Medical Missions: Get Ready! Get Set! GO!

Dr. Bruce Steffes

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DEDICATION

This book could not have been written without the help and patience of literally hundreds of people. My sincere thanks goes out to the dedicated staff of World Medical Mission (the medical arm of Samaritan’s Purse), to the Christian Medical and Dental Association of the USA and to Ms. Shirley Brinkerhoff without whose encouragement this volume might not have appeared. Most of all, I thank my family and my precious wife who have supported and encouraged me over the past dozen years as I have stumbled through the process of trying to figure out exactly what God’s call on my life means.

This book is dedicated to my parents, Carl and Ardith Steffes, whom I love and for whom I thank God each day. It is also dedicated to my other heroes—the men and women who serve on the front lines of medical missions.
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As we look back on over a decade of short-term medical missions, we find the need for the material in this little book Medical Missions: Get Ready, Get Set, Go! as great as it was when we wrote the first edition of our longer handbook, The Handbook for Short-Term Medical Missionaries (ABWE, 2002).

Why focus Medical Missions: Get Ready, Get Set, Go! only on medical missionaries? We healthcare professionals who consider medical missions face stresses that most missionaries do not ever face in any significant way. We, of course, have the same stresses about fundraising, culture shock, health and the myriad of other issues that will be covered in the other of these two volumes (a second volume entitled Handbook of Missions: Get Ready, Get Set, GO! will be published soon), but the stresses induced by our profession are uniquely ours. We are perfectionists in environments which make that laughable; professionals without our tools; performing by necessity in areas beyond our training and out of our comfort zone—and we are always acutely aware that our decisions carry life and death consequences. Intensely focused on results, we are often blind-sided by things we didn’t see coming and which are out of our control. Our self-image is often intertwined with our professional image—but we cannot practice our profession the way we have been trained. To make it worse, we have been taught in the medical environment that while “holistic” is a word that is tossed about as a desirable thing, we are very cautious about ever sharing our faith with a patient. How can we come to an intellectual, spiritual and professional value system that allows us to function in this new environment?

This volume includes some previously unpublished material. These are stories that really happened. I learned the most early in my experience when the learning curve was so great (and my ignorance equally great). Therefore, many of these stories are from that time and from West Africa where I did much of my initial short-term ministry. I think the lessons learned are not restricted geographically, however.

FOREWORD

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They are sandwiched between the eleven chapters and are usually—but not always—demonstrative of some point or another in the chapter. Sometimes, they are just stories that I thought needed to be told. I share them for what they are worth. I do hope that they serve as an encouragement to you—you are not the only one to feel lost and frustrated at times. I also hope that they will serve as an example of the kind of lessons that God may teach you. What will become clear to you from these stories is that involvement in missions is not about what you can do for God but what He can do in (and through) you.

There is a new chapter on the topic of medical education as a short-term and long-term paradigm. As I have spent more time on the field, the need in my heart to leave a legacy by teaching others has become greater and I think the best way to eventually indigenize our mission works is to partner, mentor and educate until we work ourselves out of a job at that particular locale. We can all teach and should, whether we are “academic” physicians or not.

May God richly bless you as you seek to serve Him, to represent Jehovah-Rapha and to obey Christ’s final words to heal and to make disciples.

—Bruce Steffes, MD
North Carolina
January, 2009
CHAPTER 1

MEDICAL MISSIONARY EXTRAORDINAIRE

“Pith helmet securely in place to protect me from the scorching sun, I leapt from the pontoon of the plane into the menacing undergrowth of the frozen tundra. Wearing knee-high boots to protect me from poisonous vipers and the bites of toothy reptiles of gargantuan proportion, armed with a machete in one hand, my black bag brimming with powders and potions of amazing potency personally discovered and laboriously harvested from the jungle, and with my Bible in my other hand, I face lions and tigers and bears as I conquer disease and put death and illiteracy on the run. Too busy to respond to yet another letter from the Nobel Peace Prize committee, I strive only to push back the frontiers of ignorance on one side as I single-handedly correct all mistaken areas of culture, religion, economy, education, and geography on the other, all for the good of my fellow men and in response to God’s calling in my heart . . . .”

Extreme, and more than a great deal confused! But we suspect that all of us in medicine have a bit of Walter Mitty\(^1\), MD, DDS, RN, PA, DO, PharmD, ETC, medical missionary extraordinaire, lurking deep in our imagination. Medical missions intrigue every one of us who has ever endeavored to use our medical knowledge to help others. It fascinates even those who do not consider themselves particularly “religious.” It is a rare person who cannot parrot “Dr. Livingstone, I presume?”—that famous question from a time long ago when the endeavors of a medical missionary and explorer gripped the imagination of the entire populace on both sides of the Atlantic.

Most of us have not committed our lives to the sake of medical missions (and certainly not as literally as some have had to do), but if

\(^1\) Author’s note: Since the first edition appeared in print, I have received multiple questions about Walter Mitty. A fictional character in James Thurber’s “The Secret Life of Walter Mitty” (published 1939), this meek and mild man had a vivid fantasy life. A staple of tenth-grade English anthologies when I was in high school, it has apparently slipped from the public consciousness. Sigh.
you are reading this, you are probably interested in exploring what God would have you do as a short-term medical missionary. You would like to consider going as a medical missionary but there are a lot of things you don’t know. The Great Unknown may be holding you back. If you start to make a list of what you don’t know and your uncertainties, it gets longer and longer and looks scarier and scarier. We know—it happened to us. We looked and looked for some book or resource to give us all the answers and the handbook we wrote (Handbook for Short-Term Medical Missionaries)\(^2\) grew out of an effort to find those answers. Caveat Emptor! We will be honest—we don’t have all of the answers yet. Probably never will. We do know now that God can make up the deficit and that the journey will often show you more about yourself and your relationship with God than about anything else.

The role of medical missions and the role of short-term missions are topics that are being argued hotly by missiologists (people who study the role of missions). We are going to avoid that deadfall as surely as we avoid the deadfall ahead of us on the jungle path. Grabbing a vine overhead, we swing out over the ravine, mindless of. . . Oops, sorry, it won’t happen again! Back to our point: what is not arguable is that short-term medical missions is a phenomenon of the late twentieth century and the movement shows no signs of abating early in the twenty-first century. Despite debates over the desirability of short-term medical missionaries (defined here in this book as people serving less than two years and often only a few weeks), it remains a fact that many present-day missionary medical facilities are deeply indebted to these people. The career missionaries and mission enterprises are thankful for the relief provided by short-termers, without which their hospitals and clinics might not remain open. Despite our Walter Mittyesque daydreams, a short-term volunteer, who does not know the language, culture, national diet or native diseases, will rarely have a major impact on the indigenous culture or regional health statistics, but he or she can be a blessed sight to the staff who needs a break for personal, ministerial, familial or educational reasons. There are many benefits to all con-

cerned—the career missionary, the short-term missionary and the short-term missionary’s church and support team at home. We have listed some of the reasons in the accompanying table, admitting that the list can be much longer. However, honesty compels us to recognize that there are significant challenges in serving for short terms overseas. Many of these challenges are also present for career missionaries facing the field for the first time, but the very brevity of the short-term experience may serve to magnify the effects. Likewise, not all of the challenges are unique to medical missions and may be seen with any short-term or long-term endeavor in another culture. Failure to recognize what is happening to you as a short-term missionary (including the very real effect of culture shock both going and coming back) can make the experience miserable for you and your hosts, souring the entire experience for everyone. The report of an unfavorable experience will have a definite negative impact upon those back home who are considering similar trips. It does strangely satisfy those at home who predicted doom and gloom though—and you will have some of those! How then do we avoid a bad experience?

The first questions must be, “What is the role of medical missions?” and “Why do I want to be involved?” The answer to the first will be handled in a rather brief fashion. That short answer raises a number of profound theological questions of eternal significance but we leave that study to you. The answer to the second is also short, but one upon which we hope you will meditate for the rest of your life.

Why should God’s church (that means you) be involved with medical missions?

Jesus was. His ministry of healing and the message of salvation are intertwined in every book of the four Gospels. Matthew 14:14 (KJV), “And Jesus went forth, and saw a great multitude, and was moved with compassion toward them, and he healed their sick.” His healing was not designed as a “hook” to get people to listen to the message but a totally consistent outflow and consequence of His love for the people around him. It was not designed to be manipulative or to be impressive in a false way. Involvement with medical missions means that in a very real and unique way you can become the hands of Christ.
Healing is totally consistent with God’s nature. He is Jehovah-Rapha (Jehovah-Rophe), as described in Exodus 15:26: “He said, ‘If you listen carefully to the voice of the LORD your God and do what is right in his eyes, if you pay attention to his commands and keep all his decrees, I will not bring on you any of the diseases I brought on the Egyptians, for I am the LORD, who heals you.’” Psalm 67.2 (KJV) reads “That thy way may be known upon earth, thy saving health among all nations.” The major driving force for medical missions must be evangelism, the telling of God’s love for mankind. Medical missions that does not have evangelism as its raison d’etre is really just social work, not missions, and while that social work may be a good thing, it is not the best thing (Psalm 127:1, “Unless the LORD builds the house, its builders labor in vain . . . .”). The hospital and clinic can be a fruitful and fertile ground for evangelism when the medical work is done as a work of compassion and a natural outflowing of Christ’s love in us. As David Kilel, the chaplain at Tenwek Hospital in Bomet, Kenya, pointed out, “More unreached people will go through our hospitals than our churches.” My wife and I will never forget our experience of visiting the Tamberma, an unreached people group of the northern part of Togo, West Africa (see page 8). A primitive tribe, their lives are as saturated with fetish and ancestor worship as it seems possible to be. We were very surprised when, after hearing the gospel message given by the veteran missionary, two of them responded with the news that they were already following the “Jesus path.” When we later asked how they had heard, they explained that they had been to the small Christian hospital almost 300 miles away for medical care. It is probably safe to assume that they would not have gone that far to hear a sermon preached, but medical necessity required them to do so. There they saw a sermon lived out and they responded to their Savior.

There are many good reasons and benefits why you personally should get involved in short-term missions, and there are many jobs on the mission field that you can do. You can bring new medical expertise to your chosen area of service. Your family can experience a new closeness with God and with each other. You can introduce your family to your career in a way you cannot do in the US. You can serve to
help make missions a reality to your church. The list can go on and on. A word of caution: Do not undertake a short-term mission for “the experience” of medical missions. A short-term mission trip should be taken only when you are certain that God has called you to go and you are going for the “right” reasons—because God has told you to go and because you want to become closer to Him through your obedience. Harry Blackaby and Claude King state in their “Experiencing God” workbook, “God is far more interested in your having an experience with Him, than He is interested in getting a job done. You can complete a job and never experience God at all. He is not interested just in getting a job done. He can get the job done any time He wants. What is He interested in? You and the world—knowing Him and experiencing Him.”

“It is my experience and that of all Colonial doctors that a single doctor in Africa with the most modest equipment means very much for very many. The good which he can accomplish surpasses a hundredfold what he must have. With appropriate drugs and sufficient skill and apparatus for the most necessary operations, he can in a single year free from power of suffering and death hundreds of men who must otherwise have succumbed to their fate in despair.”

—Albert Schweitzer, On the Edge of the Primeval Forest

SOME REASONS TO GO ON SHORT-TERM MISSIONS TRIPS

1. God has told you to go
2. Service to the missionaries
   - Giving them time for furlough, continuing medical education, personal time, or a break from calls
   - Teaching them new techniques and skills
   - Bringing needed supplies, medications, and equipment
   - Fellowship, laughter, and friendship
   - Continued prayer and advocacy upon your return
3. Service to the nationals
   - Medical care
   - Medical teaching
   - Biblical teaching
   - Teaching of other skills
   - Fellowship, laughter, and friendship
   - A sense that your church and country care about them and their struggles
   - A lifelong commitment to pray for your newfound friends and a renewed sense of the field “white unto harvest”
4. Personal growth
   - New cultures and new experiences
   - Expanded worldview
   - A deeper awareness of the role of God in your medical practice
   - A deeper awareness of the need to understand that a medical cure is for a lifetime but a spiritual cure is for eternity
   - A deeper awareness of the need to trust God for daily life
   - A reordering of your priorities
   - A renewal of the enthusiasm you had when you went into medicine
5. Family growth
   - A chance to have quality time together
   - New cultures and new experiences encountered together
   - Introduce or reinforce a set of values and a worldview to your children
   - Let your children experience medicine and career in a first-hand manner not often possible at home
   - Introduce your children to missions as a possible career option
6. New medical experiences and learning
   - Stretching beyond your zone of comfort
   - Pick up new skills and newfound confidence in old skills and training that stand you to good stead
   - Experience with new diseases and treatments
   - Diseases you haven’t seen before or heard of since your training
   - Use your experiences as a way to talk to your medical colleagues of your faith
7. Service to your church upon your return
   - Bring a new sense of the reality of missions and vibrancy to your church’s mission program
   - Act as an advocate and prayer warrior for the mission field you are most familiar with
   - Act as a resource person for others interested in medical missions
8. Introduce yourself to the possibility of a career in missions
SUGGESTED READING


After a long trip through desolate areas, we reached the dirt road that led to the Tamberma. Officially considered an “unreached people group” by the mission groups, they are a very primitive people who migrated to that area from Benin. They are strongly influenced by ancestor worship and fetish ceremonies. As we rode, we began to see small family compounds that have odd two story circular towers and a mud wall that
encloses the compound and joins the buildings. We stopped at one where our missionary friend has stopped before and she negotiated with the patriarch to visit the whole time for 1,000 francs without being hassled at each step for a “petit cadeau”, a small gift (of money). That didn’t stop the begging, but made us feel some better about ignoring the constant requests for money. This family group had been visited enough by outsiders that they all had something to sell and the people were quite insistent at times. They were also quite dirty. Most of the older males were smoking pipes and the older women had a small hole in the middle of their lower lip. The traditional thing for the women to wear there is a small white stone (that makes it look like a tooth dangling) but one of the younger women had just a small stick in the hole. When we asked why the stick instead of a stone, we were told she didn’t want to make the hole too big. One time before, when our friend visited, one older woman had a palm nut there—it was some sort of cure. Almost everyone was wearing an amulet or necklace of fetish significance.

We entered into their compound. The walls were about 10–12 feet high. The first thing we passed was a small lean-to created by several bundles of thatching leaning against the wall. They kept pigs in there. After entering a narrow passageway, we passed several towers of mud about three to four feet tall; these represented the spirit ancestors. There were some metal hooks and spears from which were hanging the skulls of several animals (to remind the spirit ancestors of past sacrifices) and fresh feathers from recent sacrifices. These structures are rebuilt every few years on exactly the same spot so that the ancestors are continually honored.

An older woman was spinning cotton thread by the age-old drop spindle method. The raw cotton was wrapped around a stick and the small spindle was dropped below and spun to con-
tinually draw the strands into a long thread. She had the classic scarification of the Tamberma on her skin. As a child, she had made the beauty marks in the lateral aspect of the abdomen and when she was old enough to develop breasts, the marks were made in the middle of the abdomen. They cover the entire abdomen. The woman also showed us the marks on her back, but I didn’t catch their significance or timing. I took her picture with her permission and she too asked for a petit cadeau—the old man sent her scurrying.

We were invited into their home. The first little room had an enclosed space to the right. An opening below allowed the chickens to live in there and the flat surface on the top served as a place to grind corn. Small windows allowed in light and there were also small slits around the wall that they explained allowed them to shoot arrows at their enemies if they were attacked. The second room was very dark and served as storage but they were quick to point out an area that represented even older and more venerated ancestors—it was not significantly different from the rest of the mud wall, but it was so dark that I couldn’t see well. Both of these first rooms were only about six by eight feet. I could just stand upright, but my head was close to the ceiling. The smell was NOT attractive. No mission report will ever be the same once someone invents aroma-vision.

The third room was smaller yet and served as the stairwell to the upper level. On the right were remains of a fire and they explained this was where they cooked when it was raining. The stairs to the upper level consisted of a Y-shaped stout branch with notches cut out for the feet. It was strong and stable but the footing allowed only proper placement of your feet. We were told that the original purpose of the two stories was protection from marauding lions (and I would imagine from two-legged marauders as well). Once on the higher level, there were three
“turrets”—two of them granaries and the third a room where one of the women and the children slept. There were other small “rooms” that were created and were sometimes of different levels that marked off different sleeping areas. The “bedroom” was about 6 feet across and had a door that was entered by backing down into the room. The floor of the room was about two feet below the floor of the surrounding areas and would allow a child to stand, but not an adult. There was virtually no cross-circulation but it was still a little cooler, especially on this day where standing in the shade of a tree caused rivulets of sweat to run down your back and your clothes were plastered against your skin. They offered to let all of us enter but I looked at the size of the door with great misgiving. My wife declined the honor, too. A missionary later told us he had gotten stuck trying to get down into the room. Our host offered to show us the inside of one of the granaries. He climbed up another branch “ladder” and then stood on mud steps that were built into the side. He lifted the thatched roof and used a hooked branch coming out of the top of the thatch to hang it neatly on the side—the inside was divided into three parts with sorghum in one part, millet in another and the fruit of the baobab in another.

The elevated view made it easy to take pictures of nearby compounds and I took advantage of that. By this time, we were surrounded by twenty or more people all crowded on the roof and each trying to sell us some treasure or another. When we finally headed back to our car, we stopped at the shaded meeting place under the spreading tree and our missionary friend presented the gospel to the entire clan. The old fetish leader seemed to be translating faithfully all that she said and when she asked, two of the group said they were following the Jesus path already. Upon questioning, the young man and his sister were not theologically sophisticated—that would be very hard to do
in that setting without someone to teach them. But they had the basic principles down—they were sinners, God’s Son had paid the price for their sins and they were trusting in Christ for their salvation in the hereafter. Knowing they were considered an unreached people group, I asked how they had heard of Christ. The young man said they had heard the gospel at the hospital in Tsiko last year when he had taken his mother there.

The trip to Tsiko in the south of the country was a several hundred mile trip for them. However, it was the nearest high-quality hospital, so they made the trip. This saved man points out exactly why medical missions is so effective and why an unbalanced emphasis on just church planting can be inappropriate. Many mission agencies are abandoning medical missions and yet Christ was a healer. I doubted that anyone in that country had traveled 300 miles to hear a sermon or to attend a church. I suspected that even getting people to church in the same village was a low-yield effort. As David Kilel at Tenwek Hospital has said, there are more unsaved peoples in our hospitals than in our churches. This woman and her family traveled hundreds of miles to receive care. While there, they may or may not have heard a real sermon, but they certainly saw a sermon, saw Christ’s love and compassion lived out and responded to the invitation to accept Christ. They understood the spiritual consequences of healing and sought out the Healer.

As we left, grateful for the air-conditioning in the 106 degree heat, I prayed in my heart that God would send someone to minister to these people. They were so bound up in and captive to their ancestor veneration and the fetishism. I prayed that the word they had heard would take root. I was encouraged that two people had already heard and had previously decided to follow Christ, and I prayed for strength for them. They have no Bible in their language and no one to teach or encourage them. Our mis-
sionary friend had taken some of the other tribal nationals from a nearby city to visit them in the past—even the nationals were shocked that there were such primitive people and that they lived like that.

“Pray to the Lord of the Harvest that He will send workers.”
Okay! You are willing to consider it, but what you really want to know is about the snakes, the food, sleeping in the mud huts, malaria, personal safety, disgusting parasitic disease, ad infinitum. There are lots of books that cover that stuff (including our own).

A better first question is:

With whom should you travel?

Answer: The group that offers an experience that best fits your desires and needs. Now to the next question:

What! Wait a minute . . .

Well, we certainly do not know all the answers that are right for you, but if you insist, we will share some of the questions to ask yourself to help you determine what might work best for you. None of these questions have "right" or "wrong" answers except where they are "right" or "wrong" for you.

What group and kind of mission experience is right for you?

Answer: A good question, but in order to answer that question, you really need to answer this question first:

What do I really hope to gain from this experience?

Answer: Usually, any single type of trip can neither give you all possible types of experience, nor meet all possible permutations of your desired conditions. For example, the experience in a mission hospital is different from that of a trip emphasizing “black bag evangelism.” An experience emphasizing general medicine is different from
one emphasizing teaching and the building of relationships. A trip that is likely to emphasize the volume of patients seen is probably not the best one to give you time to develop personal relationships. You get the picture.

However, most of us cannot easily give specific answers to the question of what we hope to gain. We struggle to give answers such as, “I want to do good for people,” “I want to see God at work,” “I want to get a real grasp of the reality of mission life,” or “I want to share the good news of Jesus Christ.” All are laudable answers and probably true, but they don’t help much with the specifics. You can be effective in situations where the answers may not be entirely in line with your preferences for, as the Apostle Paul pointed out in Philippians 4:13, “I can do everything through Him who gives me strength.” Short-term missions is a great way to find out how much this is true in your life, but in the beginning, as you learn to apply this principle, you will minimize some of the potential stress if you stick to the areas where you know you have personal strengths, gifts and talents. Answers to the questions below may shed some light for you. They do not all need to be answered affirmatively, but the answering of them will help you through the thought process.

**When and where should I go?**

► When can they use me and when do they really need me? Can I serve more effectively at a time of year that is less popular with potential short-term medical missionaries than others?

► Are there local climate conditions (altitude, rainy season versus dry, allergies, extremes of temperature or humidity) that I need to take into account?

► Are the living conditions ones to which I can adapt?

► Do I have personal medical needs that can only be met in certain places?

► When can I get free from my usual commitments here at home?

► If I want to take my family, when can they get free from their usual commitments of schooling, work, and others?
Does the purpose and format of this trip match my skills and interests (or am I willing to stretch enough to fit the bill)?

Can my skill in another language be used to effect there or is my lack of language skills something that is not going to be a problem?

Does the work I am going to visit match well enough with my philosophical and doctrinal positions that they will accept me and I them? Can I continue to support them, at least in prayer, when I come home?

Is there enough available professional supervision and experience in the type of medicine we will be practicing to make me feel reasonably comfortable?

After reviewing the work format for this trip, am I willing to accept the possibility that the laboratory, diagnostic, therapeutic facilities and the time to see individual patients may all be limited?

Can my family go with me?

Is there a place for my family to serve?

Is there flexibility enough to allow my family and me to do things we want to do apart from the group, before, during, or after my commitment to the work?

Do I know missionaries on the field there or do we have some point of mutual interest that can be used to advantage?

What is my budget, both of money and time?

Do I have enough time left between now and my hoped-for departure time to allow me to get all of my needed vaccinations, passport, visas, tickets, and make my reservations?

Do I have enough time available, considering the travel to and from the location, getting over jet lag and my need to still be effective?

Since you will be funding most of these trips either personally or through your own fund-raising (see Chapter Three), is this trip within the scope of reasonable possibility and faith?

Am I the adventurous type or do I want to have the details taken care of for me?

If I travel alone (outside of a group), am I willing to attend to the large number of details that such a trip entails?
If I travel alone (outside of a group), are my language, travel and adaptation skills enough to let me handle problems that arise?

Should I work with a group on this trip or look for an experience where I might be largely by myself?

Am I willing to exchange the security of a group situation and a strong leader for being told what to do and having to conform to the schedule of the group?

Am I able to be flexible enough to conform to or at least tolerate with grace the doctrinal, religious, and philosophical nature of the group I will work with?

Is fellowship with fellow believers and professional colleagues an important part of the experience for me?

If I go as a member of a group, am I willing to accept the possibility that I might have less one-on-one time with the missionaries and nationals with whom I come in contact?

Most people who are going on their first few mission experiences are going to opt to go with a group or organization that has done something like this before. It is not absolutely necessary but it often helps to have a safety net as you learn how to function in a new environment.

What questions do I ask to find a credible organization?

Have they adequate experience in planning and facilitating such trips?

Can they give adequate support before and during the trip if I run into difficulties?

Are the team leaders experienced?

Do they have financial integrity?

Do they have a good grasp of the culture, politics and sensitivity to special needs where you will serve?

Are they detail-oriented, both in briefing you about the trip and in attention to (and assistance with) the myriad of details involved with your trip?
Are their trips the sort of trips that fit your plans, hopes and limitations?

Is evangelism the ultimate role of your trip and are you going to be working with some organization that will be able to follow-up with any people who come to know Christ as a result of your trip?

There is a new organization which is trying to give some standardization to the short-term missionary experience. You can read more about this effort, the kinds of questions they (and you) ask and the organizations which have already received their Standards of Excellence award at www.stmstandards.org.

There are many good organizations that provide short- or long-term opportunities for serving medically overseas. Word of mouth, trips planned by your church or sister churches, organizational publications, and the Internet are all ways to find trips and groups that might be suitable. The list found in “Appendix D—List of Organizations” has both religious and secular organizations and provides information on how to contact each one for more information. You will also find information about organizations that may help you with finances and discounted or free supplies.

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4 A more comprehensive list will updated from time to time and posted in the “Handbook” section of our web site www.brucesteffes.net
DO YOU NEED TO CHANGE THE OIL AGAIN, BOY?

Confusion about the importance of my role in things plagues me. I understand intellectually how it should be—but often my heart and ego don’t play along.

My wife and I took some exploratory trips into medical missions. The very first of those was done without any preparation to speak of—and I slammed into the wall. I am not sure how evident it was to others that I was struggling—still not sure I want to ask them because I would be embarrassed. Inside, I was really struggling with almost all of those things listed in Chapter Five on the challenges of short-term medical missions and I wasn’t at all sure that I wanted to do something like that again.

However, a short while later, we found ourselves in West Africa, and this time I was a bit better prepared—I thought. I realized that my role could not just be about medicine. Realizing the problem I had with ego, I had prayed and studied much about servanthood. I read the Bible, I read books, I gave myself pep talks. I was ready. I was very proud of my humility and I was ready to serve.

The first Sunday we were there, we were invited to the home of one of the single missionary ladies. As I looked around, I identified several things that could be done to make her life a bit better. I had grown up as the son of a maintenance man and had worked my way through high school and undergraduate college by doing some plumbing, and I had a hobby of fine woodworking. I had learned from my father how to tear into anything and fix most of it. I also knew that the only maintenance man on the hospital compound was run ragged. Here was someplace I could help and besides, it would help keep me busy in my expected free time. Nothing like being an unreconstructed Type
A personality!

So I offered to help. She declined. My ego responded, “Hey, wait a minute! Don’t you know who I am? I am a surgeon and businessman, have an MBA, make fine furniture and have many skills you need.” I replied verbally, “Well, just call if I can be of help.”

That afternoon, I was reading a book when the phone rang. She was on the other end. “I have something for you to do for me—I need the oil changed in my car.” Change the oil? I had scraped through college and medical school paying my own way and I certainly knew how to change the oil—but one of the luxuries I allowed myself now that I could afford it was that I would never have to change the oil. My ego sang the refrain, “Hey, wait a minute! Don’t you know who I am? I am a surgeon and businessman, have an MBA, make fine furniture and have many skills you need.” I at least had the good sense to feel ashamed of my visceral reaction. I replied, “I would be glad to do it.” I meant it but I didn’t really mean it.

As I have mentioned, I was naïve to the ways of life at a mission hospital and all the spare time I thought I would have was a figment of my imagination. I also struggled with the Harmattan, the dust-carrying winds from the Sahara. I had caught a cold in the plane ride over (thanks to the hacking person in front of me) and I was coughing and wheezing so badly that I had to sleep sitting up in a reclining chair in order to breathe. Still, I could have changed the oil even on my worst day. In fact, each morning I would hear a clear reminder from the Spirit, “Are you going to change the oil today?” I would explain to the Lord just how ill I was and how busy I was but I would assure Him that I meant to keep my word. I didn’t bother to tell Him how important I was—I was sure He would know, His being omniscient and all. I am quite assured that He did
indeed understand *exactly* how important I was.

We were scheduled to leave on Sunday. It was late afternoon Friday a month later. It had been a good week and I was looking forward to going home. I still remembered my promise to change the oil and I was finally making serious plans about when and how to honor it. The missionary surgeon and I were walking homeward into the setting sun. We rounded a building and my world was rocked. There her car sat on the ramps and she was getting ready to crawl under it to change the oil and filter. As clearly as any verbal message I have ever heard, the voice echoed in my head, “*Now are you going to change the oil?*”

I was glad that I could crawl under the car because the tears were streaming down my face. My Lord had not asked much—but I was unwilling to do it because I was doing “important” stuff.

Sometimes I am a slow learner. Shortly thereafter, we went to Kenya. I decided I would do better. I asked the surgeon how I could help him around the house. He replied quickly, telling me about some job fixing some shelving. There was a short unheard conversation:

> “*Hey, wait a minute! Don’t you know who I am? I am a surgeon and businessman, have an MBA, make fine furniture and have many skills you need.*”

> “*Do you need to change the oil again, Boy?*”

The shelves were fixed the first Saturday.
“Why, I’d rather eat a live mamba than ask for support!”

“Nobody will give money to a physician—too many people already think we are rich!”

“Perhaps I can go the ultra-devout route—I won’t ask for money and if the Lord wants me to go, He will provide it!”

“I won’t be able to take a safari with my own funds if I ask for support for our ministry.”

“I don’t want to feel like I am begging.”

“I am not sure it is biblical to ask for support.”

“I don’t want it to appear that I think I am more spiritual than others, trying to live by faith.”

Do any of those statements sound familiar? We have used them all and with any thought at all, you too can come up with at least ten more. Sometimes God really does want you to pay for your trip entirely by yourself. But it must also be admitted that sometimes paying for everything yourself is just an excuse to cover your pride and embarrassment at asking. You may have a self-sufficient personality that causes you to want to pay your own way rather than being dependent on others or asking anyone for money. If you are a physician, you make a good income, but you are also aware of the high ongoing overhead expenses for your equipment, staff salaries, building payments, and medical malpractice insurance. As you go overseas, these expenses continue while your income may not be high enough to pay for your trip. You should not be embarrassed to share your ministry and ask for support if necessary. Indeed, you may be robbing someone of a true blessing if you do not share the opportunity. There is a sound biblical rationale behind the practice of allowing others to help with your ministry. Once you have an understanding of it, you will be able to share
the blessings you will receive by allowing them to share in your support. Don’t be selfish!

Adequate support for your trip consists of two parts. The first is financial and perhaps the hardest for which to ask. The second is prayer support and that is sometimes the hardest to actually get in a consistent fashion despite the glib promises you may receive before you go. We will try to help with ideas for both.

Examples of financial support for God’s ministers

Levites: In the Old Testament economy, Levites were the “professional” ministers. They were to rely on God for their income and financial stability. It was provided by the tithes and offerings of their fellow Israelites. They gave so that the Levites could dedicate time and effort to serving God in a way that their compatriots could not do.

Nehemiah, the Old Testament prophet: He used financial support even from unbelievers. His approach in Nehemiah 2:1–8 is a good model. He prayed before he asked. In fact, he prayed about it for three months before he acted! He asked the king for specific items, and he thought carefully about those things for which he needed to ask.

Jesus was supported by others: He didn’t do tent-making as Paul was later to do, although as a trained carpenter, He certainly could have done so. The Son of the God who owns the cattle on the thousand hills had financial supporters. He relied on people such as Joanna and Susanna who helped “...support Him out of their own means” (Luke 8:3).

Jesus instructed His followers in Matthew 10:7–10 to minister and trust Him for their physical provisions: ‘As you go, preach this message: ‘The kingdom of heaven is near.’ Heal the sick, raise the dead, cleanse those who have leprosy, drive out demons. Freely you have received, freely give. Do not take along any gold or silver or copper in your belts; take no bag for the journey, or extra tunic, or sandals or a staff; for the worker is worth his keep.”

Jesus instructed his disciples to heal people physically and spiritually and to trust to the goodness of others to provide for their need.

5 Again? Who says you are not a minister? Listen, trust us on this one and follow along.
The apostle Paul was supported by others: we are so used to the truth that Paul had a tent-making career in Corinth that we forget that Christians other than those in Corinth helped him financially and in other ways. Paul chose to make his own living in Corinth despite his assertion that he had the right to be supported by them, because he did not want anyone to misjudge his motives. He did receive assistance from other individuals and churches. In Romans 15:24, the original language is clear that he was talking about money when he wrote and asked for support, “. . . when I go to Spain. I hope to visit you while passing through and to have you assist me on my journey there . . . .”

The Apostle John wrote referring to the need for God’s people to back their own (3 John 1:7–8), “It was for the sake of the Name that they went out, receiving no help from the pagans. We ought therefore to show hospitality to such men so that we may work together for the truth.”

There really are good reasons to ask for support

It is a chance for you to see what God can and will do in your life. It will enlarge your faith and increase your confidence in God and in what the two of you can do. No matter what your personal resources are, there is always a God-sized project that your resources are inadequate to handle. The needs on the mission field are great and the resources of the national churches are limited. Maybe this is how God is going to show all of which He is capable. If you have sensed God’s call to go on this mission trip and you are in need of partial or total financial help in order to go, just remember that this does not come as a surprise to the Lord. He is always aware of your need, and He has prepared a way to meet this need. Remember, “The One who calls you is faithful and He will do it” (I Thessalonians 5:24).

It stimulates and encourages a missionary vision in the body of Christ. You can serve as a model for others who are considering such service. You can mobilize others to serve Christ. You can act as an advocate and minister for missions, facilitating the communication between the missionary and his or her missionary agency and your church and your sphere of influence.
Don’t rob others of a chance to be blessed. If someone does not know of an opportunity to be part of God’s work, he can’t be blessed by being part of it. Many people take seriously their spiritual gift of giving, or perhaps have a particular interest in the ministry that you are joining, or the ministry in a particular part of the world. Your trip might just be the thing for which they are looking and for which God has primed them. Don’t be selfish and rob them of the chance to be part of your ministry.

People who give financially may also be some of your strongest prayer warriors. They have demonstrated their willingness to be involved by literally putting their money where their mouth will be. The money you may be able to do without; the prayers you cannot.

God has sanctioned this method of support. It can teach you humility and dependence on others and on God. It can increase your awareness of your inadequacy for the job, a prerequisite for recognizing the adequacy of God. We are instructed in Romans 12:2 not to conform to the world. By going against our culture’s reluctance to depend on others, we are more closely following God’s economy. In this sense, raising support is a matter of obedience to God’s Word and calling, by not following your feelings of self-sufficiency that may be rooted in (perhaps sinful) pride. All Christians need to live by faith (2 Corinthians 5:7, Hebrews 11:6) regardless of how they receive their paychecks or how big they are. If God has laid this on your heart and you need financial support, then He will provide everything you need to fulfill your ministry, including emotional strength and perseverance (Philippians 4:19; 1 Thessalonians 5:24). For further study and consideration, see Numbers 1:47–54; Deuteronomy 18:1–6; Jeremiah 29:11; Matthew 16:25; Luke 6:38, 8:1–3; 1 Corinthians 9; John 15:16.

Raising support does not make you more holy or less holy than other Christians. There’s nothing you can do or fail to do that will alter your eternal position in Christ (see Ephesians 1:3–4, Romans 6:5–9). It does help you to develop as a person by increasing your people skills, by teaching you flexibility and patience and by giving you a sense of being an alien in a strange land. And it does increase your understanding of living by faith.
It opens opportunities to witness. A successful professional performing an altruistic act is, sadly, enough of a novelty in our society that it intrigues others. This may give you the chance to tell others why you are doing what you are doing.

Even if you are now persuaded that there is nothing wrong in receiving support, it is still very difficult to ask, especially if you have never done anything like that before. The first thing to do as you plan your finances for mission ministry is to deal frankly with your feelings. Recognize that during His ministry, your role model, Christ, was unemployed, homeless, and dependent on his friends for lodging and support. The key to success in missionary service, however, is to “take on the characteristics of a servant and humble yourself.” Humility and a “servanthood” mentality will let God use you for His Kingdom. The best place to begin this quest is in the area of your finances. Make a commitment to trust God for the money you need. Step out in faith and make a commitment to go; then eagerly anticipate how God will open the doors for you to do so. Here are some steps you can follow that may help: 1. Pray. 2. Keep a biblical perspective. 3. Spread the news of your

YOU DON’T KNOW ANYONE TO ASK? CONSIDER THIS LIST OF PEOPLE YOU MAY HAVE CONTACT WITH ON A DAILY BASIS:

- advertising agencies
- apartment manager
- Avon lady
- baker
- bank presidents
- banker
- barber
- beautician
- Bible bookstore
- brothers & sisters
- butcher
- Chambers of Commerce
- Christian business groups
- church directories
- church members
- church missions committees
- church-related news ads
- civic clubs
- coach
- college friends
- community leaders
- dentist
- doctor
- editor of local newspaper
- eye doctor
- family attorney
- fellow workers

(cont’d on p. 27)
trip and your need. 4. Pack. If the Lord is in it, it will happen!

**Prayer** is the most important foundation of this entire trip. Throughout this entire book, you will be reminded to pray so that you will make the right decisions and so that the Lord will bless your work. Pray that God will provide and He will tell you how best to do the fund-raising. Many people immediately default to George Mueller’s approach to fund-raising—pray but tell no one of your need and make no solicitations. Somehow that seems more spiritual to many of us and avoids the obvious embarrassment. However, it may not be right for you. Remember, that other great men of God used other means. Hudson Taylor prayed mightily, kept people informed but made no solicitations. Dwight L. Moody prayed, kept people informed, and actively solicited for the Lord’s work. The Apostle Paul blatantly asked, “What would the Lord have you do?” All prayed and all trusted God for His provision.

**Keep in mind the biblical perspective.** The verses above and the pattern that God has established for the support of those who are obeying his commands are clear. These verses may also help:

“Every animal of the forest is mine, and the cattle on a thousand hills. . . .

(cont’d from p. 26)

| florist               |
| former college professors |
| former customers       |
| former employees       |
| former high school teachers |
| foundations            |
| friends                |
| friends of relatives   |
| grocery store clerks   |
| high school friends    |
| exercise class         |
| insurance agent        |
| Kiwanis Club           |
| local businesses       |
| local radio stations   |
| mailman                |
| military personnel     |
| milkman                |
| missionary societies   |
| neighbors (current & former) |
| office building directory |
| parents                |
| parents’ work associates |
| pastor                 |
| printers               |
| retired people         |
| Rotary Club            |
| service station manager |
| Sunday school classes  |
| teammates              |
| telephone directory    |
| veterinarian           |
| wedding lists          |
| youth group            |
The world is mine, and all that is in it” (Psalm 50:10,12).

“And my God will meet all your needs according to his glorious riches in Christ Jesus” (Philippians 4:19).

Obtain a commission from your church. In Acts 13:1–3, we read that Paul and Barnabas were selected by the leaders through the leading of the Holy Spirit. They were called out, commissioned and sent by the local church. They later returned to this church to serve and were accountable to them. If at all possible, seek the support and blessing of your church. You should be sent by your church. It is the Biblical pattern and it has a built-in accountability program—you are accountable to them and they are accountable to you. Starting first with your pastor, then with your church mission committee, give them the trip brochure or some other literature that fully explains the nature of the organization with which you are traveling and the particulars of your trip. Be sure to explain the purpose of the trip and share your testimony, your calling to go, and your vision of what might be accomplished. Ask for their spiritual blessing on your proposed trip. Ask them to pray with you, for you, and to keep you accountable. Once they have approved you, they may be able to assist you with finances from the organization and may also be able to assist you with your personal fund-raising.

How do I spread the news of my trip?

> Ask if the pastor or any of the other people in your church would like to go with you. Ask if they can challenge others to help. It is always easier to raise money for someone else, and they are in the position and have the platform to do it. Explain to your pastor or the group what the total cost of the trip is and what part of the total price you are able to cover yourself. Explain that you will need to raise funds for the rest. Emphasize that while you may be writing or asking some of the people in the church, you have no expectations that the church or the church members will be responsible for any or all of the needed money. Remember to be sensitive to any restrictions that your church places on your fund-raising.
Keep in mind that some churches have part of their budget set aside to help people on trips such as the one you are taking. Perhaps your trip would be eligible for such help. If the organization with which you are traveling does not provide the service, consider asking your pastor if your church could be the organization that oversees the financial aspect of your trip. As a volunteer serving in an overseas ministry under the auspices of a recognized charitable organization, you may be able to claim your out-of-pocket expenses related to the ministry as deductions for US tax purposes. This includes transportation to and from the field, as well as food and lodging while performing your volunteer duties. Please refer to IRS Publication 526 and consult your tax advisor for specific information. This arrangement has the advantage of providing (and requiring) financial accountability for yourself and allows a tax-deductible gift for those who give gifts to your ministry. If your proposed ministry is in line with things that are part of the church’s vision, the pastor and church may be willing to act as your financial agency. However, be aware that because of increasing IRS scrutiny of the charitable nature of church funding, the pastor and leadership council of your church may decline to allow that.

Call or write your friends and family. At first blush, it is often hard to come up with very many names, but review your Christmas card list, your parents’ Christmas card list, your relatives, the list of people in your Bible study, your cell group or Sunday School class, your schoolmates, your teachers, your coworkers, Christian businessmen’s and businesswomen’s clubs, and so on. Hint: Perhaps the third grade class picture from forty years ago is overdoing it just a bit!

Spend some time writing a straightforward one-page letter that gives the nature of the trip, why you feel you should go and what the reader can do to help. ALWAYS personalize it. NEVER write a form letter, addressed to “Dear Friend or Relative” or “Dear Coworker”. You probably would not write a check in response to such a letter. Neither will they. Suggest an amount or a range of amounts that might be appropriate for them to give. Make sure the date for the deadline is clearly spelled out. Sign it and add a brief personal note as a postscript. We have written a sample letter that contains all the essential elements (see
Appendix C). Feel free to copy it, modify it, and make it sound like you wrote it. Just make sure all the critical elements are included: who, what, where, when, why and how much. If you need to have them send the money to a third party, be sure to spell out the particulars (including the account number or any other identifying information). Caution—many groups do NOT want donors to include the person’s name (on whose behalf the check is being donated) written on the check itself. Rather, the donor may need to write the name and any identifying information on a separate piece of paper. Improper handling of this detail may result in the loss of the giver’s ability to deduct the donation for tax purposes.

- Send it out. Be sure to enclose a self-addressed (or one addressed to the proper organization) and stamped envelope for their convenience.
- After giving enough time for the letter to be delivered and for the recipient to think about your request, follow up your letter with a phone call. Many more people will give you a positive response if you follow up your letters with a phone call. We know of professionals who make it a rule to NEVER send a check in response to a letter appeal, feeling that if the person asking does not care enough to call, then neither do they care enough to write a check.
- Look for groups that you can personally address. In your presentation to the group, share everything you wrote about in your letter (who, what, where, when, why and how much), especially remembering to share why and how you feel you are called to go. The best way to relate to an adult audience is through an illustration. Share a story from the hospital where you will serve or from your reading of a missionary book. Remember to keep it short and to the point. Offer mission trip brochures and invite others to go with you. Communicate your financial and prayer needs and distribute self-addressed (or properly addressed) envelopes for them to use. Make sure there is a personal touch. A challenge to everyone is often interpreted as a challenge to no one! Perhaps you may close your talk by saying you need “investors in your ministry.” Just like someone would invest in the stock market to get dividends, you need people whom God leads to invest in your “company” that will pay “eternal dividends.” Communicate your
deadline. Pass a sign-up sheet around the group. Be sure to follow-up with a call or letter thanking them for the opportunity to speak and present your vision. You can communicate with them from the field and again when you get back from the field.

► If your children are going with you, encourage them to share about their trip in school and with their friends. Suggest to your children that they need to think of ways they can minister while they are there and then use those ideas to challenge their friends to contribute toward the purchase of a tape recorder and some Christian music tapes for the pediatric ward at the hospital, or Christian children’s books, or balloons, or puppets, or candy or toys or . . . you get the idea. Let your children talk to children’s groups or use their ideas when you talk to children’s groups.

► If you are a physician or dentist, you have a built-in constituency of people who think favorably of you—your patients. Make a flyer. Make copies of your picture on an 8” x 10” piece of paper and give a short description of what you will be doing. Post them in your exam rooms, at the front desk and on the hospital bulletin board. The flyer should answer the questions of who, what, when, where, and how much is needed. The World Medical Mission makes the following suggestion: “If you are a physician, as soon as you know the cost of your trip, divide it by the number of patients you see in your office each month. Put an advertisement next to the cashier’s window stating that you are donating a certain percentage of each bill paid that month to enable you to serve overseas. State that if a patient would like to contribute something more toward a need at the hospital or your direct costs, they can add that amount to their bill or place it in a mission box. This is also a great way to get your staff involved.”

► If you work as an employee, ask your boss to give you paid time off as their contribution to your trip. It may help to point out that this can be a great public relations move, demonstrating that the company cares for the needs of the world and is sending their employees to help.

► Write a short news release for your paper. Include the “who, what, where, when, why and how” of good journalism and include a picture of those who are going. Contact the editor personally. He might be
interested in a human-interest story on you and your trip. Offer to help them with background information, pictures or other information they may need.

**Other methods of fund-raising**

Here are some other examples of special programs:

- **World Medical Mission Resident Fund:** WMM has a fund available to help residents in medical training programs to serve overseas. It will pay up to $500 of the total cost of the trip based on financial need. Contact them at World Medical Mission, PO Box 3000, Boone, NC 28607.

- **In an effort to foster the growth of a new generation of medical missionaries, Samaritan’s Purse and World Medical Mission have established the Post-Residency Program. This two-year fully-funded program supports Christian physicians while they serve in an established evangelical mission hospital, immediately following residency. As a physician in this program, you will work within your specialty alongside career medical missionaries, gaining practical experience while being exposed to medical missions and the power of the Gospel to change lives. In addition to the support from World Medical Mission, you may qualify for additional help from Project MedSend. Student loan repayment grants are offered for physicians while they serve in this program. For more information, call toll-free 800-528-1980 ext 1355. Visit the website at www.samaritanspurse.org/index.php/WMM, or email postresidencyprogram@samaritan.org.**

- **MAP International Medical Fellowship (Reader’s Digest International Fund):** the Medical Assistance Program (MAP) has a fund that will pay up to 100% of the actual airfare for medical students and residents. To obtain an application, write Medical Fellowship Coordinator, MAP International, 50 Hurt Plaza, Suite 400, Atlanta GA 3030 or call 404-880-0540. You can also go to www.map.org and follow the links.

- **Christian Medical and Dental Association:** the CMDA awards several grants to medical students each year to work in mission hospitals. To obtain more details, write: CMDA, P. O. Box 5, Bristol, TN 37621 or call (423) 844-1000.
Medical School/Residency Programs: medical students and residents should check with their respective medical schools and residency programs. Some have grants or fellowships available to help cover the cost of overseas service.

The American Society of Tropical Medicine and Hygiene has the Benjamin H. Kean Traveling Fellowship in Tropical Medicine that provides travel expense for medical students who arrange clinical or research electives in tropical areas. Airfare and up to $700 toward living expenses is covered. Applications can be downloaded from http://www.astmh.org/funding/kean.pdf.

Employee Matching Fund Programs: some organizations have programs to match gifts given by their employees to non-profit organizations. If the funds used for your travel are all channeled through recognized 501(c)(3) charity, the money you send in for your trip could qualify for a matching gift.

Your church mission committee, local foundations in your community, and your local CMDA chapter (if you are a physician) are other options.

The last option is planning ahead and using Christ-honoring principles in your long-term financial plan. You plan for your retirement, house payments, and much more. Consider setting up a charitable remainder trust or similar instrument. See if your mission agency will let you set up an account in your name for future use by you. With either of these options, it is possible to set aside money each month for the charitable remainder trust or mission fund. Gifts from the charitable remainder trust can be used as contributions to a mission agency to cover your travel expenses. Regular giving promotes steady growth, and the funds are then available when you decide to serve. This will also balance your tax deductions over several years.

The care and feeding of a support team

This may sound like an extreme statement, but this is the best bit of advice contained in this book: If you are leaving on a short-term mission trip without having prayed about it thoroughly, without having
prepared spiritually for what you are going to face and without a bevy of Christians praying for you, don’t go. It is that simple. It is that critical. This is a team effort. Your preparation by prayer and Bible study is your responsibility (see Chapter Four). Your team’s responsibility is to pray faithfully. God is responsible for preparation and the outcome (Ephesians 2:10). Fortunately, the only prerequisite to make your team of prayer warriors is a willingness to pray for you faithfully while you are gone, so the list of potential recruiting prospects is great. Your obligation to them is to give them the information they need so they can pray knowledgably and wisely.

Earlier in this chapter, the statement was made that it was often easier to get someone to contribute money to the effort than it was to get consistent, effective prayer on your behalf. The reasons behind this are many. Some make the promise to pray for you glibly, figuring it is a way to sound spiritual. For some, it is the cheaper alternative to their pocketbook. For most, it is a matter of good intentions gone awry. Virtually all of us have promised to pray for something and then guiltily realized at a later time that it had slipped our mind. We meant to do it, we were vitally interested but it just didn’t happen. It is your job to help them remember.

There are many ways to do this effectively. The steps that should be covered are:

- Make the recruitment and sign-up process memorable.
- Educate your team.
- Use some memory device to help remind them of their promise.
- If at all possible, keep up a flow of timely information from the field.
- Give it a memorable wrap-up upon your return.

**Make the recruitment and sign-up process memorable** so that it sticks in their mind. Recruitment of your team should be given considerable import. Do not just limit the list of possible candidates to those who have given money or other tangible forms of support. Some of the most staunch prayer warriors are those who are the aged, or in nursing homes, or in tight financial straits, but they have had a track record stretching back fifty, sixty or seventy years of talking with God on an intimate basis. They are often the ones with both experience and
the freedom to uphold you before God in their prayers. As you talk to various individuals and groups about your trip, present your need for financial support but also present your need for prayer support. Tell them that you are looking for a serious commitment. Ask them to make a written commitment by signing up on a list or by asking them if you may put their name down on your list of members of your prayer team. In a few days, communicate again with them by personal visit, telephone call, snail mail or e-mail, thanking them for agreeing to pray for you.

**Educate your team.** Send them progress reports of your readiness to go. Send summaries of the basic geographic, social, economic and religious climate of the country you are visiting. Look up the country you will visit in the encyclopedia, the Internet or in Patrick Johnstone’s *Operation World* or *Operation World Prayer Calendar*. This suggestion is especially valid for countries with which they might not have familiarity. Send brochures about the group you are traveling with. Send photocopies of newspaper articles of interest pertaining to the region you are visiting.

### 10 WAYS YOUR CHURCH, FAMILY, AND FRIENDS CAN SUPPORT YOU

1. Provide for some of your personal expenses
2. Provide supplies for your trip
3. Form a prayer support team (hospital band idea)
4. Hold a commissioning service to bless and encourage you before the trip
5. Write notes of encouragement which you will open each day of your trip
6. Go with you to the airport to see you off
7. Hold a short prayer outside the terminal or at the edges of the ticket area before you check in
8. Give you a small package filled with items of encouragement—bookmarks, tapes, poems, notes, special Scriptures, etc.
9. Welcome you home with banners and signs when you arrive at the airport
10. Allow you to share your experience

*Taken from the VIM International (IMB) Preparation Guide*

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*Johnstone, Patrick and Jason Mandryk *Operation World Prayer Calendar: Authentic, 2001. ISBN 978-1884543593. It is somewhat dated and has not been updated, but it still has great material in it.*
ing to the trip. Forward e-mails and newsletters from the field that tell them what is happening where you will be. See if someone has professional or amateur videotapes about the work or previous trips. Send them brief biographies about the people and missionaries with whom you will work.

**Use some sort of memory device or reminder to help them remember on a daily basis.** This is where your imagination can have full run. Prayer cards are the old standby and still have their place. Most missionaries have had printed up postcard-sized pictures of themselves, their families and contact information. You can do something similar. Computers and graphic art programs can make this easy, fun and affordable. The trick is then to get them to look at it. Be imaginative in how it can be displayed.

► Refrigerator magnets are not just for the refrigerator—they can stick on their desk, their dashboard, and their bathroom mirror. One easy way is to use your computer (or your friend’s computer if you are not computer literate) to print your own business card sized reminders and use the self-adhesive flexible magnets designed for business cards.

► Give some small gift that can be easily displayed that will remind them of the country where you are—miniature flags, pins (including the make-your-own kind), postage stamps, maps and other memorabilia.

► One particularly effective tool, especially for the men, is to give them a small piece of currency from the country (if you can get it ahead of time) and ask them to put it in their wallet—each time they pay for something, they will see it and will remember you and what you are doing. Since they will probably keep it, it is a good long-time reminder to continue praying for that country.

► Ask them to tie a string around a wrist or finger as an unobtrusive way to be reminded many times a day to pray for you. The plastic patient identification bracelets used in hospitals is another way to accomplish the same end. They can write your name and country on it and wear it the entire time you are gone. It is a great opening to witness to their friends and co-workers. Tattoos are probably a bit too much to ask—but might still be effective!
Magazines (especially in-flight magazines), the Internet and the like give many options for inexpensive items (pins, buttons, T-shirts, etc.) that can be personalized in a way that would provide an effective reminder for prayer.

Other suggestions are highly effective but a little more labor-intensive. Some have created a “prayer calendar” and people have committed to sign up to pray for a certain portion (hour, day or week) of their trip. Some have appointed someone willing to be a prayer coordinator and that person has been responsible for frequently reminding—by personal call, phone, mail or e-mail—people to pray for you. If a special prayer need comes up, having such a person has the advantage of giving you someone to whom you can contact quickly and consistently while on the trip.

**Ongoing communication with your prayer team is very important.** They have invested in your ministry. You would not like it if you invested in a mutual fund and received no information about what was happening with your investment. Your investors will not either. Sending a postcard detailing answers to prayer and new prayer requests a week after you arrive in country is great. An acceptable alternative is e-mail, especially with the occasional digital picture attached. E-mail is a real blessing to missionaries, both long and short-term. If you have appointed a prayer coordinator as described above, it also gives you the added advantage of having a person responsible for getting any other communication to the team as well. Not everyone has e-mail, so if you choose to communicate by email, having a communication coordinator will facilitate the transfer of information from you to your team. Communication with those at home is a very effective tool. Whether that is by e-mail newsletter and digital pictures or by regular letters and postcards, regular communication is a must. It does not have to be a polished piece of prose but should reflect what you are finding and how it is affecting your mind and heart. Suffice it to say, if you have built a close relationship with your support team before you leave, you may have some items of deeper sensitivity that you can share with them about your struggles that you might not be able to share with a more general reading audience.
This next item would seem to go without saying, but it will not. Write thank you notes for each gift as soon as you get it. There is no doubt that you are busy and have many things on your mind and on your schedule, but there is no acceptable substitute for a personalized thank you. They deserve the thanks and your mother will be proud.

**Follow-up when you get home is very important.** All good military commanders insist on an after-action report and it is highly recommended that you put your thoughts down on paper. Analyze what the Lord has done, what was done well and what might be done better next time. As vivid as your memories are when you get back, and it seems that you will never forget, you will forget. Share your report with your supporters, both financial benefactors and prayer warriors, and be certain to thank them for their help. A small souvenir (including such things as a coin, a flag, a postcard, or a bookmark) is often much appreciated, especially if personally presented with a word of thanks. As your mother told you—and she is usually right—the thought here is the important thing, not the size of the gift. A tract in the local language along with a note that reminds them they have sent the Gospel; a letter opener to remind them with every use that they have helped open the hearts of others; a piece of currency to put in their wallet to help remind them of their newfound financial priorities; a calendar from that country to remind them to pray daily for the missionaries there and the people you have left behind.

Conduct a “Shareholders’ Meeting.” Invite those that have had a “share” in your ministry over to your house for a report night. Show your good slides, your best video or PowerPoint presentation and have everyone that went give a report. Keep it short and leave time for questions. Share your frustrations, failures, and triumphs. They will want to know more about your reactions than hearing a travelogue. Lace the evening with humorous anecdotes. If you can, bring something home to serve at this meeting from the country you visited, e.g., tea, coffee, candy, etc. Close the evening with a short time of prayer for the hospital place where you served.

Don’t forget to give a report to your church if possible. Express your appreciation for their support and prayers; share briefly the
impact of your ministry on yourself and the people you served, emphasizing the spiritual aspects. Let them know your trip and their prayers and support have reaped a spiritual harvest.

In summary, missionary physicians overseas desperately need you to help them hold up their end in remote locations under trying circumstances. Don’t let money stand in your way. Trust the Lord that when he says, “Go!” He will always provide the way. As Abraham went “by faith,” believe that God will also honor your commitment to serve him to the ends of the earth. Dillon writes, “As you raise support, God will increase your faith in miraculous ways. He will lead you to new friends and through new experiences. When an effective strategy is followed, support-raising, rather than being a nightmare, becomes an exciting journey of spiritual growth. And if that is God’s will for you, it is a process you won’t want to miss.”

SUGGESTED READING

GOD PROTECTS FOOLS
AND LITTLE CHILDREN

I trudged through the
inky blackness that is the
African night. It was hot
and humid. Earlier, on the
way up to the hospital, the
brilliant African sky
blazed above me, show-
ing me more stars than I
had ever seen before. The
Milky Way splashed across the sky like a spill of light. Now, I
didn’t look up. I wouldn’t have seen it. The same dust-filled
Harmattan wind sweeping down from the Sahara desert that
made my breathing wheezy blocked everything more than 100
yards away from sight. I kept my eyes peeled, making sure that
I didn’t step on a viper, mamba or cobra. The cone of light from
my flashlight was my only physical reality. As I carefully
stepped along, an old familiar Bible verse came to my mind,
“Thy word is a lamp unto my feet, and a light unto my path” (Ps.
119:105, KJV). It suddenly became clear that the Word of God
illuminates but in doing so, only allows me one step at a time—
the rest of my walk in life has to be on faith. It would be foolish
to run on such a night, trying to outrun the circle of light and yet
I often tried to outrun God’s illumination in my life. I shook my
head in frustration. The greater questions of life were not the
only things I didn’t understand that night.

I had been called out of bed to see a patient. I had not been
sleeping well—the heat, sweat and reactive airway from the dust
in the air had kept me tossing and turning as I wished for one
cool breath. Upon receiving the call, I had walked into the
makeshift hospital which was lit only by two kerosene lamps. I felt like I had gone back decades or centuries in time and certainly the resources I had were not much advanced beyond that point.

Her ebony skin glistening with sweat from carrying her comatose boy through the African night, the mother’s eyes pleaded for the life of her boy. On the stretcher, the 4-year-old boy whimpered spasmodically; whimpers that were the only interruptions to his deep slow breathing. A quick examination showed only a mild enlargement of his liver, but no obvious etiology for the coma. Florence, the Ghanaian nurse, interpreted from Ewe to English, relating a history of episodes of abdominal cramps followed by coma. She then offered some additional information in an almost shy manner. The child had eaten some fruit about 4 PM the previous afternoon. Florence said that she knew of a child who had eaten the same fruit when it was not ripe. That child had gone into a coma, but survived. In examining the child once again, I realized that the child was acting more as if he had been poisoned than as if an infectious cause was present. It had been almost 12 hours since the fruit had been ingested and I doubted the efficacy of a NG tube or laxatives at this point in removing further toxins. Given the very limited options for diagnostic tests, I ordered a blood count, a sodium level and a blood glucose. That nearly exhausted my entire diagnostic armamentarium. I opted to treat the child empirically with both a broad-spectrum antibiotic to cover possible bacterial meningoencephalitis and with intravenous quinine for cerebral malaria. I felt this therapy was warranted given the high mortality expected if either one of these conditions was present. I also admitted to myself that those were the only diagnoses I could effectively treat. Florence had demonstrated the good sense to send the hospital guardian after a sample of the fruit. The guard brought in both a ripe and an unripe fruit to show me. It was the
size and rough shape of a small green pepper but bright yellow in color. The seeds reminded me of a horse chestnut but were completely black with a whitish-yellow fleshy attachment. It was not something I recognized and Florence did not know the French or English translation of its name—in any event, I had very little to treat anything with even if I had recognized it. With heavy heart and a murmured prayer, I turned away and walked back home. I was missing something—something big. This child might die because of my ignorance. What was I doing here, anyway? I am a surgeon—not an internist or pediatrician. I was used to the cutting edge of the technology—not to working at a hospital furnished by the “Junk for Jesus” program.

Back in my room, I crawled under the limp sheet and tried to get as much of the anemic breeze from the ceiling fan as I could get. Unable to sleep, my mind worried the problem like a dog at a bone. Florence called about an hour later and reported a 19,000 white blood cell count and a glucose of 56. Electrolytes were normal. I knew I had ordered enough glucose in the IV to treat that blood level, so I thanked her, but as I hung up she said, “By the way, Docteur, the child is beginning to wake up.” I praised the Lord, but I was frustrated that I still didn’t understand what was going on.

We were staying with the missionary physician. He is an early riser. When I heard him stirring, I presented the case to him. He had no answer either, but found a book on tropical medicine on his shelf. Under food poisoning, we read:

“The ackee,\(^8\) Blighia sapida (Sapindaceae), is a tree that is native to West Africa, but now widely distributed throughout the tropics. Consumption of the

\(^8\)My note: Alternative spelling is “akee”
seeds and unripe fruit can cause profound hypo-
glycemia . . . . Poisoning occurs mostly commonly
among . . . children under the age of 10, usually
between December and March.”

The child was under 10 years of age, it was January and this
was West Africa. Bingo! There wasn’t a picture in that book to
confirm that the ackee fruit was the one I had seen earlier, but
everything else fit the case I had. Later, by looking into a dusty
old tropical medicine book found in a box in a cupboard, we
found a picture of the fruit that confirmed that the fruit I had
seen last night was the one talked about in the first textbook. In
treating cerebral malaria, extra glucose is given in the IV to
counteract the hypoglycemic effect of quinine and of malaria. I
had treated the child’s poisoning properly without knowing it.
We saw the child again within the hour and he was fully recov-
ered. We instructed the parents in a high starch diet and after
some continued observation, discharged the child later in the
day. The child’s parents are believers at one of the local congre-
gations. There was rejoicing there that day.

I have had to learn this lesson time and time again: physi-
cians on the mission field must rely on the Lord to make things
turn out to His glory. I am still not good at it. There is an old
saying that may apply: “God heals but the physician sends the
bill.” Another one that may be equally accurate: “God protects
fools and little children”. There is yet another older one that may
be more accurate, “I am Jehovah-Rapha.” Jehovah-Rapha—
The Lord who heals. In that, I must rest.

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9 Goldsmith, R and Heyneman, D, *Tropical Medicine and Parasitology*, Appleton
and Lange, Norwalk, CT, page 798–799. The hypoglycemia is due to the action
of two polypeptides, hypoglycins A and B.
10 Exodus 15:26
SPIRITUAL PREPARATION

“There is nothing special that happens to you on a 757 crossing the ocean.”
—Harry Gebert, MD, medical missionary

These words by a veteran missionary are a humorous reminder of a serious truth—your heart must be right before you go. If you are not a soul-winner on this side of the ocean, you will probably not be one there. If you do not spend time in the Word or in prayer here, you will probably not do so there. You would not dream of entering a marathon without running endless miles before the event to build up your stamina, endurance and strength, yet many short-term missionaries will make the mistake of going on their mission without proper spiritual preparation. It may not be in vogue here in North America to talk seriously about spiritual warfare. Sometimes the concept is hard to take seriously in the comfort of your home. However, it is real. The presence of the Holy Spirit, the peace of God, and the knowledge based on experience that you can trust Him will make a difference in your trip. This does not mean that before you go you have to be transformed into a reincarnation of Dwight L. Moody or Charles Spurgeon or be the next Mother Teresa, but it does mean that you have to have a solid relationship with God before you go.

Proper preparation must be a top priority, but unless you make it happen, it will not happen. To carry our running analogy a little further, there are mornings you must drag yourself out of bed to run when you do not really feel like it. You do it because you realize that you must discipline yourself and work hard in order to achieve your goal. Spiritual preparation takes the same dedication. Start early and train hard!

Proper preparation requires clarification of your call to go. Some people get very uncomfortable with the idea of talking about a “call to
missions” in the context of short-term missions. Although it usually is not the audible voice of God, you must have a sense and conviction that God’s will for your life includes your proposed trip. You must “know” that you will have a defined purpose in God’s economy and plan to carry it out, even if you have no idea what it is. If you are going on a short-term mission trip just for the “experience,” you should probably just take a good vacation. There is an increasing tendency to emphasize the effect of a short-term mission trip on the participant and trips are being promoted with this as the main benefit of the trip. This is reflective of our culture’s “Me Generation.” While it can be argued that a short-term mission trip will have a salutary effect on you that will be far beyond your expectations, it is perhaps an error to make that the primary justification for the trip. Your overriding motivation for the trip must be that you have realized that God has called you and your family to provide service to the Lord, the missionaries on the field, and the hurting people surrounding them. You are going to try to communicate in whatever way you can that Jesus Christ is Lord and He has saved you personally. You are going because of a realization that an understanding of the Great Commission has made it imperative for you and your family to help bring the good news of His salvation to every man, woman and child. You have a personal responsibility to fulfill the Commission. You are obeying.

In order to discharge this privilege, duty and sacred responsibility fully, we must strive to be filled with the Holy Spirit. We must ask for His help to empty ourselves of “Self”—all our visions of self-glory, our improper motivations, our problems, our worries, our ego and whatever else that may get in the way. We need to learn how to be as transparent as possible so that when the people to whom we minister see us and our actions, they see Jesus Christ. We must rely as completely as possible on the Holy Spirit in order to face uncertainty and live our lives in a way honoring to Christ. With language and cultural barriers being what they are, we may truly be the only Bible that they ever read.

Whoa! This is getting much more spiritual that you counted on! After all, you are only a physician (or dentist or nurse or medical tech-
nician or . . .). But before you try to get a refund on your tickets and change your call schedule back, it may help to get a grasp on a few important concepts that might make this process easier for you. The first is that God knows exactly what and who you are, and you will not surprise Him. The second is that you can do all things beyond your own abilities because you can do them through Christ’s power (Philippians 4:13, “I can do everything through him who gives me strength”). Third, you are not responsible for the results, only the attempt. Ephesians 2:10 reads, “For we are God’s workmanship, created in Christ Jesus to do good works, which God prepared in advance for us to do” (italics added). If He prepared the works in advance, He knows what will come of it.

We must maintain a growing, personal relationship with Jesus Christ. Practicing the disciplines of prayer, Bible study, church attendance, meditation and time alone to listen to God are vital and critical to the process of becoming more Christ-like. Prayer is not just asking God to move in our lives. It is the process of God’s moving us into conformity to His will. He will not do this unless we pray.

It is often difficult to have a meaningful prayer life, especially if you are not used to doing it. Do not set arbitrary time limits or feel you have to use formal terms of address in order to pray properly. Prayer is just spending time with a God who loves you and there is no “right” way. Be thankful that as children of God, we have the Spirit that allows us to call God Almighty “Abba,” “Daddy.” He is thrilled to hear from His children. Talk—and listen.

The important thing is for you to begin praying right now. It is never too early or too late to seek the Lord and His guidance in this proposed trip. Make sure that someone is praying with and for you as well. It is sometimes helpful to pray together regularly with a family member, member of your church or an accountability group, friend or fellow traveler for a dedicated time of prayer for specific and more intimate concerns. If you are traveling with your family, you should definitely have times of group family prayer. The prayer should begin now, continue throughout the trip and after you return.

Pray about every aspect of your mission experience. Listed below
are some ideas that you may find helpful in preparing your heart and that will affect the outcome of your service to Him. The list is by no means exhaustive and the Holy Spirit will bring many more Scripture passages to your mind. He will lead you to pray about other concerns. This list, or one that you have modified to include specifics for your trip, may be duplicated and given to each member of your support team.

Suggestions for Prayer

► Explore your own salvation and the blessings from it. Read 2 Corinthians 4:1–11. Spend time thanking God for your salvation and praise Him for specific blessings which come from knowing Christ. These include (but are not limited to) forgiveness for your sins, certainty about your eternal destiny, the privilege of praying and knowing God hears, power for living now, and the opportunity to give yourself away on behalf of His Kingdom.

► Ask God to fill your life with His power for this venture. Jesus said, “If anyone wishes to come after Me, let him deny himself, and take up his cross, and follow Me” (Mark 8:34). Only the Holy Spirit can deliver us from the demands of our selfish natures. Envision every area of your life: your relationships, your vocation, your personal resources, your physical health, everything—and surrender each area afresh to the Lord Jesus. Confess and repent of sins the Holy Spirit reveals to you. Make restitution where it is needed.

► Pray for a “me last” attitude which claims no rights or privileges for yourself. Your attitude, both at home and overseas, should be the same as Christ’s. In Philippians 2:5–8 we read that even though He was God, He took on Himself the role of a servant and displayed an attitude of humility and helpfulness, of willingness to identify with people and to accept the cost of obedience to God. In the end, it cost Him His life.

► Pray for an awareness that what God wants from you may not be what you feel is your strongest suit, but that “obedience is better than sacrifice” (1 Samuel 15:22).

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11 This and the subsequent list have been modified from lists in uncopyrighted material by the Volunteer Missions International division of the International Mission Board.
Pray for the missionaries, their families and for your interaction with them. Pray that you would have a spirit of encouragement and not of criticism. It is crucial that you put aside now any tendencies toward criticism. Negative comments from short-term volunteers are rarely upbuilding to career missionaries who are paying a great price to make Christ known.

Pray for those to whom you go to minister. Pray that they will be strengthened and encouraged by your presence. Pray also for the patients you will treat, that God will sensitize you to their needs, and that they will see Jesus Christ in you.

Keep your eyes, ears, and heart open to what God may be showing you.

Claim Christ’s victory over the adversary. Pray that Satan might be prevented from disrupting plans in any way. Pray for the Lord to intervene where evil forces are at work.

Pray for the witness of believers in the area, for boldness and encouragement.

Pray for churches in the area to reach out to people and their needs.

Pray that lost people will become open to hearing about Jesus and then accepting Him as their Lord and Savior.

Pray for those in positions of leadership within the country, for their salvation and witness.

Pray for national and missionary families to be united through the Holy Spirit.

Give honor and glory to the Lord for your participation in this trip.

Pray for the other team members: for their health, ministries, and spiritual growth.

Pray for opportunities to serve, witness, and speak.

Pray that you will remain open to any type of mission work, including here at home.

Prayer and Bible study are the main foundations of spiritual preparation but the following are additional things that can help to put you in the right state of mind and spiritual readiness:
Learn a simple way to lead someone to Christ (see Chapter Six). Remember that you are not the one doing it. It is the power of God’s Word and the Holy Spirit that will draw them to Himself. You do not need to have extensive knowledge of various arguments against tenets held by other cults and world religions. Most of those to whom you will witness have little sophistication in those matters, and those who do can be referred to the missionaries or someone else more qualified. Your responsibility is to tell what God did in your life and what He is willing to do in theirs. Use Appendix B to develop a testimony suitable for sharing in a new culture.

Read stories of faith and missionary biographies and reflect on the unchanging nature of God. If He did it before, He can do it again.

Read books emphasizing the church’s call to missions. Several suggestions are listed in the bibliography in Appendix A.

Read books about missionaries that have served or are serving in the country where you are going.

Study Scripture passages before you go and/or do a mission related Bible study on the trip (two are suggested later in this chapter).

Collect reminders of His faithfulness, e.g. Lamentations 3:21–25 (NIV): “Yet this I call to mind and therefore I have hope: Because of the LORD’s great love we are not consumed, for his compassions never fail. They are new every morning; great is your faithfulness. I say to myself, ‘The LORD is my portion; therefore I will wait for him.’ The LORD is good to those whose hope is in him, to the one who seeks him.”

Start a journal to chronicle your experiences of what God is doing and continue it through the trip to record both the physical and spiritual journey.

Ask missionaries, agencies and nationals for stories of the history of spiritual outreach by the work or agency in that country.

Look up the country (and surrounding countries) you will be visiting in Patrick Johnstone’s Operation World—The Day-to-Day Guide to Praying for the World, other reference materials, or on the Internet. Pray for a better understanding of the needs of the people and the works that are ongoing in the country.
Preparation of your heart and soul is more important than what you pack. Along with your passport, visa, money, and Bible, make sure you take a properly prepared heart and mind, bolstered by ongoing prayer.

SUGGESTED READING
Lisech, Howard and Bonnie Lisech, “Abide in the Vine (14 day Devotional Bible Studies)”, Deeper Roots Publications (Orlando), 1995, ISBN 1-930547-16-1—Also available in 21 and 50 day editions
Lisech, Howard and Bonnie Lisech, “Ripe for Harvest (14 day Devotional Bible Studies)”, Deeper Roots Publications (Orlando), 2000, ISBN 1-930547-07-2—Also available in 21 day
Lisech, Howard and Bonnie Lisech, “Walk as He Walked (14 day Devotional Bible Studies)”, Deeper Roots Publications (Orlando), 1997, ISBN 1-930547-00-5—Also available in 21, 30 and 50 day editions
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Prepared by Volunteer Mission International division of International Mission Board
**ALTERNATIVE STUDY**

Study the following verses to see what the New Testament teaches about missions and our approach to them:

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KEEPING YOUR PRIORITIES STRAIGHT

Tears sprung unbidden to the eyes of the missionary surgeon and threatened to overflow. His voice broke as he related the story of a failure that changed his priorities in patient care.

Overworked and overwhelmed. Too much to do and too few resources. This was the normal way of life in this small mission hospital. Given all the other demands on his time, the missionary surgeon was grateful that this very ill young man represented no great diagnostic challenge. The story was classic for Salmonella enteric fever, more commonly known as typhoid fever. He was obviously in the minority of patients with the disease who perforate their distal small intestine. His history was that of severe pain, fever and abdominal distension of sudden onset after two weeks of nausea, mild diarrhea and fever which had been treated ineffectively by the local healer. He had suddenly worsened. The long and expensive taxi ride to the hospital had done nothing but empty his pockets and made him wince every time the driver hit one of the numerous potholes. His abdominal exam in the clinic area was consistent with the catastrophic turn of events. The surgeon swung into action.

History and physical—check. X-ray to confirm free air in the abdomen—check. Placement of a central line under the collarbone for fluids and monitoring—check. Basic lab work and blood drawn for type and cross for possible transfusion—check. Large amount of fluids to counter the shock—check. Tubes in the nose and bladder—check. Appropriate broad-spectrum antibiotics—check. Notification of the OR crew and anesthesia provider—check. Operative permit—check. Rearrangement of the other demands on his time as the only physician at the hospital—check.
With the patient asleep on the operating table, he worked quickly and adroitly. A long midline incision revealed intestinal content freely flowing in the abdomen. Mopping it up, he identified the holes, deftly oversewed them, irrigated copiously with saline to get rid of the intraperitoneal contamination and then closed the muscle and fascia, leaving the skin and fat packed open to prevent wound infection. An excellent technical exercise. Nothing left to do but pray.

The young man’s vital signs were still unstable in the recovery area and despite excellent care, he died several hours later without regaining consciousness.

The surgeon struggled with yet another “unnecessary” death. Too many patients died because they presented too late, beyond human help. It was wearing and seemingly so senseless.

The nurse touched his shoulder. “Can I talk with you?” Of course. “Why did you do it that way?” He bristled—he had trained at a top-notch university, had left a successful practice to come to Africa. He thought swiftly over the previous events. Everything had been done perfectly given the constraints of the system. How dare she criticize him?

Her tone was conciliatory, “I’m sorry, I didn’t ask that well. You did a great job medically but I just wondered why you took him to the OR without taking five minutes to tell him about Christ and offering him a chance to be saved.”

The tear escaped and ran down his cheek.
CHAPTER 5

RESPONDING TO THE CHALLENGES
OF SHORT-TERM MEDICAL MISSIONS

Scenario one: It was a simple question. “How was your night on call?” He raised his bowed head and stared mutely as tears filled his eyes and sobs racked his large frame. For this pediatrician of thirty years experience, death was not an unknown visitor in his suburban practice, but it was infrequent and rarely unexpected; to lose six precious little children to malaria, meningitis and anemia in one night was overwhelming. He had done the best he could with the little he had, but the pain of the failure was tearing him apart.

Scenario two: Suddenly the child vomited round worms before the horrified eyes of the visiting short-term nurse, who was participating in a temporary clinic deep in the jungle. The limited supply of vermifuge was gone. For the lack of a few cents worth of medication, there was nothing to be done.

Scenario three: With burning indignation, she examined the little five-year-old. The trusting liquid brown eyes stared at her out of a face disfigured by a huge mass in the right cheek area. “Five days, indeed,” the doctor sputtered. The fetid smell of the necrotic mass was overwhelming. With careful movements, she could put a gloved finger past the bony fragments of the remaining upper jaw and directly into the sinus. A molar was pushed by the mass to the middle of the hard palate and was lying with two of the three roots bared. The child choked on her own drool as she struggled to swallow. The hospital had no formalin to preserve the tissue for pathological examination, no pathology lab within hundreds of miles, the X-ray machine was malfunctioning, and a microbiology lab was only a dream. Even if the diagnosis was made, there was no one capable of performing this sort of massive

\[\text{\footnotesize A special thanks to Dr. John Bullock, a retired missionary orthopedic surgeon to Bangladesh, for his seminal thoughts as expressed in a lecture at the ABWE Medical Interface Conference, July 1999.}\]\n
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surgery, there was no chemotherapy available or affordable, nor were there any radiotherapy units willing to treat this poor patient.

Participating in medical missions is one of the greatest privileges you will ever have. Perhaps the greatest. Despite the three scenarios above, you will most likely return home with many success stories—stories of physical and spiritual healing. But there are significant challenges in serving in the medical and dental professions for short terms overseas. Make no mistake. Short-term medical missions can be a difficult, mind-blowing, paradigm-smashing, teeth-gnashing sort of experience sometimes. In North America, specialization is the rule, and patients, medical societies, hospital credentialing committees, state licensing boards, and the courts all endeavor to make sure you do only what you are judged competent to do. On the field, you may be the only one even remotely qualified to do something. After all, you have a book and understand what it says better than the national healer or fetish doctor. That awareness still doesn’t make your first-ever craniotomy with an open book any easier. You will be challenged beyond your level of comfort, and that is where you begin to learn about medicine, about people, about yourself and about God. “God, surely this isn’t what You meant when You said, ‘I can do all things through Christ who strengthens me?’”

It must be understood that the following list of potential challenges in mission medicine is not comprehensive, that not all of these problems will be present in all situations, and that not all of them have good answers. They are not listed in order to intimidate you or talk you out of going. They are offered with the prayer that if you have a chance to think about some of these before you are hit from all directions, it may prevent some times of anguish, anger, frustration and lost efficacy. Everyone who has ever gone has felt those reactions. You will too. Thinking about these and evaluating some of your expectations and preconceptions before you are facing them may help. When you begin to feel these stresses on the field, talk about them with one of the missionaries or someone who has been through them. Most of all, ensure that you have proper spiritual preparation before leaving; a regular
prayer support base before, during, and after the trip and a willingness to trust the Lord for the daily grace it takes to face the day’s challenges.

**You will face:**
- Primitive conditions
- Limited supplies and medications
- Antique and/or malfunctioning equipment
- Uncertain power supply
- Poor anesthesia
- Low level of education and uncertain motivation of the national workers. These men and women are intelligent but have learned their jobs often by rote rather than by obtaining a full understanding about how and why things work. They also may not have what you might consider a “professional” approach or hold the professional standards that you hold. It may just be a job to them.
- The flip side of the coin: working with nurses or operating room (OR) personnel who, despite their inadequacies in their training, may have greater experience and knowledge than you have about a specific set of diseases or treatments. This can be hard on the insecure professional with an ego problem.
- The crush of many patients, and their families, neighbors and interested bystanders, who are waiting for treatment or perhaps just enjoying the entertainment provided by this novel experience.
- Poor patient understanding, poor cooperation and poor compliance compounded by illiteracy and intense poverty (e.g., they may sell needed medications for the money it will bring because eating is more important than medicine).
- Suspicion of your presence. Some native languages don’t even have a word for “volunteer.” They assume some ulterior motive.
- Lack of thankfulness. Some groups believe you should be thankful to them for giving you the opportunity to gain merit with your god by “doing good” to needy people.
- Lack of hygiene and sanitation, along with an inability to either afford to change dressings or keep those dressings clean.
Complicated cases due to maltreatment, neglect, delayed seeking of treatment and/or underlying malnutrition.

Frequent patient deaths and sub-optimal results.

Language barriers: the interpreters may change or misunderstand the message in both directions of the conversation.

There is danger of the short-term missionary overloading the facility and staff. Surgeons may try to do too many or too complicated procedures; non-surgical physicians may try to treat too many patients or not understand how to most effectively care for large numbers of patients in a climate with limited resources. On rare occasions, physicians may become so intimidated and afraid of making a mistake that they slow down to the point of becoming a hindrance to normal patient care and flow.

New Diseases: “DNK” (Do Not Know) is your most common diagnosis, and you lack the diagnostic armamentarium of laboratory and imaging studies.

The short-term missionary is asked to function beyond his comfort zone, usually not within his specialty or disease knowledge base.

All of these lead to an acceptance of a lower standard of quality, at least as defined by North American standards.

This is all complicated by

Jet lag and fatigue
Humidity
Insects
Friction between expatriate personnel and between national and expatriate personnel
Internal personal stress
Culture shock
Illness (especially traveler’s diarrhea)

And yet it is worth it! Promise! As you read this chapter and the pertinent parts of the rest of this book, begin to prepare your mind and heart to accept some of the changes in the way you do and think about things. Perhaps the most important piece of advice: Go with the atti-
tude of a servant, willing to serve and to learn. You must go ready to
serve rather than to be served. You must accept the fact that while you
have much to teach, you have more to learn. Prepare to go with prayer
and Bible Study and have a prayer team back home supporting you
throughout your time overseas. This is often the only way you can get
through the day. Sometimes you will literally feel that power of the
prayers of the saints uplifting you and guiding you.

Don’t be unduly judgmental of the missionaries, the work they do
and how they are doing it. You are not there to criticize or change
things radically; you are there to come alongside, to help and to
encourage the missionary and national staff. The Holy Spirit is
referred to in John 16:7 as parakletos—the One who comes alongside.
As God’s children, we are also to be parakletos in these situations. Do
not assume that the people who are career medical providers are just
hopelessly out of touch. Usually, the compromises they have made are
ones they had to struggle with because it was contrary to their feelings
and training, too. Even if you have to struggle to accept it, give them
the benefit of the doubt and assume that they understand better than
you the reasons behind whatever they are doing. Short-term partici-
pants do not know the culture, the diseases, the costs, the government
regulations, or the other demands on the career missionaries. If there
were a simple solution, they probably would have already instituted it.
Ask questions, observe carefully and think hard about what you are
told and what you see. Then after waiting a sufficient time to see if
there are any obvious drawbacks to your ideas, humbly offer a possi-
ble solution. An arrogant short-term missionary can do more damage
with his or her attitude and comments than can be counter-balanced by
any amount of good that he or she does.

Be prepared for health care settings that perhaps are not as clean
as what you normally encounter. They will most likely be overcrowd-
ed as patients and loved ones spread out in whatever space is available.
Other common conditions include a lack of reliable plumbing, water
sources, and cleaning supplies. As circumstances allow, your example
of good techniques for hygiene and minimizing contamination may
become valued. You will have to choose methods, however, that pre-
serve the hosts’ and patients’ sense of self-respect and avoid situations that cause undue embarrassment.

Remember that medicine per se is NOT the raison d’être for your being there nor for the hospital’s existence. The basic goal of medical missions is evangelism. Present Jesus Christ to patients, their family and their friends. In contradistinction to the type of care advocated in the United States, it may not always be desirable from either a cultural or evangelistic standpoint to do outpatient therapy or rush them home after a procedure. Many patients and family members come to know Christ as they see the loving care and integrate it with the messages they hear during the ward visits and services. A medical cure has an effect of less than 70 years; a spiritual cure for the uniformly fatal disease of sin is eternal in its effect.

Despite the overwhelming need, set realistic goals for yourself. You are unlikely to change the culture of either the hospital or the country, and ill-advised attempts to do so can be seen as insensitivity or arrogance. For example, as the result of a two-week visit to Kenya, you will not change the incidence of female circumcision no matter how desirable it may seem to you nor how obvious it may be to you that it should be stopped. You are also unlikely to single-handedly change the national health statistics. You are not in a competition to see X number of patients or do X number of cases. The success of your trip will not be judged by numbers; it will be judged by God. Take the long view and pace yourself. Since realistically many short-term medical missionaries may be near the end of their careers, remember that you are not “the man you used to be,” and if you are honest, you probably never were and certainly won’t be again! That’s okay. Plan a margin into your schedule that takes into account your age and physical health. Cultures other than our own venerate age and your effectiveness may therefore actually be increased rather than decreased. Take comfort in that fact and take advantage of it.

As a corollary to that, be sensitive to the pressures already on the national and missionary staff. Do not try to overproduce (which stresses the system unduly), and don’t do difficult surgical cases that require care beyond the skills of the nursing staff or beyond the follow-up abil-
The same person who is helping you do a case is often the one who came early to set up, the one who will clean up the room, the one who will clean and sterilize the instruments and who will take call with you. He wants to understand what you want and make you happy, but your accent sounds strange to him too! Let the expatriate staff set the pace. You may be there for a sprint but they must pace themselves for a marathon. Do not criticize if the career missionary or local health care provider elects to exercise his prerogative to arrive late for clinic or leave early to do other activities. You may not understand the other demands on their time.

Be sensitive to the hospital’s need to charge the patients for their care. It is often easier on the conscience of the visiting physician to want to see all patients who come and to even offer to pay for their care, but such a course of action may be counter-productive in the long run. The ultimate goal for most mission hospitals is to become self-supporting and to be turned over to the Christian nationals. Setting unreasonable expectations in the populace for low cost or free medical care does not always facilitate such a program, especially if the national church does not have access to an ongoing source of income. There will always be too few resources and too many patients.

Also be sensitive to the financial impact of your treatment on the patient and the patient’s family. Most of the hospital’s day-to-day operating budget comes from patients who make only a few hundred dollars a year. Ask your host missionaries about their normal treatment protocols. Order what is normally ordered and in the lowest useful quantities. For chronic conditions, it is often more valuable in the long term if you try to treat them with drugs that will be available at that facility or in local pharmacies long after the wonder drug for that condition you brought with you has run out. For lab work, order only what is absolutely needed. Often the laboratory work is done manually and may cost the patient more than the treatment you would order for the condition you are considering. Having said all of that, in general, it is better to treat maximally for the disease the first time, because they often cannot afford a second attempt or return. To save face because
they cannot pay, they may not return. One missionary physician with
extensive experience in village clinics in Kenya advised to treat for
two classes of diseases: the ones in your differential diagnosis that are
certain or most likely and those that are the most lethal.

Redefine “quality medicine” for the setting, based on the expecta-
tions of the patients rather than yours. Sometimes just being seen is all
they expect. The American philosophy of medicine does not apply in
this new environment. You will not have access to the medications and
treatment modalities you are used to having. Your expectations as to
the nature and results of your therapy may be wildly expensive and
therefore impossible for them. Be willing to set different endpoints for
certain diseases than you would in the US, e.g., in osteomyelitis, sup-
pression of the disease may be more reasonable and attainable in the
Third World setting than cure is. Do the most good for the greatest
number of people given your limited resources. Remember, function is
many times of higher priority than esthetics. Keep it simple. Function,
not perfection, is the goal.

Try to work quickly and efficiently. One short-term missionary
refused to see more than ten patients a day, his usual number back
home in his practice. He didn’t want to feel rushed. He was of little
help to the missionary who wanted some relief. There are huge num-
bers of patients to see. Pare your notes down to the absolute minimum.
You are not going to be sued and a long review of systems through an
interpreter can take forever. Concentrate on the patient’s presenting
complaint.

Remember that most mission hospitals are located in cultures that
value relationships more than events or a successful outcome. Failure
to recognize the importance of personal greetings or acting like a
prima donna often will do more to destroy your testimony than a bril-
liant medical save will enhance it. Don’t assume anything about the
knowledge or skill of the staff but DO respect the knowledge they do
have about local diseases, treatments and customs. LISTEN to the
advice of national and expatriate nurses. Impart teaching and training
wherever possible, whether medical or biblical. Teach the missionary
staff. Teach the national staff. It makes more sense to take time to
make sure you have imparted some new knowledge or skill that can be utilized for years than to use the time to see one more patient today. If possible, take improved equipment or books with you to leave if they facilitate what you have taught. When you return home, look for technologies that are suitable for that mission field. If the missionaries need them and you feel led to provide them, please do so. Above all, work harder than you are asked and encourage, encourage, encourage.

Relearn to trust your training, experience and skills in physical examination. Look for the evidence of the Lord’s healing in cases that are beyond your skill and/or resources, and give Him the credit. Primum non nocere (first, do no harm) is still a good principle if you do not understand what you are seeing, but also always remember that the patient’s only alternative to your educated guess may be the native healer or the witch doctor (who may do harm more often than you do). Be willing to attempt new things under supervision or if there is no other reasonable alternative. In cases that turn out badly by your standards, trust in His wisdom and learn from the patient’s clinical course. Always offer eternal healing.

**TEN COMMANDMENTS FOR PROVIDING MEDICAL/DENTAL CARE OVERSEAS***

A. I’m here to serve, not to be served.
B. I know the American philosophy of medicine doesn’t apply here. I need to do the best I can for the most people.
C. I accept that I won’t have the medicines and equipment I desire and need.
D. I don’t know much, so I’m here to learn.
E. I’m not here to change things, so I won’t criticize. I recognize that short-term participants don’t know culture, diseases, costs, government regulations, and the other demands on the career doctors.
F. I’m here to work hard and will do more than my share.
G. I will not attempt things beyond my capabilities but will attempt new things with supervision.
H. I will encourage the national and missionary staff.
I. I will happily conform to standards of conduct to protect the testimony of the hospitals.
J. I will love and respect the patients I treat.

*Taken from CMDA Mission Survival Kit
Bring needed supplies, instruments, technologies and medical handbooks with you to the field. *The Physician’s Desk Reference, The Merck Manual, The Handbook of Clinical Medicine in Developing Countries* (from Christian Medical and Dental Association), an up-to-date *Current Medical Diagnosis and Treatment* (Lange), any good tropical medicine handbook and most of the spiral bound handbooks available for various specialties are always helpful for you to have while you are there and for you to leave for the subsequent use of the expatriate and national medical staff. The *Primary Surgery* textbooks by Maurice King (Oxford Press) are also valuable for surgeons and non-surgeons alike, but are difficult to obtain in the US (see the bibliography). Scrub suits and gloves in your size and any other instruments or supplies that you feel you must have are best brought by you with you. Glucometer supplies, dipstick chemistry sticks, pulse oximetry, broad-spectrum parenteral antibiotics are always needed. Contact the missionaries a few months in advance to see what medical and personal things are needed and plan to bring an extra suitcase or two of such things for them. Contact your drug representatives, hospitals, and sources of medical supplies and drugs early enough to allow time for paperwork, shipping and backordering. There are many organizations and companies that will work with you to provide limited but valuable amounts of drugs and supplies for free or at a reduced price, but all of them require some time to process your request. Do not bring expired medicines without clearing it with the career missionaries where you will be working.

Stay in touch with the friends you make on the field, pray for them, support them, and return to the field at a future date if possible. Make the offer to be accessible by e-mail to serve as a consultant to the career missionary physician for any problem cases within your professional specialty that he may have in the future. Your understanding of his resources may make you very valuable to him. With digital cameras, pictures of findings and X-rays can easily be sent. Consider leaving them a digital camera. It is valuable for the transfer of both clinical and missionary family pictures.

Take pictures and notes of the disease you see. It is a great way to
talk to family, friends, church, medical colleagues and local medical society meetings when you return. Some of these cases will make great cases to present at Grand Rounds and such speaking opportunities will give you an excuse to give your testimony.

Rediscover the joy of practicing medicine without the pressures of third party oversight, financial pressures and malpractice concerns. Enjoy the pleasure of sharing the good news of Jesus Christ with your patients and the privilege of consulting chaplains for spiritual counseling for your patients as needed. Take time to personally spend in the Word and to reflect on the experience you are having. Write down your reactions, both positive and negative. Ask God to help you work through them and to learn from them.

Love and respect the patients you treat. Take this opportunity to see the Great Physician work without the trappings of modern medicine to interfere. Learn His art; copy His love. In all things, extend grace. As St. Francis said, “Preach the Gospel daily—if necessary, use words.” Learn to live your life as a “flagrant Christian.” God is responsible for the outcome; you are responsible only for the effort. After your trip, you will never be the same.
LET THE DEAF HEAR

I had just about fallen asleep when the phone rang. Koffi was a deaf mute who had lost control of his motor scooter because he couldn’t hear the auto coming up behind him. The nurse reported a nasty compound tibia-fibular fracture. I dressed and went to the triage area immediately. They had not yet taken the X-ray and I could not believe my eyes—they were taking him out of the posterior splint to get the film, letting the foot just flop around this way and that. The pain must have been excruciating but this gentle slender giant of a man stoically put up with the pain. The X-ray suggested that several centimeters of bone were missing. Actually, “missing” is not quite the right word—the family held out a plastic bag with most of the missing pieces of bone. They had picked them off the road! They were of course not usable, but it certainly confirmed my reading of the X-ray. He could not communicate verbally nor could he read or write. I explained the grave situation to the family and began to prepare him for the OR.

I ordered cloxacillin as one of my

Koffi’s X-ray demonstrating the missing bone.
pre-op drugs and then found out that the hospital was out of stock! Trying to understand why this critical drug was out of inventory was a waste of time. Lacking a better alternative, I decided to use some cefuroxime that had expired nine months earlier. It was a powder still in an intact vial. I hoped that it was still good and this was a case where no one could argue that it was not better than nothing. Under anesthesia, we explored the huge gaping hole in the bone and soft tissue of the lower leg and we also found that he had a lacerated tendon on the back of the hand. Knowing that I was way out of my league and that such fractures had a high incidence of non-healing (even if I could somehow figure out how to bridge the bony gap), I gave serious consideration to an amputation as the best and fastest solution. I had never seen the needed reconstructive operation before—but I remembered something: I had once seen an X-ray which had been made following an operation for such an injury. Maybe I could actually do something. I would try to save the leg, maintain the distance between the ends of the bone, stabilize the bone and then get on e-mail to see if I could get some advice from the short-term orthopedic surgeon who had performed that previous operation in Kenya.

Under a long-acting spinal anesthesia, we scrubbed, irrigated and prepped. I had little experience with such devices but I knew I needed to place an external fixator, a rig reminiscent of the Erector Sets® that I played with as a child. The only one they had was an antique set and at first I didn’t think we had all the right parts, but with some study of what parts I had, I figured out a Rube Goldberg contraption that I thought would work to stabilize the bone. The OR crew told me that the surgeon for whom I was standing in had previously had a great set of really nice heavy duty external fixators, but because they were so valuable they had disappeared on patients when they went to the other
hospitals in the country. They were never returned. I put the pins in to bone fragments, put the fixator frame on to stabilize the bone and then carefully removed all necrotic and filthy bone and muscle and closed the skin loosely. Once I had the fixator on, I sent my surgical tech up to work on the hand while I finished the leg. Once he got it numb, clean and prepped, he found the middle finger extensor tendon was cut. So I dressed the leg and then repaired the tendon.

When I wrote the orders, I requested that they get a 100,000 franc deposit from the family on the external fixator and then charged the normal discounted price for the surgery. I knew we HAD to get this fixator back someday. I knew the family would go ballistic about the price but it was the only one we had left. Even that price I was charging ($130) didn’t cover the cost of replacing the equipment if they went somewhere else with it.

Over the next few days, I took digital pictures of the wounds and of the X-rays. I sent it off with my e-mail explanation and request for help. I got a prompt reply from my friend. It was in orthopedic surgeon jargon and so a series of e-mails was necessary to get it down to the level of bone work that a general surgeon without experience might understand (like “A goes to B”). He was able to get a donated compression plate of the exact right length and he was able to secure a high-quality external fixator.

While we were waiting for this equipment to come from the States in the luggage of another short-term visitor, we continued changing the dressing regularly and to clean the wound over the intervening weeks. The fixator system was too weak but with the addition of an external splint, it maintained the length satisfactorily. His course was complicated by an unexpected set of seizures. I did the usual limited workup that I could do and gave him valium and phenobarbital. I was never sure why they suddenly developed, but the medication kept them under control the
rest of his hospitalization. Epileptic seizures are major problem in the developing world with little ability to diagnose and treat them.

Finally, after almost four weeks of waiting and wound care, we were ready to proceed with the definitive surgery. It was already a busy day on the schedule. During rounds, we met some male members of the family had finally shown up for the first time. Prior to this time, we had been talking only to a woman who stayed with him; we knew she had no authority in that culture to make any decisions. The men and the rest of the family had not visited him at all and in his isolation as a deaf mute, I am sure he was quite lonely. They had shown up to announce they could not afford the planned surgery. In much of the developing world, these decisions are not made by the involved individual but by their extended family and often upon consultation with the entire village. I nodded at their proclamation and said, “Of course you can’t.” They looked at me rather quizzically. I said, “Of course you can’t—it is far too expensive for you but we will do it anyway to save his leg.” I got the X-rays and explained to them the best I could exactly what I planned to do. I had already done something similar with Koffi, showing him the pictures and drawing pictures. I asked whether they had any questions. Their next question, “When can we take him home today?” Somewhat baffled, I told them “Never.” What hadn’t they understood? I started over. I explained the problem again, explained again that the surgery would be free and explained again that amputation was his only alternative to this surgery. They finally came clean with their fears. They argued that we would promise all that but then charge them something they couldn’t afford to pay. We would then come after them in a court of law and throw them in prison. I denied that. To my bewilderment after my best explanations and all my reassur-
ances, they still were going to take him home. I explained that in that case, they would not be allowed to leave until they had paid for the external fixator that he had fastened to his leg. They said “ok” but then paled when I said it was 300,000 cfa (approximately $490—the real cost of a replacement set). They had not paid for all of his previous surgery yet and that had only been 80,000 cfa—to them, 300,000 cfa seemed like a national debt. I informed them that if they left without paying for it, they were stealing since I would not give permission for such a valuable piece of equipment to leave the hospital grounds. They then wanted me to take it off completely and they would take him home—and I explained that his foot would “fall off” and he would never walk. We went back and forth until I had them completely befuddled. They finally agreed to let him stay and to undergo the free surgery. I was frustrated with their obstinacy—until it reminded me of my own stubbornness and so much of how God must look at us. I was offering a treatment they could not comprehend for a condition they could not truly comprehend, which should be at a price they could never afford, and despite the offer of free care, they were suspicious of the offer because we might come back and somehow trick them. They would rather suffer an injury and even lose a leg than to accept something freely given. Their response reminded me of humanity’s response to God. Christ offers all of us something the magnitude of which we cannot grasp, the cost of which we cannot fathom, the price for which we cannot pay and yet we are suspicious that we are somehow being taken advantage of if we become Christians. We would rather turn down His offer and suffer eternal damnation than accept what is freely given.

Without giving them a chance to change their mind, we took him to the operating room. In the OR, to my chagrin, I found that the old pins were bent and about ready to fall out.
Fortunately, my orthopedic friend had warned me that they were much too small and had sent some much more sturdy ones. Cutting and measuring, I split 4" of the upper tibia at an angle and slid it down into place, keying it to fit into the distal tibia. The fragment was screwed into place and a compression plate was screwed into place to reinforce it. Free cancellous bone graft was taken from the hip and packed around it. It was wired to reinforce it. I now had a piece of full-thickness bone on top, then half-thickness, then two half-thickness pieces screwed and plated together, then a half-thickness piece screwed into the full-thickness. I moved some skin and subcutaneous tissue to get well-vascularized tissues over this whole area so it would heal and left a lateral skin defect that would be skin-grafted later at a third operation. A cast was applied. It had only taken 2.5 hours to do something I had never seen before but it had seemed much, much longer. At the end, I was sweating and was exhausted at the strain of the unknown.

Later, in an e-mail to me, my son made reference to my hobby of woodworking when he wrote, "When I read that account of fixing that guy’s leg, I could only think to myself, ‘Thank God, he had a doctor that moonlights as a carpenter.’
Then looking again at your description of their desire to pay for something they couldn’t dream of covering, I now think they should thank their doctor that he has a God who also moonlit as a Carpenter.”

Postscript: I saw him for the last time about six weeks later. The skin graft had been placed, had healed nicely and he was using crutches and doing partial weight-bearing on the leg. He would require the cast for several more months. He disappeared from follow-up before the final cast was removed and I never did see any final X-rays on the leg. He was shown the way of salvation through pictures but we have no idea of whether he comprehended what we were trying to get across or whether he ever came to Christ as his Savior. I can only pray that the Spirit could draw him to Himself and that through his care, he somehow “heard” the call of Christ.
CHAPTER 6

PERSONAL WITNESSING

As a healthcare provider, if we had a cure for our patient’s disease and refused to tell him or her how to be cured, we would consider it unethical and unprofessional. As a healthcare provider, if we had a cure for AIDS and allowed 30 million to die this year without telling even a single person how to avoid death, it would be reprehensible and inhumane. Excuses about difficulty and expense would be irrelevant. Governments would spend their entire budgets to cure their people. As a Christian healthcare provider, we know a cure that would prevent eternal suffering and death for literally hundreds of millions of people. Furthermore, the efficacy is complete, there are no true deleterious side effects and the tremendous price has already been paid. The disease? Sin. The cure? The death of Jesus Christ in our place, and the resurrection that gives us eternal life.

Sadly, we are often not as good at sharing that good news as we would like to be. 1 Peter 3:15b commands us that we should, *Always be prepared to give an answer to everyone who asks you to give the reason for the hope that you have.* There are many methods of doing personal evangelism available (Evangelism Explosion, FAITH, and others), and you may find taking such a course to be valuable. In order to give some help to those who have not taken such a course and who are not in the habit of sharing Christ regularly, three different ways are presented below. Find one that you are comfortable with (or make up your own) and use it regularly. The first two have materials that you can order so you can more fully understand the method.

Just remember, you must be sensitive to the Holy Spirit and to the person with whom you are talking. Some questions or comments, and their response to them, can give you a clue about whether the time is right to talk to this particular person about what Christ has done for you. There is an expression that you should “run it up the flagpole and
see who salutes.” The CMDA “Saline Solution” calls these comments “faith flags.” You can wave a faith flag to determine how ready the person is to receive the gospel. You are looking to see where God is already working. One way to do it is to mention some spiritual topic that is part of your life—church, an event, or a person—and then ask something like “What is your religious background? I have never heard you mention a church and I was wondering about that.” Other such comments: “I am glad I don’t have to go through something like that again alone,” “I am sorry to hear about that. When something similar happened to me, I am not sure I would have made it if I hadn’t had my faith to fall back on,” and for the more direct “I just realized I have never told you about something very important to me, my relationship with Jesus Christ. Would you let me tell you about it?”

You can never tell what impact your words will have. Remember: you cannot (and should not try to) talk someone into accepting Christ. You are not responsible for their salvation. The Holy Spirit is in charge of that. You are only responsible to tell what you know and what Christ has done in your life (Daniel 4:2, It is my pleasure to tell you about the miraculous signs and wonders that the Most High God has performed for me). You are responsible for praying for someone to share with and to have the courage to share it. You do not have to be a Biblical scholar or have all the answers to all possible questions in order to share what Christ has done for you.

Consider the following verses:

▸ For it is by grace you have been saved, through faith and this not from yourselves, it is the gift of God. Ephesians 2:8
▸ I came to you in weakness and fear, and with much trembling. My message and my preaching were not with wise and persuasive words, but with a demonstration of the Spirit’s power. 1 Corinthians 2:3–4
▸ No man can come to me unless the Father who sent me draws him. John 6:44

14 The Saline Solution is a relationship-based evangelism course designed for use in your US-based practice but has a great number of ideas which are very suitable for witnessing through your medical care on the mission field. The DVD set is available through the Resource section of www.cmda.org.
That is why I told you that no one can come to me unless the Father has enabled him. John 6:65

We are therefore Christ’s ambassadors, as though God were making his appeal through us. 2 Corinthians 5:20

So is my word that goes out from my mouth: It will not return to me empty. Isaiah 55:11

There are two important principles that can guide you in sharing your faith by using verses from the Bible. It is important to have the person read the verse aloud so they can hear it. This principle comes from Romans 10:17: Faith comes from hearing the message, and the message is heard through the word of Christ. It is then also important to ask, “What does this say to you?” or “What does this mean to you?” when the person has finished reading the verse. This principle comes from Luke 10:25–26: On one occasion an expert in the law stood up to test Jesus. “Teacher,” he asked, “what must I do to inherit eternal life?”

“What is written in the Law?” he replied. “How do you read it?”

It is important that you let God do the work. You do not have to hold long theological discussions or give complex explanations of the text. Merely listen in a way that shows you are paying attention. Limit your comments to those that encourage the person to talk, such as “Umm,” or “Uh huh.”

Remember:

► The nonbeliever will be doing the reading out loud.

► The nonbeliever will be doing the talking. Listen in a way that he or she will want to talk.

► The Holy Spirit will be doing the convincing.

► God’s Word will bring conviction.

Many people feel that they cannot witness if they have not memorized all the verses they are going to use or might have to use to answer any questions. While you may certainly wish to memorize God’s Word for many good reasons, not having memorized the verses is not a reason not to witness. Whatever verses or method you decide
to use, mark your Bible before hand. Highlight the passages and underline the important words. Write the next verse at the top of the page both right side up and upside down—that way you can know where to go next even if you are sitting across from the person and sharing the Bible from that vantage point. A small card kept in your Bible or your wallet as a crutch is not acceptable. There is no evidence that people are more likely to be saved from a glib and polished presentation than from hearing the Gospel from someone who stumbles through it.

The three methods that follow have been tried and true for many people but may not be right for you. Feel free to adapt any of these as best fits your personality, your needs and your situation. It is not so important how you do it. Just do it!

METHOD ONE: THE BRIDGE PRESENTATION

One method that works well in informal settings is the “bridge presentation.” Practicing this so you can do it smoothly is helpful but it is not designed to be a sophisticated, highly polished presentation. Because of the visual component and the small number of verses, this works particularly well in a cross-cultural situation.

► Wave the Flag. Ask the sort of questions mentioned above. If they express interest, then . . .
► Tell your story. It is a good place to start. Others are usually interested, they can relate to it and they will find it hard to dispute. The best evidence for your story is your changed life. They may doubt your par-

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15 In marking your Bible, there is a caution. Be sure to know your target audience. There are some groups (in North America and abroad) who hold the Bible to be the HOLY Bible. Writing in it in any form is looked on as defacing that which is holy. To show them a marked Bible will successfully cutoff any opportunity for you to witness to them or to get them to believe that you really do honor God’s Holy Word. For example, some old German groups hold this belief. Muslims put their holy book on a stand as a mark of reverence and usually do not even touch it with their left hand. Some people carry an unmarked Bible just to witness or minister to such people.

16 Modified from material presented at the Billy Graham Training Center at the Cove (www.thecove.org), which is based on the Becoming a Contagious Christian program developed by the Willow Creek Association (www.willowcreek.org).
ticular set of beliefs, they can criticize your church or denomination but they cannot avoid the fact that *something* changed your life! You are not setting yourself up as a model Christian, only one giving glory to God. See Appendix B to tell your story in a brief, clear and concise way.

▶ You need to convey (without necessarily using these particular verses) the following truths about the four points of the gospel message:

**Truths about God:** God is loving and giving (1 John 4:10), holy (Leviticus 19:2; 1 Peter 1:15–16) and just (2 Thessalonians 1:6–9).

Truths about all people: We are sinners (Romans 3:23), the just result of sin is death (Romans 6:23a) and in God’s eyes, we are unclean (Isaiah 64:6).

**Truths about Jesus:** He is God with all of His attributes (John 1:1, 14). He gave His life as our substitute (1 Peter 2:24). Salvation comes not because of our works, but because of grace, the gift of God (Ephesians 2:8-10).

**Truths about Us:** We (you and I) must believe to receive Jesus and become children of God (John 1:12). We must ask Jesus to be our Savior and Lord (1 John 1:9).

▶ Use the “bridge presentation” to actually share these ideas. There are 7 steps. You can use a blank piece of paper, a whiteboard, or a dirty windshield.

(continues on p. 78)
A. Write “Us” and “God.” Point out that we matter to God and He wants a relationship with us. At this point, draw the box around the two words to suggest that God wants “us” included in a relationship with Him.

B. Draw the lines that show the separation between us and God. Explain that we have rebelled against God (either actively or passively) and that our sins have therefore separated us from Him.

C. Describe the things that we do to try to please God to get His favor (e.g., attend church, read the Bible, give to charity, good works). Point out that the Bible says it is never enough. Draw lines that try to bridge the gap but all fall short (Romans 3:23, For all have sinned but fall short of the glory of God).

D. Point out that the Bible says the sins we have done require punishment and that punishment is death (Romans 6:23a, For the wages of sin is death . . .). Write that word on your diagram.

E. Explain that God did for us what we could not do for ourselves. He built a bridge between us and Him. That bridge is His Son, Jesus Christ. He took the penalty for us by dying on the cross (John 3:16, For God so
loved the world that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life.) As you talk about this, draw first the horizontal line over the gap and then the vertical line to finish the cross.

F. Place an “X” over the word “Death” and explain that when Jesus paid the penalty for our sin, death was cancelled out as a result of sin and He gave us eternal life (2 Corinthians 5:21, God made him who had no sin to be sin for us, so that in him we might become the righteousness of God.)

G. Explain that in order to receive this gift of peace with God and the eternal life that results, you have to cross over to the other side by personally choosing to accept Christ. (Romans 10:9, That if you confess with your mouth, “Jesus is Lord,” and believe in your heart that God raised him from the dead, you will be saved. As you explain this, draw the stick figure on the “Us” side and a line with an arrow to the other side. Draw a second stick figure on the other side.)

When you are finished, check your friend’s understanding of what you have shown him by asking:

► Does this make sense to you?
► If you use this illustration, where do you think you are now?
► Is there any reason you wouldn’t want to cross over to the other side?

If the person agrees to accept Christ, then help that person pray a prayer of confession and acceptance. If he or she is not ready or not sure, don’t press. Ask if you can clarify any points and answer any questions or concerns they have. Tell them to think about it and offer to talk again later about any questions they may have.

**METHOD TWO: SHARE JESUS WITHOUT FEAR**

The following notes are adapted from William Fay and Ralph Hodge, *Share Jesus Without Fear* (Nashville: LifeWay Press, 1997). The following resources will enable you to learn more about this way of sharing about Jesus without fear. Order these by calling 1-800-458-2772.
• *Share Jesus Without Fear* Workbook by William Fay and Ralph Hodge.
• *Share Jesus Without Fear Leader Guide*.
• *Share Jesus Without Fear Kit*.

Prepare your Bible by highlighting the following verses and writing the next verses at the top of the page (remembering to do it right side up and upside down).

- Romans 3:23
- Romans 6:23: Circle the words *sin*, *death*, and *in*.
- John 3:3: Draw a cross in the margin near John 3:3. Draw an X beside the cross. Alongside the cross you have drawn, write the question, “Why did Jesus come to die?” The X reminds you that this is the only exception in the process. You don’t want to ask, “What does this verse say to you?” after the person reads this verse. Not many nonbelievers know the answer to this question. You would be applying undue pressure. He or she may feel unfairly put upon the spot.
- John 14:6
- Romans 10:9–11
- 2 Corinthians 5:15
- Revelation 3:20

Having marked your Bible or New Testament, you are ready to share Jesus without fear. To do so, you simply follow three steps.

**Step One**

*Use questions like those below that determine where God is working.*

- Do you have any kind of spiritual belief?
- To you, who is Jesus?
- Do you believe there is a heaven and a hell?
- If you died right now, where would you go? If heaven, why?
- If what you believe were not true, would you want to know it?

*If the answer to the last question is “Yes,” then open your Bible and proceed to Step Two.*
If the answer to the last question is “No,” do nothing but thank the person for their time.

**Step Two**

Let the Bible speak. Ask the person to read the verse aloud. Then ask, “What does this say to you?” Listen to the person.

- Romans 3:23 “All have sinned.”
- 2. Romans 6:23 “The wages of sin is death.”
- John 3:3 “You must be born again.” (Remember, ask, “Why did Jesus come to die?”)
- John 14:6 “I am the way.”
- Romans 10:9–11 “If you confess . . . you will be saved.”
- 2 Corinthians 5:15 “No longer live for themselves.”
- Revelation 3:20 “I stand at the door, and knock.”

Now you are ready to use the closing questions in Step Three.

**Step Three**

Close with key questions.

- Are you a sinner?
- Do you want forgiveness for your sins?
- Do you believe Jesus died on the cross for you and rose again?
- Are you willing to surrender your life to Christ?
- Are you ready to invite Jesus into your heart and into your life?

After you have asked these questions, just be silent . . . and pray. Do not push. If he answers affirmatively, offer to pray with him in a prayer for confession of sin and acceptance of Christ as Savior and Lord. If not, offer to answer any questions they have at the time and then offer to speak with them again if they wish.

**METHOD THREE: THE ROMAN ROAD**

There are many variations on the so-called “Roman Road,” but every one leads to the throne of God. As you use this method to show Christ to unbelievers, you may find it helpful to underline these vers-
es and then at the top of the page, write the next stop in the road. Write them the right-side up in case you are sharing a Bible and write them upside down, in case you are seated across from the person and sharing the Bible. Have them read the verses so there is no mistake what the Bible says. The suggested “conversation” is not a script but is an example of what might be said to make a smooth continuation to the next point. Obviously, their questions and the leading of the Holy Spirit may change things considerably.

King David, the psalmist, wrote that the fool has said in his heart that there is no God. For those who do not consider themselves to be fools, God says that His existence and His qualities are evident if we just look around us. If there is indeed a God, then we must either accept Him as God or deny that He is God—there is no meaningful middle ground. If there is a God, an eternal, totally good but totally just, all-wise, all-present, all-knowing God, then we must seek to know more about Him. If we do not, then what we become by following our own ideas is not a pretty picture.

Romans 1:20–21

_for since the creation of the world God’s invisible qualities—his eternal power and divine nature—have been clearly seen, being understood from what has been made, so that men are without excuse. For although they knew God, they neither glorified him as God nor gave thanks to him, but their thinking became futile and their foolish hearts were darkened._

Romans 1:28–32

_for they have become filled with every kind of wickedness, evil, greed and depravity. They are full of envy, murder, strife, deceit and malice. They are gossips, slanderers, God-haters, insolent, arrogant and boastful; they invent ways of doing evil; they disobey their parents; they are senseless, faithless, heartless, ruthless. Although they know God’s righteous decree that those who do such things deserve death, they not only continue to do these very things but also approve of those who practice them._
Many people think they will go to heaven because they have lived a good life. Perhaps, they treat all of their neighbors fairly. Maybe they volunteer for charity work and have never broken the law. Maybe they were even baptized or go to church regularly. But the Bible, God’s Word, says that no one can live up to God’s standard of righteousness.

**Romans 3:10–12**

*As it is written: “There is no one righteous, not even one; there is no one who understands, no one who seeks God. All have turned away, they have together become worthless; there is no one who does good, not even one.*

**Romans 3:23**

*For all have sinned, and come short of the glory of God ....*  
If all of us have “missed the mark” and since God is totally without sin and cannot tolerate the presence of sin, what can we do that will ever make us good enough to be with Him? The answer is “nothing.” But fortunately, that is not the end of the story. God could, and did, do something. Not because we were good enough, not because we deserved it, and certainly not because we were on His side! If we got what we deserved, it would be death—eternal death. God gave us what dead people need—life. It was a gift, freely given, but like any gift, must be accepted.

**Romans 5:8–10**

*But God demonstrates his own love for us in this: While we were still sinners, Christ died for us. Since we have now been justified by his blood, how much more shall we be saved from God’s wrath through him! For if, when we were God’s enemies, we were reconciled to him through the death of his Son, how much more, having been reconciled, shall we be saved through his life!*  

**Romans 6:23**

*For the wages of sin is death; but the gift of God is eternal life through Jesus Christ our Lord.*
Salvation cannot be earned. Everyone is a sinner and deserves death, but God gives eternal life. So how can we receive God’s gift of eternal life?

**Romans 10:9–10**

*That if you confess with your mouth, “Jesus is Lord,” and believe in your heart that God raised him from the dead, you will be saved. For it is with your heart that you believe and are justified, and it is with your mouth that you confess and are saved.*

Is just accepting Jesus as Savior and Lord of your life all you have to do? Is confessing honestly that Jesus will be Lord of your life and believing that Jesus lives again after being crucified all you have to do? Yes. There is nothing else we can do; no works that will add to the work that Jesus has already done on our behalf, nothing of value that will add to the price he paid for our sins. Are you a sinner? Do you want forgiveness? Do you believe Christ died for you and rose again? Do you want to accept Christ as your Savior? (If they answer “Yes,” help them pray to accept Christ and go over the following verses to give them God’s promises to them. If they decline, offer to answer any questions they may have. Do not press. Offer to talk with them in the future if they wish).

If they accept Christ, then go on to the following verses (writing them down so they can reassure themselves in the future may be helpful):

**Detour to Ephesians 2:8–9**

*For by grace are ye saved through faith; and that not of yourselves: it is the gift of God: Not of works lest any man should boast.*

**Back to Romans 8:1–2**

*Therefore, there is now no condemnation for those who are in Christ Jesus, because through Christ Jesus the law of the Spirit of life set me free from the law of sin and death.*

There is no boasting in heaven because we will be there solely due to the work of Jesus Christ. But now no one can condemn us either!
We are set free from the consequences of death because Christ has brought life.

**Detour to 2 Cor. 5:17**

*Therefore, if anyone is in Christ, he is a new creation; the old has gone, the new has come!*

But how do we know that we are now saved? God has promised it and He keeps his promises but the Holy Spirit deals directly with our spirit, testifying that we are now God’s children and then He “seals” us, making sure we are always God’s children. Once we are children of God, nothing can separate us from the God’s love!

**Romans 8:16–17**

*The Spirit himself testifies with our spirit that we are God’s children. Now if we are children, then we are heirs—heirs of God and co-heirs with Christ, if indeed we share in his sufferings in order that we may also share in his glory.*

**Detour: Ephesians 1:13–14**

*In whom ye also trusted, after that ye heard the word of truth, the gospel of your salvation: in whom also after that ye believed, ye were sealed with that holy Spirit of promise, which is the earnest of our inheritance until the redemption of the purchased possession, unto the praise of his glory.*

**Romans 8: 38–39**

*For I am convinced that neither death nor life, neither angels nor demons, neither the present nor the future, nor any powers, neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord.*

As new Christians, we are to be “living sacrifices.” In other words, we are to no longer follow our old desires, dreams and inclinations. Rather we are to have a new way of thinking, a new set of priorities and a new center of our life. In doing so, which we can only do
because Jesus Christ had paid the price of sin for us and because we are willing to accept His free gift, we can now have something we have never had before: joy and peace despite the trials and troubles that may come your way.

**Romans 12:1–2**

*Therefore, I urge you, brothers, in view of God’s mercy, to offer your bodies as living sacrifices, holy and pleasing to God—this is your spiritual act of worship. Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God’s will is—His good, pleasing and perfect will.*

**Romans 15:13**

*Mai the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit.*
SOMEONE GAVE HIS BLOOD FOR ME

He spoke only Hausa and was hundreds of miles away from his ancestral home. Resting under the tree had seemed so innocuous. He hadn’t seen the green tree viper. It had seen him.

One of the first patients that morning was Innocent—perhaps not in the usual sense, but that was certainly his name. After the viper had bitten him late the evening before, his friends had found a national healer who had performed incantations, made literally dozens of razor cuts on his head and leg and charged him plenty. Innocent’s continued bleeding despite that treatment frightened him and he prevailed upon others to bring him to the mission hospital.

The diagnosis was clear. Small fang marks were rather unimpressive but the slow and constant ooze of blood from his head and leg was very much so. His dressings were soaked with non-clotting blood. As I was early in my experience as a short-term missionary surgeon, I knew virtually nothing about treating poisonous snake bites. I knew that there were supposedly seven varieties of poisonous snakes in this country but only one that caused a coagulopathy—an inability to clot.

Redressing the wounds as tightly as possible to staunch the flow, I escaped to read everything I could find in the rather pathetic library. I discarded the idea of using the internet to look up information—the phone connection worked only sporadical-
ly and was terribly slow in any event (4–9 baud was the usual). I found nothing of much help.

Antivenin is expensive and rare in Africa—but I thrilled when the nurse said that he had found ten vials in a refrigerator. Even more miraculously, it was still in date! Not knowing how much to give nor how to give it, I was reduced to reading the insert. It was from a French company but fortunately, one side was printed in English. I scanned it feverishly—under dosage, the instructions essentially said “give enough”. Thanks for the help! We had no clotting studies, no assays for fibrin-split products and no way to determine the severity of the envenomation. So I did what all good physicians do—I picked a number out of the air. I decided that “four vials” was the exact initial dose. Even that drew gasps from the nurses—it was $80 a vial and in a country where the average income for a worker was only $200 a year, that was a bill equivalent to 18 months of manual labor. I was beset with uncertainty—how much, how often, how to monitor it?

He tolerated the initial dosage without any reaction to the horse serum and we settled down for what turned out to be a long wait. He bled. And bled.

I had arrived at the hospital at a point in time when there was a major conflict already in progress over the issue of blood donation. Most of the nationals were very reluctant to donate blood. They felt that to do so was to lose one’s vital life force and perhaps leave oneself open to various forms of enchantment and witchcraft. Even the Christian nationals on the hospital staff had recently decided that they would no longer give blood unless there was enough payment to make it worth running such risks. They refused to donate to this man. They didn’t know him and he was from a different tribe. His “friends” who had dropped him off had deserted him to avoid being held responsible for any bills. He had no donors.
Fortunately, he was O-positive, a common blood type. Although the nationals would not donate blood, I was O-positive and one of the first units came from me. Having traveled in Africa, I could no longer donate blood in the US and I was pleased to be able to be of some help in this way again. He had started out with a normal hematocrit and we let him bleed to a very low level before transfusing him, but when he got low enough, we would transfuse more. Every time a missionary or expatriate would come on the grounds for the next two weeks, I was like a six foot leech, convincing them to donate a pint of blood for this man. He got very pale at times when blood was hard to come by—sometimes showing a disturbing similarity in color to the sheets on his bed.

Over sixteen days, I gave up on him at least twice and each time I was surprised when he was alive in the morning. Gasping, fatigued and pale—but alive. Against all normal blood-banking recommendations, I gave three units of my own blood over that two weeks in a desperate attempt to keep him alive. During that time, I also gave several more vials of the antivenin. The decision to give more antivenin was not done on a scientific basis but was done with a prayer and with the strong conviction that if something was not done, he would die. The expatriate nurses reprimanded me for wasting the resources and running up a bill that he could never pay. I countered that God had provided it, was capable of providing more and I would use it since my only seeming alternative was death.17 I understood the problem of limited resources and the health of a population—but faced with

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17 It wasn’t until many years later when preparing to give a lecture on poisonous snakes in Africa that I realized there was no antivenin made anywhere in the world for that particular snake—it is too uncommon a cause of problems to make it financially feasible. I had given that antivenin to no effect.
an individual’s death, I found I could not make any other decision.

There was only one nurse who spoke Hausa fluently. The rest of the time communication was very difficult for all of us with a chain of two or three interpreters from one language to another to another to another. I most often communicated with looks and gestures—and he complied willingly. I have no doubt that he was very lonely—and very scared.

One day, the toxic process suddenly reversed; he quit bleeding. With two more units of blood, he rapidly gained strength and I praised God that the venom had finally self-destructed. A morning shortly before his planned discharge, he had found two translators. One spoke Hausa and the local language; the other was a hospital chaplain who spoke the local language and English. He had a question for me. “I understand that you gave your blood for me. Why would you do that when my countrymen would not do that for me?”

My reply was simple. Because Someone once gave His blood for me. With that opening, the chaplain took off. I bowed out to make one fewer link in the communication chain but I prayed. Later in the day, I rejoiced to hear that this Muslim patient had accepted Jesus Christ as his Savior.

It is customary in Africa for hospitals to hold their patients “hostage” until their families and communities pay the bill. Even though our services at the missionary hospital are highly discounted, this man’s bill was in the range of a thousand dollars—a staggering sum. He didn’t have it and his people were over 300 miles away. What to do? We finally decided that he could stay in the cooking area (a building outside the hospital) until they showed up (because we really needed the bed space) but he begged to be permitted to go north to his home area for help. He argued that he was a man and couldn’t take care of himself properly without his wife to help. He understood that he
had a financial obligation but he proposed that he would go to the north of the country, get his family and return to stay until he was redeemed. I was skeptical; I thought we had seen the last of him.

In less than 48 hours, he was back with his family—a remarkable feat of travel in that country especially when done without money. The very first thing he did upon his return was to take his wife and children to the chaplain and to demand that the chaplain tell them about this Jesus and what He had done for mankind. They too were saved.

Postscript: He worked around the hospital for almost a year to pay off part of his bill before being excused from paying the rest. During that year, he joined a local church and grew in the faith. He had a huge grin and would always come to me to greet me and to chatter to me in Hausa which I did not understand at all. During his time of inability to clot, he had apparently had a sub-arachnoid hemorrhage (bleeding into the space around the brain) and it had caused damage to his cranial nerves, making him very cross-eyed. This was disconcerting when he talked to me because I never knew where to stand so he could see me best. But the important thing was this: he could see his eternity clearly now and in the eyes of God, he was truly innocent.
CHAPTER 7

OTHER THINGS ONE COULD DO

Medical providers themselves often feel that they need to do more.

Spouses and families are often concerned that they don’t have the
talent to go on medical mission trips. The only talent needed to serve
on the field is a willing heart! Every child of God has been given a gift
of the Spirit and living has given you a long list of experiences and
abilities, even if you think they are not special. Just because the Lord
has called a missionary to be a teacher, translator, preacher, evangelist,
pilot, or physician does not mean that he or she is automatically
blessed with all the skills nor all the time necessary to do everything
he or she must do. There are literally hundreds of ways that the spouse
and children of visiting staff can make a major impact. Experience has
shown that your time abroad will be most satisfactory if you can look
back on any job well done.

Missionaries are just like most of us, reluctant to ask for help.
They know you are suffering from jet lag and adjusting to a new cul-
ture. If it isn’t too far in their past, they remember those feelings all too
well! They also don’t know you, your background, your abilities or
your inclinations, but they are always grateful for the help. Getting
involved is easy. Just go to the station hostess or to a missionary and
explain your desire to help. It will be accepted!

The missionaries will appreciate any special skills you may have
if you put them to use for their benefit or for the benefit of the mission
outreach. Your efforts will continue to bear fruit long after you leave.
Your mere presence there, demonstrating Christ’s love, will have an
effect.

A caveat: Keep your expectations on a reasonable level. Don’t try
to do too much, but rather try to show Christ’s love and do a good job at
what you do. Set time limitations, if appropriate, by telling how much
time you will have to give. Also, ask to be included in daily activities
As you can see from the list to follow, many of these tasks do not take special skills, but they are needed, appreciated, and demonstrate your servant heart. God will make it special.

Clerical
• Type
• File
• Transcribe
• Teach computer skills
• Process data
• Inventory and organize supplies

Accounting
• Balance the books
• Perform audits if you have the skill

Household Help
• Prepare food; invite missionaries to eat with you; entertain other guests
• Teach cooking to national women
• Grocery shop for missionaries
• Assist with laundry for guests

Patient Care
• Hold, bathe babies in the nursery
• Walk patients
• Serve as an aide in the outpatient ward
• Clean equipment
• Visiting children’s and women’s ward; bring stuff from home to use
Teaching
- Teach missionary kids topics in which you have expertise
- Teach basic hygiene to patients, if language is not a barrier
- Teach handicrafts (bring necessary supplies from home)
- Teach VBS; help the missionary kids stage a play or musical, etc.
- Teach puppet creation (sock puppets), stage construction, and presentation techniques

Sewing
- Sew clothes for missionaries
- Sew hospital items: gowns, surgical linens, caps, scrubs, baby caps, baby blankets, baby clothes, curtains, privacy partitions
- Teach a sewing class for women
- Sew holiday items for compound celebrations of holidays

Organization
- Help organize pharmacy or central supply
- Organize records system or X-ray files
- Organize operating theater (operating room) or ward supplies
- Organize and label the medical reference library
- Create shelving, clean storage areas, etc.
- Start a lending library; organize a medical library

Bible Teaching
- Teach with a flannel graph
- Share in patients’ chapel
- Lead in prayer meetings
- Preach in church
- Hold weekly Bible study
- Teach Sunday School
- Lead regular prayer meetings for spouses and single missionaries
- Lead Bible Studies, women’s groups, etc.
- Do studies of popular books (bring copies and workbooks)
- Teach a method of Bible study
**Cleaning and Painting**
- Offer to do guest house spring cleaning
- Teach staff different and/or better cleaning methods
- Paint hospital items such as IV poles, beds, cupboards, etc.
- Paint wards, chapel, furniture
- Clean windows

**Babysitting and Childcare**
- Offer to care for MKs
- Care for an orphan child
- Do activities with children on compound: hikes, games, etc.

**Other Ministries**
- Provide special music
- Play the piano or other instrument
- Make balloon animals for kids in hospital
- Fly Parafoil kites with the children
- Visit staff in their homes
- Organize a party for the compound
- Listen, pray
- Cut and style hair

**Other Skills**
- Carpentry—build a playground
- Assist with vehicle maintenance
- Plant or work in a garden—bring the seeds from home
- Draw/paint pictures on hospital walls
- Take pictures to send back to the missionaries
- Organize a holiday party with favors, banners, etc. that you bring with you

**Summary**
As you can see, the list is almost endless. Whatever your interests or skills, they can be well used on the mission field. You are only limited by your imagination and willingness to help. You are encouraged
to get involved and minister to missionaries and nationals alike. Sometimes, the most valuable thing you can do is to be a friend. Many missionary wives and many missionaries themselves are hurting and need a friend. Relationships on the mission field can be a strain. They are often forced to live and work in close proximity with people that, despite their missionary status, may not have qualified as close friends back home. One of the most valuable services you can provide is to listen and to be non-judgmental. You are not responsible to provide an answer to their problem. Listen without offering advice and with prayerful support for them. When you return home, keep confidential what you have learned, continue to pray and continue to be a good friend to them through the distance. Some short-term missionary wives have complained that they have trouble bonding with the long-term missionaries. This is often true where there are frequent visitors on the missionary compound. This seems to be almost uniquely a complaint among the women. This may be partly due to the God-given differences between men and women. Men are often very happy and satisfied with a three- or four-week relationship but women who give their hearts in friendship are often very hurt when the short-term missionary wife goes home and then never keeps up any form of communication. Make a point of staying in touch—through prayer, e-mail and letters.
LOAVES, FISHES AND ANTIBIOTICS

Only 18 years old, she was 8 months pregnant—and dying. Her neck was stiff as a board and she had a fever and signs of septic shock. Her friends had brought her to the hospital from a local midwife’s establishment after she had arrived there in coma and having seizures. Our hospital was over-full and I was under strict orders from the nurses not to admit anymore. When they called me in the middle of the night, I regretfully advised the nurses to tell her to go to the governmental hospital but ordered the appropriate antibiotic immediately so it would begin to work.

The next morning, I was shocked to find that they had kept her there because her family refused to move her to the other hospital. They had then disappeared before they could be made to move her. They had not informed me of this development. She was in grave difficulty—she was posturing and had several primitive neurologic signs that promised a bad prognosis. Her diagnosis was clear—we were in the meningococcal meningitis belt of Africa, it was the right time of year and she fit all the criteria. A spinal tap should yield water-white fluid—her cerebrospinal fluid was such thick pus that it barely dripped out of the needle. Gram-negative diplococci were everywhere on the smear examined under the microscope.

Although the World Health Organization has a list of essential drugs that it strives to make available for purchase in the developing world, the best drug for this infection was a third-
A generation cephalosporin antibiotic that was not yet on the list. Two much older drugs—ampicillin and gentamicin—were what were usually used but resistance to the drugs was an increasing problem. Resistance usually meant death. Despite the resistance, those two drugs were usually all we had. I had been able to buy 20 vials of the wonder drug before I came but that is only enough to treat one seriously ill patient for 10 days. We had been trying to use it wisely. My journal from a week before yielded an example, “I was called out of bed at 3:30 to see a 35-year-old woman who had delivered a stillborn premature (7 month gestation) infant five days ago. She did not feel well and became comatose sometime yesterday. They took her to a local dispensary that sent her on to us. She was very ill, had the gasping respirations that are suggestive of impending death and the spinal tap was very cloudy. Her diagnosis and treatment of her meningitis was swift and correct, using some of our precious supply of Rocephin® to treat her, but she died less than two hours later. She could have been kept alive only with several days or weeks on a ventilator and even then that would have been very iffy. In this situation, the resources are not here.”

After giving this pregnant patient one dose during the night when the nurses had first called me, I had only four vials of the precious antibiotic left. That might be enough to completely treat one of the infants who would likely come in. We are taught in medical school never to partially treat someone because of the risk of inducing bacterial resistance to the antibiotic. Yet, I could not look at myself in the mirror if I did not give the patient in front of me the best treatment I could in order to take care of someone who “might” come in. I gave one more gram of antibiotic that morning. There was no one there in the waiting area with whom I could discuss her bad prognosis.

Since this was early in my mission experience, I had
learned how to do C-sections but was not yet really comfortable with them. The nurse midwife was also there in the emergency triage area. She was having trouble with a woman with twins, one of which was trying to come down in some strange way. She thought it was both arms coming through the cervix and was unable to reduce the child. The woman had not sought care during her pregnancy so we were handicapped by a lack of knowledge. We agreed that a C-section was most appropriate and she was rapidly taken back and prepared.

Adequate help in the operating theater is always a problem and the hospital also lacked warmers for the newborn babies. Despite the tropical heat, they can easily become too cool in the air-conditioning of the OR and not do well. My wife was an accountant, but she can hold a baby in her warm arms just fine, so she agreed to help. This was her first time in the operating room and it turned out that she was not particularly intrigued by what I did for a living. She supported the wall with all her might until her attention was turned to keeping the babies warm and cuddled.

The C-section went well but it was a difficult footling breech (the feet were coming down first). I gave the nurse an unmitigated amount of grief over the fact that she could not tell the difference between feet and fingers. The first-born was the girl and the second was a boy. One was just over 7 pounds and the second just under 7 pounds. They were good-looking little kids and everything went well.

While we were working on that first case, there was a knock on the door into the OR from the hallway. The nurse leaned in and suggested that if the woman with meningitis was going to die in all probability (which was true in my opinion), “Why don’t you take the child?” It must be admitted that I was just getting the hang of C-sections and I certainly had never made that sort of life and death decision before. So I did what every smart
physician does—I looked at both nurses. They nodded. Of course! I really considered any survival by the mother to be in the realm of the miraculous, so salvaging one life seemed the only logical thing. The risk of prematurity at eight months gestation was less than the risk of the mother dying and taking two lives with her. After I finished closing the fascia and I had turned it over to OR technician to finish closing the skin, I walked out to the nursing station with my wife—who had her arms full of babies, one in each arm. The joy of turning the babies over to the family helped make up for the sorrow of talking to the mother of the 18 year old with meningitis about the options. Her husband still had not shown up. Grandmother concurred with the proposed C-section, so my wife and I wheeled the stretcher with its unfortunate patient upon it through the swinging doors and down the hall to the operating room.

The room had been rapidly turned over. Moving without wasted motion, we got the room and patient ready and then prayed for wisdom and skill for us and for healing for the patient. We always pray with the patient if they are conscious of what we are doing but in this case we prayed for us and for her.

She seemed to fight the effects of the intravenous anestheti
cic agent ketamine, but it always wins. We did a rapid uncomplicated C-section and delivered a healthy appearing 36 week gestation 4 and a half pound little girl. She was a little slow to breathe but came around without difficulty. She then became feisty and it was clear that she would likely do very well. After I closed the uterus and fascia, the assisting technician closed the skin while my accountant cum baby attendant wife and I took the baby out to the family. The young husband was there by this time and was a basket case. It is unusual to see that much grief for a wife. Women are often treated more as chattel and to have that personal display of grief was unparalleled. He was a school-
teacher and was of a different mindset than most. He was cer-
tain that if we were just bringing out the baby, his wife must
have died. We assured him that she was unchanged (albeit still
with a poor prognosis) and might do better now that her system
was not stressed by the pregnancy. I assured him that we would
continue to do everything we could for both mother and infant.
I had started the child on antibiotics for the meningococcus in
the operating room and I would continue those until I was cer-
tain she was okay. We prayed with him and fervently sought
healing for her and peace for him. When we went back in the
operating room, the nurse (who doubled as an anesthetist) made
some comment to me about the husband’s unusual and unex-
pected amount of grief. I replied that men always felt that way
in the first year, but it was after that year that it made less dif-
ference. That earned me a well-deserved smack alongside the
head from her and later I was in serious danger from my wife
when the story was repeated to her.

I was surprised the next morning on rounds that she was
still alive. Her fever had gone as high as 106°F and she was still
densely comatose. I had the decision to make again—should I
waste the precious antibiotic? Three grams was still enough to
treat a baby. With a sigh, I ordered it again. The baby was
already on the breast of a wet nurse and was doing well without
signs of infection.

The next day, my patient was unchanged and her tempera-
ture was down to a maximum of 104°F. With only two grams of
antibiotic left, the decision was easy. It was given. I didn’t
expect her to live but at least my conscience would be clear.
When she died, I would have done all I could. The third day, the
fever was down a bit more and I gave the last dose.

Before I went into the room on the fourth day on rounds, I
was concerned—I was out of the wonder drug and had to rely
only on the old stand-bys. When I opened the door into the iso-
lation room, I was shocked to see her sitting up and breast-feed-
ing her baby. The only neurologic residual she had was a palsy
of her sixth cranial nerve. From that point on, she slowly
improved and was discharged on the tenth hospital day. She, her
family and most of the village had seen a miracle and they cor-
rectly deduced that it was a spiritual battle that had been won. A
great number gave their hearts to follow Jesus.

Before I came to this hospital, I had purchased the original
20 grams of the antibiotic at a special discount from the com-
pany which manufactured it. They would not sell me more at
that heavily discounted price. I had paid less than 30 dollars for
the four doses of drug that this patient had received. It was re-
ally the widow’s mite. Someone from my church had given me the
money, apologized that it was not more but requested that I do
something that would help me minister when overseas. The
amount of drug I used was inadequate by all human wisdom. It
needed to be multiplied to do the job. I don’t know for absolute
certainty if the drug I used was really needed. Maybe the ampi-
cillin would have done it alone. But then again, just maybe I saw
a miracle. I rather think I did. It was certainly clear in my own
mind that it was not me who healed her. I knew who did. And I
certainly saw a healing that had eternal consequences for her
and for her friends and family.
CHAPTER 8

EDUCATION AS A SHORT-TERM MISSIONARY PARADIGM

“I’m not a family doctor nor a general surgeon—is there a role for me on the mission field?”
“I am an academician—is there a role for me on the mission field?”
“I am a specialist—is there a role for me on the mission field?”
“I am a superspecialist—is there a role for me on the mission field?”

Yes, there is a role! First, let’s set things straight: God does not need your abilities. There is nothing you can do that God just has to have done for Him in order for His plan to go forth. He wants your availability, not your ability—but it is equally true that you have no talent or gift that He cannot use for His glory.

Why work in the developing world as a medical educator? The need is great, your educational credentials open doors, you may be the best person to do it and the impact of your work can go far beyond one institution. You may affect the country, the region or the continent for Christ.

There is a lot of criticism of America for a lot of reasons—and admittedly many of those criticisms are valid. What is rarely criticized is our ability to produce medical professionals of the highest caliber—and such credentials are the master key to entry to most countries in the world including those who would not accept a Christian under any other mode of entry. The majority of the world is understaffed by physicians and suffering from brain drain.

There is a more selfish reason to consider medical education as a short-term missionary paradigm. Over the years, more people have expressed to me their vague dissatisfaction with short-term medical missions and expressed their desire to accomplish more than they seem to be accomplishing by participating in short-term trips. Education is a perfect solution. It allows leverage of one’s effort in order to leave a legacy. As surgeon, I can go and do 50 cases, take lots
of pictures of weird pathology and come home to bore my friends with my PowerPoint presentation. Maybe, if I am fortunate, I can give Grand Rounds at the hospital and also speak to the 50 who show up on a Wednesday night service at church to hear what I have seen and experienced. Such experiences are worthwhile but after several such trips, it somehow seems less gratifying than it once was. However, as a surgeon-educator, I might go and do only 40 cases but by teaching the missionary surgeon or the national surgeon those techniques, he might go on to do 400 or 4,000 over his career. Each of those patients has a great need that might be answered physically and spiritually and through my students, I can reach them. At home, I may be “just” a doctor in a small town, but to those residents in a training program, I am “Professor” and they will hang on to every word, telling the next batch of residents exactly how the “Professor” did it. If I am truly an academic physician, I bring lectures and techniques to a dry and thirsty land, delivering legitimacy, professional companionship and learning to other professors of medicine—professors who are too few in number and who struggle with their inadequate resources and a lack of access to the latest trends of medicine. Through me, they can have that access. I am affecting the care of a nation—and modeling Christ in lands where His name may not be able to be spoken openly.

Let’s explore the plight of medical professionals in underserved countries. They have great needs and struggles and understand very well all of the challenges listed in Chapter Five. They face the massive brain drain, poor working conditions, uncertain career paths, the lure of better paying jobs with NGOs (Non-Governmental Organizations), limited numbers of training programs, too few funds to support research and training, limited support by other medical specialties, very little continuing medical education and limited resources to implement health initiatives. Those deficiencies are underscored by the realities of practicing medicine in the developing world—lack of specialized equipment, unreliable electricity and water and the lack of biomedical support and general maintenance.

Let’s look at just one country as an example; there are many
worse. In Afghanistan at the time of this writing, of 213 teaching staff at Kabul Medical University, there are only 2 PhDs and 150 Master Degrees. They estimate that they need 40–60% more instructors within 10 years. And there are larger social issues: in a country where males can’t examine females, 80% of the graduates are male. Medical care is an urban phenomenon—urban areas have 90% of the health-care providers, leaving the rural population without care. There is also a shortage of the necessary consumables; they are deficient in both availability and inventory.

Are you needed? Are you the one to answer the call? As with all missionary efforts, you must be sure you have the correct motivation. You must answer a call from God and not just respond to a compassionate twinge of conscience. Your expectations must be in line with your motivation. You are not likely to be able to simply transplant your program and your technology to this resource-poor environment. Therefore, your efforts and any programs you institute must be technologically and culturally appropriate in order to achieve any degree of success at all.

Career missionaries may serve in either a tent-making role (as Paul describes his mode of support in 1 Corinthians 9, here in this context, it means living as an educator on the local economy while preaching Christ when and how possible) or as a missionary under an agency, either in a secular environment (creative access is the popular term) or in a Christian environment. Only the latter option is particularly effective for short-term medical educator missionaries although there are a few exceptions who manage to make it work in the first two situations.

There are a growing number of short-term medical educators—but the programs or agencies are often small, focused on a single institution or country and therefore difficult to identify by someone who is interested in serving in this way. These programs can have variable results if they are not well designed or are not well carried out, but they can be a major help and blessings to tent-makers or established Christian training programs. The ability of those on-site educators in a secular environment to bring in experts from North America and
Europe enhances their effectiveness and credibility in the national medical environment.

One very great need for academic physicians and surgeons is someone to serve in the role as medical educator in a Christian training program. Here are some programs that are training (largely) Christians in a Christian mission hospital or in conjunction with other programs and which could use your help:

► In His Image, a family practice training program (www.inhisimage.org)
► CURE International (www.cureinternational.org)
► Pan-African Academy of Christian Surgeons (www.paacs.net)
► Medical Missions International (www.mmint.org)
► INFA-MED (www.chak.or.ke), a family practice program at the Kijabe, Lugulu and Tenwek Hospitals
► Christian Internal Medicine Specialization (CIMS) program—Mbingo Baptist Hospital in Cameroon. Contact Dennis Palmer at palmerdd47@gmail.com.
► New medical school project in Swaziland–Africa Future Foundation (www.africaff.org)
► Many others in India, Philippines and other parts of Asia

**Here is some advice to the potential missionary educator**

Don’t be a missio-tourist—rather, please return to the same place repetitively. Doing so may keep you from underestimating the problem of inadequate infrastructure. It certainly builds relationships more effectively (often it is the third visit or later before they really begin to accept you as a partner in their work). Because you have a deeper understanding of their needs, it helps you secure equipment and supplies and recruit personnel for your next trip. From a practical educational standpoint, it helps you reinforce the topics you have previously taught and allows you to build on them to reach the next level. It will help to keep you from promising what you cannot deliver—always a danger in an enthusiastic short-term missionary.

View your visit a tactical battle to advance a strategic war. You will not solve all of the problems of the country and the educational
system. Work and plan with the missionaries on the ground and with the administration of the training program to effectively solve a discrete problem that you can solve. If you are not sharply focused on a small piece, you rarely accomplish much and without agreement as to the strategic goals, you can spend all of your time and efforts on something upon which nothing can be built. Do ensure that you are teaching something that is desired, practical, reasonable and sustainable.

Control your personal response to the situations you find. Do not play the role of “hot shot” from out of town and do not be a prima donna. Do not forget that EVERYTHING is based on relationship and the most brilliant medical cure will not salvage a damaged relationship. Do not be frustrated by the inevitable slow pace of progress. Accept the fact that the people there are probably doing better than you would do if the roles were suddenly reversed. It is helpful to have a clear and strictly delineated idea of what you hope to accomplish—a clearly defined and detailed curriculum goes a long way in achieving this goal.

With your credentials, it is possible that you may be perceived a real threat to the professionals who are trying to make a living within the country, despite your best intentions to avoid giving that impression. You can protest all you wish but it will take time and action to prove to them that you are there to help and not to take advantage of them. Above all, do not accept fees from patients or the institution (tent-makers excepted) but be comfortable with the hospital’s need to charge. If you receive gifts or funds despite your protestation, make sure that you donate them to something for the benefit of those with whom you are working.

Maybe you are a resident or student at the start of your career in medicine but are intrigued by the idea of medical education as a missionary career. First—do not be in a hurry. Be adequately trained before you go—you will be the same age in twenty years no matter what you do. Adjust your expectations and clarify your motivations. During your medical school and residency, try to arrange a rotation or two that will help you get a better grasp on the reality of mission life
and a missionary medical educator’s life. Keep your expenditures down—student loans are a leading cause preventing medical personnel from committing to the mission field. MedSend (www.medsend.org) is a real blessing to new missionaries with debt on their mind. They have a ministry which helps you serve God on the mission field by paying your student loans while you are on the mission field. Talk to them sooner rather than later in your career—they can help you prevent foolish and unnecessary debts and expenditures. Identify others in your circle who will mentor you and who will pray for you during this long process. Friends, families and churches are excellent resources for such people. There is also a wonderful program run by the Christian Medical and Dental Association Center for Medical Missions entitled “Nurture the Future”. The program is designed to encourage you during the training and to prepare you for service on the mission field. You can contact them by e-mail at cmm@cmda.org. The Center for Medical Missions can also help you with places to serve during your training and give great advice about possible funding options.

Many residents ask about specialty residencies and fellowships. They feel called to a specialty but are not sure that they can ever go to the mission field as a specialist. Rest assured that you can go as a specialist and if God is calling you into such a program, there must be a reason even if it is not clear to you at the present time. For those who wish to have a career as a medical educator, try to establish some formal affiliation with your training program that will continue once you leave the program. These credentials give you credibility overseas, give you a network of potential speakers and resources to call upon and may provide a safe and reliable environment for employment during your furloughs. They are a great way to ensure that you are maintaining your medical knowledge.

There is a great program underwritten by World Medical Mission (Samaritan’s Purse) called the “Post Residency Program”. This innovative program places the graduating resident into a mission setting for a period of two years, paying a modest salary and their expenses, for
the purpose of giving him experience in the mission field. Obviously, this is done with the ultimate goal of long-term service. Please check their website at www.samaritanspurse.org or e-mail postresidencyprogram@samaritan.org.

Even if you can’t serve abroad, how can you help from home? There are several things that you can do that will promote and support the overseas program of your choice:

► Promote and encourage overseas residency experience for your training program or specialty. Work to encourage your accrediting body to approve such experiences for the residents.

► Encourage your institution to partner with and to help another overseas institution. Please make sure that whatever help and whatever program is created will avoid exacerbation of the brain drain. In general, bringing nationals from other countries to train in the US has not proven to be a very good idea. Ensure that the program is selecting and transferring appropriate technology and techniques. Help them develop an appropriate curriculum. Encourage research protocols that can be carried jointly in both your home institution and the overseas one. Maintain an appropriate international level of quality in all that you do—and be sure to remind your impatient North American friends that it always takes five times as long as you think it should.

► Recruit personnel and gather supplies including educational materials.

► Insist on allowing the use of your intellectual property in the developing countries at reasonable rates (or preferably free)—books, CDs, web-based learning tools, ATLS. Similarly, since the working environments may be distinctly different, allow your work to be adapted to the third world environment.

► Keep in mind that whatever you do may need to serve as a template which allows others to copy your work without reinventing the wheel.
“IT’S CHEAPER TO HAVE ANOTHER CHILD”

In pediatrics, one of the most important things one can do upon seeing a child for the first time is just decide the answer to this simple question, “Is this kid sick?” This one clearly was. This four-year-old lay limply in his mother’s arm, responding minimally to any stimulus. If that stupor wasn’t enough of a concern, the classic appearance of “flesh-eating gangrene” of his right buttock and leg rang alarums.

The child was from a village on the other side of a town 60 miles away. At a local clinic, he had received an immunization in his right buttock. Later, the hospital nurse explained to me that the way most of these clinic nurses had learned to give shots was to stabilize the needle by sliding it along their bare thumb. Any bacteria on the unclean skin were therefore neatly inoculated into the buttock. By the time he showed up at our hospital, he had been sick for twelve days. They had not sought care previously, presumably for financial reasons.

After intravenous fluids and broad-spectrum antibiotics, he was taken emergently to the operating room. I had already
warned the family that this would require resection of an amazing amount of tissue and that he might die no matter what. I found necrotizing fasciitis (a gangrenous infection of the layer surrounding all the muscles) and lots of gangrenous changes in the fat and skin—but the muscles, nerves and vessels were intact. I removed most of the skin, fat and fascia on the buttock and most of the thigh. I knew I would need to come back.

The next morning, the tissue around the edges that had looked healthy the day before was now dead and dying. This is the common course of this disease. Each day for several days in a row, I took the child back to the OR, cutting more tissue away each time. I was creating a huge wound and there was essentially no skin remaining from the ankle to the top of the pelvic crest. One day, I needed to bring the little boy back for debridement, but the parents had decided I could not—they were going to take him home. Actually, their exact words were these: “Doctor, it is cheaper to have another child.”

My Western physician mindset kicked into full gear. Did they know the child will die without care? Don’t they care? Is life really that cheap? None of their excuses held water in my outraged opinion. They mumbled something about taking him to the Italian hospital in their town. I told them they must get care for him or he would die—after all, they had neglected his care the first 12 days! I would make them sign a release of liability form if they took him. I was going to protect the reputation of the hospital and God’s reputation at all costs. I was thoroughly disgusted at their decision but upon reflection, not entirely surprised—the mother has been making strange comments for several days. I had plenty of self-righteous indignation.

Too much, actually. I had not asked the right questions, had not read between the lines and had not listened adequately. I had forgotten the very important fact that rational people make
rational decisions—but you have to understand their rationale. I was judging from my Western perspective and assuming it was right and applicable in all conditions. I had forgotten the reality of the bone-crushing poverty that underwrote every decision that patients and families have to make in much of the developing world. Here is what turned out to be the truth: In that hospital and many others in Africa, food is not provided for patients by the hospital but rather by the family. This family had spent all their money getting to the hospital. They had run out of money. They were among a people of a different tribe and village. They had no one to borrow from and didn’t know from where they could steal food. Essentially, the entire family of five was starving to death. We in North America never have to make that sort of critical decision. Frankly, I would probably make the same decision they were making if I were forced into the same situation they found themselves in—it makes more sense to lose one person than to lose six people. It didn’t mean they didn’t care. They just saw no viable option.

Oh! The flames of my righteous indignation sputtered out and were replaced by embarrassment and compassion. Because it is customary in that part of the world to hold a patient “hostage” until they pay their bill, we decided that we would discharge this child; but since they could not leave until the bill was satisfied, we would continue to keep the child in the hospital ward on a mat (where he spent much of the day playing anyway). We would continue the care as if nothing had really changed. In fact, nothing much really had except that now we understood. Using only $50 given to us by a donor friend, we gave the donation to the hospital chaplain and arranged for him to give the family some money each day, enough for the high-protein diet that the boy needed, enough for the rest of the family to eat and enough for them to purchase necessary medica-
tions. By going through the pastor, we made sure that it would look as if it came from the nationals and not from the white visitors. We hoped to avoid the problem of being perceived as Santa Claus. By doing it that way, we also ensured that the pastor would have plenty of time to talk to the family. The family was satisfied. Their honor was intact because they had told us they couldn’t pay anymore and if we were so foolish as to keep taking care of the child and to feed them besides, that was clearly our problem. We were happy too—we already knew we weren’t going to get paid for this case and now we could help the child heal.

A few days later, I stopped on rounds and looked at the leg. It was the most amazing dissection I had ever seen—and it was mostly the work of the flesh-eating gangrene and not mine. All the muscles could be separated and the nerves, vessels and all critical structures were beautifully displayed. I would have been pleased if I could do such a fine job in the anatomy lab. To God’s glory, prayers were being answered and the leg was granulating in without signs of further infection.

I had to leave to return home shortly thereafter but the child stayed for another couple of weeks. He was skin-grafted a few days after my last visit to him and had excellent take of the skin-graft. He was ultimately discharged, completely healed. The entire family accepted Christ and there was a great witness in the village where many others came to accept Christ.

I guess God can watch out for His own reputation and His own children without my help—and He doesn’t need me to be so quick to judge what I don’t understand.
CHAPTER 9

REENTRY

Why is there a special emphasis and a whole chapter on reentry?
Aren’t you just coming back home?
“Well, yes . . . and no. Mostly no.”

Upon our first trip to Africa, we returned to our home almost bursting with excitement, eager to tell of our experiences and our newfound closeness to God and the knowledge of God’s work in our lives. Our parents had met us during our layover at the first US airport and we had dinner together. We could hardly enjoy it—we shrunk from the noise, the hustle and bustle of life around us and the tremendous number of choices on the menu. We could barely decide what to order and we could not enjoy the huge portions. Figuring things would be better once we were in our home church, we were crestfallen when a church member did not even realize we had been gone. In response to our comment that we had been in Africa, she responded, “Really? That’s nice. We spent the summer in Myrtle Beach,” and she regaled us with story after story of their summer adventures. We never got to say anything further. This is not an uncommon experience.

“Reverse culture shock” or “cross-cultural reentry” is an inevitable part of your trip and can be for some the most stressful and long-lasting part of your trip. It is important that you have an understanding of what you might go through. No one can return from a short-term medical mission experience and remain unchanged. If you have not used the experience to build your spiritual strength and your relationship with God, it may merely intensify your areas of weakness. Often, those weaknesses will be more glaring upon your return. You will also find that you will see these same dynamics in missionaries who have returned from the field and a better understanding of what they are going through will help you minister to them more effectively.

Reentry shock has to do with change. Time does not stand still.
There will be changes within your home environment during your absence and there were will be changes within you. Things that accentuate the magnitude of the changes and the length of the time that the changes exist will increase the severity of the reverse culture shock. If you have not worked and had time to understand and ameliorate the expected effects, the severity of the shock will be greater. For example, an involuntary or unexpected return is harder than a voluntary or expected return because there has not been sufficient time to process the change. The greater the difference in cultures between the mission field and the home culture (and the better you adapted to the other culture), the more difficult will be the reentry. A lack of previous experience with such a transition will make it more difficult. Older persons, with a history of similar life transitions, may not be as bothered as much as younger people. Conversely, the more you stayed in touch with changes in your home culture and the more supportive and familiar your environment is upon your return, the easier it is.

Storti, in his book *The Art of Coming Home*, describes the concept of “home” as having three key elements: familiar places, familiar people and routines and predictable patterns of interaction. Even a short mission trip will alter those elements. It is logical that the first two are affected largely by time. The longer you are away from your home, neighborhood and city, the more they will change. New businesses will open, familiar ones close, buildings and neighborhoods will change appearance, traffic flow patterns will change and so on. The more time you spend overseas, the more likely it is that family members and friends will die or be born, marry or divorce, make new friends and develop other interests that may not include you. You may be forced to face grief or have personal reactions to those changes that are out of step with others who have handled their reactions and already moved on.

Changes within you are an expected, and even desirable, part of your trip. You have had a unique and life-changing experience and in both a literal and figurative manner, traveled far beyond your family and friends. However, the consequences of having experienced those changes and your reactions to those changes are often more frequent
and greater than expected. You have developed a new viewpoint of your country, your religion and your beliefs and the contrast (and conflict) with those held by your friends and family can cause distress to both you and to them.

After the first blush of excitement about being home fades, there are common reactions to being home that are rather universal. They include the following general areas but they are not listed in any particular order:

► American materialism and life-style is something you will face daily when you return home. It may not seem to be as attractive as it once was. After seeing poverty at its worst and having emotionally connected with people whose lives hold little hope, it is sometimes hard to face the conspicuous consumerism and wastefulness of life in North America. The site of a fully-stocked grocery superstore or a multi-page menu can paralyze the returnee. Since the pace of life in most developing nations is much slower and social interaction emphasizes interpersonal relationships, the impersonal and hectic pace of life in North America can be overwhelming and seemingly undesirable. You may find yourself now angry with those around who do exactly what you used to do and then angry with yourself when you fall back into the cultural norms and resume the same behavior that was so repulsive to you when you first arrived home. Remember to extend grace to others and to yourself. The real trick is to learn what Paul talked about in Phil 4:11-13, “I am not saying this because I am in need, for I have learned to be content whatever the circumstances. I know what it is to be in need, and I know what it is to have plenty. I have learned the secret of being content in any and every situation, whether well fed or hungry, whether living in plenty or in want. I can do everything through him who gives me strength.”

► There may also be a real dissonance between your values upon your return and those of other Americans. This is sometimes because the American culture has changed while you are away, but it is sometimes because you have achieved a new sensitivity to the cultural mores, sexuality, depravity, racism, denominationalism and other characteristics of life in North America. This new perspective can give you a clear
vision of the worth and legitimacy of some values held by others and of the isolationistic or self-serving viewpoint of many Americans. Politically, you may find yourself more patriotic because you better understand the good in the American lifestyle, but paradoxically, in some areas, you may be less jingoistic, better understanding the impact of American politics and business decisions. You may have a greater sympathy of the appeal of some other political systems to people who have nothing. You may understand why some consider the “Ugly American” stereotype to be valid. We can only suggest caution in your verbalization of these new ideas. It is very common to hear upon your return that “It must be good to back in America” and of course, it is. However, you will not be able to hear that question without thinking, “Yes, BUT . . .”

Perhaps the second most profound impact is the apparent apathy, disinterest and misunderstanding of those around you. You are far more interested in what you were doing overseas than anyone else is. With sometimes falsely high expectations of your return, your welcome back is often best described as underwhelming. Even if you admit that few welcomes could possibly live up to your expectations, it is so hard to come home and have no one who wants to listen. You want to tell your stories, not to show off or because you crave attention, but to explain to people you love how and why you are now different. How can you have a relationship with someone you love if they don’t know what is important to you? Without telling your stories, especially about something this important, you must remain a stranger to those you love. Also, telling your stories helps to justify why you made such a dramatic decision in the first place. Even if you find an audience, there are two things that will affect how the audiences process your report of your experiences.

The first is how they view missionaries in general and how they view you specifically. Many people have difficulty in relating to missionaries. They may be suspicious of your motives and have a stereotype of missionaries as being boring, ill-dressed, hyper-spiritual, fun-avoiding, fixated on missions and unable to make it in the real world. For those who are Christians and who may have ignored God’s call to
missions, there may be feelings of guilt, ambivalence and internal tension. They may also be jealous of your trip and experiences. If you spend a lot of time telling how wonderful things were on the mission field, it can also engender feelings in your listeners of being rejected, devalued and unappreciated. The second difficulty that can arise is in how they handle the information. One possibility is that the presuppositions of your audience are so loaded with half-truths and imaginings that they tend to pay attention to only that which reinforces what they wish to believe. Alternatively, they may be suffering from information overload. Nightly, the television screen brings pictures of the war victims and the starving into their living rooms. Daily, radio, newspapers and magazines bring more information of similar distressing nature. All people have to develop some way to handle this information and denial is the most common defense mechanism. Such a numbing reaction may limit your families’, friends’ and colleagues’ reactions to your experiences.

If you fail to recognize that this is largely their problem and not yours, this can lead to feelings of rejection and loneliness. Remember to take it slow and not overwhelm your listeners. Tell them only as much as they want to hear or seem able to be able to digest at the time. It is important for you to realize that part of the problem with communication may lie with you. Much of what has become important to you is difficult to put into words. If you compound the problem of the listener’s limited interest with your limited ability to verbalize ideas and concepts that may not solidify for months or years, it can lead to poor communication. The disappointment created can cause a tendency to quit trying or lock up these feelings and experiences without allowing them time to age and ferment sufficiently. You must often meditate for months on an experience before all of the significance is evident. Select the experiences to share that you can get hold of and leave the others until later. Just don’t forget them.

A related problem opposite to apathy is sometimes seen. Some people hold unreasonable expectations of high productivity. These expectations can be internal. This is manifested by the short-term missionary who tries to over-achieve. This is often seen in short term medical
mission trips that host clinics that emphasize number of patients seen, or numbers preached to or some similar yardstick. This puts the pressure of success upon the people and the success is therefore not dependent upon God. God may not (and probably does not) judge the success of your endeavors with that yardstick at all. Pressure from an external source comes when donors want success stories as a “payback” for even meager donations. Some trips can supply these stories, others cannot. In the context of an alien culture, it may be hard for a North American to judge what the real impact is of what you have done. This is especially true on shorter trips. Success should be measured by the degree you followed your understanding of what God’s will is for your life, not by some artificial temporal metric. It does not matter whether that metric is internally or externally generated. Judging success by God’s criteria requires an eternal perspective that, no matter how hard we try, we cannot completely obtain.

Another common complaint by those returning home is a sense of personal disorientation. At first you have a sense of not belonging in your own culture. The cultural change from poverty to wealth as we described above can aggravate this feeling. Serving and dealing with people who do not have the same world perspective and broad experience as you now have can make it worse. There is often a realization that you don’t want to be like these people at home. Often you feel a lack of a defined support group. On the mission field, there was a sense of being a member of a dedicated, hard-working team that had unified goals. You may have had a sense of high self-motivation, fostered by the sense of community and a defined role. Now you may have entered an culture that favors independence and you have lost a sense of self-worth and no longer have a definite goal in your life. On the mission field, as an expatriate, you were someone “important” and may have had access to social circles that are now no longer available to you. You have gone from being someone important to someone who is like everyone else. The highly spiritual atmosphere of the mission field has given way to two or three services a week. Even outside the area of ministry, you may have to exchange a vacation on safari for one that involves a long car trip to Aunt Tilda’s house. Now you have a standard
of living that is relatively more modest than you could have afforded on the field.

You may have a significant change in your personal relationships. It is sometimes hard to realize that people have been able to get along without you and moved on with their lives. You have been “out of sight, out of mind”. You may have had changes in your physical appearance to which they react either favorably or unfavorably. Those changes are visible to you in the mirror and with some honest self-assessment, reactions can be predicted and dealt with beforehand. It is much more difficult to gauge the social, emotional and spiritual changes in your life. Your interests and concerns have diverged from those at home. When they realize that you are now marching to a new drummer, the emotional reaction from your loved ones can be profound. You may face jealousy and represent a threat because your new ideas, experiences and spiritual insights may challenge the status quo and the standards at home. You may now be more sensitive to racism, chauvinism, bigotry, and denominationalism—and may be more apt to react critically when you see those things in the people you love. You may be less ethnocentric and demonstrate more tolerance of other theological viewpoints. Dogmas and practices of your culture that are important to them may no longer be as central or as absolute to you.

Your loss of interest in “things” and a better understanding of the Christ’s role in your life can cause great turmoil in your relationships. You may find that finances and possessions are a point of contention. It is almost axiomatic that service on the mission field, even for the short term, requires some financial sacrifice. This sometimes includes making a deliberate choice between types of housing, cars, vacations and other possessions. Be prepared for the resentment that your sacrifice may cause in others (even if they don’t support you financially) and be prepared for the twinge of jealousy within your heart when you see what others have. Sometimes, you will find yourself cloaking your reaction in a mantle of spiritual superiority toward others.

How you handle this disruption in relationships is very important. The most important thing is that you do not hold yourself out to be consciously or unconsciously superior to others. Do not be expectant
of special treatment because of your experience on the mission field. Serving on the mission field is not somehow more blessed by God than if one obeys in any other thing in life. You are not a special case and you have no right to judge others. Your identity should be secure in who you are in Christ.

Do not make the error of trying to apply the same high-power ministry methods in your own home environment that might have worked for you on the mission field. Such methods can be a major turn-off in your North American culture. It is good that you are willing to be bold for Christ, but it is important that you are willing to be sensitive to the Spirit’s leading, realizing the cultural differences.

You do not want to lose the valuable knowledge, insight and experiences you have gained, but neither do you want to destroy your relationships. It is important that you realize that it is not “either-or” but rather “and”. Keep alive your new horizons and deepened consciousness, but do so by using those same skills that have been newly honed overseas on those at home. Use respect, trust and integrity, just as you did overseas. Realizing that you may otherwise be as popular as a reformed smoker, do not try to impose your new insights on others—some will resent it, some will think your faith has been diluted, and still others that will be convinced that you have fallen into error or heresy. You must realize that that you and your family and friends have all changed—communicate as much as possible, try to understand and if that fails, extend grace to each other.

Another common area of dissatisfaction upon return is your experience with your church and Christian friends. It is very common for returning missionaries to make complaints that fellow Christians in their local church have a lack of spiritual focus, that the worship services are not alive or meaningful enough, that they do not understand you, that the pastor won’t accept your advice, that the people have their priorities wrong, that the church doesn’t have an adequate emphasis on missions and so on. It may or may not be true, but an inappropriate attitude and reaction will not change it. It must be realized that the function of the local church is not the function of a mission organization. It cannot select its members by level of spiritual maturity, train-
ing or commitment. There is by definition a broad spectrum of emo-
tional and spiritual maturity. The pastor must accept people where they
are, not where he would like them to be. Lastly, the church has a much
broader focus than just evangelism or just missions.

Pastors and the churches aren’t always so pleased with returning
missionaries either. They often are too “heavenly minded to be any
earthly good”, expect to be served rather than to serve, are not under
the authority of the pastor and deacon board, are too reliant on the
team concept, have a sense that the mission field is superior to the
church in method and purpose, are more critical than constructive and
feel they have the answers to the problems of the church.

The solution to these problems lies largely in your own court.
When you return to your church, make an appointment to make a con-
cise report of your experience to your pastor, answering any questions
he may have. Express your interest in sharing your experience. Ask
how you can serve the purposes of the pastor and the church as
teacher, speaker, committee member and so on. Make it clear that you
are under his authority. Thank him for his support and prayers and
those of the church.

Don’t be critical. Be a servant. Be accountable to others—people
who will help you maintain the level of spirituality and retain the new
insights, but who will keep you honest. If people are not reaching out
to you, make sure that you reach out to them. If you are not demon-
strating an interest in their lives, they are unlikely to demonstrate more
than a polite interest in what you did. Make sure you get your prayer
team and supporters together to give them a thorough report and
express your heartfelt appreciation. Look for opportunities to tell your
story and show your pictures, slides or PowerPoint presentation to
civic organizations, youth groups, Sunday School classes, school
groups, school classes, missionary support groups and so on. Write
letters to supporters and friends when you return. Invite people to your
home. Write an article for the church newsletter. Be interviewed for
the local newspaper or on a local radio show. Keeping these potential
opportunities in mind, prepare while you are overseas to share when
you return with the idea of challenging others. Record or purchase
music of the country. Purchase curios that illustrate your story. Share parts of your journal to tell the story. Send e-mail updates from the field to friends and supporters. Tell the story of your ministry, how it is affecting you and share prayer requests. Take pictures of a day in your life overseas. Take pictures and notes on interesting medical cases and present them at Grand Rounds, local medical societies or other medical gatherings.

► It is important to honestly evaluate and gauge your thoughts and emotions as you adapt to life back at home. It may take months or even years to completely reacclimate. Not all parts of your life will adjust at the same rate. You may find your professional life is affected more than your personal life or that those may not be in sync with your spiritual life. Remember that the longer the time away, the longer the recovery time often is. It often like climbing a sand dune—very slow, with two steps forward and one step backward. In one sense, reentry will never end. The effect of your experience and the changes it wrought will (God willing) be life long.

Loneliness, rejection, disorientation, disruption of personal relationships, and disruption of your relationship with God are common. You may feel alone, misunderstood and alienated. Escape and withdrawal are common reactions. Expect that you might be overly judgmental. Expect you will lose your patience. Expect that you might have an unreasonable hypercriticalness about the trivial and the unimportant. These are irrational and strong feelings, but normal ones. You may find yourself self-monitoring your actions, feelings and conversation for fear of saying something wrong or inappropriate. It is helpful to remember that acceptance of your home culture does not have to undermine your new insights and experiences, nor invalidate your experience. Readjustment is not an either/or experience—it is an integration of new experiences and new thoughts with old ones. Extend your tolerance and open-mindedness to your own culture.

Look for someone with whom you can share your turmoil. You have left the support structure you had on the field and now you must establish a new support structure. These may be with new people rather than with your old friends. Often what you need to share has
more to do with squaring your feelings about your home culture with those you have about the economic depression, poor health conditions, malnutrition, pollution, illiteracy, and social inequity where you served. It is difficult for someone who has not experienced those feelings to understand. You must keep channels of communication open with others who were with you or who have had similar experiences. Keeping a journal of their thoughts has helped some as well. Try writing out your prayers and recording your stresses and the insights you gain from them. Some returnees gain from the reentry strategy of presenting to groups interested in learning about their travel experiences. This way they can channel their excitement for surgical and medical missions abroad to those who share common interests. Withdrawal from God is a common mistake—there is nothing “wrong” with you or less spiritual about you because you have these feelings. If you struggle to handle this in your own power rather than with God’s help, you will suffer needlessly.

**How can you avoid these problems?**

Here are some things you can do that can help:

- Preparing your homecoming starts with making sure people know you are gone and by keeping them informed while you are gone. As mentioned in a previous chapter, you should strive to be sent with the blessing of your church. A public commissioning or prayer service will help. See if you can have articles placed in your church newsletter or bulletin. Perhaps a bulletin board about your activities can be maintained while you are gone. You can talk to various men’s and women’s groups, youth groups, Sunday school classes and do the same on your return. Establishing a support group before you go and keeping them informed is the best way of generating a group of people interested in your return and your ministry while you were gone.
- One thing you can do to make homecoming more tolerable is something you can do even before you leave the field. Take good care of your health and if you think you have something that needs to be treated, do so before you leave. Everyone likes souvenirs of their trips, but sometimes parasites, intestinal worms and lice were not what you
had planned to bring home. Treatment on the field is often more con-
venient and cheaper than at home. If you have some problem that can-
not be properly treated on the mission field, make plans to see your
physician as soon as you return home.

It is important to get good closure of this mission experience. 
Wonderful memories of the experience are fine, but continuing to try
to live on the mountaintop is impossible. All directions are down from
the top. Accept the bittersweet nature of this time. Expect the ambiva-
lence you may experience about going home. You must recognize and
come to terms with the reasons you are leaving the mission field to
come home—your project has been completed, new area of service,
your commitment has come to an end, etc. Although it is difficult to
leave the place where you experienced such spiritual highs and such
growth, you need to recognize that your return is also God’s will for
you. It should be viewed as the way God leads you to yet another pas-
sage in your life.

It is very tempting to feel guilty about how much work remains.
Don’t allow guilt about remaining work to persist. No missionary can
complete God’s work. The question is whether you completed His task
for you as you understood it.

It is also important that you leave the field with a clean slate. If
your ideals, actions or words have caused a clash with anyone, do your
best to make sure you have done all you can to heal those rifts. Don’t
let your frustrations over your ideals about how relationships should
be, how the hospital should take care of or charge patients or other
similar points of contention spoil what was otherwise a great experi-
ence. Even if you have no such areas to correct, it is very important to
say good-bye properly to all those folks with whom you need to take
your leave. Don’t work up to the last minute—you won’t get all there
is to be done finished anyway and you will miss out on a great blessing.

Another major error that can ruin your homecoming is the failure to
schedule sufficient time to return, to experience these feelings and to
adapt. All the problems of reentry tend to hit at once and you may not
find much patience in your family and friends. It is not uncommon for
them to think (and sometimes say), something like “You have been
home three days. Get over it.” It took you a while to get used to the new culture and reverse culture shock also takes time. Schedule yourself sufficient time, warn your family about your possible reactions, and also remind yourself.

Reentry with a family is a special situation. Before you leave the field, encourage your children to take special things and lots of pictures home to North America. Be aware that your family members may be feeling the same sort of grief over a change in or loss of close-knit relationships, and the loss of personal significance. This grief and concerns about peer-group acceptance can be more severe than you expect, especially if you have been gone a long period of time. This is often a time that may precipitate a crisis of faith, especially in teenagers. Parents may grieve at the loss of the close family relationships they had on the mission field as the children’s desire to make up on missed extracurricular activities and see missed TV shows and movies cause the family to fragment. The best solution is prayer and non-threatening, accepting open talk. It is important to realize that there are often marked individual variances in reentry. The members of your family are probably feeling the same sorts of things that you are feeling but they may not be feeling them (or resolving them) at the same rate that you are. Be patient with each other. If there seems to be a major problem, do not hesitate to seek counseling help from your pastor or mental health professional if you need it. It is not a sign of weakness or a sign of a loss of faith. At the end of this chapter there is a list of organizations and resources that may help in this sort of problem. Seek help if you need it.

▶ Even if you are not having problems beyond the ordinary, it is very important to get debriefed. If you went with a group, some of them have a formal process that they will want you to go through. If you went alone or the group does not offer that service, it is important to do it with your family or for yourself. Philippians 4:8, 9 “Finally, brothers, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things. Whatever you have learned or received or heard from me, or seen in me—put it into
practice. And the God of peace will be with you.” Storti writes “Moreover, simply because reentry can be frustrating, lonely and generally unpleasant at times is not to say that is either a harmful experience or even a negative one. After all, frustration, loneliness and unpleasantness are very often the precursors of insight and personal growth. Maybe reentry doesn’t always feel good, but then feeling good isn’t much of a standard for measuring experience”.18

Debriefing is the measuring of that experience. It is the process of thinking about what you have learned about yourself, about God, about others and then putting it into practice. It is sometimes easiest to do it with someone else but a few hours of quiet time putting down the answers to the questions below can be very productive. After you have answered them, pray about what has been revealed to you, put them aside and review them in a couple of days, a couple of weeks and a couple of months to see if you have any further insights. You may find that you have forgotten much of the clarity of the lessons you were taught. That loss of clarity is a very rapid process, so it is important to do this as soon as possible after you return.

• Was I effective on this trip? What did I do right? What did I do wrong? What would I like to work on expanding or improving next time? What would I like to make sure I don’t do again?
• What have I learned from God about myself on this trip? What have I learned about others? What have I learned about God? Which of these surprised me the most? What disappointed me the most? What has God taught me about how to deal with these?
• What have I learned from fellow workers that I would like to incorporate into my life? What have I seen God do in the lives of others? How can I seek those experiences for myself? What barriers do I have in my own life that might prevent God from working?
• What insights do I have that might help fellow workers? What suggestions do I have that might improve the next trip, either for the group or for myself?

• How do I incorporate these new insights into my life? What will I change about my day-to-day life? How will this trip change my outlook on my family, my job, my church, my Christian witness, and my involvement with missions at home and abroad? What are the obstacles in my life that will preclude me from incorporating these changes into my life?

It must be recognized that sometimes it seems obvious that your trip was not “successful”. It was not the glowing, mountain-top type of experience you had hoped to have. That is even more reason to go through debriefing. In going through this process, it may become apparent to you that your trip wasn’t “successful” but that does not mean that it was a waste of time and money or that God didn’t show you exactly what He wanted to show you. You may just have missed it at the time. It may be that the trip was not a good experience precisely because there is a major disconnect between how you see yourself and your life and how God sees you. Such “bad” experiences can be some of the most enlightening of your life if you let them be.

Once you are home, one of the biggest problems is how to maintain a sustained effectiveness. By that, we mean how you make sure your experience is not “wasted” and that it continues to bear some sort of fruit. There are many things you can do. One of the first is to realize that you are now a tangible link between your church and the place and culture you left. In the short run, make sure you have brought suitable gifts or reminders for your support team and make arrangements to give them a full report using whatever tape recordings, video, pictures and souvenirs you had prepared to bring back to them. Speak to whatever groups you can get permission to address. In the long run, support the ministry you visited. Pray regularly and get updated prayer requests. Stay informed about the mission field. Keep a lively correspondence going by e-mail or snail mail. Be supportive of your new friends and missionary friends. To whatever extent you can, support the work financially. Think about what projects you can develop that will help advance the work of the mission where you were. Be a recruiter for other people to go as short-term help. Return yourself for
the short-term. Consider being part of a mission board or agency. Be part of your church’s mission committee and be an advocate for that mission field whenever possible. Lastly, prayerfully and seriously consider the option of career missions for yourself.

**ORGANIZATIONS**

**Alongside, Inc.**  
P.O. Box 587  
Richland, MI 49083-0587  
Phone: (269) 671-4809  
URL: www.alongsidecares.net  
Restoration and growth programs for missionaries.

**Barnabas International**  
PO Box 11211  
Rockford, IL 61126-1211  
Phone: (815) 395-1335  
E-mail: barnabas@barnabas.org  
URL: www.barnabas.org  
The mission of Barnabas International is to edify, encourage and strengthen servants in ministry.

**Consultation on Debriefing & Renewal**  
Mission Training International  
PO Box 1220  
Palmer Lake, CO 80133  
Phone: (800) 896-3710 or (719) 487-0111  
E-mail: info@mti.org  
URL: www.MTI.org  
Seminars and workshops to assist mission leaders and missionaries in reentry. Also, they host the Mental Health and Missions Conference, an annual conference for those committed to serving and supporting a healthy missions community.
**Fairhaven Ministries**  
#1-8191 Rogers Rd.  
Vernon, BC V1B 3M8  
Canada  
Phone: (250) 260-1616  
E-mail: info@fairhavenministries.org  
URL: www.fairhavenministries.org  
Retreat center and/or counseling for returning missionaries.

**Heartstream Resources**  
101 Herman Lee Circle  
Liverpool, PA 17045  
Phone: (717) 444-2374  
E-mail: HeartstreamResources@hotmail.com  
URL: www.heartstreamresources.org  
Residential programs with professional services. Programs of restoration and renewal for cross-cultural workers wounded or depleted in service.

**Link Care Foundation**  
1734 West Shaw Str.  
Fresno, CA 93711  
Phone: (559) 439-5920  
E-mail: info@linkcare.org  
URL: www.linkcare.org  
Residential programs to help families or individuals focus on leaving and grieving, transition, adaptation, closure and action planning.

**Mission Family Counseling**  
Stratford oaks Building, Suite 306  
514 S Stratford Rd # 306, Winston-Salem, NC 27103-1835  
Phone: (877) 623-5559  
E-mail: care@mfcs.org  
URL: www.mfcs.org  
A mission of providing pastoral counseling and support to missionaries, ministers and their families.


Emmaus Road International
7150 Tanner Court
San Diego, CA 92111
Phone/Fax: (858) 292-7020
E-mail: Emmaus_Road@eri.org
URL: www.eri.org

Publications, seminars, training courses, ministry trips and speakers bureau to help equip individuals, churches, and agencies to develop cross-cultural ministry and support of missionaries.

SUGGESTED READING

19 Deeper Roots Publication, 2100 Red Gate Rd., Orlando, Fl 32818, (407) 293-8666, E-mail: DeeperRoots@aol.com, URL: www.DeeperRoots.com
In a mission hospital in Papua New Guinea, I was asked to see a young child with a several month history of respiratory problems. They had placed two chest tubes and still the lung did not seem to fully expand. After careful examination of the patient and of the chest X-ray, I was convinced that I saw lung markings all the way out to the rib cage. The lung was not collapsed but actually the child had one of a few possible rare conditions—all the names of which are a mouthful. They are all congenital conditions with altered anatomy so that the air comes into the lung but it does not escape, thereby blowing up the lung distal to the one-way valve created by the altered anatomy. The slowly inflating mass crowds the remainder of the normal lung so it can’t work properly and also interferes with cardiac function and filling. I also thought of the possibility of some sort of somewhat more common hyperinflation syndrome—I wished for a rigid broncho-
scope (a lighted tube to look into the lung) so I could safely look down his trachea to check out the condition of his bronchial tubes but knew that would not ever happen here. A CT scan would have been nice, too. “If wishes were horses, all men would ride,” my grandmother was fond of reminding me. I wanted to ride.

I talked at length with the parents, explaining the severity of the problem but also the lack of any good alternative. He was slowly suffocating. He needed either volume reduction surgery to remove the mass or perhaps even a complete removal of the lung. The lack of medical sophistication at that little mission hospital offered severe obstacles to his proposed therapy. Without the ability to ventilate and give anesthesia to just one lung while we worked on the other side and without a good ventilator post-operatively, I was not sure he would survive no matter what we did. I did mention that the child might do better by being evacuated to Australia, but of course that was not a real consideration because of the associated high cost. The family brushed off the suggestion and insisted we could and should do something in that little hospital. There was a nearby district hospital that functioned as a referral center but the other missionary physician was convinced they could not do better than we could and often did worse in his experience. I did not make an immediate decision, preferring to read a little and pray over it. I really wanted the family and nurses to get to the point that they almost beg me to do the surgery so that when the inevitable bad result came, they were not unduly upset with me.

I grabbed my trusty digital camera and took some pictures of the X-rays, sending them in e-mails to some friends who were radiologists. The next day, the short-term pediatrician, the career missionary and I went back to talk once again to the family of the little child with the lung problem and they agreed to surgery despite the risks that we plainly laid out.
On the appointed day, our first case on the surgical docket was little Yambo with his lung problem. Everyone, including myself, was rather anxious about the case. Pre-operative prayer was short but intense. I helped the nurse anesthetist\textsuperscript{20} slide the breathing tube into the right mainstem bronchus. We would only inflate one lung during the surgery, allowing the other to collapse. He tolerated it well, maintaining adequate oxygen levels when ventilating only that one lung. With that hurdle passed, we flipped him with his right side down; the family physician helped me as I did a full chest incision from front to back on the left side, just below the shoulder blade. The findings were exactly what I hoped—a huge, non-compressible emphysematous mass (a piece of lung with lots of overextended air sacs) that arose from the upper lobe, connected only by a one inch bridge of tissue that carried the main air tube and the vessels to this abnormal lung. My radiologist friend had been right in his e-mail—I had suggested a rare diagnosis (lobar emphysema) and he had trumped me with an even rarer diagnosis (adenocystic malformation of the lung). He was right and I was glad—because his diagnosis was easier to fix than mine. I had trouble working the whole inflated thing out of chest cavity but when I did, I found the remaining lingula (the middle lobe on the left) and the lower lobe to be apparently normal in character even though they were completely collapsed. Once we put a stapler across the narrow bridge of tissue that connected the mass to the normal lung and amputated the mass, we pulled the breathing tube back into the main trachea (from its previous position on the right side) and

\textsuperscript{20} The anesthetist had parents who were cannibals, a practice which persisted in the highlands of PNG until the mid 1970’s. There were fascinating discussions about which part of the body tasted better—and no, it doesn’t taste like chicken. More like pork. In fact, the term for human meat was “long pig.” She is now a missionary in Africa, showing the redemptive power of Christ’s love.
the other remaining lobes on the left now expanded very nicely. We were all very relieved with how quickly and well the procedure had gone. We closed with two chest tubes left in. Everyone seemed to really enjoy the case. The family practitioner had enjoyed seeing the virgin chest anatomy and I was just plain giddy with the outcome. The anesthetist complimented me on my calm during the case and the skill with which I did the case. I tried to demur but the truth was that I was pretty pleased with myself, too! Being aware that “pride goeth before a fall and a haughty spirit before destruction,” I quickly readjusted my thinking. It was clear that this was all had to be to God’s glory—we had no real business tackling something like this there and the Lord had made it all work out. I really saw His hand in helping me to make the rare diagnosis so clearly in the beginning. I also firmly believe that all the prayer on behalf of this little one from hundreds and thousands on the e-mail chain had been
effective.

My MD assistant had left a little early during the closure of the chest and went to talk to the family. He came back to tell me an interesting story. He had found the mother to be very distressed. During the surgery, she had collapsed outside on the grass—she had been watching through the picture window\textsuperscript{21} during the surgery and saw me take the huge mass out her little boy’s chest. She was sure I had seriously harmed her child. I never thought about how it looked from her standpoint—but then again, I have never had patients’ families watching my surgery before.

The child had a rough post-operative course with problems with low oxygen blood levels and presumed heart failure. We only had refurbished oxygen concentrators and we were never

\textsuperscript{21} The matter of a picture window in the operating room has thus far been unique to Papua New Guinea in my experience. This Stone Age culture is based on revenge. If you hurt me, I kill you. The missionaries put in a window in the operating room to convince the local people that we were doing the best we could and that we were open about what we were doing. When the case was ready, the curtains would be drawn back and dozens of people were staring in the windows through cupped hands. I often wondered what they thought. The second craniotomy (opening the skull) I ever did was done in PNG and was like my first one in Kenya—with the book open since I had never seen one before in the United States but had no choice but to do something. It was bad enough to be anxious about opening someone’s skull—but to have people, some of whom had bones through their noses and most of whom had machetes in their hands, judging you on unknown criteria and willing to carry out their judgment with execution was just a wee bit unnerving. It will tighten your sphincters! Fortunately, the patient survived.
quite convinced that they were functioning at full capacity. Still, with some diuretics and heart stimulants, the child continued to slowly improve and his oxygen levels remained okay (as long as the nurses and family left the oxygen on and in place!). In 48 hours, his enlarged liver had become nearly normal in size and the enlarged heart had reduced in diameter. He was slowly weaned from his oxygen bit by bit each day. We were looking forward to discharging him soon.

On the eleventh post-operative day, I was all done with rounds before I realized that Yambo was not there. When I asked, the nurses told me that he and the family had “absconded” yesterday without telling anyone. If it had been a matter of affording food, we could have helped. If it was concern about money, we could have helped. As it was, he left without even his prescriptions for digoxin and diuretics. He had been so close to coming off the oxygen that I could only pray that the Lord would take care of him and he would not be too badly in need of oxygen. It was very frustrating, especially since I had made a point to explain to the family carefully about what we were doing and how long he would need to stay. We tried to send messages to his village to get him back but he was never seen again at the hospital.
As Frank Sinatra sang, “Regrets, I’ve had a few.” We all wish we had the wisdom to avoid a mistake or live a certain time or event over. Here, presented without comment, are some remarks made by ourselves and other short-term missionaries we have talked to over the years. They were all made in reference to previous short-term mission trips:

“I wish I had not set personal achievement and ‘numbers’ above experiences and relationships. I should have made a point to do more local sightseeing, had more new experiences, visited their (the national) homes when invited, gone to more national churches, and invited more nationals into my home. Instead, I was more concerned about how many patients I could see and how many procedures I could or should do.”

“I wish I had achieved a better balance in the number of patients I saw and of surgical cases I did. I overworked myself and the staff and I lost out on a lot of the blessing.”

“I regret that I did not spend more time telling of Jesus’ love to my patients. I let the language barrier intimidate me.”

“I should have spent more time in spiritual preparation before the trip.”

“I should have asked more people to pray for me. I never realized how important that would become on a day-to-day basis.”

“I wish I had not been so reluctant to ask for and accept support from others who wanted to help. I thought I needed to do it all and people wouldn’t want to give financial support to a physician.”
“If I had it to do over, I would work at a deeper relationship with one or two nationals with whom I ‘clicked.’”

“Next time, I will start sooner to develop relationships with the nationals. I focused on relationships with other expatriates to my detriment in the area of my relationships with the nationals.”

“I regret having isolated my children as much as I did from the nationals and from the hospital. I was too concerned about health issues (what diseases they might pick up), and they lost out on a great deal of cross-cultural growth and experience because of it.”

“I wished I had encouraged my children to spend more time with my spouse in the hospital. It was the greatest experience along that line that they would ever receive. They can’t do that here in the States. I think it would have made a difference in how they accept the downside of being physician’s children.”

“I wish I had kept my big mouth shut and kept my criticisms to myself until I better understood the dynamics of what was really going on. My well-meaning comments actually fed the flames.”

“I am sorry I let so many chances to encourage both the national staff and missionaries get away from me.”

“I wish I had kept a journal in much more detail. So many of the vivid experiences and details I thought I would never forget are already fading.”

“I wish I had gotten national help with my household sooner than I did. I was afraid that I was somehow taking advantage of her but she was grateful for the income and I was grateful for the help while my husband worked at the clinic.”
“I really regret having criticized the career missionary when I got there for having household help. I soon realized how much time it takes to take care of my family there and if the missionary wives were going to have any ministry, they had to make that choice.”

“I wish I had brought my spouse with me.”

“I wish I had brought my family.”

“I wish I had brought my pastor with me.”

“I wish I had stayed longer.”

“Next time I will try much harder to find out what I could bring for them (the missionaries) when I come.”

“I should have not been so much concerned about the extra luggage cost and brought some more things that would have made a difference to the missionaries and to the work.”

“Next time, I will take more advantage of the opportunities to speak to the staff, various national groups and churches.”

“I am sorry I did not give and show more grace in my relationships with our team, the missionaries and the nationals.”

“If only I had taken more pictures.”

“I am sorry I ran out of film for my camera.”

“I wish I had done a better job of taking pictures so I could present the work more effectively on my return home.”
“I regret that I did not give more thought before I went to some of the issues the physicians on the field face so I would not have been so taken aback and been so disturbed by some of the things I had to work through.”

“I needed to keep in better touch with the missionaries once I returned home. No wonder they feel sometimes like they are forgotten.”

“I tended to forget too quickly what the experience was like when I returned to my harum-scarum lifestyle.”

“I am only sorry that I didn’t do this sooner.”

“I regret that I had not woken up much sooner to the fact that I spent my life not striving for what was really important in the last analysis. It is too late now for a career in missions; I wish it wasn’t.”
WHY NOT ME?

It was not an auspicious start for this short-term mission trip. The year was 2002. I was in London’s Heathrow Airport on my way to Afghanistan to work on a hospital project for Samaritan’s Purse, the international Christian relief organization. On my way there, I would go through Islamabad. From one of the overhead televisions in the terminal blared the announcement: Pakistan was warning Americans to stay away because of the potential for terrorism and violence. It would not be the last time I wondered what I was doing on this trip.

I called my contacts back in the US and I was assured that I could safely travel on—and they would have someone meet me at the airport. Pastor Ishaq, my Samaritan’s Purse contact, picked me up at the hotel shortly after my arrival. He is a fourth generation Pakistani Christian who descended from Sikhs who had migrated here. As a Baptist preacher, he has started over 15 churches with memberships between 20 and 200. The Christians in Pakistan are largely dirt-poor, are definitely a small minority in this Muslim country and are treated as third-class citizens.

The next morning after my arrival, I was to catch a ride on the United Nations plane that was going to Mazar-I-Sharif in the north of Afghanistan, near the Uzbekistan border. I was bumped from my scheduled flight and then from the one two days after that. It gave me a lot of unexpected time.
While stranded in Islamabad, I went with Pastor Ishaq into the slums of Islamabad. Although already very familiar with the poverty of the developing world, the poverty in those slums was jarring. He took me to three different slums, all Christian, all located in flood plains. They were squatters on this land that was otherwise unusable. A recent flood had wiped their shacks away. Despite the personal neatness that was evident, the air reeked from the ubiquitous garbage. Buffalo wandered along in the refuse, adding their dung to the aroma. Despite the bitter cold of this time of the year, many inhabitants were still living in tents given out by an NGO. One poor man had been burned out Monday. Monday morning, he had virtually nothing; Monday evening, he had absolutely nothing.

The best of these buildings were mud over brick and had a tin roof, but only a few were as fancy as that. Built with shared common walls, the walls and roofs were often of whatever material could be had. Since much of the building material they used had already been discarded as useless by the original owner, it had to be skillfully and artfully arranged so that one hole in one layer was covered by the intact area of the second layer. Rain and wind still had no difficulty finding ingress.

The first church we visited was next to the church elder’s home. Parking on the road, we followed a dirt path down the steep bank of the ravine and walked across a two foot wide concrete girder that spanned the creek and the refuse. There were no rails and the drop was about 20 feet to the small creek choked with garbage on both sides. There were smoldering fires here and there in the garbage. I thought of the Biblical and historical description of Gehenna outside the walls of Jerusalem—chronic fires that burned in the refuse of the city. Following the three to four foot wide paths that wend their way between the mud brick walls, I was soon lost as the paths twisted this way and that
between the poor little hovels. We were greeted with great enthusiasm and hospitality. It was obvious that Pastor Ishaq was held in high regard here. Each of these little homes gave shelter to members of multiple generations and had a minimum of six people. One old man we visited for prayer had three sons, their wives and fourteen children living in an area no greater than 12 by 24 feet. There was no electricity in the whole of the slum.

We then drove to the second slum. We drove through nice middle class neighborhoods, turned a corner and descended into the hell of the slums. In this second one, we joined a church service already in progress. The building was wired for lights, but there was no electricity ever available here either. Dozens of pairs of shoes were neatly lined up outside. I added mine and padded into the darkness in my stocking feet. We were led to the seats of honor on the stage in front. They were singing lustily in that typical Eastern harmony and rhythm that sounded so harshly dissonant to my Western ears. One man was using two pieces of metal that slapped together in time to the rhythm, another played a tambourine and yet another played harmonium. Their faces and smiles attested to their devotion.

On the way to the third slum, Pastor drove by the huge mosque in Islamabad. He said it was the biggest in the world and could hold over 100,000 worshipers. Leaving the mosque, we drove through neighborhoods filled with spacious, expensive homes for the rich folk. These homes were huge, with walled compounds and armed guards outside. From there, we drove less than a kilometer, soon finding ourselves magically transported from the neighborhoods of the richest to the homes of the poorest of the poor who lived in the “Hundred Quarters” slums. There are more than 900 families in this small flood zone area of a quarter square mile. Each family consists of six or more people on average. If you do the math, at least 5,400 people scratch out an
existence here on this quarter square mile of desolation. We found our way on foot to an open court that they have been using for worship services. This open plaza belonged to the whole community and was their only option for use as a church. It was wide open to the elements and they had to compete for its use with weddings, funerals, rallies and other such community gatherings.

After visiting the second slum, I had asked Ishaq and his nephew what they would do if they had a little money to help these people. I was taken back when they emphatically said they would build a church first. In response to my questions about why that choice (instead of my ideas of micro-enterprise or something), they said that these people lived in these slums because they had no other choice, but they deliberately segregated themselves in order to live with and draw strength from other Christians. The presence of a church building will give
some meaning to their lives that outweighed the other inconveniences of poverty. I asked how much they would need. They needed several churches but the cost of one church was 150,000–200,000 ($2,500–$3,000) rupees, ironically the same amount as the rent for one month of the nice homes we had previously seen.

In walking through the slums, Pastor asked me to take a picture of an attractive laughing woman. She posed but told him she would rather go to Hell than follow Christ. I didn’t fully understand the interchange but it was obvious to me that Ishaq was not condemning her. He would not try to force her to Christ, but would rather try to love her to Him.

On the way back to our car, Pastor showed me a triangular piece of bare land, the only spot in the entire slum without a building upon it. There was a sign printed in Urdu announcing that a Christian church would go there. They had just received permission from one of the government agencies to build on this piece of land and the hope in Pastor’s face was easily visible as he talked of his dream. The land did not seem to have anything going for it except that it was literally the only unoccupied area in the entire slum. It jutted out into the shallow ravine where the garbage-choked creek ran. A church in the midst of the pollution—how fitting.

The following Sunday, I went back to honor the invitation to speak to the congregations in the slums. It was a bright spring day in the high 60’s. It was the Spring Festival and it is celebrated in Pakistan by the flying of kites. Since a kite is something that is cheap enough for even slum children to make, the skies above were alive with kites, skittering, twisting and diving in the light breeze. The bright sunshine and warm air made the slum look a little brighter but showed the poverty in greater relief.

After the service was over, we went to the second slum and
held a second service. After each, I held an impromptu medical clinic before leaving. Despite a wonderful day, my heart was heavy with the suffering of my fellow Pakistani Christians.

The next day, I was finally able to get a seat and fly out on the UN flight to the town of Mazar-I-Sharif. I found myself alone on a military airport in occupied territory and was thankful for two UN officers who helped me into town.

Much to the disgust of the team already on the ground, I only had ten days left to accomplish all that I was supposed to accomplish. To their amazement and mine, God was gracious and allowed me to focus. By the time I returned to Islamabad ten days later, I had been able to complete all my assignments.

Before I had gone to Afghanistan, I had been invited by Pastor Ishaq’s son to preach in the Protestant International Church on Sunday—they were without a pastor and I would be the interim pulpit supply. I was honored at being asked. However, on the evening before my appointed day, my hosts told me I would not be preaching there as planned. I asked why out of curiosity and received a rather circuitous answer that never made sense to me. I was asked to speak to my friends in the slum instead. That was fine with me.

That Sunday morning, we drove to the G8 slum. It was a good service. After we had left to run an errand, the Pastor received a phone call and his face went pale. The Protestant International Church had been bombed. We hurried to the hospital to see if we could be of assistance. It was chaos in the hospital, with little security. Newsmen and bystanders everywhere. Pastor prayed with many. One American diplomat’s wife had been killed. Although they did not permit me to practice any of my surgical skills because of licensing issues, I offered my services to the American ambassador who had come to see after the Americans. Wild rumors were flying everywhere. The final total
was five dead and 42 injured of the 150–200 in attendance that morning.

Having done all that we could do at the hospital, we then went with the church treasurer to the church. There was broken glass and blood everywhere. Even the ceiling was spattered with blood. Unimpeded by anyone, the two suicide bombers had strode in that sunny morning and wrecked havoc in their hatred. They had thrown grenades and then exploded the grenades that they had strapped to their body. The terrorists were blown into pieces, presumably in hopes of obtaining Paradise. The preacher that morning had been badly hurt. I later found out that he had a permanent injury of his brachial plexus which left his arm seriously paralyzed. He also suffered a compound fracture of his lower leg.

When I heard about the injury to the speaker, I was shaken to the core. One thought kept running through my mind, “It could have been me”. I spent a lot of time over the next few weeks thinking about this near-miss with death. As I thought more deeply, I went from “why me” to “why not me”. What did God have in mind for me in the future that He spared me from this horrible situation? I still don’t know the answer to that question. I did know that I had spent over three weeks in a relatively high risk environment but had peace the entire time. I was convinced that the safest place I could ever be was in the center of His will for my life.

Postscript

Once home in the US, I could not get the image of my Christian brothers and sisters living in those Islamabad slums out of my mind. After expressing my feelings to my wife, we committed to fund the construction of one of the needed churches. Upon hearing about it, another older saint in our church con-
tributed the funds for another. An article in a publication by Samaritan’s Purse led to more donations. There are now at least nine churches in the slums where there were none before. That wasn’t the only unexpected result of this trip. In the spare time, I was also able to write and finish up the *Handbook for Short-Term Medical Missions*. The main purpose of the trip was also accomplished. The hospital in northern Afghanistan was opened a short time later along with a clinic and several schools. Turned over to the townspeople, that hospital is a constant reminder that Christians cared for them when no one else including Muslims was doing anything in that town. I pray that it will be a reminder that Christ loves them, died for them and offers them everlasting life.

Jeremiah 10:23 (NIV), “I know, O Lord, that a man’s life is not his own; it is not for man to direct his steps.”

And I thought I was just going to Afghanistan to help write some policies and procedures . . . .
CHAPTER 11

I’VE COME AND GONE—WHAT NOW?

In Chapter Ten, the last person said, “It is too late now for a career in missions; I wish it wasn’t.” But is it? Is it too late for you to rearrange your life to honor Christ’s principles in your life?

What did you learn on this short-term medical mission experience about how to serve the Kingdom of God better? We read in Romans 10:9–15 (NIV), “That if you confess with your mouth, ‘Jesus is Lord,’ and believe in your heart that God raised him from the dead, you will be saved. For it is with your heart that you believe and are justified, and it is with your mouth that you confess and are saved. As the Scripture says, ‘Anyone who trusts in him will never be put to shame.’ For there is no difference between Jew and Gentile—the same Lord is Lord of all and richly blesses all who call on him, for, ‘Everyone who calls on the name of the Lord will be saved.’ How, then, can they call on the one they have not believed in? And how can they believe in the one of whom they have not heard? And how can they hear without someone preaching to them? And how can they preach unless they are sent? As it is written, ‘How beautiful are the feet of those who bring good news!’”

Not all are called to go and be career missionaries. Those who preach must be sent. As you have now seen and perhaps experienced, being sent requires an intensive program of prayer, support, and encouragement. Who is more qualified after this trip to do that for others than you are? You will have been there and you will have a better understanding than most of your friends and fellow church members. You will have seen the difference that prayer and even small bits of financial aid can make. You will be able to empathize better with the difficult row that career missionaries have to hoe and you will be a more effective cheerleader and prayer warrior.

Medical missions is not about how much we love people or even about how much we love God; it is about how much God loved us. Can we truly say that we are compelled to tell others because of Christ’s
love? Was His death in vain or should we truly no longer live for ourselves but rather live for Him?

“For Christ’s love compels us, because we are convinced that one died for all, and therefore all died. And he died for all, that those who live should no longer live for themselves but for him who died for them and was raised again.” (2 Cor 5:14–15, NIV)

What is Christ’s love compelling you to do?

We close this book with some wise words from a veteran medical missionary:

You have seen medical missions. Their faces are imprinted on your mind; their blood was so recently washed from your hands. You have heard the cries and you have wiped the tears, from their eyes and from your own. For a brief time, you became part of their lives, and they became part of yours. Medical missions took on a shape, but even more than a shape, medical missions became a name and a face. What will you do next?

The Lord said (to Moses):

“I have indeed seen the misery of my people . . .
I have heard them crying out . . .
I am concerned about their suffering . . .
“So I have come down to rescue them!” (Exodus 3:7–8)

God never gets on an airplane and flies back to suburbia. The eyes and the ears and the concern of God are forever directed toward the misery and the cries and the suffering of His people. Before you volunteered, before you gave a second thought about the needs of the people served by medical missions, God’s heart was breaking over their suffering. It has always been so, and will be so until the end of time.

“So now, go. I am sending you!” (Exodus 3:10)

Moses had already tried to rescue the people in his own strength, and failed miserably. That is why God finds him on the far side of the desert tending sheep. Moses is trying to hide from the misery and cries of the people and, in doing so, is running from God’s call on his life. But God invites Moses to participate in His own amazing redemptive
purpose, and Moses’ life will never be the same!

Medical missions is not something we do, it is something God is doing, and we have the great privilege of participating in it. God is healing, God is redeeming, God is changing lives! “Through God’s mercy, we have this ministry” (2 Corinthians 4:1). It is only by the mercy and the grace of God that He invites us to participate in ministry. It is a profound mystery but it is clear that we are the instruments God has chosen to rescue His people, to redeem His creation. “He has committed to us the message of reconciliation” (2 Corinthians 5:19).

What are we doing with the invitation of God and the message committed to us? Therein lies our only hope for fullness of joy, deep meaning, and freedom from all that would entangle us. Trouble free? Absolutely not! You have tasted some of the many difficulties encountered in medical missions. Cultural differences, limited resources, lifestyle changes, ingratitude, personality clashes, persecution, danger, sleepless nights, excessive demands—the mission field has all of these and more. But these are “achieving for us an eternal glory that far outweighs them all” (2 Corinthians 4:17). If the call of God for your life is medical missions, then you are among the most privileged. For God has “come down to rescue them” and He is calling you to witness and participate in His miraculous work!

Seek the will of God, listen to His voice, and stay involved in medical missions! It may mean a career change. It may mean a new structure to your medical practice or new priorities in the way you make and spend money. Maybe you are called to regular volunteer service or recruiting others or identifying resources to strengthen a specific ministry.

The life of Jesus Christ gives us a clear model for Kingdom ministry. Matthew chapters 8 and 9 vividly portray Christ’s teaching, preaching, and healing. “When he saw the crowds, he had compassion on them, because they were harassed and helpless.” If your experience in medical missions has opened your eyes to the suffering of the crowds, then listen closely for the calling voice of the Lord of the harvest. That voice bears your name.

Get Ready! Get Set! GO!
APPENDIX A

SUGGESTED BIBLIOGRAPHY

*Books of special value are marked with an asterisk.

MEDICAL MISSIONS

Crane, Sophie M.

Dietrick, Ronald
*Modern Medicine and the Missions Mandate: Thoughts on Christian Medical Missions*. Woodville, Tx: Medical Benevolence Foundation

Hale, Thomas and Cynthia Hale

Ewert, D. Merill, Ed.

Grundmann, Christopher

Kuhn, W. Ted, S. Kuhn, H. Gross

Seel, David J.

Steffes, Bruce, M. Steffes

23 Out of print. There is no date of publication but is approximately 1983. No ISBN listed.
VanReken, David E.


**MISSIONS & MISSION PHILOSOPHY**

Adolph, Harold


Blue, Ron


Blackaby, Henry T. and Claude V. King


Borthwick, Paul


Bosch, David J.


Cuthbert, Melbourne, J. Lockerbie


Fielding, Charles


Gaukroger, Stephen


Goldsmith, Elizabeth


Hoke, Steve, Bill Taylor

Howard, David
*Missions Alive: Experiential Games for Youth.* World Changers Resources (PO Box 830010, Birmingham, Alabama), 1993, ISBN 1-56309-071-6

Johnstone, Patrick

ISBN 0310400317

*Johnstone, Patrick

Miller, Darrow

Olson, C. Gordon

Pippert, Rebecca

Piper, John

Rowell, John

Saint, Steve

Telford, Tom

Tucker, Ruth
RAISING SUPPORT

Barnett, Betty

Bromley, Dana, J. Allum

Dillon, William P.

Morton, Scott

Nouwen, Henri J. M.

Sommer, Pete

MEDICAL BOOKS

Auerbach, PS., ed.

Cook, John, B. Sankaran, Ambrose EO Wasunna, ed.

Cook, John, B. Sankaran, Ambrose EO Wasunna, ed.
Davis, Mark

Dobson, MB

Eddleston, Michael, S. Pierini

Jong, Elaine C, R. McMullen, ed.

*King, Maurice (ed.), P. Bewes (ed.) et al

*King, Maurice (ed.), P. Bewes (ed.) et al

Note: Primary Surgery wiki (courtesy of the Canadian Network for International Surgery is available at http://ps.cnis.ca/wiki/index.php/Main_Page

*King, Maurice (ed.), E. Ayim (ed.) et al

Krawinkel, M, H. Renz-Polzer

Krol, J. (ed.)

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Available from TALC (Teaching Aids at Low Cost), PO Box 49, St. Albans, Herts AL1 5TX, United Kingdom. E-mail: info@talcuk.org. Web site: www.talcuk.org
Lamb, Ron
*Portable Mission Dentistry*, 1999 Available from Dr. Ron Lamb, PO Box 747, Broken Arrow, OK 74013-0747

Leppard, Barbara

*Palmer, Dennis, C. Wolf*


Rosenfeld, Geoffrey V. and D. Watters

Schwab, Larry

Stanfield, P.

Tyring, Stephen, O. Lupi and U. Hengge

VanRooyen, Michael, T Kirsch et al

Wilson-Howarth, Jane

World Health Organization
This is a partial list of the organizations that you may find helpful to you as a short-term medical missionary. A more complete list is available for download from the “Handbook” section of www.brucestefes.net.

CHRISTIAN ORGANIZATIONS

• **ABWE**  
  See Association of Baptists for World Evangelism

• **African Inland Mission International (AIM)**  
P.O. Box 178  
Pearl River, NY 10965  
Phone: 800-254-0010  
E-mail: Through the web site  
Web site: www.aimint.org/usa  
  
  Africa Inland Mission International, Inc. is an interdenominational foreign mission organization serving in 14 countries in Africa and in various urban centers in the United States. AIM’s primary goal is to establish and develop maturing churches through the evangelization of unreached people groups and the effective preparation of church leaders.

• **American Baptist Churches Board of International Ministries**  
  Box 851  
  Valley Forge, PA 19482  
  Phone: 800-222-3872  
  Web site: www.abc-usa.org and www.internationalministries.org  
  
  ABCBIM needs general practitioners, surgeons and other health professionals to serve in Africa, Asia, the Caribbean, Central and South America and Europe.
• **ABWE (Association of Baptists for World Evangelism)**
  P.O. Box 8585
  Harrisburg, PA 17105-8585
  Phone: 717-774-7000
  E-mail: info@abwe.org
  Web site: www.abwe.org
  Independent Baptist, fundamentalist faith mission agency, planting such churches in about 50 countries. Medical missionaries in Bangladesh, Brazil, Ukraine, The Gambia, Togo, Philippines. All medical workers (including short-term teams) from independent Baptist churches.

• **Baptist Medical Dental Fellowship**
  4209 Royal Avenue
  Oklahoma City, OK 73108-2033
  Phone: 405-606-7027
  E-mail: BMDF@bmdf.org
  Web site: www.bmdf.org
  To provide a professional fellowship of Baptist physicians and dentists for the purpose of enhancing their Christian growth, church involvement, and support of Christian missions. Opportunities in short-term missions, continuing medical education programs for missionaries and other areas of service.

• **Catholic Medical Mission Board, Inc.**
  10 West 17th Street
  New York, NY 10011
  Phone: 800-678-5659 or 212-242-7757
  E-mail: info@cmmb.org
  Web site: www.cmmb.org
  CMMB’s primary mission is to ship medical supplies to facilities throughout the developing world. CMMB also initiates and operates healthcare programs that help build the capacity of local communities to provide long-term sustainable healthcare. Volunteers of all specialties serve two weeks to two years in Catholic health care facilities. Short-term volunteers work in Kenya, Haiti, the Dominican Republic and St. Lucia. The organization arranges room and board for all volunteers, plus airfare and stipends for long-term workers.
• **Catholic Network of Volunteer Service**  
  6930 Carroll Avenue, Suite 820  
  Takoma Park, MD 20912-4423  
  Phone: 800-543-5046 or 301-270-0900  
  E-mail: cnvsinfo@cnvs.org  
  Web site: www.cnvs.org  
  CNVS is an umbrella organization of 200 full-time, faith-based volunteer programs that place people in direct service throughout the world. Publishes RESPONSE, a free directory of volunteer programs.

• **Christian and Missionary Alliance**  
  See The Christian and Missionary Alliance

• **Christian Medical and Dental Associations—**  
  **Global Health Outreach**  
  Contact: Samuel Molind, DMD  
  Box 7500  
  Bristol, TN 37621-7500  
  Phone: 423-844-1000 or (regarding applications) 423-844-1007  
  E-mail: gho@cmda.org  
  Web site: www.cmda.org/gho  
  Global Health Outreach is the mission arm of the Christian Medical and Dental Society. GHO sends physicians, dentists and specialty teams into developing countries world wide to share their expertise and their faith with people suffering from physical and spiritual pain.

• **Episcopal Medical Missions**  
  606 Rathervue Place  
  Austin, Texas 78705-3128  
  Phone: 210-506-5649  
  Email: emmf@emmf.com  
  Web site: www.emmf.com  
  Medical and dental student ministry opportunities are available. Episcopal Medical Missions Foundation is an effort on the part of health professionals and other lay members of the Episcopal Church to organize and augment the support of our medical missionaries as they deliver medical and spiritual aid in mission stations of Honduras, Jamaica, Haiti, the Dominican Republic, Nigeria and Uganda. We welcome contributions of time, talents and funds from any and all, regardless of denomination.
• **Fellowship of Christian Physician Assistants**
P.O. Box 2006  
Bristol, TN 37611  
Phone: 423-844-1015  
Email: contactfcpa@fcpa.net  
Web site: www.fcpa.net  
Fellowship of Christian Physician Assistants is affiliated with CMDA and other groups. Matching grants are available for medical mission trips.

• **International Mission Board**
International Mission Board, SBC  
3806 Monument Avenue  
P.O. Box 6767  
Richmond, VA 23230-0767  
Phone: 800-999-3113  
E-Mail: Through the website  
Web site: www.imb.org  
The Mission Board of the Southern Baptist Convention, it has extensive missionary efforts in multiple countries for both career and volunteer medical missionaries.

• **International Service Fellowship (InterServe/USA)**
7000 Ludlow Street  
P.O. Box 418  
Upper Darby, PA 19082-0418  
Phone: 610-352-0581 or 800-809-4440  
Fax: 610-352-4394  
E-mail: ot@ludlow.net  
Web site: www.interserve.org or www.interserveusa.org  
InterServe is a fellowship of Christian professionals in mission. Although our personnel work in marketplace occupations, individuals raise their own support so that their skills can be a gift to others. Long-term and short-term placements, including medical electives, are available.
• **Medical Education International (MEI)**
  P.O. Box 7500
  Bristol, TN 37521
  Phone: 888-230-2637
  Email: mei.director@cmda.org
  Web site: www.cmda.org (and click on Missions/Medical EducationInternational)

  Medical Education International (MEI) is the educational medical missions outreach of the Christian Medical Dental Association previously known as COIMEA. We use medical/dental education to impact national physicians and dentists for the Lord Jesus Christ.

• **Medical Ministry International**
  P.O. Box 1339
  400 N. Allen Drive, #204
  Allen, TX 75013
  Phone: 972-727-5864
  E-mail: mmitx@mmint.org
  Web site: www.mmint.org

  One and two week opportunities for volunteers to work in medical, dental, surgical and eye clinics, helping the poor who have little or no access to health care. Dentists, primary care and specialty physicians, surgeons, optometrists, nurses, health educators, other health professionals, translators, techs, fix-it people, general helpers, and spouses can come.

• **Mennonite Central Committee**
  21 South 12th Street
  P.O. Box 500
  Akron, PA 17501-0500
  Phone: 717-859-1151 or 888-563-4675
  E-mail: Through web site
  Web site: www.mcc.org

  Mennonite Central Committee (MCC) is a relief, service, and peace agency of the North American Mennonite and Brethren in Christ churches.
• **Mennonite Medical Association**  
  183 Grandview Drive  
  Harrisonburg, VA  
  Phone: 540-433-5059  
  E-mail: sajmma@aol.com  
  Web site: www.mennmed.org  
  It is a fellowship of around six hundred physicians, dentists, and medical/dental students who are members of congregations of Mennonite and Brethren in Christ Churches. Professional persons not members of such congregations, but in harmony with the purposes and faith of this organization, may become associate members. We present the need for physicians and dentists in mission and church-related projects, both abroad and in North America.

• **Mercy Ships**  
  P.O. Box 2020  
  Garden Valley, Texas 75771-2020  
  Phone: 800-772-SHIP or 903-939-7000  
  Fax: 903-882-0336  
  E-mail: Info@mercyships.org  
  Web site: www.mercyships.org  
  This nondenominational Christian group operates the *Africa Mercy*. This hospital ship docks in major ports in Africa and runs many ministries from there. Mercy Ships uses physicians specializing in family practice, internal medicine, pediatrics, anesthesiology, and ophthalmic and maxillofacial surgery. All other hospital-associated professionals are desired. Short-term volunteers serve two weeks to three months. Longer-term volunteers may serve as spouse teams and may even bring their children aboard the ship.

• **Mission Society for United Methodists**  
  6234 Crooked Creek Road  
  Norcross, GA 30092-8347  
  Phone: 800-478-8963 or 770-446-1381  
  E-mail: Via the web site  
  Web site: www.themissionsociety.org  
  The Mission Society for United Methodists (MSUM) is a voluntary mission agency for United Methodists and those of Wesleyan tradition. It presently has more than 200 missionaries, some of whom are jointly sponsored by other mission agencies to work in countries in which the Mission Society does not itself have a field. Its short-term ad medical-dental ministries are very active.
• **Mission to the World**  
  1600 North Brown Road  
  Lawrenceville, GA 30043-8141  
  Phone: (678)-823-0004  
  E-mail: medical@mtw.org  
  Web site: www.mtw.org  
  Medical professionals, translators, and support personnel are all needed! The Medical Missions Department has several short-term ministry opportunities to offer to individuals in the field of medicine and dentistry. Medical, dental, academic and opportunities; disaster relief ministries; and advanced medical leadership training are available for students and trained professionals.

• **Nazarene Medical Organization**  
  17001 Prairie Star Parkway  
  Lenexa, KS 66220  
  Phone: 877-626-4145  
  E-mail: ncm@nazarene.org  
  Web site: www.ncm.org  
  NHCF, part of the Nazarene Compassionate Ministries International, is a fellowship of over 2,400 Christian health professionals. Our purpose is to support the medical mission work of the Church of the Nazarene. We sponsor six medical teams each year and many individual volunteers. We provide free medical and dental care for our missionaries and much more.

• **Medical Teams International**  
  P.O. Box 10  
  Portland, OR 97207-0010  
  Phone: 800-959-HEAL  
  E-mail: info@medicalteams.org  
  Web site: www.nwmedicalteams.org  
  Since 1979, Medical Teams International (formerly known as Northwest Medical Teams) has provided disaster response and emergency relief to refugees of wars and to victims of earthquakes, floods, hurricanes and famines. The organization provides long-term health development programs in Africa, Asia, Latin America, Eastern Europe and the former Soviet Union. On average, the organization deploys 100 teams per year including dental ophthalmology, plastic surgery, family practice, OB/GYN, orthopedic and ENT.
• **Pan-African Academy of Christian Surgeons**
  9508 Tamarisk Parkway
  Louisville, KY 40223
  Phone: 502-425-6254
  Email: info@paacs.net
  Web site: www.paacs.net
  The PAACS is an interdenominational ministry that trains African Christian surgeons in Africa, to offer Christ’s healing mercy to Africa’s poor in Christian hospitals. This training is currently offered at mission hospitals in several countries in Africa and one in Asia. The five-year curriculum is certified by the Loma Linda University School of Medicine. Surgeons of all specialties, anesthesiologists, gastroenterologists, radiologists and OB-Gyn are needed to help train general surgical residents.

• **Presbyterian Church (USA)**
  Mission Service Recruitment
  100 Witherspoon Street
  Louisville, KY 40202
  Phone: 888-728-7228, ext. 2530
  E-mail: msr@ctr.pcusa.org
  Web site: www.pcusa.org/msr
  Volunteers specializing in health administration, family practice, internal medicine, pediatrics, public health, and surgery are deployed in projects throughout the world. Physicians in public health and family practice are very much needed. A two-year commitment is required.

• **Prison Fellowship International**
  P.O. Box 17434
  Washington, DC 20041
  Phone: 703-481-0000
  Email: info@pfi.org
  Web site: www.pfi.org
  Prison Fellowship International is a network of 105 prison ministries around the world, over 100,000 volunteers serving the body of Christ in prisons. The PFI Global Assistance Program (GAP) seeks to meet the basic needs of prisoners, ex-prisoners and their families through short-term medical projects and HIV/AIDS education/prevention. Since 1995, more than 600 medical professionals and support volunteers have brought relief and hope to more than 95,000 prisoners through GAP projects in Africa, Latin America, Eastern Europe and the Pacific.
• **Project MedSend**  
P.O. Box 1098  
Orange, CT 06477-7098  
Phone: 203-891-8223  
E-mail: info@medsend.org  
Web site: www.medsend.org  
To develop funding to repay educational loans for career healthcare workers as they minister among the underserved at home and abroad.

• **Samaritan’s Purse**  
See World Medical Mission

• **SIM International**  
Mail Box 7900  
Charlotte, NC 28241  
Phone: 803-802-7300  
E-mail: info@sim.org  
Web site: www.sim.org  
This evangelical Christian ministry needs physicians in family practice and general surgery for volunteer service projects in Africa, Asia and South America.

• **TECH (Technical Exchange for Christian Healthcare)**  
Contact: Richard Wood  
P.O. Box 1912  
Midland, MI 48641-1912  
Phone & Fax: 989-837-5515  
E-mail: mail@techmd.org  
Web site: www.techmd.org  
TECH is a non-denominational Christian Organization founded to promote and improve the efficiency and quality of care provided by medical mission groups. They promote standards of biomedical care and assist in procuring and identifying solar, electrical, water, maintenance and equipment needs.
• **The Christian and Missionary Alliance**  
  P.O. Box 35000  
  Colorado Springs, CO 80935-3500  
  Phone: 719-599-5999  
  Email: webmaster@cmalliance.org  
  Web site: www.cmalliance.org  
  The Christian and Missionary Alliance (C&MA) is an evangelical denomination with a major emphasis on world evangelization. Among our ministries are medical clinics and a hospital in Africa.

• **United Methodist Volunteers in Action**  
  315 West Ponce De Leon Avenue, #750  
  Decatur, GA 30030  
  Phone: 404-377-7424  
  E-mail: sejinfo@umvim.org  
  Web site: www.umvim.org/  
  United Methodist Volunteers in Mission enables construction teams, medical teams, disaster response teams, and evangelistic/educational teams to share their faith in Jesus Christ through utilizing each person’s unique skills and gifts in hands-on mission service in a global context.

• **World Medical Mission**  
  Agency Box 3000  
  Boone, NC 28607  
  Phone: 828-262-1980  
  E-mail: wmminfo@samaritan.org or use web site  
  Web site: www.samaritan.org  
  World Medical Mission is a part of Samaritan’s Purse. A non-denominational specialized service agency of evangelical tradition engaged in relief aid, children’s programs, evangelism, support of national workers, and supplying equipment. Specializing in meeting the needs of victims of war, poverty, natural disasters, and disease while sharing the Good News of Jesus Christ.
SECULAR ORGANIZATIONS

- **International Medical Volunteers Association**
  P.O. Box 205
  Woodville, MA. 01784
  Phone: 508-435-7377
  E-mail: info@imva.org
  Web site: www.imva.org
  The International Medical Volunteers Association (IMVA) is a nonprofit organization that promotes, facilitates, and supports voluntary medical activity through education and information exchange. Our interests are primarily in developing countries. We provide information about volunteer opportunities and offer practical advice on how to find and choose compatible assignments. We do not, however, send or sponsor volunteers ourselves.

- **Doctors Without Borders USA (Medecins Sans Frontieres)**
  333 7th Avenue, 2nd Floor
  New York, NY 10001-5004
  Phone: 212-679-6800
  Fax: 212-679-7016
  E-mail: See web site
  Web site: www.dwb.org
  The world’s largest independent nonprofit emergency medical aid organization has served in 83 countries, helping victims of war, natural disaster, and hardship. Assignments involving primary care last six months to a year; however, members of quick-response teams, such as surgeons and anesthesiologist, may make commitments that are as brief as six weeks. Primary care professionals are always needed, as are physicians in other specialties, including ob-gyn, general surgery, anesthesiology, and tropical medicine.

- **Interplast**
  857 Maude Avenue
  Mountain View, CA 94043
  Phone: 650-962-0123 or 1-888-INPLAST (1-888-467-5278)
  E-mail: info@interplast.org
  Web site: www.Interplast.org
  Interplast is a nonprofit organization providing free reconstructive surgery for needy children and adults in developing nations. It functions by organizing work teams of plastic surgeons and other professionals and also by emphasizing the teaching of national personnel.
Medical Missions: Get Ready! Get Set! GO!

- **Operation Giving Back (American College of Surgeons)**
  Web site: www.operationgivingback.facs.org
  Based on the input of active and potential surgical volunteers, the ACS has created Operation Giving Back. It is designed to be a comprehensive resource center where surgeons can find the information they need to investigate and participate in volunteer opportunities.

- **Operation Smile**
  6435 Tidewater Drive
  Norfolk, VA, 23509
  Phone: 888-OPSMILE (888-677-6453) or 757-321-SMILE
  E-mail: credentialing@operationsmile.org
  Web site: www.operationsmile.org
  Teams of plastic surgeons, anesthesiologists, dentists, nurses, and speech and physical therapists are enlisted for two-week surgical missions to developing nations. The first several days are spent screening patients; the remainder are devoted to surgeries. Patients are typically children who have cleft lips or palates, bums, or tumors.

**WEB SITES: CHRISTIAN**

- **Adventist Development & Relief Agency International (ADRA)**
  www.adra.org
- **Christian Church (Disciples of Christ), Week of Compassion**
  www.weekofcompassion.org
- **Christian Medical Fellowship**
  www.cmf.org.uk
  CMF, linked with Medical Missionary Association, together have extensive links abroad through a variety of channels: overseas hospitals, UK-based mission societies, sister organizations to CMF in over 60 countries, aid agencies and individual health professionals.
- **Christians Abroad**
  www.cabroad.org.uk/
  There is an extensive list of medical mission opportunities and general advice.
- **Church of Christ International Health Care Foundation**
  www.ihcf.net
• Church World Service & Witness National Council of Churches of Christ in the USA  
  www.churchworldservice.org

• Lutheran World Relief  
  www.lwr.org

• Mission Finder  
  www.mfinder.org
  
  This web site is a search engine listing thousands of opportunities in short-term missions, medical missions, orphanage work, opportunities for retirees, work with American Indians, tradesmen and other professionals, training and training for missions. There are links for travel, insurance, shipping and other resources.

• The Episcopal Church Relief and Development  
  www.er-d.org

WEB SITES: SECULAR

• Healthcare Volunteer  
  www.healthcarevolunteer.com
  
  Non-profit portal that connects all volunteers and job seekers interested in health-related volunteering or health-related work to appropriate opportunities. It is the world’s largest listing of health-related volunteering opportunities.

• International Health Care Opportunities Clearinghouse  
  http://library.umassmed.edu/ihoc/
  
  This Web site is designed for health-care professionals and students who are interested in volunteer work, employment, or studying with under-served communities at home or abroad. It lists hundreds of service organizations which are entirely secular or which do not require a certain faith to participate.
AID, SUPPLY, MEDICINE & EQUIPMENT AGENCIES

- **Blessings International**  
  5881 South Garnett  
  Tulsa, OK 74153-0292  
  Phone: 918-250-8101  
  E-mail: info@blessing.org  
  Web site: www.blessing.org  
  Partnering with local churches and humanitarian groups, we serve as a resource of essential medicines for short-term medical mission teams, US clinics, and disaster relief outreaches. Provides pharmaceuticals and medical supplies at about 10% or less of their value. Contact them for an application form and current lists of available drugs and supplies.

- **Brother’s Brother Foundation**  
  1200 Galveston Avenue  
  Pittsburgh, PA 15233  
  Phone: 412-321-3160  
  E-mail: mail@brothersbrother.org  
  Web site: www.brothersbrother.org  
  Provide pharmaceuticals, over the counter medications, medical supplies and equipment and various other goods for shipping overseas. The costs vary by the amount requested.

- **Christian Orthopedic Partners (COP)**  
  P.O. Box 4712  
  Crofton, MD 21114  
  Phone: 877-261-3211  
  E-mail: copcmm@olg.com  
  Web site: www.christianorthopedicpartners.org  
  COP provides about millions of dollars worth of orthopedic goods annually at no charge for children and adults. Usually the request is from a missionary doctor in the developing world. COP is an all-volunteer fellowship of orthopedic professionals who serve crippled children and adults with physical deformities. They provide free surgery, limbs, braces, wheelchairs, crutches, walkers, and rehabilitative services throughout the world. Although there is no charge for the items, donations are appreciated.
• **CHOSEN Mission Project**  
  3638 W. 26th Street  
  Erie, PA 16506-2037  
  Phone: 814/833-3023  
  E-mail: info@chosenmissionproject.org  
  Web site: www.chosenmissionproject.org  
  Christian Hospitals Overseas Secure Equipment Needs. An interdenominational specialized service agency of evangelical tradition engaged in providing medical supplies, purchasing service, equipment, and technical assistance/training to Christian medical facilities. They deal with large medical equipment. They remanufacture or rebuild all of their equipment and charge 18% of fair market value, plus shipping.

• **CrossLink International**  
  427 North Maple Avenue  
  Falls Church, VA 22046  
  Phone: 703-564-5465  
  E-mail: info@crosslinkinternational.net  
  Web site: www.crosslinkinternational.net  
  Pharmaceutical warehouser equipping medical mission teams, hospitals and clinics with medicines, medical supplies and recycled eyeglasses.

• **Equip Inc**  
  P.O. Box 1126  
  Marion, NC 28752-1126  
  Phone: 828-738-3891  
  E-mail: equipwebmaster@gmail.com  
  Web site: www.equipinternational.com  
  Equip, Inc. is a relief and missionary sending and training organization. They offer nine courses for missionary training including Missionary Medicine Intensive, Emergency dentistry, Primary Eye Care and Community Health Evangelism.

• **Glasses for the Masses**  
  Fairview UMC  
  2505 Old Niles Ferry Rd.  
  Maryville, TN 27803  
  Phone: 423-983-2080  
  Collect donated glasses, labels them with the prescription and makes them available to mission teams.
• **Healing Hands International**  
  455 McNally Drive  
  Nashville, TN 37211  
  Phone: 615-832-2000  
  E-mail: kpost@hhi.org  
  Web site: www.hhi.org/  
  Church of Christ supported humanitarian aid agency that warehouses medical supplies for use by medical missionary teams overseas and disaster relief supplies for use in the US.

• **Helping Overseas Directory**  
  Web site: www.helpingoverseasdirectory.org  
  This directory seeks to aid short-term mission trips, getting medical supplies, and other forms of overseas involvement.

• **InFOCUS and Eye Deal Eyewear**  
  19728 Saums Road PMB #136  
  Houston, TX 77084  
  Phone: 281-398-7525 or 866-398-7525  
  Email: infocus@infocusonline.org  
  Web site: www.infocusonline.org  
  InFOCUS trains mission teams and medical volunteers how to provide eye care, including eyeglasses, to people in developing countries. InFOCUS offers quarterly training workshops. Main topics include: How to measure visual acuity, how to use the FOCOMETER, how the eye works, how to recognize common sight problems, how to dispense eyeglasses and how to assess, treat or refer patients.

• **Interchurch Medical Assistance (IMA) Worldhealth**  
  P.O. Box 429  
  New Windsor, MD 21776-0429  
  Phone: 410-634-8720 or 877-241-7952  
  E-mail: imainfo@imaworldhealth.org  
  Web site: http://imaworldhealth.org  
  IMA World Health serves the needs of short-term, volunteer medical mission teams, including physicians and church-related groups, by providing medicines and medical supplies through its inventory of donated products and the IMA Medicine Box® program (prepackaged units of WHO recommended drugs). Some drugs by Abbot, Becton Dickinson, Bristol-Myers Squibb,
GlaxoSmithKline, Johnson & Johnson, Merck & Co, Inc and Pfizer are available. IMA can handle larger sized and container shipments upon request. For the most current list of products contained in the Medicine Box, please call.

• **International Aid**  
  17011 W. Hickory St.  
  Spring Lake, MI 49456-9712  
  Phone: 616-846-7490 or 800-968-7490  
  E-mail: iai@internationalaid.org  
  Web site: www.internationalaid.org  
  International Aid Inc. is a 501 (c-3) non-profit mission relief organization located in Spring Lake, Michigan. Although we are involved in general relief, the major part of our work is in medical relief. We work with mission organizations and hospitals throughout the world, primarily in developing countries or those that are economically depressed. LAB-In-A-Suitcase is a low cost, portable battery operated lab designed for remote regions.

• **International Dispensary Association**  
  P.O. Box 37098  
  1003 AB  
  Amsterdam, The Netherlands  
  Phone: 31-020-403-3051  
  Fax: 31-020-403-1854  
  E-mail: info@ida.nl  
  Web site www.ida.nl  
  Wholesale pharmaceuticals. IDA Foundation is the world’s largest not-for-profit provider of pharmaceuticals and medical supplies, offering a wide range of quality assured products from stock. IDA is specialized in providing the pharmaceutical products included in the WHO Essential List of Medicines.

• **MAP International**  
  4700 Glynco Parkway  
  Brunswick, GA 31525-6800  
  Phone: 800-225-8550  
  E-mail: On the website  
  Web site: www.map.org  
  A nondenominational service agency providing medicines and supplies for medical work, health development and emergency relief. Also have a TRAVEL PACK, a prepackaged unit of WHO
listed essential drugs ready for transport. They have an extensive list of European generics which can be ordered through them and shipped directly to your mission site.

• **MAP International Medical Fellowship**  
  Medical Fellowship Coordinator  
  MAP International  
  50 Hurt Plaza, Suite 400  
  Atlanta, GA 30303  
  Phone: 404-880-0540  
  E-mail: mstevenson@map.org  
  Web site: www.map.org and follow links  
  The Medical Assistance Program (MAP) has a fund that will pay up to 100% of the actual airfare for medical students and residents. Annual deadline is March 1.

• **Medical Ministries International**  
  See contact information above. They also recycle large quantities of surplus medicines and medical supplies for overseas use.

• **Medlend**  
  35 Baywood Avenue, Suite I  
  San Mateo, CA 94402  
  Phone: 650-375-1800  
  E-mail: info@medlend.org  
  Web site: www.medlend.org  
  This non-profit organization lends mobile medical equipment to assist other non-profits providing medical care in developing countries. Most equipment is small enough to go on passenger planes.

• **Northwest Medical Teams International**  
  In addition to their teams (listed above), this Christian group has shipped over millions of dollars worth of medical supplies and food to recipient nations.

• **REMEDY**  
  3-TMP, 333 Cedar Street  
  P.O. Box 208051  
  New Haven, CT 06520-8051  
  Phone: 203-737-5356 or 203-785-6750  
  E-mail: remedy@yale.edu  
  Web site: www.remedyinc.org  
  REMEDY is dedicated to teaching hospitals and other medical organizations how to reclaim the millions of dollars of unused medical equipment that is disposed of yearly in the US.
• **Science with a Mission, Inc**
  602 Massapoag Avenue
  Sharon, Mass 02067
  Phone: 781-784-6907
  Email: Alynne@sciencewithamission.org
  Web site: www.sciencewithamission.org
  Science with a Mission provides immunoassay diagnostics for use in the poorest regions of our world. Their tests do not require electricity, expensive equipment, etc.

• **World Dental Relief**
  P.O. Box 747
  609 North Main Street
  Broken Arrow, OK 74013-0747
  Phone: (918) 251-2612
  Fax: (918) 251-6326 fax
  E-mail: dentalreliefinc@aol.com
  Web site: www.dentalrelief.com
  World Dental Relief, Inc., is a charitable, non-profit relief organization with a state and federally licensed warehouse to receive and distribute dental supplies and equipment to dental healthcare projects around the world. The “Portable Mission Dentistry” book written by Dr. Ron Lamb provides a “do it yourself” guide for dentists providing portable dentistry in remote settings. World Dental Relief actively helps train dentists in the techniques and equipment necessary to deliver dental care to people who have limited or no access to dentistry. Many types of lightweight portable dental equipment are available through the World Dental Relief Warehouse. Dental supplies are available from the World Dental Relief Warehouse for dental relief projects and clinics worldwide. The Dental Mission Warehouse usually charges 15% of value plus shipping.

• **World Medical Mission**
  See listing on page 168.
  A nondenominational specialized service agency of evangelical tradition engaged in relief aid, children’s programs, evangelism, support of national workers, and supplying equipment.
• **Worldwide Lab Improvement**
  Contact: Ed and Carol Bos  
  3607 Gembrit Circle  
  Kalamazoo, MI 49001  
  Phone: 269-323-8407  
  E-mail: mail@wwlab.org  
  Web site: www.wwlab.org  
  WWLab is a specializing in equipping medical laboratory facilities in mission hospitals and clinics in developing countries. Our mission is to provide affordable and durable equipment as a means of improving health care in these countries. WWLab can provide on-site equipment installation and technical training, and can supply reagents and other expendable supplies on an ongoing basis.

It is difficult to find opportunities for medical students, other students or for healthcare providers working in fields of training that are unique to the United States, such as EMTs and CNAs. Here are links to some organizations that may offer what you seek

**MEDICAL STUDENTS**

• The CMDA Center for Medical Missions maintains a list of rotation sites.  
  Web site: www.cmda.org  
• Primer for International Health Rotations, Opportunities, Programs and Scholarships: University of Utah School of Medicine  
  Web site: www.utah.edu/umed/students/clubs/international  
• American Academy of Family Practice list of residencies with international rotations  

**NON-CERTIFIED MEDICAL PERSONNEL**

• Catholic Network of Volunteer Services  
  Web site: www.cnvs.org
SHORT-TERM MISSIONS FOR STUDENTS
(1–3 WEEK)

• Global Health Ministry
  Web site: www.globalhealthministry.org

• Healthserve
  Web site: www.healthserve.org/electives

• Helping Hand Medical Mission
  Web site: www.hhmm.org

• IMVA
  Web site: www.Imva.org

• Health Volunteers Overseas Web site: www.hvousa.org

• Crudem Foundation
  Web site: www.crudem.org
Dear _____________________________,

I recently heard about an opportunity to go on a mission trip with the (organization) to a (location) in (country) that needs my help. As I heard about it, I really sensed God calling me to be a part of this mission.

The experience will be working with (description). I will be working with a team that will be involved with a health clinic and the team will be also working with orphanages, in schools and with the local congregation as they try to have an outreach to their town. (Or if a hospital, describe your work there) If God speaks to your heart, as He has to mine, I would love for you to go with me. For more information, just give me a call at or you can call the office of (organization) at (phone number).

But if God is not calling you to go overseas with us, you can still take part in reaching the people there with the message of Jesus Christ by sending me to share that message. I would like to ask you to prayerfully consider helping me to go by providing a financial gift. The total cost of the mission trip will be

*Depending upon whether or not you are able to contribute any personal funds to the mission yourself choose from the following two paragraphs.

**OPTION 1:** As I have looked at my own finances, I have determined I will personally be able to pay for $______________ of the trip price, leaving a balance of $______________. Would you be willing to invest $25, $50, $100, $200 or another amount to help me be a part of this vital outreach to the people of (country name)?

Continued on next page
OPTION 2: To help with this total need, would you be willing to invest $25, $50, $100, $200 or another amount to help me be a part of this vital outreach to the people of (country name)?

So that all gifts will be tax-deductible, I have arranged for my church (or the organization with which you are traveling) to accept contributions for my mission trip. They, in turn, will send a check covering my cost to the travel agency. Checks should be made payable to (name of church or organization) and enclose with it the separate piece of paper that I have enclosed with this letter. Please fill in your name and mailing address and it will show that the check is to be designated for (your name/name of mission trip or account number).

For your convenience, I am enclosing a self-addressed envelope. I am also planning to give you a phone call within the next week to answer any questions you might have and to see if you would be able to help. My deadline to have all my funds in is (date).

Please know that it is not my desire to pressure you in any way. If now is not a good time for you to be able to help, I certainly understand. In any case, please pray for me as I seek to raise the funds to go and while I am ministering overseas. Your prayers will be a great encouragement. If you would like to receive updates on what is happening and be a part of my prayer support team, I would certainly appreciate it. Please call me at (your phone number), write me at (your address) or e-mail me at (your address). Please remember to include your own e-mail address.

I promise to give you a full report of what the Lord is doing in (country name) when I return.

Sincerely,
APPENDIX D

TESTIMONY WORKSHEET

Introduction:
Name: __________________________________________
Profession: ______________________________________
Hometown: _______________________________________

Why I came on this trip:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What my life was like before becoming a Christian:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How I became a Christian:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What it means to be a Christian—impact on my life:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
How others can have a similar experience—the plan of salvation:

______________________________

______________________________

______________________________

Give the opportunity for others to make a decision for Christ:

______________________________

______________________________

______________________________

My summary statement and thank-you:

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________
Dr. Bruce Steffes is a surgeon and educator living in Linden near Fayetteville NC. He is a native of Lapeer, Michigan. His undergraduate work was at Baptist Bible College of Pennsylvania and the University of Michigan – Flint College. He graduated from the University of Michigan College of Medicine and then trained in general surgery at the University of Florida. Since that time, he has been also awarded a Masters of Business Administration from the Fuqua School of Business at Duke University and was certified in tropical medicine by the American Society of Tropical Medicine and Hygiene.

As a surgeon and as an entrepreneur in Fayetteville, NC, he underwent a personal and spiritual crisis that changed the focus of his life. Serving always as a volunteer and with a focus upon supporting the true heroes in the trenches, he and his wife (an accountant by training) have used their surgical, business and administrative skills in multiple hospitals and other missionary efforts in the developing world. He has spent the majority of each year since early 1998 as a volunteer physician and general surgeon in Haiti, Belize, Guatemala, Brazil, Kenya, Uganda, Togo, Zambia, Sierra Leone, Liberia, Angola, Papua New Guinea, Afghanistan and Uzbekistan. He has also visited several other countries and medical works in developing nations. He serves regularly with the Mercy Ships and World Medical Mission (Samaritan’s Purse) doing short-term (up to six month) stints. He and his wife have worked with two orphanages in Jinja, Uganda. He has worked with several agencies and NGOs as a volunteer.

He is especially interested in medical education. An active member of the Continuing Medical and Dental Education Commission of the Christian Medical and Dental Association, he assists in their mission to bring current medical information to those serving on the front-lines in developing countries. When in the US, Steffes served as a volunteer associate clinical professor of surgery at Duke University in order to teach residents laparoscopic surgery; served as surgical fac-
ulty at Mulago Hospital, Makerere University in Kampala, Uganda and now is the Surgeon-in-Residence at Methodist University Physician Assistant Program teaching anatomy, physiology and general surgery to PA students each fall. He is also associate professor in surgery at Loma Linda University. Additionally, Dr. Steffes is a guest lecturer yearly at the West Virginia University Clinical Tropical Medicine and Parasitology Training Course.

In his efforts to mobilize interest, personnel and finances for medical missions, he is a speaker in churches, service groups and missionary conferences here in the US. In aid in that effort, he and his wife have written the “Handbook for Short Term Medical Missionaries,” published by ABWE (2002).

In early 2006, he became the Chief Executive Officer of the Pan African Academy of Christian Surgeons (PAACS—www.paacs.net), a general surgical training program for African residents. PAACS is a rural-based health initiative and is a Commission of the Christian Medical and Dental Association. It is a strategic response to the great need for surgical manpower in Africa. Using rural mission hospitals and a cadre of volunteer board-certified surgeons and missionaries, it is designed to teach the best practices of surgery and apply them to the resource-poor environment in such a way that “brain drain” is avoided and that high quality Christian Surgeons will be produced and remain in their countries for their lifetimes.

Steffes is a fellow of the American College of Surgeons, the West African College of Surgeons and the College of Surgery of East, Central and Southern Africa.