



Center for Medical Missions

A ministry of Christian Medical & Dental Associations

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Welcome to this issue of *Your Call*. Many of you are already out of school for the summer but there are also many who will be continuing through the summer months. For those of you going on a mission trip, I pray the trip will be life changing and that the Lord will use it in whatever way He needs to encourage your next step in preparation for missionary service.

I've had fun putting this together because I have had plenty of things to share with you. All of the articles are important but please pay special attention to the announcement section.

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Remember you can contact me at susan.carter@cnda.org.

○ SHAME! WHERE IS THY BLUSH?

by Rev. Stan Key

Were they ashamed when they committed abomination?
No. they did not know how to blush"
(Jeremiah 6:15, ESV).

In the 6th century, the nation of Judah was on the eve of destruction. Moral decadence had brought her to ruin. The real problem, however, was not Judah's perversions and sins. These were symptoms of a deeper root cause: shamelessness. Judah "did not know how to blush." When a culture reaches this place, the barbarians are at the gate.

Sound familiar? Walk the mall, visit a high school or college campus, channel surf, or listen to talk radio and you will experience firsthand the blatant shamelessness of our post-modern American culture.

- **Language** in routine conversation that a generation ago would have caused a sailor to blush.
- **Clothing** (plunging necklines, skin-tight dresses, baggy pants, T-shirts with obscenities) that boldly announces the wearer's disrespect for others and disdain for common decency.
- Lack of **Courtesy** and civility toward others (holding doors open, eye contact, road rage, words like "thank you" and "please").
- **Humor** that focuses on subjects that were once considered sacred, private or taboo (God, sex, death, the bathroom).
- **Behaviors** that not long ago caused embarrassment are now brazenly flaunted for all to see (sodomy, abortion, addictions, living together without marriage).

Hamlet said it well, *O shame! Where is thy blush?* We have gotten to the place where we glory in our shame (Philippians 3:19). We are living in the twilight of civilization.

Shame is to the community what the warning light on the dashboard is to your car. When working, it alerts you to the fact that there is a problem under the hood that needs to be addressed. now! Though the little red light may annoy you and cause you to change your plans, it would be the height of folly to disregard it. or worse, to disable it.

I, for one, am ashamed of our shamelessness. But more than that, I tremble for the future of a culture that no longer knows how to blush. Before it is too late, let us pray for a rediscovery of God's gift of shame. Like guilt, shame is a good thing that leads us to the cross of Christ where God is finally able to lift the hood and fix the engine! He took our guilt and shame on himself (Hebrews 12:2). Those who cast their sins and

rebellions on the Man hanging on that cross will discover the power and freedom to live a new life of dignity and grace as children of God. Those who believe in Him "will never be put to shame" (Romans 9:33, NIV 2011).

Have you checked under the hood lately?

Announcements

Orientation to Medical Missions Conference

Our pre-field orientation conference is quickly approaching. I believe we have the schedule prepared and all the speakers identified for the conference scheduled for July 20-23. This session will be for everyone except WMM Post Residents and appointees of CHSC. Their session will be July 25-28. If you plan to be in the field by July 2014, this will be your opportunity to participate in an orientation course designed specifically for new medical missionaries. Previous participants would tell you that if at all possible, you should participate in this conference. We have purposefully designed it for both the medical missionary and his/her spouse.

This year the conference will be held at Jubilee Retreat Center in Abingdon, Virginia. That's just up the road from Bristol. This will allow everyone to stay in the same place, facilitating fellowship and saving lots of driving time to and from the hotel to CMDA's headquarters. You can find more information at www.cmda.org/orientation. If you are interested in participating in a conference, please let me know right away by emailing susan.carter@cmda.org.

Where to Serve

Have you ever checked out www.cmda.org/wheretoserve? It is a very long list of places that are looking for help - sometimes long-term and sometimes short-term. I know the majority of you reading this e-newsletter are not yet ready to serve, but there might be a few that are. If you are ready, or if you are only wondering about your future placement, this list will give you some great places to research and pray about. If you have questions about a specific place, you will need to make contact with the person listed. If you have a general question, I will be happy to try to answer. susan.carter@cmda.org.

Jesus Film App

www.jesusfilmmedia.org is a part of the Jesus Film Project. From this site you can download films for free to use to share Christ. They have 64,000 films in more than

1,100 languages. There is also an app for your mobile device. I thought this was a neat resource that you would want to know about.

Fellowship in Correctional Medicine with Generous Loan Repayment for Missionaries

By Ty Hopkins, MD

We have begun the inaugural year of our Fellowship in Correctional Medicine. The primary goal of the fellowship is to enable missionary health professionals to pay off their loans and get to the field. The Lord has given us work for three full-time physicians who are well paid for their work, while they hone their skills for the mission field.

What the fellowship offers:

1. It pays well--\$250,000 to \$300,000+ for 40 hours a week. This means you pay off your loans quickly.
2. A family and ministry friendly--no call--schedule. You can choose 24 to 40 hours per week, three to five days a week. No nights, weekends or holidays ever. Plenty of time to be with family, speak in churches, raise support, network and connect with a sending organization.
3. The commitment is fairly short (two or three year options). We firmly believe you can pay off large loans in two years. We work to get you tax benefits and financial counsel as appropriate.
4. It is good training for missions because:
 - It requires learning a new culture--prison. Inmates have their own worldview and language and are as fatalistic anyone.
 - It is definitely caring for what the Bible calls "the least of these." Jesus and Paul specifically entreat us to visit prisoners.
 - It is a resource-poor environment--like much of the mission field (all of the developing world).
 - It is an independent clinical setting. Like on the mission field, you don't have a full spectrum of specialists working in the same building. You learn to take care of things yourself.

5. You work with a team of missions-minded Christians whose main goal is to see you succeed in getting to the mission field. Like iron sharpening iron, we make an effort to mentor you and encourage one another.

- We are working toward obtaining accreditation to make this an official academic fellowship.
- At this time, the prisons we cover are in Southwest Virginia.
- Commitments typically begin in July. Though we anticipate having another opening this September or October.
- It is simple primary care. It is open to all specialties.
- It is quite safe. The prisons are a very controlled environment.
- This opportunity can be appropriate for: a physician just finishing residency, a graduating resident who may qualify for MedSend or the WMM fellowship but who has a spouse with educational loans or other financial commitments, a missionary who needs to pay loans off before returning to the mission field, a missionary on an extended home assignment or others.
- We have one fellow now. We hope to have three fellows concurrently within two years.
- We complement and work alongside--not in competition with--MedSend and World Medical Mission.
- We love and support these ministries and want to see them flourish.

Vision: We seek a world where individuals will be healed physically and spiritually, while their communities become places of health, prosperity and stability. We enable this transformation of people and cultures around the world through healthcare missions.

Our mission is to enable healthcare providers to work where they have been called, unencumbered by educational debt, and to monitor their progress in their roles as healthcare providers, teachers and examples.

I am happy to answer any questions via email at tyhopkins@gmail.com

Turbocharging Community Health

by David Stevens, MD

Continued from March

6. To Treat or Not to Treat? Another early decision was whether we would train our community volunteers, many with minimal education, to treat common diseases. Here is the decision tree that we climbed down to get to the root of our answer. These questions will assist you in making your decision based on your local conditions.

- Were there significant medical needs in the community? We identified the 10 most common easily treatable illnesses, looked at their incident rates in the community and identified how many patients were admitted to the hospital with complications. We found a significant unmet disease burden.
- Were diagnostic and treatment modalities available on a timely basis? There were few clinics or other places the local people could get treatment. The few government facilities were poorly staffed, equipped and supplied. People had to walk long distances to get treatment. "Bush Doctors" preyed on their plight by scavenging used vials and empty medicine bottles, stealing medicines, claiming knowledge they did not have and setting up "practices" in the community. Vials were filled with river water and contaminated syringes and needles were used to give injections again and again. Aspirin was sold as an antibiotic. Dangerous medicines were given with no knowledge of their effects or proper dosage.
- Could we properly train our CHHs? We thought we could if we limited their repertoire to only 10 diseases, most of them not requiring dangerous drugs. We realized it was going to take repetitive teaching and then ongoing supervision with frequent monitoring in the field. We decided before we even began that we needed to be ready to abandon this component of the program if it was not working well.
- Could we minimize risks? We identified a number of risks:
 - Our CHHs could give medications when they were not needed or for the wrong condition. Were they diagnosing correctly? We ascertained that one-on-one mentoring was needed during training and the early days in the field so our supervisors could help them apply the newly gained knowledge and observe the results.
 - They could give the wrong dose of medicine. Thirty years ago, malaria could still be treated with chloroquine in our service area, but adult doses given to young children could kill them. To avoid incorrect dosing, we adopted a unit dose packaging system for all our medications. Each

envelope was clearly marked with the name of its contents, the expiration date of the medicine, for what age it was appropriate and how it was to be taken (using symbols for those who could not read).

- As we had a large problem with corruption, theft and fraud in our service area, recruiting the right people and good close supervision were obviously the first safeguard, but we wanted to lower temptation with good systems. All pill envelopes were sealed and then enclosed in zip lock bags in groups of 10 for easy inventory. Medicines were kept in a large locked wooden "medicine box" by the local committee. Before new medicines would be issued, the CHHs had to have their medicine bags inventoried to show medicines present or the money they had received for them. They turned in their money to get another batch of medications.
- Added Benefits - We did not pay our volunteers, but we realized they would incur expenses as they served. Mothers with children with gastroenteritis would bring them to their homes and they would have to use their own sugar and salt to make oral rehydration solution. Others might desperately need medicine but couldn't afford it. CHHs might be too far from home to return for a meal and have to provide food at a local "duka" (store). For these reasons, we built a small "profit" into their medicines sales. It was not large enough to give a stimulus to sell medicines when they were not needed but high enough to cover some of their expenses.

Overall, our medicine system worked well. It gave our CHHs higher respect in the community as they treated malaria, peptic ulcer disease, small wounds, burns, cough, worms and other diseases, as well as provided vitamins. A medication distribution system might not make sense in your area so use this decision tree to find out.

7. Fund Your Program - You can do community health with comparatively little funding compared to curative outreaches, but funding can turbocharge your program when used properly. You can do more and expand quicker.

Community health outreach gives a high return on a small investment but I've never seen a program that is totally self-supporting. There are costs for supervisors' salaries and benefits, transportation, computers, stationary supplies,

training and much more. How do you fund it?

A number of streams are available for funding that should come together to make it happen. Missionary salaries and expenses may come from their ministry accounts, which is a gift in kind to the program though few missionaries are actually involved in the program. In our case, we had only one or two missionaries involved full-time in the early days.

You can generate some income from program activities. Our medication program also included income opportunities for each committee to do local projects and for the central office to help fund activities. This amount wasn't huge, but it was significant to show to outside funders we were doing our part to fund our work. Our hospital provided some services gratis, another gift in kind.

What we did not generate from medication sales, we raised from mission funds to help cover the cost of our evangelism and discipleship efforts including purchasing Bibles, tracts and other materials and to cover the cost of spiritual training for the CHHs. We wanted to show our secular funders that we weren't using their funds for "proselytizing" activities.

The vast majority of our funds came from project grants we received from government and parastatal organizations. My philosophy, as I've expressed elsewhere in this book, is not to use the Lord's money for things the secular world will pay for as long as there are no strings attached to impede our ministry goals. We initially got USAID funds for two three-year cycles of funding. When the U.S threatened to withhold aid funds to Kenya over political issues, we approached EZE (now EED) a large German parastatal that had helped us on other projects. They helped hold us accountable to accomplish what we had set out to do, an added bonus to receiving the funding!

6. You Don't Want to Own It - It is better to have a friend who owns a truck than it is to own it yourself! If you own it, you have all the problems associated with ownership, yet most people only occasionally need a truck for hauling. It is a lot of easier to put some gas in the truck and return it.

The same is true in community health work. You want to indigenize your program. It often takes time to fully nationalize your community-based outreaches, but the process should start from day one. Not only do you need a great deal of input to understand community problems but you must also give the local health committees the latitude to make decisions and even mistakes as they work. Your central efforts need to be seen as facilitation of the community's

efforts so the local people, government officials and others see "your" program as their program. How do you make that happen?

First, send the right messages and back them up. We told our local committees that they program belonged to them and they made the decisions. Preceding that, we had many discussions about concerns with that strategy. Should we make it a church-based program? We didn't because we thought it would limit our target audience to our own church denomination members. Should we limit it to committee members, health helpers or Christians? That was a harder question. If we did, we would still be holding "veto" power over local decisions. After lots of prayer and discussion, we didn't. Instead we worked hard to help local councils come to that decision. We had a few trainees come through that really didn't know Christ as their savior, but they came to Christ during training with prayer and testimony.

It is not easy to give up control but it pays off in many different ways.

If you use volunteers, sooner or later some of them will ask to be paid, especially if you are associated with a hospital or have outside funding from a grant-making organization. The problem is not hard to handle if you have truly made your local committees in charge. You just tell the volunteer that they need to talk to the local committee since they are in charge.

Politics exists in every country and community. As someone from another country, you don't completely understand the local politics and you definitely don't want to get into the middle of it. It is much better if the local committees deal with those issues.

True indigenization is like raising kids. To teach them responsibility, you set them increasingly free with more and more responsibility. The same is true in emancipating your local committees from central support. As they learn to motivate, train, equip, supervise and hold people accountable, you can step further and further back from the process, giving less and less of your resources from your central office. Do this slowly but methodically based performance, not on time. Is this local committee solving problems, showing initiative and managing its people well? As they prove themselves, you step back and become the encourager, providing advice only as it is requested. As the same time, you praise them for their accomplishments and give them credit with others for their successes.

To be continued next month

"Peace ... from Where?"

by Daniel Tolan, MD

It was his second time to be diagnosed with and operated on for colon cancer.

The first time, three years earlier, the cancer was close to the rectum. Through the hands of a skillful surgeon, the tumor was resected and the bowel was able to be reconnected. I heard the man voice thankfulness he did not need to have a colostomy. Ten days following the first surgery, he experienced a bowel obstruction. Adhesions (scar tissue) had formed requiring a second operation to relieve the obstruction. There was a small band of tissue compressing the bowel in one area. It was easily snipped in two and normal bowel function returned quickly. I watched this man, and was quite impressed, as his faith in God remained steady throughout the whole experience. His daughter told me that for as long as she could remember, no matter how he felt or what his schedule looked like, he would begin every morning reading his Bible and praying. He was committed.

Over the next three years, he would occasionally experience abdominal pain from a partial bowel obstruction. Each time it was brief and would resolve on its own without requiring surgery. Although I am sure he had inner struggles, his family said that never once did he complain or question God.

Now, it was three years later, and he had just been diagnosed with a second cancer in another location of his colon. Another bowel resection with more large-bowel removed; however, there was a complicating factor. Adhesions from previous surgeries required lots of extra dissection before the tumor could be removed. But since the tumor was again found early by colonoscopy, there was complete expectation for full recovery. However, the post-operative course did not go well. Soon after surgery, he began experiencing pain along with bloating of his abdomen and could not eat. He waited patiently, keeping the same sweet, humble and gentle spirit about him. I could tell he trusted his God. I saw him communicating with Him early each morning.

Ten days passed and still no improvement. In fact, with virtually no nutrition during this time, he was now growing quite thin. X-rays again showed a bowel obstruction. With his past history of forming extensive adhesions, doing additional surgery was risky. The best outcome would be to wait for the obstruction to resolve spontaneously. IV feedings were started to give him nutrition.

This man had spent more than 30 years in Africa as a missionary surgeon. He was still needed. Why would this happen to him? He led a very busy hospital that had great ministry and spiritual impact in the community. Shouldn't God just heal him so this man could get on with his work? What purpose was this serving? These were questions in my mind. I'm sure they were present in his as well. He seemed peaceful.

By now the situation was growing desperate and finally the decision was made to operate again. The risks were much higher. I was on another rotation and was not there for the surgery. Because I had grown to love this man, I called the OR after about two hours ... "What? Still in surgery? This should have taken about an hour!" After five hours I heard the news. Four hours of dissection passed and the point of obstruction could not be found. The adhesions were almost like cement. It took more than an hour just to find the stomach. Dissection around the duodenum became so dangerous that after four hours of operating a decision had to be reached. It was too dangerous to proceed. The obstruction could not be relieved. A tube was placed directly into the stomach for drainage and the abdomen was closed. If this man was to live, he would live on hyperalimentation (IV feedings) through a permanent IV line.

The following day around 6 a.m. I stopped in to see this man. The missionary doctor, now a patient, was reading his Bible and praying. He said this was his daily routine and commitment. He said God is faithful. God is faithful he said? Was he faithful to this man? This man had been so faithful in service to Him ... why this now? Why not just heal him?

He was at peace, however, I watched him closely and saw it.

He went to his daughter's home. Was this the end? What would happen?

It was my home too. This man was my father-in-law. He still got up to read and pray every morning...before anything else. I have never seen such peace in a man with such a bleak future. He had no complaints. He did not seem to change in any way except he could not join us in eating at the table.

Where did his peace come from? The right answer...from the Giver of Peace.

So, when you face hard time just go to the Giver of Peace?

Sorry, I don't think that is the way it works. It starts long before that!

Speaking in a recent sermon, our pastor said, "We are all devoted to something no matter where in life we are." Then he instructed us to ask ourselves this question,

"Where does my choice(s) lead me and what does it leave me with?" That is a powerful question. I ask you the same question.

You can even rephrase it if you would like. "Am I making the choices that lead me where I need to be and leave me with what I truly need?"

Think about my father-in-law Dr. Steury, the founding doctor of Tenwek Hospital in Kenya, Africa. He made the choice to trust God long before being faced with colon cancer (twice), surgery for adhesions (twice) and then the final blow - you will only eat again through IV feedings. He still trusted.

Trust is not something you decide to do and...BOOM...there it is. No, trust is relationship. Relationship is a growing process. A process takes time and commitment. I saw this commitment in Dad Steury. If he was not in an emergency surgery at the hospital at 6 a.m., I knew where he was. Walk by his small home office at 6 a.m., and there he was...reading and praying. I saw it. I stayed in their home various times, once for three months, and each day was the same. Building relationship and trust in his God began at 6 a.m. It was a way of life.

This left him with genuine devotion to God. And this led, and left, him with a peace in his Father in even the most difficult of times. He did not need to go searching for peace in a time of need. He already had it from years of knowing his Father ... starting at 6 a.m.

Genuine devotion will only come out when Christ Crucified is constantly before us. (Our pastor said this too.) Keep Christ Crucified constantly before you. Every decision, every choice, everything. "Where does my choice lead me and what does it leave me with?"

The end of the story...

One Sunday afternoon, we were eating one of Dad's favorite dishes. He was sitting at the table with his "feeding" coming through the IV tube. He said, "Maybe I will taste some of the soup broth and then later I will let it drain out of the tube in my stomach." (Remember, he still had the bowel obstruction and anything in his stomach had nowhere to go.) I watched as he enjoyed the taste of about a cup of soup broth, the first he had in about two months. About an hour later he unclamped the stomach tube but nothing drained out. Where was it? He tried again about two hours later. Nothing! He drank some more liquid. Tried the drainage tube a couple hours later.

Nothing! Was it passing through his bowels? Too good to be true? No, it was true. He started eating. A few days later, the tube was removed and his IV feedings were stopped. Jesus had healed him!

His Father decided to nourish his body again by mouth...just like he did his soul every day starting at 6 a.m.

Where will your choices lead you and what will they leave you with?

Forgiveness

by Dr. Ron Koteskey

As fellow missionaries, they were your closest friends. They had prayed with you for the last six months as you developed a plan to reach the people in your city. It was successful beyond your wildest dreams. But now they have a book coming out about your plan-claiming it as their own! Of course, you are glad for the success in reaching people, but how could they have done that? Can you ever forgive them? Even if you can forgive them, can you ever forget it, or can you ever really trust them again? Let us consider some of these questions.

How could they have done that?

Being hurt by someone you love is inevitable. Sometimes the people hurting you do it intentionally, planning it carefully and then carrying out their plot. Other times they do something without forethought. Most often they do not intend to hurt you and do not even know they have done so. The Old Testament clearly distinguishes between intentional and unintentional sins.

Having your brother or sister turn on you is as old as the human race itself, as found in the story of Cain and Abel in Genesis 4. It occurred repeatedly in the book of Genesis, as shown in the life of Joseph and his brothers who first planned to kill him, but then decided just to sell him as a slave. How could they have done that?

Sometimes you are the one who is amazed at what you do. The first missionary Paul wrote about this in himself in Romans 7. He just did not understand why he did what he did. He did not do the things he wanted to do, but he did the things he hated. Paul was saying, "How could I have done that?"

What if I can't forgive?

When praying the Lord's Prayer, we ask God to forgive us as we forgive others. Following that prayer in Matthew 6, Jesus said that if we forgive people who sin against us, He will forgive us. However, if we do not forgive others, He will not forgive us. He

illustrated this in Matthew 18 with the parable of the unforgiving servant when Peter asked about how often to forgive. The one not forgiven was the one who did not forgive.

The goal is always forgiveness, but the time it takes to reach that goal may be very different for different offenses and for different people. You must be careful not to rush into a premature, shallow forgiveness, in which you say, "I forgive you," but still really hold the offense against the other person. Generally the more serious the offense, the longer it takes to reach genuine forgiveness. If someone "borrows" an everyday dish without asking and breaks it, forgiveness may come quickly. If the dish was a treasured family heirloom, the forgiveness may take longer. If the offense is sexual abuse as a child or adolescent, the forgiveness may take years or decades. We must not rush into premature forgiveness.

People often cite Joseph's clear forgiveness of his brothers in the last chapter of Genesis as an example of how we should forgive. Remember that it was more than 20 years after the offense when he first saw his brothers, and the first time he saw them (Genesis 42) he pretended to be a stranger and spoke harshly to them. By the time they came the second time, he was ready to begin to deal with forgiveness.

What if I can't forget?

You will probably never actually forget. Forgiveness does not mean that you are no longer able to remember the incident. Some people say we should "forgive and forget." Others quote Jeremiah 31:34 and Hebrews 10:17, pointing out that God forgives and forgets.

Of course, this does not mean that God literally cannot remember that the events ever happened. If that were the case, God would no longer be all-knowing. He still knows that the sin occurred, but He no longer holds it against the person. He does not develop amnesia, but He will never bring that sin up again.

Of course, not having the memory constantly occurring as it once did may be a result of forgiveness, but it is not the means of forgiveness. Forgiveness literally means to "give up" or "give away." The dictionary defines it as "to give up resentment against" someone. Forgiving someone frees you from being consumed with resentment about the offense, but it does not erase the memory. You may need that memory to avoid future abuses from an unrepentant person. God does not erase our memories, but He redeems them so that we can get on with our lives.

Joseph pointed out that his brothers had intended to harm him, but that God used it for good. He had not forgotten what happened 40 years earlier, but he no longer carried the resentment and wanted to punish them (Genesis 50).

What if I still don't like them?

You may never really like people who have hurt you so deeply. Forgiveness and reconciliation are two different things. Forgiveness means that you give up your resentment and your desire to punish the other person, not that you necessarily become best friends.

You may say, "Doesn't God want us to love everyone?" Of course, He does. Such is commanded in "love one another as I have loved you." But the kind of love that can be commanded is *agape* love. It is the kind of love in which you make a decision to be committed to the best interests of that person. It does not necessarily mean that you are good friends (*phileo*). Unfortunately, the English language does not have adequate words to express the meanings of these Greek words, so we use the word "love" for both.

God commands you to be committed to the best interests of all persons, not to be best friends with them all. After some time, you may grow to like the person and become good friends, but that will not always be the case. Notice that Joseph was kind to his brothers, reassured them, told them not to be afraid and said he would provide for them and their children. He did not say they were his best buddies, and he clearly favored Benjamin over the others, the ones who sold him into slavery.

Even though you may not be the best of friends with others who have hurt you, you can still work effectively with them. Being willing to forgive others benefits you as much as it does them. It frees you from carrying that resentment, freeing you to do God's work.

What if they don't ask for forgiveness?

This is a difficult situation. It is complicated to try to come to terms with someone unwilling to accept responsibility for actions that have offended or hurt you. We are often tempted to become resentful. Unfortunately, carrying around the resentment and bitterness is a heavy burden, and that burden is on you, not the one who offended. You may be carrying such a load related to someone you will never see again; that person may even be dead. Being willing to forgive, being open to forgiving when they repent or forgiving before God even if you cannot see the person lifts the load from you.

Thus, granting forgiveness, or turning the final judgment to God, is often more for your own sake than for those you forgive. Joseph granted forgiveness to his brothers even

though they did not ask for it. The burden was taken from him, and he could get on with his life. If you continue to carry that load, many times you are granting the offender the power to continue to make you miserable and limit your effectiveness.

What if they won't forgive?

You may ask forgiveness, but the other party will not grant it. This is also a difficult situation. You must genuinely request forgiveness, make restitution as far possible and continue to demonstrate acts consistent with repentance. If the other persons will still not grant forgiveness, you have done all you can. The burden is now on them. You may still feel some of that burden, but God does not hold you responsible.

For other topics, please visit www.missionarycare.com. Also please let your non-medical colleagues know about these free resources.