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**Indications and Usage**

As an adjunct in the short-term treatment of pain accompanied by tension or anxiety in patients with musculoskeletal disease. Clinical trials have demonstrated in these situations relief of pain is somewhat greater with than with aspirin alone. Equagesic is not intended for use longer than 10 days.

**Contraindications**

Usage in Pregnancy and Lactation

An increased risk of congenital malformations associated with the use of meprobamate (meprobamate, chlorpromazine, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided.

Because of the known effect of non-steroidal anti-inflammatory drugs (NSAIDs) on the fetal cardiovascular system, when given in doses that produce fetal levels comparable to the third trimester of pregnancy should be avoided. Salicylate products have been reported as causing fetal alterations in maternal and/or fetal hematopoietic, mechanistic decreases, birth weight, and perinatal mortality. The possibility that a woman of childbearing potential may be pregnant at the institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug. Meprobamate causes the placental barrier. It is present both in umbilical cord blood and in fetal serum and milk, and, therefore, mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is continued in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Equagesic is contraindicated in patients with acute intermittent porphyria and in patients with a history of alcohol or meprobamate use. Use of these drugs may be accompanied by a worsening of the patient's condition. The thalamic and limbic system. Aspirin is a non-steroidal anti-inflammatory with antipyretic and antirheumatic properties.

**Effects of ACE inhibitors may be diminished by the concomitant administration of aspirin due to its indirect effect on the renin-angiotensin conversion pathway.**

Anticoagulant: Concurrent use of aspirin and acetylsalicylic acid can lead to high serum concentrations of anticoagulants, resulting in increased bleeding risk.

Acute anticoagulant effect (APAP and Kineton): Patients on anticoagulant therapy should be monitored closely for drug-drug interactions and the effect on platelets. Aspirin can change Warren's hypercoagulable patient profile. The effects of anticoagulants can vary due to the varying sensitivity of the platelet to aspirin.

Atrial fibrillation: Salicylate therapy may cause the hypercoagulable patient effects of beta blockers may be diminished by the concomitant administration of aspirin due to inhibition of renal prostaglandins, leading to decreased renin levels and increased blood flow.

Corticosteroids: In patients receiving concomitant corticosteroids and chronic use of medications containing aspirin, withdrawal of corticosteroids may result in salicylate toxicity because corticosteroids can increase platelet turnover and lead to increased bleeding risk.

Hyperkalemia: In the hypercoagulable patient, salicylates may increase the risk of hyperkalemia.

[Summary of clinical studies of meprobamate with aspirin did not include sufficient numbers of subjects to evaluate the effects of meprobamate on clinical laboratory function. 0.5 to 2 mg percent represents the usual blood-level range of meprobamate after therapeutic doses. 3 to 10 mg percent usually corresponds to findings of mild to moderate effects.]

**Geriatric Use**

Safety and effectiveness have not been established for pediatric patients under the age of 12 years (See Contraindications). 

Clinical studies of meprobamate with aspirin did not include sufficient numbers of subjects to evaluate the effects of meprobamate on clinical laboratory function. 0.5 to 2 mg percent represents the usual blood-level range of meprobamate after therapeutic doses. 3 to 10 mg percent usually corresponds to findings of mild to moderate effects.

**Adverse Reactions**

General

Fever, hyperpyrexia, thirst

Allergic or anticonvulsant reactions to aspirin, meprobamate, or related compounds, such as carbatrol, carbamazepine, mostertol, anticonvulsant anti-inflammatory drugs, salicylates, or thymol. Equagesic is also contraindicated in patients with the syndrome of asthmatic, rhinitis, and nasal polyps. The aspirin component of Equagesic may cause severe angioedema, bronchospasm, urticaria, or anaphylactic reactions.

Reye’s syndrome: Aspirin should not be used in children or teenagers for viral infections, or with or without fever, because of the risk of Reye’s syndrome with concomitant use of aspirin in certain viral illnesses.

**Warnings**

Equagesic should be prescribed cautiously and in small quantities to patients with a history of salicylate intoxication or anorexia. Effects: Since CNS-suppressant effects of meprobamate and aspirin and meprobamate antagonism or meprobamate and aspirin may be additive, additional caution should be exercised with patients that take one or more of these agents simultaneously. Alcohol Warning: The alcohol content of this preparation may interfere with the following laboratory determinations in urine: 5-hydroxyindoleacetic acid, homovanillic acid, uric acid, spectrophotometric detection of barbiturates, and vanillylmandelic acid (VMAC).

Carcinogenesis, Mutagenesis, Impairment of Fertility

Meprobamate is not known to affect fertility. Since CNS-suppressant effects of meprobamate and alcohol or meprobamate use while taking aspirin.

**Drug Interactions**

Anticoagulant: Concurrent use of aspirin and acetylsalicylic acid can lead to high serum concentrations of anticoagulants, resulting in increased bleeding risk.

Acute anticoagulant effect (APAP and Kineton): Patients on anticoagulant therapy should be monitored closely for drug-drug interactions and the effect on platelets. Aspirin can change Warren's hypercoagulable patient profile. The effects of anticoagulants can vary due to the varying sensitivity of the platelet to aspirin.

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[Summary of clinical studies of meprobamate with aspirin did not include sufficient numbers of subjects to evaluate the effects of meprobamate on clinical laboratory function. 0.5 to 2 mg percent represents the usual blood-level range of meprobamate after therapeutic doses. 3 to 10 mg percent usually corresponds to findings of mild to moderate effects.]

**Usage in Pregnancy and Lactation**

Contraindications


Since CNS-suppressant effects of meprobamate and alcohol or meprobamate use while taking aspirin.

**Precautions**

General

Equagesic should be prescribed cautiously and in small quantities to patients with a history of salicylate intoxication or anorexia.

Effects: Since CNS-sus...
I suspect it was the daily room inspections back in my high school boarding room days, but whatever the reason, I can’t stand a mess. Add to my credo, “A place for everything and everything in its place.”

Don’t get me wrong, I’m not OCD or a neat freak but I just function better if there is reasonably ordered environment around me. I’m more relaxed, focused and efficient.

I think many docs are the same way, which makes it difficult for all of us to live and function in the mess that medicine is in these days. Practice is complicated, unpredictable and lots of extraneous things keep us from taking care of patients. It is messy to get paid. It is messy to get treatments approved. It is messy to deal with ever changing practice standards and government regulations.

So you work harder, you work smarter, you work longer but it still doesn’t seem to get much better. You for sure aren’t relaxed, focused, and efficient!

It reminds me of mowing my lawn the other day. First, I had to throw all the sticks out of the lawn that my two Labradoodles had dragged in from the woods. Some were chewed into a dozen pieces. But before I got back from the first lap with the mower, my dogs had dragged more sticks into the lawn. They were making a mess faster than I could clean it up and get my job accomplished.

In the midst of trying to provide excellent care for our patients, we have a highly charged political atmosphere, an increasing lack of collegiality, a potently adversarial malpractice environment, decreasing professionalism, and a loss of ethical consensus.

Who is going to clean up this mess?

It is obvious that none of us is going to be able to do it alone. We don’t have the time, the expertise, the power, or the experience. In fact, no group, professional or government, has all these necessary, but that doesn’t mean they aren’t going to attempt it . . . which in itself is worrisome. As bad as things are now, we have a built in inertia into further change fed by fear that the solution could be worse than the problem. “Better the devil we know than the one we don’t know.”

In this issue of Today’s Christian Doctor, we take a look down the road of medicine and do our best to see where it is going. If we know the path, we can be better prepared for the journey and perhaps even take a different route.

One thing is clear. In these troubled times we need Christian doctors to mutually support and encourage each other. We need colleagues that can remind us to keep our eyes on the Savior instead of our own anxieties and burdens. We need to remember that all potential solutions need to adhere to biblical principles. We need a united voice in order to have a place at the table where the decisions are made.

Like heading west to settle, it is too dangerous to travel alone. The best safety is banding together in a wagon train with those of like mind and common purpose who will support and care for each other.

If we ever needed CMDA, we need it now.

That is one reason why in this issue we are introducing a new paradigm to grow our organization. It is simple, compelling, and doable. I believe it will take us to over 25,000 members in the next few years - not to build an institution, but to grow this movement of Christian doctors who need each other in these difficult times.

• Only together can we bring up the next generation of Christian doctors.
• Only together can we be an effective voice into medicine and our culture.
• Only together can we help each other to not lose sight of why we went into medicine and dentistry.
• Only together can our individual candles merge into a bright light and become an even greater witness for God. We need each other and other Christian doctors need us.

The river is raging. It is difficult if not impossible to row alone, but the more people we get into the boat manning the oars the better off we all will be.

As you read this issue, think about that and personally commit to using our new tools to tell a Christian colleague about CMDA. We will all be better for it.

And then rest in this. No matter how big the mess, we have a hope and a confidence in a Savior who not only offers God sized solutions, but also can give us a peace that passes understanding.†
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George C. Gonzalez, MD is the New President-Elect

Every two years, the CMDA membership elects a new President-Elect, who serves in this capacity until replacing the outgoing President two years later, with his or her term commencing with the annual CMDA national conference. This year, in Orlando, outgoing President Ruth Bolton, MD, will hand the gavel to incoming President Bruce MacFadyen, MD. CMDA recently announced the result of this year’s election. The new President-Elect is George C. Gonzalez, MD.

Dr. Gonzalez is the Vice-President/CFO of Peachwood Medical Group, a multi-specialty group practice in Fresno, California. He has been active with CMDA since his UCLA Medical School days. For the last twenty years, he has developed and grown the Fresno CMDA Chapter into an active group which meets monthly. Dr. Gonzalez is also a team leader for GHO and for the last three years has led a team to the Dominican Republic of which half of the group is from the Fresno chapter. In addition, he is a board member and medical director of the Pregnancy Care Center in Fresno, Vice President and board member for Medical Missions International, and Sunday School teacher at his local church. Dr. Gonzalez has served as a CMDA Trustee since 2004.

In his vision statement posted online and adapted here, Dr. Gonzalez said, “I believe CMDA, as an organization, is on the right track, representing Christ our Lord, at a time of confusion and increasing ethical moral debate in the healthcare field. At such a time as this, we need a strong medical/dental organization that can unify the numerous and diverse health professionals and stand for biblical righteousness, addressing the issues of our day. I believe we are fortunate to have an excellent working staff at our national headquarters that are not only skilled, but also committed and godly.

“I am committed to working with the fellow elected board members to prayerfully develop and implement a strategic plan that will advance the Kingdom of God through our role as healthcare providers, teachers, and community role models. Our leadership role is to inform, equip, and encourage medical/dental students, residents, and other community physicians and dentists to recognize that it is the Lord Jesus who is able to bring healing and transformation to individuals and society. It is my prayer that we stay the course, continue the work, and grow in numbers so that our impact on the national and international medical and dental fields would be great for Christ’s sake and to His glory.”

Planning a Saline Solution Seminar in Your Hometown

The Saline Solution is a course curriculum that teaches healthcare professionals how to effectively and appropriately share faith within their busy practice schedules. This FREE guidebook is provided by the Christian Medical & Dental Associations for groups or individuals seeking to host a “live” Saline Solution seminar. For more information contact Melinda Mitchell at: melinda.mitchell@cmda.org, or download this FREE resource online at: www.cmda.org.
Medical Malpractice Ministry Seeks Participants

CMDA’s Medical Malpractice Ministry is looking for members to minister to other CMDA members during one of the most devastating times of their lives—a medical malpractice lawsuit, which can wreak havoc on a doctor’s family, career, and emotional and spiritual well-being. For twenty years, CMDA’s malpractice ministry has intervened with prayer, educational resources, and a commission of doctors who have faced malpractice suits themselves. If you are interested in participating in this ministry, contact Dr. Robert Agnew at BobCVS@mac.com.

“Life Support” is a free MP3 audio magazine produced specifically for students and residents. It is currently on two websites: www.cmdastudents.org and www.cmda.org.

This year’s conference speakers include:

Margaret Brand, MD – Banquet speaker: “Things I Have Learned and Things I Am Still Learning”


Patsy Sulak, MD – Plenary Speaker: “The Journey of Rest and Joy”

Linda Flower, MD - Luncheon Speaker - “Women in the Healing Professions: The Legacy and The Call”

Al Weir, MD – Sunday Worship Speaker

Pre-conference CME sessions are planned; in addition, more than a dozen workshops will be presented on various topics, including: Gifts and Talents of Women Leaders, Cross Cultural Evangelism, Communicating Bad News to Your Patients, Preventing Burnout, The Medical Marriage Dance, The Mysteries of Prayer, Expectations Christian Women Place on Each Other, Nutritional Supplementation – Help or Hype?, Personality Disorders, Pride and Self-Reliance: Mortal Enemies of Rest and Joy; and, Proverbs 31 Woman: Can a Physician Be One?

For more information or to register, go to: www.cmda.org/go/wimd.
The Christian Doctor’s Job Description

Ruth Bolton, MD
President - CMDA

This issue of Today’s Christian Doctor has a theme of “Where is Medicine Going?” One way to keep our bearings amidst all the change is to review, from time to time, our “job description” as Christian doctors. Here’s my best shot at that:

Job Title: Christian Doctor

Reports To: God. “Whatever you do, work at it with all your heart, as working for the Lord, not for men, since you know that you will receive an inheritance from the Lord as a reward. It is the Lord Christ you are serving” (Col. 3:23-24).

Line of Authority: “Submit yourselves for the Lord’s sake to every authority instituted among men: whether to the king, as the supreme authority, or to governors, who are sent by him to punish those who do wrong and to commend those who do right. For it is God’s will that by doing good you will silence the ignorant talk of foolish men. Live as free men, but do not use your freedom as a cover-up for evil; live as servants of God. Show proper respect to everyone: Love the brotherhood of believers, fear God, honor the king” (1 Pet. 2:13-17).

Qualifications: Repentant believer who understands the relationship he or she has with the living God and a loving Savior.

Credentials: MD, DO, DDS, DMD, or comparable degree (or in training for one of these).

Expectations:
1. Be holy. “Therefore, prepare your minds for action; be self-controlled; set your hope fully on the grace to be given you when Jesus Christ is revealed. As obedient children, do not conform to the evil desires you had when you lived in ignorance. But just as he who called you is holy, so be holy in all you do; for it is written: ‘Be holy, because I am holy’” (1 Pet. 1:13-16).
2. Live the life. “He has showed you, O man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God” (Micah 6:8).
3. Be compassionate and caring. “Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It is not rude, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always protects, always trusts, always hopes, always perseveres” (1 Cor. 13:4-7).
5. Have integrity in all areas of your life and work.

Continuing Education Requirements: “...grow up in your salvation...” (1 Pet. 2:2).

Other Duties as Assigned.
Following this job description will be useful at your final evaluation, when you stand before our Lord on Judgment Day. Take it seriously. God and your fellow man are watching.

Working with you for Him,

Ruth A. Bolton, MD
President, CMDA

P.S. It has been my privilege to serve as CMDA president these last two years. I pray that wherever medicine is going, Christian physicians and dentists are a part of medicine’s future as we continue to serve our fellow-“man.”
New CMDA Vice President of Stewardship Development

Jamey Campbell is pleased to call East Tennessee his home again as he returns to the area as the Vice President of Stewardship Development for Christian Medical & Dental Associations. Jamey has spent the past twelve years in development, most recently as Vice President of Development for Precept Ministries, an international ministry in over 140 countries. Previously, as Director of Development at East Tennessee State University, his alma mater, Jamey worked in the health sciences division raising funds that supported medicine, nursing, and public allied health programs.

“When Jamey told me that he believes that the only thing that stands between where we are and where we want to be is finances and his job is to help facilitate that movement, I knew he was the right person for the job,” said Dr. David Stevens, CEO for CMDA.

Jamey added, “I’m a vision caster. I believe people want to be part of something that is bigger than they are. And the synergy of 16,000+ members can do more together for the Kingdom than any one of us can individually. I’m very excited about being part of this growing ministry.”

Jamey’s responsibilities include supporting the efforts of CMDA members, raising money for CMDA ministries, providing stewardship education for our membership, and coming alongside our area and regional staff to raise money to support their ministries.

Jamey and his wife, Janeen, have two daughters, Rachel and Emily. They reside in the Tri-City area. He may be reached at: 423-844-1033, or by e-mail at: jamey.campbell@cmda.org.

Global Health Outreach (GHO)

All We Have to Say

by Samuel E. Molind, DMD, Director, GHO

The living God of the Bible is a sending God. He sent forth Abraham, commanding him to go from his country, promising to bless him and to bless the world through him if he obeyed (see Gen. 12:1-3). He sent Joseph, Moses, and a continuous succession of prophets with words of warning and of promise to His people. Then when the time had fully come, God sent His Son. God is a sending God.

Missions are the mandate of Jesus. “As the Father has sent me,” He said, “I am sending you” (Jn. 20:21). Missions are about fulfilling God’s plan and purposes. “All authority in heaven and on earth has been given to me,” Jesus said, “Therefore, go and make disciples of all nations...” (Mt. 28: 18-19).

He is sending us to do His work – a job He could handle on His own, but one He has entrusted to us. This is the heartbeat of GHO. The mission is God’s, for it is He who calls and He who sends. The challenge comes within the context of our faith in Jesus Christ. “Do you believe that I am able to do this?” He asked two blind men who had come to Him seeking healing. “Yes, Lord,” was their reply. And His response was, “According to your faith will it be done to you” (see Matt. 9:28-29).

These men had their blind eyes opened because they believed that the Lord could do the seemingly impossible. When we look at the world’s need of physical and spiritual healing today, the task can seem overwhelming, leaving us “blind” to the possibilities.

Yet, in terms of the Lord fulfilling His mission through us, His question remains the same. It is not, “Do you believe that YOU are able to do this?” but “Do you believe that I am able to do this?” All we have to say is, “Yes, Lord.”

He asks, “Would you allow yourself to be a vessel through which I will ‘make people see?’”

He asks, “Will you be the hands that bring a ‘cup of cool living water’ to the needy in my name?”

All you have to say is, “Yes, Lord.”

Join GHO as we partner with national pastors and physicians and other healthcare workers in the mission of making disciples. Take a step out of your comfort zone, resting on the promise of Jesus, and “According to your faith will it be done to you.”

*For information about GHO opportunities see www.cmda.org/go/gho
Multiplying Teachers Jesus’ Way

Jesus’ practice was to choose a small number of people to spend time with and train before sending them out to do the same with others. MEI’s partnership with the Christian Medical Fellowship (CMF) of Kenya is increasingly following this model. MEI’s first three teams focused primarily on training medical personnel in separate courses on the principles of advanced life support for cardiac and trauma patients. These courses were extremely well received, are accredited by Kenyan authorities responsible for resuscitation training, and have increased the CMF’s visibility, recognition, and opportunities for ministry in Kenya. Unfortunately, though, the courses were so popular that many of those wanting to take them had to be turned away due to instructor limitations.

This year’s team added a cardiac life support “train the trainer” course prior to the courses on initial management of cardiac and trauma patients. Top students from past cardiac life support courses were selected to train as instructors. The six newly trained instructors can now reproduce the cardiac life support course for their colleagues and, unlike the visiting MEI team, live and work in the country year round! These efforts should greatly multiply opportunities for East Africans to be trained in initial management of cardiac patients.

It will also increasingly free up MEI instructors to take this training and use this multiplication model to assist other nations requesting cardiac and trauma resuscitation training. To date, approximately 200 students have participated in each of the advanced life support courses. For more information, e-mail: mei.director@cmda.org.

Dr. Bill Cayley (r.), 2007 Team Leader, observes Kenyan instructor teaching cardiac life support principles.

*For information about MEI opportunities see www.cmda.org/go/mei*
Civil War general Nathan Bedford Forrest, known for his aggressive and effective battlefield maneuvers, summed up his military strategy simply: “Get there first with the most men.”

The Christian Medical & Dental Associations represents an army of Christian doctors—a movement that God is using to reach out to individuals with the love of Christ and to speak God’s truth to a culture that is sprinting away from its spiritual moorings.

After aggressively engaging in the cultural wars as a voice for Christian doctors in 1994, CMDA roughly doubled its membership over the next decade. That growth in membership spurred parallel growth in ministry, allowing deeper investments in campus and community ministries, world missions, and member services and resources. The surge in membership numbers heightened CMDA’s impact on public policy issues, thrusting the movement into a national leadership role on issues including abortion, assisted suicide, stem cell research, and human trafficking.

CMDA CEO Dr. David Stevens observed, “Membership is influence—influence in your personal life to help you become all God has designed you to be, and influence as an organization with larger numbers to fight for the soul of medicine. Membership is banding together as transformed doctors to transform the world.”

A Gift for Your Colleagues
With current membership hovering at just over 16,000, doubling that number again over the next ten years will require God’s grace and empowerment as well as effective growth strategies. The Board of Trustees recently enthusiastically endorsed a membership growth plan that features one-on-one, word-of-mouth marketing and puts resources into the hands of current members to reach out to their Christian colleagues.

One of those resources is Practice by the Book, a potentially life-changing and career-changing book that addresses the core of CMDA’s ministry—helping Christian doctors integrate their faith and practice. The book addresses the most important need identified in surveys of current CMDA members: Over three out of five say they joined to integrate their faith and practice.

Edited by CMDA leaders Drs. Gene Rudd and Al Weir, Practice by the Book covers topics ranging from spiritual foundations to time management to practical ways to turn your practice into a ministry. The book includes chapters on a Christian doctor’s character and competence, ministering to the poor, medical ethics, malpractice, marriage, and more.

“Membership is influence - influence in your personal life to help you become all God has designed you to be, and influence as an organization with larger numbers to fight for the soul of medicine.”

Phase 1: Physicians
The first phase of the new membership growth plan focuses on physicians; subsequent phases will focus on dentists, students, and other sub-groups of the membership. CMDA is currently providing physician members with complimentary copies of Practice by the Book to give as gifts to their colleagues. The book

CMDA Aims to Double Membership

Special Report
includes a *Best of Christian Doctor’s Digest* CD, a DVD about membership, and printed materials including an application. Members are encouraged to give the book as a gift to colleagues, personally inviting colleagues to join the CMDA movement.

Besides giving *Practice by the Book* as a gift, members will also be able to give their colleagues a 25 percent discount off their first year of membership. All the colleague needs to do to receive the discount is to mention the referring member’s name on the membership application. Group discounts are also available.

Referring members will receive a $25 thank-you coupon for each referred colleague who joins. The coupons can be applied to dues, CMDA resources and logo wear, and CMDA meeting registration fees.

A new web page, www.joincmda.org, will guide prospective members through membership application and will also equip current members with resources to use in recruiting new members. Current members can use the website to order gift editions of *Practice by the Book* to share with colleagues.

Dr. Stevens noted, “I hope members reading this will request gift books right now to share with colleagues. You will be happy to know you have helped a colleague deepen his or her Christian walk while also increasing the influence of this movement of Christian doctors. With all that is going on in medicine, we desperately need both.”

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During the first phase of the membership growth strategy, which focuses on physicians, members can get complimentary copies of *Practice by the Book* to give as gifts to Christian physician colleagues.

**To order your gift books today to share with colleagues,**

**e-mail: memberservices@cmda.org**

**or call Member Services toll-free at: 1-888-230-2637.**

**For more information about the new membership effort, visit: www.joincmda.org.**
The Changing Role of the Doctor

Job Churn, Pluralism, and the Vanishing Coriolis Effect

by Richard A. Swenson, MD

Today’s “new normal” is an unglued mindscape for some doctors, an exciting opportunity for others. How Christian doctors relate to limitless change will be governed primarily by the quality of their relationship with the One who never changes and their trust that they really are His work in progress.

Some took the lid off the blender of my life,” one splayed-out physician told me, “and that stuff on the wall is not a mirage.” Couple this with Toffler’s “a bomb has gone off in our communal psycho-sphere,” and you have the unglued mindscape of today’s besieged doctors. The enormous change dynamic of modernity extends into nearly every quadrant of medicine, dentistry, and healthcare, and it shows no sign of abating. What we had is gone; what will be is not yet here. Doctors are reeling, attempting to find their balance in stormy seas. The arrival of our future is long overdue. Meanwhile we wait, and pray, and fret. And we adapt.

In the not-too-distant past, we went through our famously rigorous training and attempted to become a clone. The Great Machine brought forth new doctors each after its kind, and it was good. Students went willingly into the funnel, descending into the vast social Coriolis effect, swirling downward into an ever-narrowing vortex, and in the end all coming out in the same place—yet another good doctor in the long tradition of good doctors, entering an esteemed profession, pouring our lives out on the altar of caring and healing. In turn, we were highly reimbursed in every conceivable way by a grateful populace.
Then came the blender. It had to happen, of course. Any honest examination of the cost curve yielded an early diagnosis of unstable angina for the entire system. As each doctor attempted compensation, the clone approach to practice style quickly dissolved into a wild pluralism. Practices today are not only dissimilar—they don’t even seem to belong to the same venerable family tree. Furthermore, stigma to these previously anomalous behaviors is blunting. Individualism and variation are now increasingly accepted as normal reactions to healthcare volatility. It’s every man and every woman for himself or herself. The new normal.

**What Is, and Was, and Will Be**

Let’s explore together some specifics of what this looks like, as well as the various shapes it might assume in the future:

- **Full speed ahead** – Many doctors continue to do what they’ve always done, in much the same way, and report high satisfaction. God bless them, each one. They have the enormous privilege of sustainability with joy. Iowa Congressman Jim Leach asked a small town 74-year-old physician when he was going to retire. “I couldn’t possibly retire!” exclaimed the doc, “…at least not until my father does.”

- **Early retirement** – Others have folded up shop early. At one large medical institution, by survey, 40 percent of the internists have contemplated retiring. After accepting the plaque and gold watch, some are sad—they miss it more than they thought. They keep up their licenses, volunteer in free clinics, and travel to missions work. Others are glad—they wish they’d quit earlier. They love golfing every day, or managing their investments from the beach house, or visiting with grandkids. One 48-year-old physician told me he retired to manage apartment complexes.

- **Off the grid** – Some doctors have dropped off the grid and stopped taking insurance, Medicare, or Medicaid. It’s cash only. The cost of care is less, administrative expenses are much lower, billing is minimal. Patients are better educated about their costs of service, and each person is treated the same—no HMO discounts or insurance strong-arming. Some doctors even practice out of their homes, keeping matters as straightforward and elementary as possible. The very bold have “gone bare,” forsaking malpractice insurance.

- **Hospital only** – When the muon was first discovered in 1937, Nobel Prize-winning particle physicist Isidor Isaac Rabi greeted its arrival with a surprised, “Who ordered that?” In much the same way, hospital-only practices—hospitalists, intensivists, laborists, ER docs—arrived on the scene almost by immaculate conception. But the timing was right, and they have blossomed and will continue as an important practice option. The development, while perhaps resulting in decreased continuity of care and diminished revenues for nonhospital physicians, has allowed for greater life-balance all around.

- **Mobility** – “Job churn” is seen across our nation as never before—in 2005, 40 percent of Americans changed their employment, fifty-five million in all—and this increasingly

### The Emerging Democratization of Healthcare

A new partnership will arise between doctor and patient as technology permits a radical democratization of healthcare. Autonomy and teamwork, once possible, are always preferred—witness the modern paradigm for diabetes care. Doctors, at first, will find the arrangement strange. Later, after appropriate boundaries are defined, doctors will discover significant advantages for themselves as well.

Patients in the future will:
- become their own primary care providers
- have full access to and/or control of their medical records, at home and away
- routinely use inexpensive home medical computers for dozens of medical functions, from B/P monitoring to dietary advice to diagnostic algorithms to paying bills to reordering prescriptions
- be able to access ALL healthcare information via the Internet
- use e-mail to communicate with doctors
- have access to hundreds of reliable home laboratory tests
- use walk-in self-referral lab and x-ray centers
- purchase a much wider variety of OTC meds
includes physicians and dentists. While mobility has been with us for decades, never have we witnessed these dimensions. Uprooting and heading toward greener grass is always a stressor, but one many risk willingly. Mid-career changes don’t even register a blip on our Richter scale. Some doctors sign on with the competition across town, or go into hospital administration, or do solely pharmaceutical clinical trials, or practice at on-site workplace clinics (more than 25 percent of the nation’s 1,000 largest employers will offer in-house health services by 2008), or join franchised retail clinics in Cub Foods (or Eckerd Drugs, Target, Wal-Mart, SuperValu, Piggly Wiggly, Hy-Vee, ShopRite, Food City, CVS, Osco, Walgreens, or Kroger). Some join a locum tenens organization—one acquaintance recently went to Australia for a year to do locums work. Many Christian doctors have explored the option of missions work for the second half of their careers.

Making ends meet – Moonlighting has a long and proud history among debt-strapped residents—a chance to pick up quick cash while gaining valuable clinical experience. But increasingly, many established doctors are taking on “side businesses” to augment their income. A recent Time article (2-27-07) detailed the specifics: one NY cardiologist who earns more after-hours by removing ladies body-hair with laser; an otherwise brilliant pathologist who sells “magnetized” water and testosterone ointment in antiaging ads; an ob-gyn and three anesthesiologists who became financial analysts.

Specialities – Some things in life are simple, some are complex. In medicine, complexity has won, as evidenced by the AMA’s listing of 110 National Medical Specialty Society websites. This trend is called differentiation, and it is a relentless subset of progress, virtually unstoppable. As complexity escalates, so will specialization, subspecialization, and super-subspecialization, offering ever more varied professional opportunities to peel down the onion. Omphalology, here we come.

Variations on a theme – When the chronic intensity of daily practice exceeds the willingness of the practitioner, change happens. Some negotiate part-time practice, or find another doctor to job-share (many husband-wife doctor couples have chosen this option). Concierge medicine (or retainer medicine, boutique medicine, executive health programs, platinum practices) has been controversial though unbowed by condemnation. Flat fee clinics—where, for example, $500 per year buys unlimited outpatient visits—are yet another recent permutation.

Where Will It Lead and How Will It End?
What are we to make of such pluralism? Is it a sign of vigor or of desperation? Are doctors pursuing individualism to find their preferred pace and practice, or are they flailing after an elusive ever-receding answer?
There’s little doubt that what we are witnessing is historically unprecedented. No one knows what shape healthcare will find itself in when the mountain quits shaking—only that it will be different. At $2.2 trillion a year (and growing $150 billion annually), our healthcare spending exceeds the national GDP of all but five countries. Few people grasp the scale and complexity confronting us.
The paradigm is changing because it must change—there’s no other option. The question is who will win the tug-of-war: single-payer, private-sector, or hybrid/mosaic. The shape of our future depends much on that outcome, and doctors are passionately divided.
In a single payer system—perhaps resembling Kennedy’s “Medicare for all”—the government will not own the clinics,
hospitals, doctors, and pharmacists, but it will be the payer.
Money will come in from both individuals and corporations
to be distributed according to formula.

On the positive side, such a system will have simplicity
(as opposed to 1,500 payers today), uniform paperwork,
and universal coverage. Practitioners will begin to settle
into a new equilibrium, even if not their political preference.
On the negative side, doctors will dislike the formula
(since when did we ever like Medicare’s distribution?)
and will chafe at the annual adjustments, arbitrary cutoffs,
bureaucracy, mandates, disincentives, payment delays, and
new forms of taxation.

In a private sector system, a panoply of diverse practice styles
will continue and possibly expand. Corporations from GM to 3M will perhaps switch from defined benefit to
defined contribution, meaning employees Johnny and Susie
will now have the $15,000 in their pocket with first-dollar decision making. This will greatly affect how they spend
the dedicated healthcare monies, where they will buy insurance (millions would choose faith-based programs),
and which type of practitioners they visit.

On the positive side, we will see responsiveness, cost competition, pricing transparency, individual responsibility,
accountability, and autonomy. On the negative side, there will be problems with complexity, too many payers, risk pooling,
even coverage, high costs for sick and elderly, inequities, and excessive profits.

Only God Knows
To call this existential whiplash would be a diagnostic
bulls-eye. It’s reassuring to know that God is not confused.
He never makes mistakes, never loses battles, and is not
taking Prozac.

He would reassure us with advice like this: Do not worry
about tomorrow. Don’t be afraid. Don’t be anxious about
anything. Guard your heart against hardness. Give your
expectations to Me. Run toward Love, not money. Always
walk uprightly before a watching world.

No matter what change the future brings, certain funda-
mentals remain—doctors will always be needed; always
practice a glorious profession; always be highly reimbursed
in both finances and prestige; always be given authority and
granted a platform from which to influence patients and culture;
and, always have abundant opportunity for service.

Perhaps a two-fold summary might look like this:

• Care for each patient as completely and compassionately as Jesus would;
• Let God be God.

We cannot control the future, but we can wrestle our
motives in the direction of obedience to Christ. Perhaps, in
the end, we’ll discover that God’s project in all this change
was... us.†

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The Business of Medicine

Developing a Christian Practice — Questions on our Members’ Minds

When Dietrich Bonhoeffer was living out his final months in a Nazi prison, prior to his execution, he wrote many letters to his family and friends that were later compiled in the book, *Letters and Papers from Prison*. In these letters he decries our attempts as the church to place God “in the gaps.” Bonhoeffer recognized that there will always be a gap between that which we desire to happen and that which we, in our own capacity, can bring to pass. It is within that gap that we most often find God to be useful, so we tend to place Him there and leave Him there. As our knowledge, technology, and social systems expand, the gap where we think we need a God grows smaller and smaller. Our tendency, even as people of faith, is to do all that we can for ourselves until we reach the boundaries of our capability and then call on God to do the rest. Bonhoeffer’s plea was that we should release God from the “gaps” and walk with Him in every area of our lives. “I should like to speak of God not on the boundaries, but at the centre,” he wrote.

Similarly, Christian doctors sometimes “bring God in” when our treatments don’t work, or when we face malpractice or experience business failure. But we tend to leave God out when it comes to the everyday business of running our practices. CMDA would echo Bonhoeffer’s plea and ask Christian doctors to “bring God in” to all aspects of our lives, including all aspects of our practice. Since God is certainly present, regardless, the necessity is to acknowledge His presence and walk beside Him as He leads. We need to ask ourselves, “If Jesus joined our practice, what would He change?”

To that end, one of our newly developed CMDA resources is the establishment of a Clinical Practice Committee, to assist doctors in doing the business of their practices well and in a Christlike manner. Dr. Gregg Albers, a family physician from Lynchburg, VA, is chairing this committee with the responsibility to provide resources to help your practice prosper in Christ while demonstrating the presence of Christ. CMDA plans to develop an active consultation service over the next year. We are developing resources that will be web based and readily available to assist you in this vital area of your life. As we initiate the work of this committee, we have asked Dr. Albers to address very briefly a few of the practice questions that doctors struggle with, in order to allow you to understand somewhat the scope of this initiative.

Can we design our office to “care” for our patients, always keeping their needs as the highest priority?

Many offices are getting away from the waiting room concept, turning it instead to a place for patient health education, collection of patient information, or giving practice information. In Christian offices, the types of reading material or programs on TV or computer can all give spiritual information that may increase a patient’s interest.

How many patients should I schedule to see in my office each day?

Scheduling depends on a number of factors, including type of practice, usual time spent with patients, needs of the patient, and office flow. If we try to always fill our time, then we probably will be running late, have our schedule overbooked, with...
little time for polite conversation, spiritual matters, or further health questions.

Try to schedule some holes in your day for phone calls, catch-up, and for spiritual time for you to pray for patients you have seen and their needs. Look back over your past year and decide with God whether you have ministered to your patients in the way that God would approve. If you have not, because of time constraints, consider increasing the time allotted for each visit.

**Should I commit to seeing uninsured patients in my practice?**

Scripture compels us to “care for the poor,” so we must honor that mandate deliberately. Some of the uninsured may be between jobs, have decided not to carry insurance, and may be willing to pay even without insurance. For those who can’t pay all at once, or can’t afford the total bill, working out a payment plan can often keep a good family appreciating your care.

Since it takes time to build relationships and build spiritual trust, the more of these patients we can keep, the more spiritual opportunities we will be provided.

In our practice we have used the tithing or ten percent principle when seeing “non-paying patients.” We encourage them to pay; but, if they cannot, we will continue to see them, and later forgive their debt, hoping to use this as a lesson about Christ’s forgiveness of our sins.

**Can I increase the number of Medicaid and Medicare patients without hurting our finances?**

There are ways to increase the percentage of Medicaid/Medicare patients that we care for without severe financial reversal. Using visit space that is not full helps to improve your overall collections. Making sure that you are doing as much as you can with each visit, and coding for it also helps. If you are procedure oriented, this often will increase your income. Planning your budget around these changes is very prudent so that if there is a negative effect, other budget cuts can help to keep it balanced.

These are often poor and needy patients, and God can use our “gift” of increasing the numbers of these patients we see to open their hearts toward His “gift” of His Son.

**How do I decide how much to pay my office staff?**

We all want to be treated fairly when it comes to pay, benefits, promotions, and job descriptions. Try to get information from other offices for comparative jobs so that you can pay your people adequately. Then look at your overall budget, your expectations for visits, charges, and reimbursement. Try to keep your salaries, rent, utilities, supplies, and other office costs within 50-60 percent of your total budget, using the remaining 40 percent for salaries for the providers. Profit should be shared by all who contribute, based on their salary percentage, or more. God will bless the practice that cares for its staff as well as its patients.

**What is a good process to set in place to evaluate my employees’ performances?**

A good evaluation looks at job performance based on the job description, employee attitude, attendance or absences, and how they work with others. Employees always dread the evaluation, so make sure that you start with as many positives as you can, and end with the areas that “need improvement.” These areas should not be surprises to the employees, rather should have been dealt with in an ongoing fashion through the year. Encourage them when you have seen improvement in their actions. This should be a time of reaffirmation, goal setting, and plans for further training. Use other “rewards” such as “employee of the month” to motivate employees to have a good attitude and to do their job well throughout the year. Praying with them often - about family or personal needs, about needs in the office, or patient problems - will motivate even non-believing employees to perform well as they see God working around them.

**How do I know how our collections are going? Benchmarks?**

Numerous ways exist to see how “collections” are going. Keep track of visits, average charges, average collection, and patients seen per day. We need to keep those who are collecting accountable for their time, and going over these figures with them monthly does that. Lack of accountability and oversight usually results in poor collections.
When the king left talents with his servants, he expected the servants to use them productively. The king held the servants accountable, and requested a report. The one who was not productive “lost his job.” Even Scripture suggests that we work fairly, work hard, and use what God has given us for His glory.

**Are there alternatives to the spiraling upward cost of malpractice insurance?**

There are alternatives to buying malpractice coverage from a standard carrier. A group of doctors can, usually with the hospital’s help, form a “self insurance” captive. These captives are administered by a legal entity, and can reduce the cost by 50 percent or more. Sufficient numbers of doctors are required, multiple specialties are covered, and a legal process to get it up and operational has to be initiated by the group to get it going.

Some doctors are able to save significant money by shopping for malpractice insurance in other states. God always calls us to be good stewards with what He gives to us. ✝

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**Note from CMDA:** These questions and the brief replies from Dr. Albers are not meant to represent definitive discussions on the issues, but to provide just a taste of the issues that this new CMDA committee wishes to develop in full for you. We certainly don’t have all the answers and really want your input and ideas. As medicine becomes increasingly deprofessionalized and competitive, as we face ethical tsunamis and pressures that seek to mold us into the world’s way of doing things, we need to proactively transform our practices into shining lights in a darkening landscape.

Pray for us as we move forward in this new direction - that God will be honored and that Christian doctors will find new avenues for peace and effectiveness in their practices. If you have questions for the committee or wish to contribute to the work of the committee, please contact us at: clinicalpractice@cmda.org.
The Whole Truth about Stem Cells and Relevant Therapies

by David A. Prentice, PhD

The evidence is clear - adult stem cells, not embryonic stem cells, hold the promise of medical advancement.

Stem cell research continues to be an emotionally charged debate, heavy on emotion and light on actual facts. Despite many claims and promises, most people—the public, policymakers, and physicians alike—do not know the whole truth about stem cell research and its near cousin, cloning. Many are surprised to learn that there are actually many sources of stem cells, though they can generally be divided into two main types—embryonic or adult stem cells. Unfortunately most of the media and political attention has focused on embryonic stem cells, and most have heard little about adult stem cells.

Embyronic Stem Cell Therapy – Hype Plus Questionable Ethics

Embryonic stem cells are taken from early embryos within the first few days of life. At that stage of our life, about one week after conception, we resemble a hollow ball with some cells inside, a stage of our developing life called the “blastocyst.” It is at that point that we can implant into the uterine wall and start obtaining nutrition from our mother’s womb. This is also the point at which scientists harvest embryonic stem cells, which involves breaking apart the embryo, resulting in his or her death.

Though we often hear that embryonic stem cells have the “potential,” “promise,” “possibility,” and “hope” to treat millions of people for a wide range of diseases, that hope has been wildly, even deceptively, oversold by some politicians and scientists that want to do research on embryos. Embryonic stem cells actually have little to offer for real treatment of disease. Their supposed advantages—unlimited growth, and the pluripotent potential for forming most or all tissues of the body—are actually hindrances when it comes to cell transplants to repair damaged and diseased tissue.

Despite over twenty-five years of work trying to control the growth and differentiation of embryonic stem cells, when transplanted into experimental animals the embryonic stem cells often continue this untamed growth, with a tendency to form tumors or unwanted tissues. For example, an attempt to treat diabetes in mice using supposedly differentiated embryonic stem cells showed that the cells did not even form true insulin-secreting cells, but they did form tumors. And a recent attempt, this time at treating rats with Parkinson’s disease, showed improvement in some rats, but 100 percent of the animals started to form tumors, formed by the nerve cells made from embryonic stem cells.

The scientific literature is filled with similar results from animal studies. Clearly, any potential treatments remain problematic. Researchers have failed to provide even one successful treatment for human patients with embryonic stem cells, and many of the scientists now quietly note that it will be decades, at best, before any possible treatment
The implication that embryonic stem cells will soon provide life saving cures is patently false, and cruelly deceives the patients and families who hope so much for cures. When asked why the claims persist, regarding Alzheimer’s disease, one noted scientist simply said, “People need a fairy tale.”

Ethically, those who promote embryo research simply dismiss the biological fact that a human embryo is a living human organism, a member of the human species. Far more than just a “ball of cells”, the human embryo looks just as he or she should at that point in our life, a stage of life in which we have all existed. If size, age, or stage of development becomes a distinguishing characteristic by which we can assign differing values of human worth, we are all at risk for becoming less than human and targets for experimentation and harvesting of useful cells and organs. Should some human beings be sacrificed for the potential benefit of others? Embryonic stem cell research destroys the youngest, most vulnerable members of the species. Is the remote possibility that medical treatments might arise from some research worth the cost of cannibalizing other human beings? Rather, it is essential that we value all human life.

**Cloning and Its Impact on the Discussion**

The prospect of cloning has raised similar wild claims and deceptive terminology. But cloning starts with creation of a new embryo. The process, termed “somatic cell nuclear transfer” or SCNT for short, involves removing the chromosomes from an egg cell, and transferring the chromosome-containing nucleus of a body cell (a somatic cell) into that egg cell. What results is a new embryo, containing the genetic information of the person who supplied the body cell. All human cloning is reproductive. It creates—reproduces—a new developing human intended to be virtually identical to the person who was cloned.

Some proponents of embryo research try to distinguish between what has been termed “reproductive cloning” and “therapeutic cloning,” but these are not different types of cloning, simply different uses for the cloned embryo. Both use exactly the same SCNT technique to create a new embryo, grown in the laboratory for several days. Then the cloned embryo is either implanted in the womb of a surrogate mother in hopes of a live birth (“reproductive cloning”) or destroyed to harvest its embryonic stem cells for experiments (“therapeutic cloning”).

It is the same embryo, but used for different purposes. In fact, the cloned embryo at that stage of development cannot be distinguished under the microscope from an embryo created by joining egg and sperm in fertilization. And “therapeutic cloning,” which has produced no therapies whatsoever, is obviously not therapeutic for the embryo—the new human is specifically
created in order to be destroyed as a source of cells for experiments.

Cloning research also poses a significant health threat to women. The process requires a tremendous number of human eggs to create a single clone, conservative estimates that at least 100 eggs would be needed for each patient, even if the process could ever be shown to work. A simple calculation reveals staggering numbers—to treat just the 17 million diabetes patients in the United States will require at least 1.7 billion human eggs, and approximately 85 million women of childbearing age to “donate” eggs. Harvesting of human eggs will subject huge numbers of women to significant health risks from high hormone doses required to stimulate egg formation. The result will be that human eggs will become a commodity and poor women will be especially targeted for exploitation on a global scale.

This fact was highlighted by the cloning scandal in South Korea. The scientist, Woo-Suk Hwang, received global accolades when he announced in 2004 and 2005 that he had produced cloned human embryos and harvested their embryonic stem cells. The shameful push for this unethical science was brought into public view when his discovery was uncovered as an outright fraud. While in fact he did not produce any embryonic stem cells from cloned human embryos, he did use over 2,000 human eggs in the experiments, in some cases paying women for their eggs, in some cases coercing young students to donate to the experiments. A large number of the women experienced significant health problems in the attempts to harvest large numbers of their eggs for experiments.

**Adult Stem Cell Therapy – Hope Plus Unquestionable Ethics**

The lack of success of embryonic stem cells should be compared with the real successes of “the other stem cells”—adult stem cells. Adult stem cells are found not only in adults, but in virtually every tissue of our body, as well as in umbilical cord and cord blood, the placenta, and amniotic fluid. Unlike destructive embryo research, harvesting adult stem cells does not require that the donor be killed.

Hundreds of scientific studies over the last few years document that adult stem cells provide real promise for repair of diseased tissue. In fact, at least two dozen studies now indicate that some adult stem cells can form virtually all tissues of the body, a characteristic that means embryonic stem cells are not unique.

The most recent example comes from scientists at Wake Forest, who announced in January 2007 that they had isolated stem cells from amniotic fluid and placenta that showed all the characteristics that most scientists claim they want in a stem cell—easily obtained, easily grown in the lab, with the ability to form the tissues of the body, yet these stem cells also did not produce any tumors. More importantly, adult stem cells have been shown repeatedly to be effective at treating disease. Studies in animals over the last several years have proven their ability to heal and repair damage from diseases such as diabetes, stroke, spinal cord injury, Parkinson’s disease, and retinal degeneration.

But the biggest news, largely unreported, is that adult stem cells are already being used successfully to improve the health of human patients. While still early in clinical studies, thousands of patients have now benefited from adult stem cell treatments. These include reparative treatments with various cancers, autoimmune diseases such as multiple sclerosis, lupus, arthritis, and anemias including sickle cell anemia.

Adult stem cells are also being used to treat patients by growing new corneas (using adult stem cells from the patients’ eyes, or even their oral mucosa) to restore sight to blind patients, and development of potential treatments for stroke. Numerous published studies now document success with adult stem cells in repairing cardiac damage after heart attacks. Adult stem cells have grown new blood vessels to prevent limb amputation from gangrene, and stimulated growth of new cartilage and bone to replace that lost through accident or disease. Adult stem cells have also been used to prevent life-threatening problems from genetic diseases for children, including Krabbe, Hunter, and Hurler syndrome. Spinal cord injuries have also shown improvement, with patients regaining some movement and sensation, and some even walking again with the aid of braces. British doctors have shown in early trials that bone marrow adult stem cells have potential to regenerate damaged liver. And a Harvard Medical School team now has FDA approval to begin patient trials for juvenile diabetes, after they showed in mice that adult stem cells could achieve “permanent reversal” of diabetes.

An advantage of using adult stem cells is that in most cases the patient’s own stem cells can be used for the treatment, circumventing the problems of immune rejection, and adult stem cells do their repair work without causing tumor formation. Interestingly, in some studies no stem cells are removed, cultured, or injected, but rather the patient’s endogenous stem cells are stimulated to begin the repair, by injecting growth factors to stimulate the existing adult stem cells in the tissue. National Institutes of Health scientist Dr. Ron McKay notes that harnessing the body’s own stem cells could offer an enticing alternative to attempts to harvest them from other sources, such as embryos, saying, “This is where stem-cell biology needs to be.” Cardiologist Douglas Losordo at Tufts University said that bone marrow “is like a repair kit. Nature provided us with these tools to repair organ damage.” He also noted that “embryonic stem cells are going to fade in the rearview mirror of adult stem cells.”
Adult stem cells are already being used successfully to improve the health of human patients - thousands of patients have benefited from adult stem cell treatments.

These quiet successes, using the patients’ own adult stem cells, are advancing rapidly and producing the therapies about which embryonic stem cell advocates can only speculate. We don’t yet understand exactly how adult stem cells work their repair magic, but they continue to surprise even the scientists. As Robert Lanza, a proponent of embryonic stem cells and cloning has noted, “there is ample scientific evidence that adult stem cells can be used to repair damaged heart or brain tissue ... if it works, it works, regardless of the mechanism.” That’s certainly the attitude of the patients who have experienced the real benefits of adult stem cells.

A Morally and Medically Superior Choice

Overwhelmingly the evidence reveals that it is adult stem cells that hold the promise of medical advancement, not embryonic stem cells. The contrast between embryonic stem cells and adult stem cells is one of hype versus hope, empty promises versus real results, and life-destroying research versus life-saving medicine. Adult stem cell research is daily proving capable of helping patients, without moral difficulties. If we truly care about suffering patients, we should put our resources behind that research which shows real promise, without crossing ethical lines. ♦

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For more information:
Letter and supplementary material can be downloaded at: http://www.stemcellresearch.org/facts/scienceletter.htm.
For current clinical trials with adult stem cells, see: http://www.clinicaltrials.gov/ct/search?term=stem+cell (initial search shows clinical trials recruiting patients; click box in upper left to show all trials, including those no longer recruiting patients.
For more information and resources, consult the CMDA website as described in the sidebar box, pg. 22.
The power brokers of 19th Century England derisively called this small group of evangelical Christians “The Saints.” Their evidence exposed evil. Their calls for justice annoyed most. Their eloquence and shrewdness mobilized public opinion. Their persistence irritated. They never gave up, but year after year, for almost half a century, they fought slavery. They lost. They lost. They lost again . . . until they finally won and slavery was outlawed in the British Empire in 1833.

That was not all that William Wilberforce and his “Saints” accomplished. They started the Church Mission Society, the Bible Society, and the Society for Bettering the Conditions of the Poor. They successfully sponsored a law requiring the East India Company to allow missionaries access to India, got King George III to issue a “Proclamation for the Discouragement of Vice,” and much more. They were lawyers, itinerant evangelists, politicians, professionals, and average folk.

Their extraordinary impact is told well in the movie, Amazing Grace. If you have not seen it run, don’t walk, to your nearest video rental store. Show it to your family and discuss it with your kids. I thought this movie was so moving that I shut down the office here at CMDA headquarters for a few hours and loaded all of our staff in a bus one afternoon to take them to see the movie. I wanted to get their attention, increase their understanding, and mobilize the troops.

It was inspiring and irritating. It was both a blessing and a boot in the pants, because today we need another band of faithful saints to take up the banner that Wilberforce and Lincoln faithfully carried and gave their lives for. We need some modern day abolitionists.

**Slavery Today**

Today, it is estimated that there are over 28 million men, women and children held in slavery. Close to six million are children bonded into labor or forced into brothels. Almost one million slaves are trafficked across international borders each year. This scourge on the freedom and souls of the helpless has contributed greatly to our epidemic of sexually transmitted diseases including AIDS and hepatitis, abortions, suicides, substance abuse, assault related trauma, and murder.

Why has slavery reared its ugly head again?

The foundational cause has not changed from the slavery business centuries ago – money. Modern day slavery generates 44 billion dollars a year, which is more than the annual Gross Domestic Product (GDP) of two-thirds of the world’s countries.

But the problem is much more than dry statistics. A CMDA board member and his wife recently took their family on a mission trip. While there, they met three girls, just
Over 15,000 victims are trafficked into the U.S. each year, held in bondage.

days after they had been rescued from a brothel. Initially these girls were cowed and fearful, but they finally began to play like children with the couple’s three young girls at a meal. Emboldened by the love they had been shown, they revealed the shocking truth that all of them were thirteen years old or younger.

If you want your blood to boil, imagine you or your daughter at that age being sexually abused day after day.

A Worldwide Problem
Many CMDA missionary members work in countries where girls and boys being forced into labor and held in sexual captivity is common. But don’t kid yourself. It is not just a problem “over there.” Much of it happens here in the West. Over 15,000 victims are trafficked into the U.S. each year, held in bondage. Many are lured by promises of jobs and money, but instead they are raped, beaten, and their money and documents confiscated. Ruthless pimps capture runaways with drugs and money and then dominate their lives.

We Can Make a Difference
What we need today is a new grass roots movement to continue Wilberforce’s vision to eliminate slavery, and it needs to begin in healthcare. A study in Europe revealed that one fourth of those held in bondage had been taken to a doctor’s office or emergency room when they were too sick to work, but the doctor and nurses providing treatment failed to recognize that these patients were being held in slavery.

Dr. Jeff Barrows, an OB/GYN member from Ohio, and Jonathan Imbody, our representative in Washington, are
leading CMDA’s multifaceted efforts to abolish modern day slavery, which include:

- Educating healthcare providers to recognize Trafficking In Persons (TIP) victims through free online CME (available on www.cmda.org);
- Publishing a systematic review of the medical literature regarding the health consequences of human trafficking in the next year;
- Reviewing the medical records of TIP victims to gather data for use in development of protocols to screen and treat future victims of human trafficking;
- Actively involve CMDA members in providing post-rescue medical and dental treatment;
- Providing “talking points” (posted on www.cmda.org);
- Working with the White House, State Department, and USAID on this issue.

Contact Dr. Jeff Barrows if you would like to be more deeply involved in these efforts at: jeffreybarrows@yahoo.com.

**Which will it be?**

I am reminded of Abigail Adams words to her husband John in the midst of the trials of the War of Independence: “You cannot be, I know, nor do I wish to see you, an inactive spectator.... We have too many high sounding words, and too few actions that correspond with them.”

Righteousness means not only sharing Christ with the lost and treating the sick, but also being a modern day prophet for truth, justice, and compassion in the public square. We need to rescue the perishing. As Isaiah said, believers have an obligation before God “… to break the chains of injustice, get rid of exploitation in the workplace, free the oppressed…” (Isaiah 58:6, The Message).^3

The problem seems daunting. Change will not happen overnight. What can one individual do? If, like Wilberforce, you are willing to be persistent, evidence based, sometimes annoying, and always faithful, who knows what God might do through you?

As for me, I rather be accused of being a saint than a spectator. Count me in! †

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Notes:
Reconciling a Good God with an Evil World

by Robert W. Martin III, MD, MAR

Note: This is the fourth article in a series on apologetics. The pages are designed for ease in copying for personal study, discussion in a group setting, or for distribution to colleagues and staff. For the sake of space savings, notes refer to books listed in the bibliography in each case. Installment five is planned for the Spring 2008 issue of Today’s Christian Doctor.

I. Introduction

“Why would a loving God allow my child to die? Why do I have to suffer, when I have done nothing wrong? All the evil in the world proves there is no God!”

No issue strikes at the heart of Christianity more than the seeming paradox of an all-loving God and the existence of evil, suffering, and illness. The following apologetic for the existence of God helps us understand how an omnibenevolent God allows evil.

II. Evil Proves God’s Existence

To paraphrase C. S. Lewis, “It is the very existence of evil that proves the existence of God” (Mere Christianity). The “Moral Law Argument” for the existence of God follows:

Premise 1—Moral Law implies a Moral Lawgiver (principle of causality).
Premise 2—There is an objective Moral Law.
Conclusion—Therefore, there is an objective Moral Lawgiver (Geisler, ST, 36-38).

This argument is based on the law of causality (i.e., every effect has a cause). Just as every prescription has a prescriber, every painting a painter, every sculpture a sculptor and every piece of legislation a legislator, then every moral law has a moral lawgiver. Therefore if there is an absolute moral law (an obligatory, prescriptive, “good in itself” duty that is binding on all people, at all times and in all circumstances) than there must be an Absolute Moral Law Giver (God).

Most critics take exception with premise 2 because they do not believe that absolutes exist. However, absolutes are unavoidable. It is contradictory to claim, “I am absolutely sure there are no absolutes.” In fact the “Moral Law” impresses instinctively and immediately upon virtually every society, past and present, that some things are absolutely wrong (Lewis, Abolition of Man, Appendix).

Anyone who is absolutely sure there is injustice in the world invokes an absolute standard of justice (God). For instance, an angry student confronted Ravi Zacharias with, “There is too much evil in this world; therefore, there cannot be a God.”

Ravi replied, “If there is such a thing as evil, aren’t you assuming there is such a thing as good? [And] when you accept the existence of goodness, you must affirm a moral law on the basis of which to differentiate between good and evil. But when you admit to a moral law, you must posit a moral lawgiver. For if there is no moral lawgiver, there is no moral law. If there is no moral law, there is no good. If there is no good, there is no evil. What, then, is your question?” (182-183, excerpted).

“It is the very existence of evil that proves the existence of God.”

— C.S. Lewis

This “Moral Law” may not be the standard by which we treat others, but it is nearly always the standard by which we expect others to treat us (Legislating Morality, 42). Unbelievers best illustrate this distinction by their reactions when forced to confront the outworking of their worldview. For example, the libertarian demands justice when someone else intrudes, harms, or inconveniences him. The pacifist protests all wars, yet demands the very safety bought by the sacrifice of others. The pluralist claims homosexuality is normal, but may be disappointed to learn her child is gay. The relativist argues there are no “absolute values” but “absolutely values” his right to push his agenda on you! Their reactions (not actions) speak louder than words, in demonstrating the Moral Law.

III. Reconciling an Omnibenevolent God with the Existence of Evil

Norman Geisler answers many additional questions raised in this challenging area (BECA, 219-224; TRE).

God freely created everything perfect and gave human beings the perfection of free choice to love Him (Gen. 1:31; 1 Tim. 4:11; 2 Pet. 3:9). God will not force anyone against their will to love Him (forced love is a contradiction). Morally free creatures can choose to hate God and...
do evil and God will grant them their free choice forever—hell. God did not create imperfect creatures. God made all creatures good with the freedom to choose to love Him. Yet some free creatures became evil by their own choice. The power of free choice is a good power; the fact that men abuse freedom does not make freedom bad.

God is the author of good, not evil. Man freely chooses to do evil. Evil is not a “thing” or substance, but the absence of the God-ordained good that should be there. Evil is a real privation/absence of good; like blindness is the real privation of sight. Evil exists like a hole in a board exists only because it is deprived of the wood that should be there.

Claiming that if God exists, He would destroy evil ignores the reality that evil cannot be destroyed without destroying man’s free choice. But love is impossible without this freedom. Further, just because evil has not yet been defeated does not mean that it will not be defeated in the future.

Although some believe that no good comes from suffering, an omniscient God must have a good purpose for everything. In fact, suffering can keep us from self-destruction, warn us of greater evil, bring about greater good, and will eventually defeat evil (Jesus’ substitutionary atonement).

Suggesting God could have created a world that would not sin confuses what is logically possible with what is actually achievable. Some free creatures will inevitably use their freedom to choose to be lost.

Finally those who argue that God should save all men ignore the fact that God does desire all men to be saved (2 Pet. 3:9), but He will not force anyone to love Him (forced love is a contradiction).

All who go to hell choose to go there (they choose it even if they don’t want it) by rejecting Christ. Those rejecting God have their freedom respected and are given their own freely-chosen destiny—hell. It is not one person in hell that would make it evil, but one more than is really necessary! A world with some in hell is not the best world conceivable, but it is the best world achievable with morally free creatures.

IV. Conclusion

Grieving and suffering people need compassion more than a lecture or even an apologetics presentation. Our patients do not care how much we know until they know how much we care.

David Biebel offers physicians excellent counsel in caring for grieving patients:

- Loving a heartbroken person may put your love and faith to the ultimate test and cost you time, energy, and love.
- Go to your heartbroken friend rather than waiting for her/him to call.
- Your love must be sincere, making her/his problem YOUR problem.
- Compassion is “your pain in my heart.”
- Meet the person where he/she is.
- Say nothing if you don’t know what to say.
- Being there is more important than almost anything else. A heartbroken person will recall very little of what was said, some of what was done, but he/she will never forget the one(s) who came and stayed, some times without saying much at all beyond, “I love you,” or “I’m sorry.”

Help your grieving friend or patient see:

- The way to gain control is by giving it to God.
- The way to wholeness after being broken is to allow themselves to be put back together by the Lord.
- The “mission” of a person who has been heartbroken is to develop deeper faith so that he/she will be able to connect with our broken world far better than a thousand three-point sermons (How to Help).

Look to the cross for reconciling an omnibenevolent God with the problem of pain and suffering. The cross represents the hatred and sinfulness of man, the amazing grace of God, and the reality that Jesus Christ is not unaware of or distant from pain and suffering.†

References


Robert W. Martin III, MD, MAR,

lives in Lafayette, Indiana, where he practices Dermatology and Dermato-pathology. He is married, with four children. He has served on the faculty of Johns Hopkins, Case Western Reserve, and now Indiana University and Purdue Pharmacy School. He has a Masters in Religion from Southern Evangelical Seminary. His Just Add Water (Volume 3.1: Apologetics for the Health Professional), available via CMDA’s website, utilizes Norman Geisler’s twelve-point “Classical Apologetic” approach fashioned after Paul’s apologetic in Acts 17. Dr. Martin may be reached by e-mail at: martinr@arnett.com.
Overseas Missions

Ghana - Year round opportunities for medical service, most specialties, ST/LT. Baptist Medical Center in “bush” of NE Ghana with 3 full time MDs on staff. Busy clinic & surgical service. E-mail: Mamprusi_HMT@yahoo.com, Earl Hewitt, MD.

Guatemala - Small 3-room clinic (Todos Santos) - northwestern Guatemala. Serving large Mayan population. Christian couples needed - FPs, PAs, RNs for ST/LT missions. Spring-like weather year round. Contact William Smith, MD; 518-623-2403; billsmith6@mailstation.com.

Pakistan - Christian physicians urgently needed for ST/LT in rural Shikarpur Christian Hospital: female (GP/FP, OB/GYN, GS) for OB/general; male/female pediatrician, OB/GYN for ST teaching GYN surgery. Contact Bill Bowman, MD; 714-963-2620; drbillbow@aol.com.

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Family Practice - Minnesota-Willmar - Do you wish to integrate your values and beliefs with your medical training to lift your profession to a higher plane? Contact 1-800-967-2711 or vmeyer@hutchtel.net to request a family practice opportunity profile.

General Surgery - Prescott, AZ - Join two Christian surgeons in a thriving “bread and butter” practice in central Arizona; mile high elevation and pine forests with mild four seasons make Prescott a highly desirable location; income potential in top decile; ER call one in seven; minimal trauma as most trauma is flown to Phoenix; opportunities for missions; contact dbrian@northlink.com for further information.

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Neurologist – North Carolina Sandhills Neurologist, exclusively out-patient practice. Fellowship in stroke and pain management welcomed, but not required. This practice is interested in the physical and spiritual needs of the patient. Located in south central NC. World-renowned golfing resort, family-oriented community with large draw area. Approx. 2.5 hrs from beaches and mountains. Contact: sandhillsneuro@earthlink.net.

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**MD – OB-274** Independent practice seeking an OB/Gyn provider. Practice located in Annapolis, MD. Currently one physician on staff and does a rotating call schedule with 5 other physicians.

**AL – MS-486 Opportunity #1** Solo physician in practice for 24 yrs. is looking to expand. Volume exceeds 500 cases. Practice provides vascular, thoracic and bariatric services. Call 1:6.

**AL – MS-486 Opportunity #2** Solo physician in practice is looking to expand practice. Would prefer physician with 2 yrs. experience and trauma background is preferred. Call 1:5.

**AZ – SG-259** “Bread & Butter” Surgery opportunity with minimal trauma in one of the most desirable communities in AZ. Currently 2 physicians. A physician owned ambulatory surgery center.


**Orthopaedic Surgery**

**GA – OS-196** Independent, SS, practice is seeking an Orthopaedic Surgeon with emphasis on Sports Medicine in beautiful SE GA. Call 1:3. Located near GA’s coast & invites you to share in the natural beauty of their waterways. Approximately 25 miles from Savannah.

**IN – OS-198** Independent, MS group is looking for an Orthopaedic Surgeon. Located within the Michiana region. Practice currently has 2 orthopaedic physicians, 12 years old with 6 exam rooms. Home of Notre Dame Football.

**Number of opportunities per state:**

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**Donna Fitzgerald**
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donna.fitzgerald@cmda.org

**Rose Courtney**
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### GA – DT-215
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### IN – DT-244
Independent practice located 16 miles from Indianapolis.

### MI – DT-226
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### MS – DT-253
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### OH – DT-221
Christian practice seeking to add 3rd associate to become partner.

### PA – 6 opportunities.

### VA – DT-256
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### WA – 1 opportunity.

### WI – DT-255
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### WA – PD-237
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**KY – FP-716**
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**NY – FP-612**
7 physician group in western New York desires to employ family physician, OB optional. Full or part-time physicians welcomed. Inpatient/outpatient required. Electronic medical records fully implemented. Short-term missions encouraged and sabbatical time for mission work provided.

**CO – FP-1056**
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**PA – FP-1105**
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**WI – MS-499**

**SC – FP-922**
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### Dermatology

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**TX – NP-113**
Independent, single specialty Nephrology group of 3 seeks a Nephrologist BC in Internal Medicine and BC/BE in Nephrology. Licensure in Texas and Oklahoma required. Inpatient/outpatient. Christian partners. Physicians and staff are encouraged to pray with patients. Northeastern Texas in an ideal place to raise a family, the residents are dedicated to preserving the unique history, flavor and personality of the area.

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- Rodney Burrow, M.D.