impact on the health situation for local people.

This research has clearly elucidated that medical missionaries are largely satisfied with their roles and are willing to work in less than ideal situations, but that role clarity is essential and needs to be given more thought. Some key elements that contribute to increased role satisfaction include having a clear mission strategy, a satisfying mix of medical work and ministry, working in a setting sympathetic to their Christian faith and working in a country that welcomes their presence as medical workers.

These cross-cultural medical workers are committed to long-term service and bring a unique set of skills to the cause. While we cannot influence changing circumstances in our countries of service, our organizations and strategies can be upgraded in such a way as to utilize these willing servants, and capitalize on the opportunities before us. We need to change our thinking regarding our purpose, as we are increasingly called to add unique value, multiply our efforts through the training of national coworkers, and model ingenious and evidence-based types of care. The people we serve in our medical work and our national colleagues are in need of the hope that our purpose brings, and it should continue.

To see the results booklet shared at the Medical Mission Summit, please click here.

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What Missionaries Ought to Know about Grief

By Dr. Ron Koteskey

You may say, "I don't need to know anything about grief. No one in my family has died, and when someone does, I'll fly home to the funeral." If and when that happens, it may be one of your easier encounters with grief because everyone there will understand your grief, and your culture has developed rituals to enable you to resolve your grief. Although we commonly think of grief as related to the death of a loved one, there are many other causes of grief.

The dictionary defines grief as the "intense emotional suffering caused by loss of any kind." Missionaries experience many losses that other people do not, so those people do not understand. There is no funeral or other ritual to assist in grieving over these losses. Missionaries may offer true, but over-spiritualized, platitudes in denial of the losses they experience. When people are dying and losing everything, we do not question their denial, anger or depression before they come to accept their loss. Regarding losses other than death, missionaries may carry a load of unexpressed, unresolved grief.

More important than the "objective" severity of the loss is each person's own interpretation of the loss. Leaving a pet may seem like a minor event to most people, but those who have had that pet for years may experience much grief. Here are several losses that may increase grief for missionaries.

Things?

Everyone understands the loss of friends and family, but what about the house, the car, the supermarket, the school, the pets, the newspaper and the toys? All of these, and more, are lost as you leave your passport country to become missionaries. Any, or all, may cause grief.

You may develop two homes, one in your passport country and one on the field. When you come "home," people there cannot understand that you feel the loss of the smells, the foods, the animals, the friendliness of the people and the music of the country where you have been serving. Losing these may cause grief when you return to your passport country.

Transfers?
Headquarters calls and you move to another field. You lose everything you have come to love over the last months or years. Grief comes again. Perhaps this culture has become home to your teens, and when you move to the new field, your older adolescents remain with other missionaries to finish school. They may be old enough to marry a national and stay behind forever—another loss and more grief.

The field committee asks you to take over a project that has not been handled well by another missionary. However, that means leaving what you have been doing so effectively—another loss. Your new project does not take off and the one you left also declines—more grief.

Travel?
Travel is exciting to many people, but it can be dreary to missionaries on deputation. You have been away from home for several years on the field, and now you are away even more. When overseas you could not get home for the funeral of a friend (no money, no flight available, no time free), but now that you are at home, you cannot get back to the field for a funeral there—unresolved grief in both cases.

Before airplanes, travel time was a time to work through the loss, through the grief. It took at least days, if not weeks, to get from country to country whether traveling by ship, train or horse-drawn vehicle. Today missionaries finish packing, step onto the plane, and are at their destination in a few hours. They have had no time to work through the loss.

Time?
That brings us to the time it takes to grieve. Grieving rituals are different in different cultures, so grief is expected to take different times in each. Grieving always takes time, sometimes a great deal of time. It may take a few days for leaving things, weeks for leaving friends and months for the death of a loved one. Some people say that such bereavement should be over in a couple months, but it often takes much longer. Those who try to short-circuit the grieving process may experience problems years later.

Triggers?
Long after your time of grieving seems to be over, you may suddenly feel the loss intensely again. "Triggers" (stimuli that bring back memories of the lost person, place or thing) surprise you by suddenly reactivating the grief. You may not even realize that you saw, heard or smelled something that brought back memories of the loss. Smell is especially likely to do this, and you will not even know why you thought of that person, place, possession or pet.

Anniversaries are particularly difficult, especially wedding anniversaries. Birthday anniversaries are another difficult time. "Firsts" are also difficult, such as the first Christmas or first family reunion. Related events in others' lives may be difficult, such as the birth of a friend's child bringing back the loss of your own, even years later when you thought the grief was gone.

Trauma?
Missionaries may be more likely to experience traumatic situations. Other cultures may be more likely to have assault, political unrest, evacuations, bombings, killings, kidnappings and so forth.

When this happens to a missionary, others become involved, and rightly so. Even though they did not experience the trauma firsthand, those helping often grieve over the loss caused by the trauma as well.

Theology?
When people working in business get moved, they blame the company. When people in the military get moved, they blame the government. When missionaries get moved, they may blame administrators at headquarters as well as God himself. After all, people have prayed about the move and have determined that it is God's will. God called us, He made us move and it is His fault. Naomi's statements about God in Ruth 1:20-21 are excellent examples. Returning missionaries may feel just as she did.

What can we do about it?

- Be honest. The loss and grief you experience is real. Do not deny it; it really hurts. Do not over spiritualize it and say what a privilege it is to suffer for Jesus if it is not. Be honest and open about your feelings of loss.
- Be informed. Reading this brochure and other material about grief helps you become informed. Realize that all of these "Ts" are especially relevant to missionaries.
- Be Christian. Too often Christians deny their feelings of grief. They may quote 1 Thessalonians 4:13 as saying that we are not "to grieve like the rest of men." Do not stop there because the rest of the verse is "who have no hope." We grieve, but we grieve like people who have hope. Look at what the Bible says:
    - Abraham grieved. Genesis 23:2
    - Jacob grieved. Genesis 37:35
    - David grieved. 2 Samuel 18:33
    - Jesus grieved. John 11:35. "Jesus wept" is one of the shortest but most important verses in the Bible. If he wept at the funeral of a friend, we certainly can grieve about our losses.
- Be missionaries. We have an excellent example of people saying goodbye to missionaries in Acts 20:17-21. Paul talked extensively about his leaving them, and then beginning in verse 36, note what they did:
    - They said their good-byes.
    - They knelt.
    - They prayed.
    - They wept.
    - They embraced.
    - They kissed.
    - They went to the ship.
    - They tore themselves away.

This is a good example of the grief expressed at the parting of a missionary. Paul had ministered to them for two years, and such grief is normal and expected. If you do not express the grief over your losses, it may remain unresolved and return to hinder your work. Be honest, informed Christian missionaries relative to your loss and grief.

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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