Your Call
Keeping you focused on God's call for your life
An e-newsletter encouraging and equipping you for a career in medical missions
Center for Medical Missions
A ministry of Christian Medical & Dental Associations

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Hi! I hope everyone has found some time for a break in their routines. I'm thinking particularly of those who just finished their residencies. No breaks for me. I'm in my busiest time of the year, preparing for two pre-field orientation conferences for new healthcare missionaries.

Which brings me to a very important word. We have a problem. It is a wonderful problem, but a problem still. We have too many people who are ready to head to the field for the first time. Our conferences are fully (actually over-) booked. So.we are not accepting any more participants in our August conferences, but we've already set the date for an extra conference, March 19-22, 2015. By the time you read this, the information and registration should be on the CMDA website. I encourage you, if you are at the point where you plan to be on the field before next August, you need to go ahead and register for the March conference. We need to keep the conferences to around 20 but no higher than 25 participants, so register early if you think the March class will fit best with your schedule. Visit www.cmda.org/orientation.

The next conference after March will be July 16-20, 2015.

Global Missions Health Conference: Don't forget it is time to register if you plan to attend the GMHC in Louisville on November 6-8. You can do that online at www.medicalmissions.com/gmhc.

There is a lot of good information in this newsletter, so I hope you find it helpful. If I can assist you in any way, please don't hesitate to ask!
Susan

Included:

Gifted

"But you will receive power when the Holy Spirit comes upon you; and you will be my witnesses..." (Acts 1:8, NIV 2011).

Michael is a radiation oncologist who spoke to our CMDA students recently, describing how he shares the gospel with his patients.
At the completion of all new patient visits, after finishing his medical discussion and answering all of their questions, he asks, "Do you mind if I share a story with you?"
They always agree and he tells them of his coming to Christ in Jamaica at the age of 23. It begins as a regular story of interest and drifts into the gospel, all within two minutes. He shares the same story with every new patient. If they want to cut him off, he politely quits the story and arranges medical follow-up. Every few months, someone is brought to a saving relationship with Christ.

Every new patient, every time, the same story-and three to four times a year someone is saved eternally. Not a description of my practice.
Does God gift some people in evangelism and others less so? I suppose so.
If we are not among the so gifted, can we avoid our responsibility to share Christ with our patients and our colleagues? Certainly not. We all stand under the command of Matthew 28:19-20 to make disciples of all nations.

And where does this necessarily start? By inviting and leading our close friends and family members to the Lord and then moving forward with that same witness into our workplace.
How then can those of us less gifted in evangelism honor this command?

1. Take it seriously. This is a command from our Lord. We have no right to let it go just because it is harder for us than others
2. Pray daily for individuals you know who need Christ. Make a list and be faithful to remember them.
3. Learn from those like Michael who do it well. How might I incorporate their skills into my practice and relationships?
4. Make a list of short stories describing God's work in your life that you might share with patients.
5. Develop transitions: "What are your greatest fears?" "Do you have a religious faith to help you through this?" "I went through something like this once." "You need to thank God for this healing."
6. Pray daily for God to make you an effective witness "this day."
7. Find ways to remind yourself at work that you are on a daily eternal mission with each person you meet.
8. Enlist a buddy or small group to whom you are accountable for your witness.

Mission Service Opportunity: Chiang Mai, Thailand

Every year, CMDA's Continuing Medical & Dental Education Commission organizes a CMDE course for healthcare missionaries serving around the globe. Next year's conference will be in Chiang Mai, Thailand from February 23 - March 5, 2015. The commission is looking for three academic assistants to help make sure everything runs very smoothly. Responsibilities include AV work (getting PowerPoint presentations ready for each session, collecting and inputting evaluations, general "gopher" work). The academic assistants will enjoy many opportunities to network and develop meaningful connections with 400+ healthcare missionaries from Africa and Asia.

You are receiving this *Your Call* newsletter because of your interest in missions. I'm guessing there must be at least three from among all recipients who could benefit from this incredible opportunity. Dr. Burton Lee is the person to contact if you have questions. burton.w.lee@gmail.com. If you want an application, please contact susan.carter@cmda.org.

I Could Have Been a Better Missionary

David Stevens, MD, MA (Ethics)

I'm an overachiever, probably just like you and most other healthcare professionals.

Okay, that is not completely accurate. I confess, I'm an over overachiever. I've always wanted to be the best of the best. I graduated AOA from medical school, not because I was smarter than most but because I worked harder than many. I was chief resident of my 40-member family practice residency program. At the young age of 34, I was the doctor in charge and CEO of a 250-bed mission hospital. Before I was 40, I had raised millions of dollars, built a dam and a 320KW hydroelectric plant, overseen the creation of a nursing school, created a large community health and development program that brought as many as 15,000 people to the Lord in a year and helped start a chaplaincy training school for Africa.

I don't tell you that to boast. The Lord accomplished all of it and gave me the joy of being along for the ride. I tell you that to give you a reference point when I say, "I could have been a much better missionary."

That is my assessment now, not then. Everyone then was singing my praises and it was nice to believe what I heard way too often. It was easy to look around and compare myself to others as we all do to measure our accomplishments. No one had accomplished as much as I had, at least in my own eyes, but I could have been a much better missionary.

I preached often to good effect. I taught staff, people in the community, church leaders and leaders from other missions. Missionaries from 24 countries came to learn from our community health program, but I could have been a much better missionary. I know because of the time that has passed and what I've seen and learned. I know because I'm wiser now than I was back then. Here is what I know now:

- I needed better missionary education during my training days. I was totally focused on learning medicine while I was in medical school and residency. I didn't take a missiology course or pick up a book on cross-cultural communication. I never read a book on how to share the gospel with an animist. In those days there wasn't a *Perspectives* course on world missions. If there had been, I probably wouldn't have made the effort to take it. I was more concerned about being able to treat rare tropical diseases than share the gospel. I see now that I was working so hard preparing to be a missionary physician that I neglected getting ready to be a physician missionary. There is a huge difference.

If I was doing it over again, I would have taken the time to more intensely prepare for the most important part of what God had called me to do-effectively communicating the gospel and discipling new converts. I would have been a better missionary if I had.

- I would have gotten better orientation before I went to the field. We had two weeks of new missionary training given by our mission agency, which was about standard in those days. Most of it had to do with mission policies and procedures and how to do deputation. That training was needed, but it was totally inadequate for what lay ahead when we landed in Kenya.

  Frankly, the mission couldn't have provided all of the training we needed even if they tried. For example, medicine is totally different overseas. In this country, we are taught it is unethical to do things you are not trained to do. In Africa, I had to do those things all the time. During language school in a remote rural area, I did an emergency tracheostomy, delivered breech pregnancies by lantern light, elevated a baby's head off a prolapsed cord during a wild ride in the back of a Volkswagen Beetle, treated anthrax and resuscitated three siblings with hundreds of vicious African bee stingers embedded in their bodies. I had excellent training, but it didn't cover any of those issues. During my 11 years in Africa, I frequently saw diseases and did procedures I was untrained to handle. We were so short staffed that I played God everyday just deciding which patients I would see and which ones would have to get by until the next day. I was ethically conflicted until older missionaries guided me in how to properly apply ethical principles in our situation. I had to learn to deal with the psychological tension of going against my professional training on the job. I would have been a better missionary if I had better orientation.

- I should have learned the heart language of the people better. I applied myself in language school, but Kipsigis is tonal, like Chinese, and you could put nine parts of speech in one word. It was not something you could master in the six months we had in school. When I got to the hospital, all our staff spoke English and many of the patients did as well, so I regressed instead of progressing under my heavy workload. The newspapers were in English; the signs were in English. If people didn't speak English and were outside their tribal area, they spoke Swahili. Our kids can speak English like Africans, but they never learned Kipsigis. Their playmates conversed with them in English since that was the language they used in school. So I learned medical Kipsigis to take histories with but never climbed off that plateau.

  I should have made time to master the local heart language. You can't really know people well unless you speak it, and it is difficult to minister when you preach with a translator. Mastering a language sends a clear message that you love the people you have come to serve and respect their culture and traditions. It enables you to build deeper relationships. It would have allowed me to better understand the ethos and values that motivated their lives. I would have been a much better missionary if I had mastered the local language.

I encourage and challenge you to be a better missionary than I was. Set aside time during your training years to go beyond healthcare to learn the skills you will need to adapt to a new culture, communicate the gospel effectively to another people group and strategies for reaching the unreached through courses, books and conferences. There is so much more available today than there was 30 years ago. Make use of it.

Find a mission organization that provides excellent training before you head overseas. My daughter and her husband had three months of intense education in the U.S. before heading overseas, including practical applications like going into stores and initiating conversations with people from different cultures in our country with the goal of sharing the gospel. Difficult? Yes, but so essential in learning to build bridges to other people's hearts.

Join us at CMDA's Orientation to Medical Missions, a pre-field orientation conference for healthcare missionaries where you will learn to deal with the unique challenges and issues you will face like different cultures' views of health and healing, healthcare rationing, medical evangelism and so much more.

Determine to prioritize language acquisition. If you can learn the Kreb's Cycle, you can master a different tongue. Just approach it with the same determination and attention that you give your medical studies and you will excel. Realize that learning a language is a lifetime endeavor and not just a year or so of focused study. You will be so glad you made the effort.

Don't make the mistakes I did. Be a better missionary!

The Concept of Culture

W. Philip Thornton, PhD
Global Impact Missions

Getting to know a target audience is not easy, but it is possible if you have the right tools for the task. Chief among those tools is an understanding of culture and how it works. That knowledge is best gained through the application of the discipline of cultural anthropology. Below is a brief introduction to the basic ingredients of culture and society and some key definitions. The content is far from exhaustive; rather, it is meant to stimulate further study in each of the areas introduced.

A. **Definition of culture**

Culture is an **integrated system** of **beliefs**, of **values**, of **customs** and the **social institutions** which embody these beliefs, values and customs.

By *beliefs*, we mean what people believe concerning reality, concerning the supernatural and concerning the ultimate meaning of life. *Values* deal with what people believe to be true, good, beautiful and normal, while *customs* refer to how people behave, how they relate to others, how they talk, dress, work and eat. The *social institutions* which embody those beliefs, values and customs are things like the church, the family, schools, clubs, unions, etc.

By *integrated* we refer to the "interconnectedness" of all parts of culture. That is to say, when you touch a culture at one point, it has ripple effects throughout the culture, even though that may not be our intent. For example, if we approach a culture where polygamy is practiced, we may determine that multiple wives is unacceptable. If by some chance we are able to address the polygamy issue but fail to see the ramifications of imposed social change, unexpected consequences can result. First, polygamy is seldom an issue of sex. It occurs when there is an imbalance between men and women, generally as a result of something like warfare. Likewise, having more than one wife is often tied to a man's wealth as well as a source of labor for working in the fields. All of this is also likely to be enveloped in some kind of religious wrapping. My point is this: By changing the practice of marriage (polygamy), ripple effects are felt not only in family relationships but also in the area of economics, labor, religion and the larger social structure.

B. **Characteristics of culture**

1. Culture is **shared**. *This refers to those things which any group of people have in common such as speaking the same language, dressing in similar styles, eating the same kinds of food, celebrating the same holidays, sharing the same beliefs and values, etc. This sharing of cultural traits guarantees predictability which allows people to live together comfortably.*

2. Culture is **learned**. *It is not biological. We do not inherit it. In all human societies, children learn culture from adults. We refer to this process as enculturation or socialization. This is the course of action where individuals are taught the accepted norms and values of the society and thus they become accepted members, fulfilling the needed functions and roles of the group. Much of the learning is unconscious.*

3. Culture is based on **symbols**. *A symbol is something that stands for something else. Symbols vary cross-culturally and are arbitrary. They only have meaning when people in a culture agree on their use. Symbols such as those expressed in art, religion, language, etc. allow people to communicate effectively.*

4. Culture is **integrated**. *All parts are interconnected such that a change in one part has ripple effects in all parts.*

5. Culture is **dynamic**. *This simply means that cultures interact and change. Because most cultures are in contact with other cultures, they exchange ideas and symbols. Without the ability to change, a culture will die.*

C. **Areas of need which all cultures must meet:**

1. Biological *(food, reproduction)*

2. Psychological *(love, belonging, esteem)*

3. Spiritual *(meaning of life, life after death, etc.)*

4. Socio-cultural *(organizational structures, mechanisms of social control)*

D. **The basic dimensions of culture.**

1. The **cognitive dimension:** *the knowledge shared by members of a society. Without shared knowledge, community life and institutions are not possible. For example, for one group in India a rainbow has two colors, hot and cold, but, for Americans, it has six colors. Likewise, Western people believe in atoms, electrons and gravity whereas Eastern people believe in spirits. In short, it tells us what exists and what does not. It arranges our experience into categories, and organizes these categories into a larger system of knowledge.*

2. The **affective dimension:** *feelings, emotions, aesthetics, what people like and dislike, notions of beauty, ways of experiencing sorrow and joy. For example, most of the Chinese people may salivate whey they see a hanging dog in front of restaurant, whereas Americans may feel pain seeing the same scene. For them the dog is a pet, not a meal!*

3. The **evaluative dimension:** *values, what is considered right and wrong, good and bad. Evaluative dimension judges human relationships to be moral or immoral. Its assumptions provide people a guideline to judge, and to determine the truth and error; like and dislike; right and wrong; moral and immoral; cultured and uncultured; gentle and rough; fair and ugly; wise and foolish; and so on.*

E. **Fieldwork (ethnography)**

The primary tool for getting to know a culture is **fieldwork**. Fieldwork implies intentional study of the culture with the goal of learning as much as possible about that culture (its religion, its social structure, it patterns of behavior, etc.) The key tool used in fieldwork is *participant-observation*. As the term implies, the learner participates in all dimensions of cultural life unless the Bible or health issues dictate otherwise. In this way, the learner comes to know both the **etic** (outsiders) view and the **emic** (insiders) view.

F. **Social Organization**

The organization of human beings into groups is essential to the survival of a culture. Each group is geared to solving different kinds of problems, as well as giving identity and support to its members. **The basic groups around which all human societies are organized are:**

1. **Marriage and Family**

a. The most basic definition of a family is a woman, her dependent children and at least one adult male joined to them through conjugal (marriage) or consanguine (blood) relationship. This means that a family unit may be a mother, her children and her brother (consanguine) as opposed to the man who fathered her children (conjugal). While we may consider this type of family out of the ordinary or even wrong, it does meet the needs of the larger society by being the basic socializing unit in the culture.

b. A family may also be either *nuclear* (father, mother, children) or *extended* (some combination of nuclear plus relatives or social kin).

c. **Marriage** is defined by social science as the transaction and resulting contract in which the woman involved is eligible to bear children. Thus defined, marriage is universal. Marriages can be based upon personal choice or they can be arranged. Arranged marriages are used to:
   - *avoid incest* (marrying one's biological or social kin. By social kin I mean one's clan or group "designated"

as kin though there may be no blood relationship)
- *establish alliances* (political or economic)
- *ensure a "proper" marriage* (from someone's point of view. Usually to keep one from marrying "beneath" himself/herself)
- or simply because marriage is considered too important to be left in the hands of young people

d. **Kinds of marriage.** Marriages come in many different forms around the world.
   - Monogamy - one man and one woman
   - Polygamy - more than one spouse
     - polygyny - man has more than one wife
     - polyandry - woman has more than one husband (often brothers)
   - Serial - man or woman has several marriages, one after another
     - Where divorce is not permitted by law or religion or is too expensive to be obtained by the larger populace, serial relationships present an interesting dilemma for the church. For example, a young man and woman are married. He impregnates her and then disappears. Her child is raised by her parents while she goes to work in a factory. There, after some years, she meets and falls in love with a fellow worker. They "live together" since divorce is not an option. Together they have two children of their own. As a couple, they come to know Jesus as their Savior and now attend church faithfully. But questions remain given their special circumstance: Are they living in adultery? Can they become legitimate members of the church? Can they receive the Lord's Supper?

e. When a couple marries, where they will live is determined culturally.
   - Patrilocal - they will live with the husband's family
   - Matrilocal - they will live with the wife's family
   - Ambilocal - they will be given a choice
   - Neolocal - they will establish their own new residence

2. **Kinship**

   When the needs of a culture go beyond what can be accomplished through the family unit, societies turn to the next level of social organization, **the kinship group**. Kinship can be determined in several ways:
   - unilineal descent (tracing one's ancestors back through either the male or female line)
   - bilineal descent (membership is reckoned partilineally for some purposes and matrilineally for others)
   - amibilineal descent (gives flexibility)

   Why is "membership" in a descent group so important? Simply because membership will determine loyalty (to whom you can go for help in a time of need and whom you must respond to when the call for help comes; for determining inheritance issues, etc.).

3. **Age Grouping (Grades)**

   Every society has some type of age grading. In the West we have teenagers, middle age, senior citizens, etc. Other societies, such as the Samburu of Kenya, structure society around important duties which are necessary to the wellbeing of society: young boys who care for the cattle, the Moran (warriors) who protect the tribe and the elders who make tribal decisions. Movement from one age grade to another frequently involves a "rite of passage."

To be continued in September

Report of a Medical Student's International Rotation in India

(Author's name and hospital name omitted for security purposes)

I will always look back on my four weeks at the hospital during the spring semester of 2014 as a pivotal time in my life and a highlight of my medical training. My experience at the hospital challenged me, encouraged me, humbled me, inspired me and strengthened me. In this paper, I will describe how the experience shaped me in each of those ways. But first, I will briefly summarize the activities of the rotation.

My wife and I left for India at the end of January 2014. After many hours on planes and in airports, we got into New Delhi late on a Monday night. We spent the next week getting oriented to life on the subcontinent. We slept off the jetlag, attended orientation at the Emmanuel Hospital Association's central office, shopped for Indian clothing and visited some tourist sites. Our week in Delhi was definitely the loneliest part of the experience. At times we felt alone and afraid in a big, foreign city. It gave me an appreciation for what immigrants, sojourners and refugees experience all over the world. At the end of that week, we left Delhi and after 18 hours on a train arrived at our final destination of The Hospital in Raxaul, Bihar, India.

During our time at the hospital, we both rotated through a variety of medical services. I spent one week on the surgery service, one week with the OB/Gyn service, one week of community health and one week on the adult medicine service. A typical day began with breakfast at 7 a.m., followed by morning report at 7:45, then chapel at 8 a.m. Afterward, we would round with the attending and any other staff on the service before spending the rest of our day caring for patients in the operating room, delivery room, ICU or outpatient department. We would break for lunch around 1 p.m., and our workday would usually end between 5 p.m. and 6 p.m. Frequently, a visiting obstetrician from Australia would give us medical students excellent lectures on obstetrics or gynecology topics in the evenings. Every third evening, I would take call in the "casualty department," which is the equivalent of an emergency department in the United States, from after dinner until 11 p.m.

I think my favorite week of the rotation was the community health week. During this week, we visited various community health initiatives which the workers at the hospital sponsor in the surrounding communities. These initiatives included rehabilitation, drug abuse programs, income generation projects for women, prenatal care and infectious disease management. I think the reason I enjoyed the community health work so much is because I saw the great work that is going on through this department in the areas of evangelism, discipleship and church planting. Through the community health projects, long-term relationships are established with members of the community, and that opens up great doors for ministry. Additionally, the potential to make a significant public health impact is very great through this community health work. As an aspiring family physician, I could very much see myself serving in this role during my future career.

My time in India challenged me in the best way possible. I was pushed out of my comfort zone-physically, emotionally and spiritually. The living conditions in India are a far cry from what we're used to in the United States. From sleeping on a hard mattress, to bucket showers, to eating the same food for weeks on end, there were plenty of creature comforts that I learned to do without in India. This was good for me, because it revealed to me the materialism and selfishness embedded in my own heart. I was surrounded by patients who were suffering so much, and my standard of living inside the compound of the hospital was far more luxurious than the conditions endured by the rural poor in the surrounding communities. I was challenged emotionally by the experience, because there was frequent anxiety over logistics and safety. I wanted to give my wife the best experience possible. And I took it upon myself, as her husband, to try to make the experience as stress-free as I could for her. Recent events in the country put us on alert and perhaps made us a bit hyper-vigilant about safety. I think the most important challenge I faced was the spiritual challenge. It was important because it grew me, so deeply, over the course of a few short weeks. I was constantly forced to depend on God for everything; my faith was challenged because everything in India felt so out of my control. This cultivated a dependence on God which I believe I will carry with me, though I know I will always need to fight my sinful tendency toward self-sufficiency.

The experience encouraged me on many levels. One of the greatest encouragements was the deep fellowship we experienced while at the hospital. We stayed in the "Western Guesthouse" with other visitors (mostly medical students and various healthcare professionals) from all over the world-Canada, Australia, the United Kingdom, Germany and the United States. We built deep friendships with some of the godliest people I've ever met. These relationships encouraged us to trust God, expect Him to do great things and pray to Him as our loving, sovereign Father. Another one of the greatest encouragements was seeing how much my wife flourished during the experience. I'll admit, I was a bit apprehensive before the trip as to how she would adjust to the new environment. This was my second time in India, so I knew the living conditions would be a far cry from anything we would see in the United States. I also knew how stressful life can be in India, and I didn't know how my wife would respond to it. By the grace of God, she adjusted incredibly well, and God was deeply and clearly moving in her life during our time there, which brings me to my next point.

The experience humbled me, partly because I found myself having more difficulty adjusting to the new environment than my wife! Perhaps I went into the trip a bit arrogant, thinking that because I had experience in India I would adapt well and she would be the one having a difficult time. That wasn't the case at all. In fact, in the midst of all the suffering we were seeing, I found myself all too often worrying more about my own earthly comfort than I was about the people around me. This was deeply humbling, and pointed me right back to the gospel. I saw that there was deep materialism and selfishness in my own heart, and that my only chance of being forgiven of this sin was through the gospel-Christ's atoning work on my behalf, and His victory over sin and death through the resurrection. I saw that I am so far from perfect and will never attain anything remotely near to Christ's perfection through my efforts. I'm a great sinner, and Christ is a great Savior.

I was inspired at the hospital because I interacted on a daily basis with men and women who were laying down their lives

for the sake of the gospel and were doing so with deep, deep joy. Many of the workers there had left their homes, lands, families and career prospects to serve God and the poor in a forgotten corner of the globe. And yet, they did so with joy and perseverance. There were so many people at the hospital who I will aspire to be like, and I was especially inspired by those who were a bit older and had spent decades laying down their lives for Christ and persevering through so many afflictions.

Lastly, I was strengthened during my time. I left more determined to live for Christ than ever and with greater resolve to live missionally, both here in the U.S. and to the ends of the earth. I see my weaknesses more clearly now, and I also see more clearly what Paul means when he says in 2 Corinthians 12:9, "But he said to me, 'My grace is sufficient for you, for my power is made perfect in weakness.' Therefore I will boast all the more gladly of my weaknesses, so that the power of Christ may rest upon me" (ESV). After experiencing life at the hospital and being brought to the end of my own strength (physical, emotional and spiritual), I see that in spite of my weakness I can do all things that God has called me to through Christ who gives me strength.

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