

**Medical Missions in Transition:
Taking to heart the results of the
PRISM survey**

September 2011

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Research Report by the Medical Missions Survey Working
Group of the Continuing Medical and Dental Education
Commission of the Christian Medical and Dental Association.

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Background

The medical missions¹ enterprise has been in existence since the work of the Catholic orders in the 14th century. Protestant missionaries were late to the game, beginning with Dr. John Thomas in India in 1773 (Campbell 2000). Medical missions work has been an integral part of cross-cultural Christian missionary work ever since. Growing steadily in numbers through the 19th century, the number of missionary doctors on the field reached a peak in 1925 with 1125, not counting the number of nurses and ancillary medical workers (Price and March 1959). As of 1958 there were 786 mission hospitals globally, with 883 missionary doctors. Each year these doctors were serving approximately 1.5 million in-patients and eight million individuals were served as out-patients. This patient contact was historically and continues to be a first and substantive point of contact for local people to encounter the gospel of Jesus Christ, the primary goal of evangelical Protestant missions. The working group estimates that in 2011 there are something less than 1000 missionary doctors serving cross-culturally for more than two years and another 1000 people serving in nursing, public health and other health professions.

¹ Medical missions in this paper refer to the enterprise of long-term cross-cultural missionary service through medical work under the auspices of a Christian missionary organization. It does not mean the concept of short-term medical missions or secular medical missions.

Medical missionaries contributed to the establishment of modern medicine in many countries of the world. Ida Scudder, granddaughter of the first American medical missionary, John Scudder, founded the Vellore Medical College in India in 1900 (Campbell 2000). Over four generations the Scudder family contributed 42 missionaries to the cause, who collectively contributed more than eleven hundred years of missionary service. Although not as spectacular, similar stories could be told about the advent of Western medicine through the work of Christian missionaries for many countries of the world.

Medical missionary work is not and has never been easy. The earliest medical missionaries to China in the 1830s, led by Peter Parker, struggled with how to apply their vocation in medicine in a way that supported the work of the mission, but they were still sorely misunderstood by the mission organizations. Here is how their dilemma was described:

The medical missionaries, while caught in the middle, were indispensable to both (medicine and ministry). It was only through the wonders of medical treatment that the message of Church's teachings could reach the people, and on the other hand it was only through the respectability of religious affiliation that the medical

missionaries could bring credit to the medical profession. (Young 1973: 272)

Medical missions have been effective in building the church of Jesus Christ in regions where it has been effectively utilized as part of the missions methodology. For example, the work of medical missions has contributed to the establishment of a church in Nepal of over a half million Christians today. In India, it has been reported that eighty percent of the Christians relate their conversion to a mission hospital experience. If a circle were inscribed with a fifty mile radius around each of the original 272 mission hospitals in China, one would find that these are the areas of revival today (Adolph 2009).

Each generation considers themselves to be at the end of an era, medical missions notwithstanding. At the annual meeting of the Church Mission Society in 1952 that is just how they felt (Anderson 1954), choosing the opportunity to summarize the history of medical missions and consider their future. One thing they recognized was the endless struggle medical work had for legitimacy within the mission agencies (Anderson 1954). Even from the beginning, medical missionaries had to defend the validity of their medical practice as missionary work (Grundmann 2005:202). The current generation of medical missionaries likewise find themselves in a time of transition. With improving health care systems all around the world, what niche are medical missionaries meant to fill? In the current situation what is the unique role and

vision for medical work in the missions endeavor? Can mission organizations provide the needed training and strategic leadership necessary for medical personnel to thrive in their missions' settings? What are the unique opportunities waiting the new generation of medical missionaries and are they prepared to make the investment and provide the leadership necessary for medical missions to take advantage of these opportunities? The time has come to consider these questions with thoughtfulness and prayer so that those committed to the cause of missions can envision an even brighter future.

Executive Summary

- Respondents have served an average of 10.84 years, and most intend to serve into their mid-50s.
- 50% work in private hospitals (including mission hospitals), and 12.5% work in government hospitals or clinics (that number rises to 24.7% in Asian countries).
- 38.7% are working in a hospital with more than 75 employees, with another 22.3% working in a setting with less than 5 employees.
- 64.8% consider the local government to be highly favorable or favorable to their presence as a foreigner, but 32.3% agree that compared to when they first arrived, getting permission to initiate effective long-term medical work for expatriate medical workers is getting harder. One reason is that the local health care system is improving, as agreed upon by 58.9% of respondents (rising to 83.3% in Asian countries). Incidentally, the more favorable the attitude of the local government toward the work of these expatriates, the more satisfied are these expatriates with their role as a cross-cultural medical worker.
- The biggest perceived challenge is not enough qualified workers.
- 33.8% of respondents reported that their role is not consistent with what they envisioned before coming to the field, which contributes to low role satisfaction. But over time role satisfaction does increase.
- 78.1% of respondents feel well trained for the work they are doing. However Gen X respondents (age 46 and younger)

report a higher perceived need of training. Furthermore, there is a direct correlation between perception of being adequately trained for their work and satisfaction with their current role.

- 83.6% are extremely satisfied or at least satisfied with their work, despite the reality among many workers of difficulties from the government, changing roles, anxiety and depression.
- Role satisfaction among medical missionaries is positively associated with working in a setting which is either explicitly Christian or at least sympathetic to their faith, working in a country where getting permission to initiate effective long-term medical work for expatriate medical workers is getting better, the presence of a strategy in their mission, their role consistent with what they assumed when they came to the field, satisfaction with the mix of work and ministry in their job and that the local country has need of cross-cultural medical workers.
- Organizational support varies, as 37.9% of workers believe their sending organization would prefer if they would stop doing medicine and would begin to focus entirely on other types of work, even though 83.6% of those surveyed consider the medical part of their work as essential or important to their purpose in being there.
- The biggest opportunity in cross-cultural medical work today was considered to be mentoring or training national medical workers, especially Christians. Likewise, improving their own ability to do “training or mentoring” was reported

by these surveyed medical missionaries to be the greatest area of need for further training.

- 42.1% disagree that short-term medical work is having a significant positive impact on the health situation for local people.
- 45.3% of respondents have experienced anxiety to self-reported degree of 4 or 5 and 30.6% of respondents have experienced depression to a degree of 4 or 5 (scales both from 0 to 5).

Methods

In 2010 members of the Continuing Medical and Dental Education commission of the Christian Medical and Dental Association approved a working group to investigate the experience of medical missionaries with a view to providing information to assist mission agencies in setting a current and sustainable medical missions strategy and to help medical professionals prepare for a career in missionary service. Inclusion criteria included licensed medical missionaries (not only MDs), with more than 2 years of work in their host country, proficient in English and associated with a Christian organization. It was called the PRISM Survey: Patterns and Responses in Intercultural Service in Medicine. This report represents the key results of this survey.

Results

Hi! I am a medical missionary. Let me tell you about myself.

I am among the 393 respondents to this survey, 49.9% were male and 50.1% female. We average 48 years of age (men 51 and women 45) and we have served as medical missionaries an average of 11 years. In this report I am going to tell you some of what was learned about myself, and my many medical missionary colleagues.

We come from 18 different countries and serve in 67 countries in all the regions of the world. 67.7% of us are physicians, 17% nurses and 15.3% are in other health-related areas.

41.2% of us intend to serve until we retire and the rest of us intend to serve into our mid-50s. There is no evidence that Gen-Xers are less committed to long-term service as reported length of commitment for Baby Boomers and Gen-Xers is statistically equivalent.

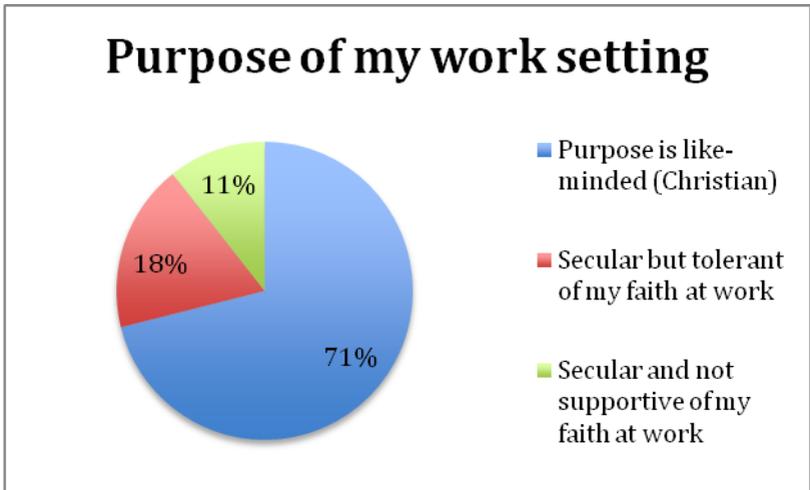
Discussion:

1. *How many missionaries do you have in your organization?*
2. *How many are working in health care ministry?*

3. *When you consider the age and experience of the people surveyed, does it feel representative? Young? Old?*

What is our work setting?

50% of us work in a mission hospital or private clinic and 13% work in government clinics. Most of us are working in facilities with more than 75 employees, and 22.3% are working in very small outpatient clinics with less than five employees.

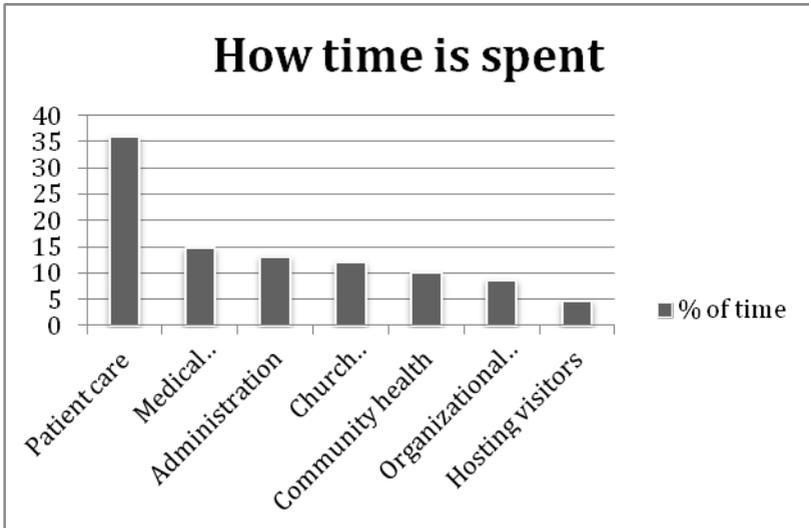


Most of us are working in Christian settings, but compared to early medical missions work, we are now increasingly working in diverse settings. More than twice the percentage of Non-Americans works in a government hospital or clinic compared to Americans.

Discussion:

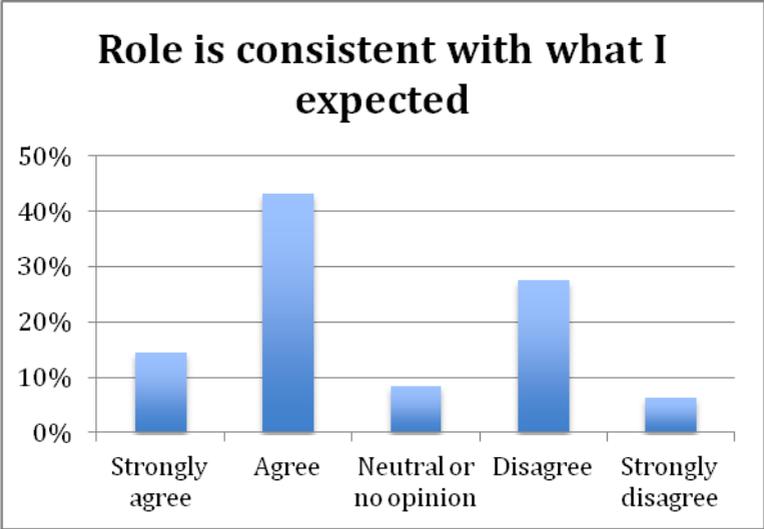
1. *What are the advantages to working in a Christian setting?
In a secular setting?*
2. *Would your organization's vision tend toward having
medical missionaries work in a Christian setting or a
secular setting?*

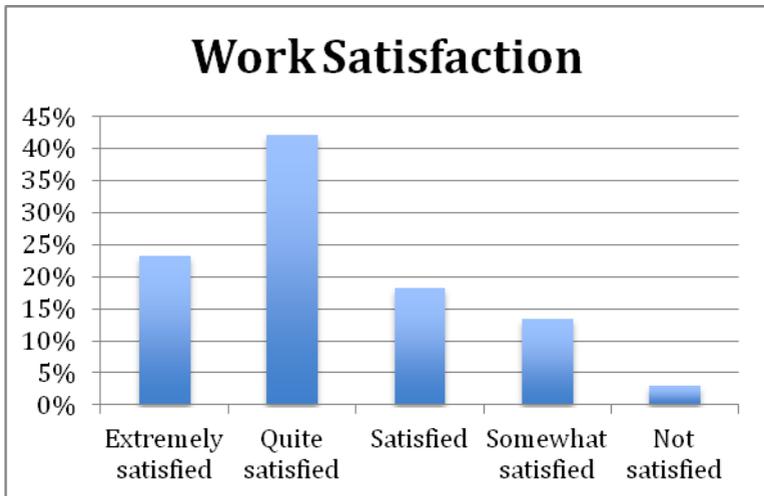
What is my role and how do I feel about it?



While on average we are spending 61.2% of our time on medical work (36.1% on patient care and 25.0% on other medical areas), we are spending 39.9% of our time on a combination of administration, organizational leadership,

hosting visitors and church-related responsibilities. Sometimes this level of multi-tasking makes it difficult to concentrate on a few areas in which we can be effective and productive.





The other respondents and I are generally satisfied with our role, even though many of us found it to not be what we expected when we came out. The most satisfied of us have these things in common:

- Working in a setting which is either explicitly Christian or at least sympathetic to our faith
- Working in a country that has need of medical missionaries and where getting permission to initiate that work is getting better
- The presence of a strategy in our mission
- Role consistent with what we assumed when we came to the field
- Satisfaction with the mix of work and ministry in our job
- Low depression score
- Men report more role satisfaction than women

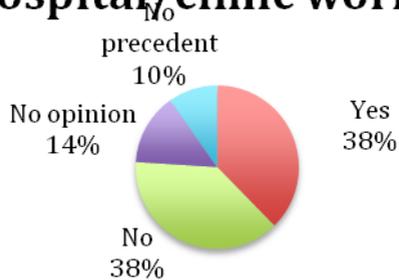
As medical professionals we are accustomed to functioning in work settings with clear goals and quality control. The diversity of methods in our mission organizations and the complexity of the settings we work in make that difficult. How might we focus our work and do more to help newer workers create clear job descriptions. Some groups have found that new workers to the field need a staged process of mentoring and coaching into their role so that by year three or four they are competent in and confident of their role.

Discussion:

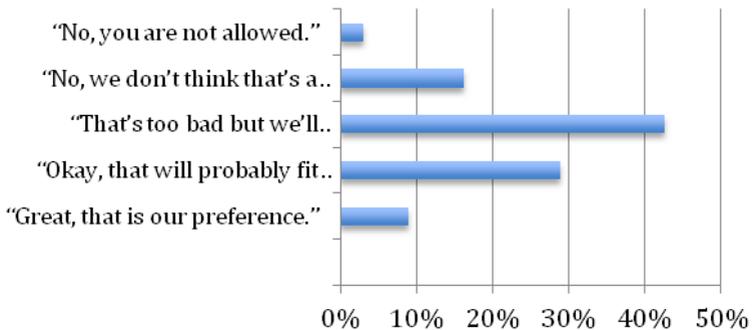
1. *“We often feel that we went to a foreign field planning to practice medicine, but the situation required us to take on many other responsibilities.” Is this a necessity in missions, or is it an organizational or leadership deficiency?*
2. *A significant percentage of these missionaries found their role to be different than what they expected? Is this normal in missions? Is it healthy? Is it avoidable?*
3. *Do you have job descriptions for people in your mission? How do you guide new workers forward in determining their role and becoming competent in it?*
4. *The call to follow Christ means sacrifice and suffering. How do we balance this call with the need for health and joy for our missionaries?*

What do we perceive our sending organizations' expectations to be?

Mission organization moving away from hospital/clinic work



Organization response if you stopped medical work



The one BIGGEST external challenge you face in your current medical work is:	Total
Not enough qualified workers	32.5%
Poor cooperation with the local system, bureaucracy, ineffective	17.7%
Not enough money or equipment	16.1%
Lack of a strategy to guide it	8.1%
Lack of support from my organization	7.8%
No plan for sustainability	7.3%
Other	10.6%
%	100.0%

I am among the 83.6% of us who consider medicine as essential or important to my purpose in being a missionary. But a third of us find our organizations to be indifferent or even opposed to the medical aspect of our work. We also feel the challenge of a lack of staff, money, equipment, a good strategy, and a plan for the sustainability of the work, and need our sending organizations to support us more in these areas.

The result is that a significant minority of us, 20-40% depending on how the questions were asked, feel we lack the strategy, training and clarity of role necessary to carry on our work. Nearly a fourth of us have seen medical missions colleagues and friends leave the field because of lack of

fulfillment in their medical work. Meaningful roles are an important means to prevent missionary attrition.

We would like to think of ourselves as a key piece in the mission enterprise, and our medical work is a part of the overall calling to preach the gospel to the ends of the earth. But we often feel that we need to find a way for our medical work to fit the vision or strategy of our mission, rather than the medical work being a part of that vision. In the Biblical model we are a body where each part does what it does best, in partnership for the gospel. The role healthcare workers play in healing is an essential part of the process of caring for people in whole ways, and supports the work of preaching and teaching.

Some of us are wondering if perhaps some mission organizations are not prepared to guide medical missionaries or utilize them well so they should not recruit them. Other organizations that intend to stay in the medical arena need to put more resources toward making the medical work they do successful. Some key pieces include incorporating the medical work into the overall mission strategy, putting more people into successful or potentially successful medical work locations, rather than allowing each medical person to strike out on their own, and even closing down unproductive or unhealthy medical missions projects.

In this day where many of us are going to creative access countries, a mission strategy and vision is called for that includes the professional role we will fill. It requires a theological and missiological understanding of vocation and ones role in society that allows for expansion of the space within which effective ministry can be done, and better tools for doing it.

Discussion:

- 1. What does it mean that nearly 40% of these missionaries perceive their organizations to prefer they as individuals leave the medical part of their work, and the same percentage of organizations are reported to be moving away from hospital and clinical work? Is it because of the cost and complexity of medical missions? Perhaps it is the case that medical missions work is not accomplishing the objectives of the mission.*
- 2. Describe your organizations' attitude toward the uniquely medical part of it? Is it an essential part? One part of many? Is it tolerated? Promoted?*
- 3. Is there support in Scripture for medical work as a part of the missions enterprise? What is it?*
- 4. What is your organization's mission or vision statement? Does it specify the medical part as important, leave room for it, ignore it, or exclude it?*

5. *One could argue that every aspect of the mission organization needs a missiologically sound understanding of its unique role in missions. Is this uniquely so for medicine? Why or why not? How does your organization think about it?*
6. *What is the general level of awareness among mission organizations regarding the changing situation in medical missions and the needs of missionaries? In the reality of competing interests and multiple priorities, how might this level be raised and medical missions be given higher priority?*

Who is interested in joining us in long-term medical missions and how do we prepare them for it?

We believe that our biggest challenge is lack of qualified workers. But who is answering the call to cross-cultural medical service today? One survey found that of a hundred people reporting having felt the call of God to missions, twelve completed training for this calling, two actually went, and only one stayed. Highly visible, large conferences such as the annual Global Missions Health Conference in Louisville, Kentucky, generate thousands of responses from enthusiastic young health professional students expressing interest in cross-cultural service; but only a handful of these ever actually persevere through to actual long-term commitment. Why is this

so? How to close this huge “interest to commitment gap” should be a high priority for the missions community.

Questions that Christian medical professionals ask when considering medical missions: What will I be giving up if I engage in medical missions? I am in debt from my medical training - how can I pay this back so that I can move in new directions? What does it mean to join a mission agency? Do I need to have formal biblical, cultural and missiological training? I want to work on a team. How can I be a missionary doctor without being consumed by medical practice where the needs are tremendous? How can I use my medical skills to reach an "unreached" people group?

Not too many Millennials were included in the survey, but we know their interest in focused internship and residency opportunities is high, so they are certainly keen to explore cross-cultural medical missions. Two-month to one-year directed learning opportunities are significant in helping a young person make a serious foray into medical missions. Furthermore these internships can effectively dispel some of the myths about cross-cultural medical missions that they may have picked up previously.

We medical missionaries feel the demand for excellence in teaching and training national health professionals, and the

training and linguistic skills needed to engage in cross-cultural evangelism and discipleship. We need more training, particularly in the areas of teaching, training, and mentoring; skills that are not typically addressed in most health professional curricula. Although most of us are spending a third of our time in clinical work, we still believe the most important contribution we can make is mentoring national medical workers, especially Christian workers. But we have no training in how to mentor, and in fact, aren't doing very much of it. Pre-field training needs to address this contradiction as well as on-going training and support of missionaries already on the field.

Discussion:

- 1. How might young medical mission candidates, who are extremely busy, be made more aware of the realities in medical missions globally? What types of training do they need?*
- 2. Do you share their conviction that mentoring and training is the most important thing medical missionaries can do? How can mission organizations strengthen their missionaries' ability to do it?*

Reasons people are leaving missions

Answer Options	Response Percent
Family or personal needs	82.0%
Interpersonal conflict	39.9%
Successfully fulfilled a commitment of set duration	29.1%
Unfulfilled in their medical role	21.9%
Change within the country	17.8%
Organizational changes	16.5%
Insufficient financial support	11.6%
Lack of spiritual satisfaction	7.2%
I have never seen anyone leave	4.1%

Although interpersonal conflict is a reason missionaries leave the field, it is not the main reason. We discovered, and in agreement with the ReMAP survey, the main reason is family or personal needs such as children’s education and aging parents.

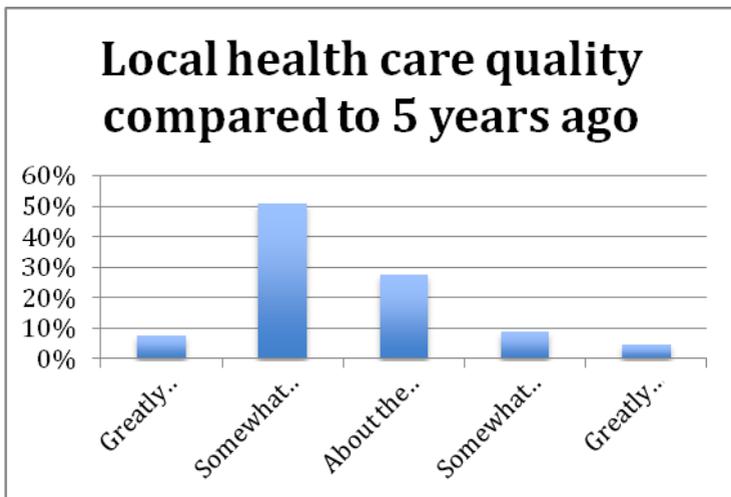
This may not be related to attrition, but one-third of us reported having experienced significant depression, and one-half having experienced significant anxiety. We are survivors, and we will likely develop adaptive methods to hide our struggles, but we need our member care workers and

organizational leaders to take it as a given that we are experiencing this level of stress, and frequently need help.

Discussion:

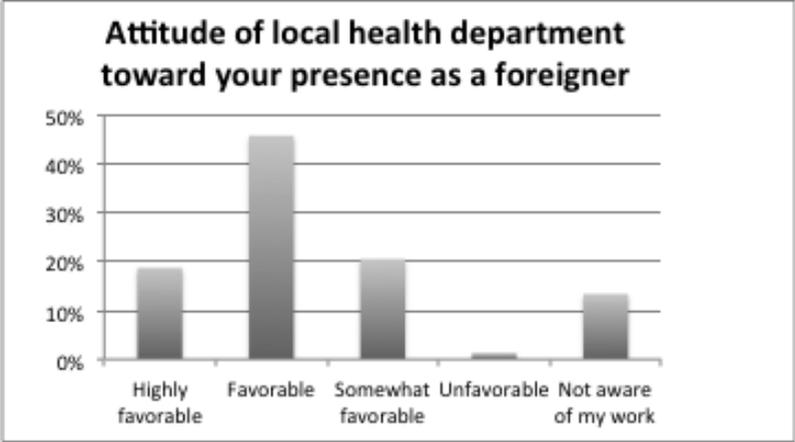
1. *How do you care for your missionaries?*
2. *Do the needs of medical missionaries differ from other missionaries?*
3. *What do you do to support newer medical missionaries to avoid the “sink or swim” scenario?*

Adapting to changes in global health



In the past it was assumed that we medical missionaries were going to fill gaps or provide essential medical services that did not exist in the countries we went to. However, national

health systems in all regions of the world are improving, in some cases dramatically, so the concept that we can or should provide the backbone of health services is no longer universally true. Although our host countries tend to look favorably upon us (see below), it is getting harder to get permission to do medical work in these countries and frankly they increasingly perceive themselves as able to tend to their own healthcare needs. It is important that we increasingly view the world as it views itself if we hope to maintain and even grow our opportunities for the gospel.

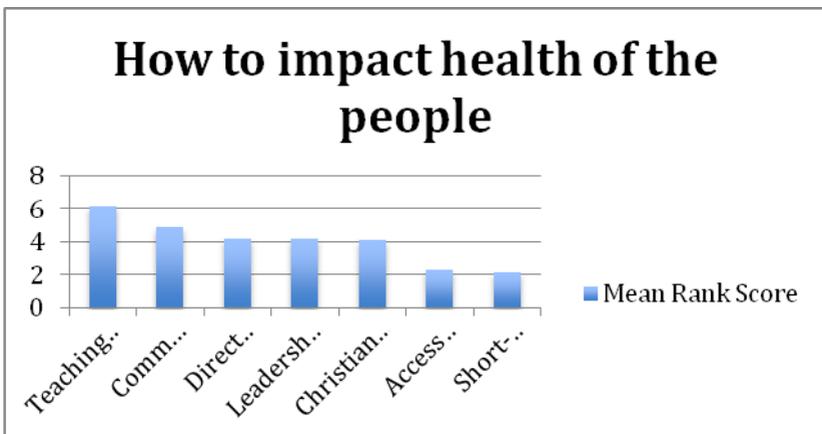


Discussion:

- 1. How important is the local government's attitude toward us? How do you view this issue in your mission?*

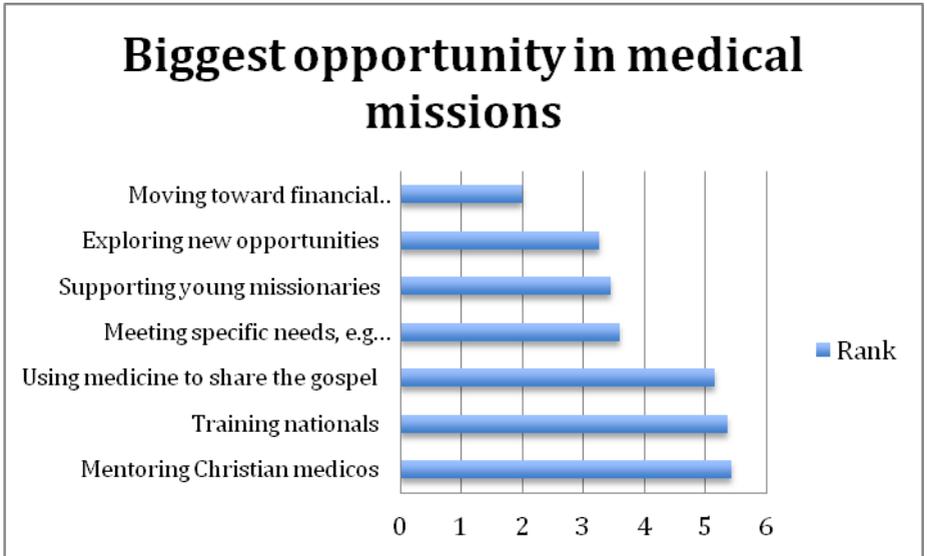
2. *What is the “world’s view of itself”? How does it differ from our view of it? Why might it be important to see the world as it sees itself?*
3. *Does improvement in the local health care system preclude a role for medical missions? What are some opportunities it might create?*

What are the opportunities and what should we focus on?



We consider teaching and training local medical professionals and mentoring Christians in medicine to be the best opportunity and best way to have a positive impact on the health of the people locally. However, we also know that credibility to train and mentor another implies that one is already successfully working in the area that one intends to

mentor that person, so meaningful clinical work is necessary if one intends to mentor national colleagues.



In the 1980's some evangelical Christians were looking for new and better ways to incorporate medicine and health care into more integrated and holistic approaches, using the relatively new language and tenets of community and public health. Another feature was for medical missions to rely on closer partnerships with the church, as God's chosen channel for the restoration of wholeness and the transformation of society. We have identified as third priority the value of

medicine as a means to share the gospel. We need to find more robust to partner with the local church in these efforts.

Short-term medical teams are now a substantial piece in the medical missions enterprise. But long-term medical missionaries do not consider short-term medical missions to be of significant value to the health of the local people.

There are many opportunities to serve in medical work globally. Historically medical missionaries were keen to serve the most underserved people. There are always underserved populations and this need will continue to exist for medical missionaries indefinitely. However, it also might be that a new era creates the need to focus on other areas of need as well. For example, it might be highly strategic to engage the national health system in its development, so as to make unique and essential contributions to it. North American family physicians in China have been instrumental in helping the Ministry of Health establish Family Medicine as a discipline. Others have successfully modeled family practice medicine and evidence-based chronic disease management in China's own community-based clinics. Health crises call for global assistance. Countries around the world welcome new technology. Medical work is a highly close-knit global society, using highly uniform standards of diagnosis and care. Disease patterns in developed countries, such as chronic diseases, are emerging in the

developing world, and call for experienced personnel and successful methods of controlling these conditions. We see unlimited opportunities.

Discussion:

- 1. What is your vision for the way medical work partners with or supports the local church?*
- 2. Do you believe that medical missions are compatible with a commitment to proclamation evangelism? Explain your understanding.*
- 3. Are you surprised that short-term missions were ranked so low? Why do you think it was?*
- 4. What new opportunities in medical missions are you seeing?*
- 5. What is your vision for the future of medical missions?*

Summary

The cross-cultural medical workers we surveyed are committed to long-term service, and bring a unique set of skills to the cause. While one cannot influence changing circumstances in host countries, mission organization policies and strategies can be upgraded in such a way as to utilize medical missionaries effectively, and capitalize on the opportunities available. The purpose of medical missions needs to be re-imagined and clarified, as medical missionaries are increasingly called on to add unique value, engage in more training of national coworkers, and model ingenious and evidence-based strategies of care, not just for individuals but for whole populations and health care delivery systems. The people served through medical work, the colleagues our respondents work with side by side, indeed all the nations, are in need of the hope that only the gospel of Jesus Christ brings. We believe this work is worth continuing to the best of our ability, in the power of the Spirit, “until He comes.”

Acknowledgements

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The reader is invited to engage in discussion with the authors.

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