Your Call

Keeping you focused on God's call for your life

A monthly 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'm sure many of you are getting excited about the school year closing. I am asking the Lord to help you finish well. Others are nervously awaiting the start of residency and still others are heading out to their first professional employment. Wherever you are in your training/career, I trust you are looking to the Lord for your strength, wisdom and courage. My prayer for you is that you will continuously be aware that you are a vessel through which the Lord will touch people's lives. You will not know what the Lord is doing in many of those lives, but never forget that He is using you if you allow Him to do so.

Correction: I need to correct a mistake I made in the last newsletter. I attributed the devotional, "Second Chances," to Rev. Stan Key. He was not the author. The devotional was written by a CMDA member who regularly contributes the CMDA weekly devotional. I found it so challenging that I wanted to share it with you, but then forgot who had written it. Since most newsletters include a devotional by Rev. Stan Key, I mistakenly listed him as the author.

If you are under appointment with a mission agency and will be leaving for the field before next summer, you will want to pay special attention to the announcement of this year's Pre-field Orientation Conference which will take place August 14-17. See details below.

I hope you will read this entire newsletter, but I want to stress that the article by Dr. Phil Thornton is vitally important. For those of you who have spent any time in a different culture, you will quickly be able to relate. For those of you yet to serve in a different culture, you may have trouble finding a frame on which to hang the information, but it will be vitally important when you do have a chance to serve cross-culturally. Please put at least that article in a place where you can retrieve it as you will need to review it again and again when the stress of a different culture starts to build.

Here is what you will find in this newsletter:

Undisciplined Disciples by Rev. Stan Key
An Open Letter to Medical Missionaries by Dr. Phil Thornton
Pre-field Orientation for New Medical Missionaries: August 14-17, 2014
Global Missions Health Conference: November 6-8, 2014
You Think About That! - You Don't Have to Come Back
Tea Mobile by Judy Palpant

I hope you enjoy and are challenged by these articles.

Susan
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Undiscipled Disciples

by Rev. Stan Key

"Whoever does not bear his own cross and come after me cannot be my disciple" (Luke 14:27, ESV).

Three times in the New Testament the followers of Christ are called "Christians." But they are called "disciples" more than 260 times! There is more than semantics going on here. The gospel of Jesus is about discipleship. The goal is not just to get people into heaven when they die. Rather it is a call to a certain quality of life and level of commitment rarely encountered in the church today. The New Testament was written by disciples to disciples in the hopes that they would produce more disciples!

Imagine a basketball coach saying to his team, "Don't worry about coming to practice. Just show up for the game and all will be well." Imagine an army general saying to new recruits, "It's OK if you want to skip boot camp. You'll do fine in battle without it." Or imagine a piano teacher saying to her pupils, "Don't worry about practicing those lessons. Just look over the score before the recital. You'll be OK."

The absurdity is readily apparent. Without preparation and discipline, it is unreasonable to expect any level of proficiency in sports, music or warfare. Yet when it comes to the Christian faith, we often get the impression that discipline (discipleship) is optional. "Don't worry about reading your Bible, learning to pray or developing skills to resist temptation. Don't worry about being part of a community or learning how to defend your faith. When moments of trial and testing come, you'll be OK."

The American church is full of undiscipled disciples. We've raised a generation of "believers" who think that spiritual disciplines are optional. They think they can follow Christ without following Christ (walking as He walked). They even have a theology that permits them to receive Christ as "Savior" without surrendering to Him as "Lord." Dear friends, this is pure irrationality!

One of the primary causes of this lamentable state of affairs is the way many of us have understood the grace of God. We've been so intent of telling the world that God is love, we have actually transformed the gospel into something it was never intended to be! Dietrich Bonhoeffer called this "cheap grace."

> *"Cheap grace is the preaching of forgiveness without requiring repentance, baptism without church discipline, Communion without confession... Cheap grace is grace without discipleship, grace without the cross, grace without Jesus Christ, living and incarnate. Costly grace. is the call of Jesus Christ at which the disciple leaves his nets and follows him... Such grace is costly because it calls us to follow, and it is grace because it calls us to follow Jesus Christ... it is costly because it cost God the life of his Son... it is grace because did not reckon his Son too dear a price to pay for our life..." (The Cost of Discipleship. p. 44f.).*

The decision to become a disciple is indeed costly. Jesus was clear about that and insisted that no one should make such a decision without first sitting down and calculating the cost (Luke 14:25-33). But before you turn back in doubt and fear, thinking the cost is just too great, think about this: have you considered the cost of non-discipleship?

An Open Letter to Medical Missionaries

by Dr. Phil Thornton, PhD

Working in another culture[1] is never easy, not even when what is being offered is both wanted and needed. When we add the extra weight of "best practices," a difficult job becomes even more complicated. In delivering medical services, both short- and long-term, in a cross-cultural context, four critical questions beg for our attention.

Given the cultural distance[2] between us (medical providers) and them (our patients)...

1. How do I get a good (accurate) diagnosis before I treat?
2. How can I ensure (as much as possible) that the medicines I prescribe (give out) will be used in the way I intend?
3. How can I make sure that what I am doing interfaces with the larger community?
4. Is what I am doing benefiting (or being detrimental) to my indigenous ministry partner and his vision?

Question #1: How do I get a good (accurate) diagnosis before I treat?

Five cultural issues come to mind which can affect our ability to diagnose accurately.

a. **The role of honor and shame**

Consider the following comparison as given by Werner Mischke of *Mission One*:

Guilt/Innocence World (primarily the West)	**Honor/Shame World** (primarily Majority World)

North America, Northern Europe, Australia and New Zealand	Africa, Asia, Latin America, Middle East, Southern and Eastern Europe
Based more on **innocence/guilt** than honor/shame	Based more on **honor/shame** than innocence/guilt
Generalizations about culture: What societies tend to value	
MORE GUILT-BASED	**MORE SHAME-BASED**
EQUALITY	**HIERARCHY**
More likely to measure worth of a person based on individual merits and performance	More likely to measure worth of a person based on age, position, title, rank or tradition
DIRECT	**INDIRECT**
More likely to communicate in a direct manner, face to face-to "cut to the chase"	More likely to communicate indirectly- through stories or a mediator-in order to "save face"
INDIVIDUAL	**GROUP**
More likely to value the uniqueness of each person, individual human rights, "my own destiny"	More likely to value the opinion of the family, harmony in the community, welfare of the group
TASK	**RELATIONSHIP**
More likely to value work accomplished, efficiency in getting the job done	More likely to value personal relationships; social harmony trumps efficiency
RISK	**CAUTION**
More likely to venture forth rapidly, experiment with new ideas, not knowing how things will work out	More likely to proceed cautiously, slowly, to keep what one has gained, even though it may be small

Medical personnel in the U.S. are much more likely to follow the cultural characteristics described in the left hand column, and they expect (if not demand) the same from their patients and co-workers. Working in a non-Western context, however, requires a different set of skills and expectations. For example, when a patient is asked to "tell me what your problem is" (the question asked by the doctor), the answer in an honor/shame culture is much more likely to be given indirectly, especially if the medical problem is seen as bringing shame to the individual patient or to his/her family or social network. It may be couched in a rather lengthy story. It may be given by someone who accompanies the patient who will act as a spokesperson (intermediary) for the patient. Or, given the role of "hierarchy" in the culture, the patient may seek the permission of one who is "ranked" above them (e.g., a wife needs the permission of her husband, or mother, or father, or

village leader) before answering the question or receiving treatment.

The opinion of the patient's family or social network, as opposed to the individual patient's opinion, will likely play a significant role in how the recommended treatment is received. This will be especially true if the treatment will disrupt harmony in the family or community. Even if the treatment needed is urgent, it can be delayed until the right people are consulted and the community is of one accord. In the final analysis, the patient in a shame/honor society is likely to move very cautiously and slowly, calculating risks, potential outcomes and opinions of significant others before taking any curative action.

b. **The trust factor**

Drawing on their comprehensive review of the literature on trust, Hoy and Tschannen-Moran (2003) offer the following definition: *Trust is an individual's or group's willingness to be vulnerable to another party based on the confidence that the latter party is benevolent, reliable, competent, honest and open.*

Being vulnerable probably does not come easy to any of us, but vulnerability in some cultures is to be avoided if at all possible. It may be the fear of "losing face" if the truth is known, or the experiencing of shame and loss of dignity if the facts come out, or the fear of retribution from another more powerful person or the community. It may be the fear that revealing too much to a powerful person like you, the physician, places in your hands the ability to control (manipulate) their lives. Such is the case in cultures where "magic" is prevalent and used by the local healer. In any case, the trust needed to obtain an accurate diagnosis may not be easily achieved. Dr. Marvin Mayers[3] notes that every relationship passes through *stages* in the development of trust. The relationship builds as the stages of trust are "passed" effectively by all participants within the trust relationship. In this scenario, trust building will take time.

So how is one to ascertain just what level of trust exists between doctor and patient? Seldom will it be expressed directly. Rather, verbal cues will be couched in carefully chosen phrases. Pauses and intonations will also indicate the level (nature) of the trust relationship. Nonverbal cues such as facial expressions, eye contact, positioning of the hands and feet, etc. are all signals of the presence or absence of trust. Reading these signs requires medical personnel to develop a rather high level of cultural acumen in addition to their knowledge of medicine.

It is commonly accepted that the basis for trust[4] hinges on the perceived *ability, integrity* and *benevolence* of the other person. That is, the more we observe these characteristics in another person, the more our level of trust in that person is likely to grow. This will be true of the doctor/patient relationship. Taking a brief look at these three "trust" builders, we note...

Ability refers to an assessment of the other person's knowledge, skill or competency. This dimension recognizes that trust requires some sense that the other person is able to perform in a manner that meets our expectations. It is highly likely that your patient will extend to you this level of trust, i.e., they believe that you have the knowledge and skills needed to help them. What may be a negative factor are their expectations. That is to say, your patient may have a highly exaggerated level of expectation about what you, a Western missionary physician, can do. If you find it necessary to lower their expectations with your diagnosis and prognosis, their level of trust in you may go down, at least at the ability level.

From a Western perspective, *integrity* is the quality of being honest and fair. However, integrity in a cross-cultural setting may be defined differently, namely the degree to which you, the physician, *adhere to principles that are acceptable to the patient and his/her social network*. This may or may not include honesty (e.g., "If you stop sleeping with more than one wife, you can eliminate this medical problem.") or fairness (e.g., in societies with a hierarchy where all are <u>not</u> viewed or treated equally). I am certainly not arguing for being dishonest with your patient. What I am saying is that even the understanding of "integrity" can be affected by culture. How well have your treatments worked out in the past, how well have you met the expectations of previous patients, how well have you met the accepted standards of social interaction...the factors affect the level of trust extended to you by your patient and, as such, affect the level of "openness" your patient may have in explaining his/her problem(s). It is in this sense that I say that integrity affects trust and trust affects your ability to achieve an accurate diagnosis.

A third factor which affects trust is that of *benevolence*. In other words, how does the patient perceive (assess) your concern for his/her welfare and perhaps the welfare of the extended family and village? What do they think your real intentions or motivations are for extending to them medical treatment? Do they think that there are political or religious motives underlying your medical services? These thoughts may never have entered your mind, but they may reside in the minds of your patients, depending on past experiences with Westerners or what the patients have "heard."

c. **Categories or Sets**

Western medicine diagnoses by identifying the "category" into which a problem falls. Once that category is identified, certain actions can be taken and/or medicines prescribed. This approach falls into what Paul Hiebert[5] calls "bounded sets." Things either belong or they don't belong in that set or category. Many cultures, however, understand their world not through the lens of bounded sets but rather through the lens of centered or fuzzy sets. With a centered set worldview, belonging is measured by *its relationship to a center point* (i.e., how far from the center an object/action/thought resides). With fuzzy sets *boundaries are ill defined.* Something can belong to two or more sets (categories) at the same time. In this case a person can be both sick and not sick at the same time.

Trying to diagnose an illness with people steeped in the centered or fuzzy set worldview can be difficult and frustrating to a medical professional from the West. We see it as being "hard to get a straight answer." Since our actions are dependent on identifying the category into which the patient's problem falls, centered and fuzzy set cultures create dilemmas in how Western medicine responds.

d. **Oral Communicators**

Western medicine operates under strict time restraints. A doctor has only so many minutes to spend with each patient. This means that there is a limited amount of time in which a diagnosis must be made and a course of action prescribed before the physician moves on to the next patient. This is particularly problematic for working with the 80 percent of the world's people who are what we call oral communicators. Consider the following characteristics of oral communicators as outlined by Paul Koehler.[6]

- *Oral communicators start and end with a story.*
- *The story houses the concepts and ideas, which are seldom extracted from the story.*
- *Oral communicators do not analyze. Logic is neither understood nor prized as a tool for argument or clarification.*
- *Oral communicators enter into a story and live vicariously with the teller.*
- *Oral communicators are event oriented.*
- *Oral cultures are highly relational. Values are tied to the group and what is experienced (rather than theory).*
- *Knowledge is functional - i.e., what is needed to maintain relationships and community.*
- *Knowledge is a sacred commodity which is remembered and told, and sometimes only for certain people to possess.*
- *Tradition is highly valued.*
- *Morality is what the community expects of you.*
- *Learning comes by hearing, imitating, repeating and memorizing through songs, stories, proverbs, etc.*
- *Oral communicators reason from experience. They think and talk about real life events.*
- *Oral communicators frequently use words set in proverbs, stories, riddles, word formulas, etc.*
- *They appreciate repetition and like verbosity.*
- *Oral cultures focus on the group rather than the individual.*
  Finally, oral cultures believe that they cannot control the events of life.

Even a cursory look at the above characteristics will highlight potential problems which Western medical professionals face in "getting at the problem of a patient." For example, the problem may be couched in a rather lengthy story, and *it cannot be extracted from that story.* It may be delivered in what we might call an obscure fashion such as with a proverb or even a song. It may be tied to an event, and getting the patient to "analyze" the problem may be difficult. The patient may prefer to tell you, the physician, the story (problem) several times while they expect you to repeat your diagnosis and plan for treatment several times (verbosity). They are likely to consider your recommendation for treatment in light of what the community thinks. Perhaps most frustrating to Western medical professionals is the idea of fate, i.e., the patient has no control over the events of life. Whether it be the time factor, or causation, or community over individual concerns, or method of delivery of the message...getting an accurate diagnosis with oral communicators is a "different ball game" than in Western medicine.

e. **Spiritual Warfare**

Determining the cause of a particular problem is the first step to remedying that problem. Western medicine will see the cause rooted in science (i.e., the world of germs, disease, human action and interaction). But many cultures will posit the cause of a problem in the "spirit world." In this world, the problem (sickness) is caused by having made the spirits angry or by an enemy placing a curse on the patient. When problems are "diagnosed" in this fashion, treatment must take a different course. Medicine practiced in this environment often results in what Charles Kraft[7] calls a "power encounter." *By power encounter I mean a demonstration of God's power working in and through God's servants based on the work of Christ on the cross and the ministry of the Holy Spirit in the confrontation of demonic activity in the lives of people.*

Western medicine does not readily give place to demonic activity as the cause of illness, yet it was the source of many illnesses in the Biblical accounts. Certainly not every medical problem is the result of demonic activity, but especially in animistic cultures, there is little doubt that the spirit world is readily at work. Given this reality, diagnosing and treating an illness must allow the possibility for spirit causation and Holy Spirit intervention. To ignore the spirit world and its activity among humans is to disregard what very well may be the root cause of the patient's problem. Likewise, treatment of the illness requires not only the skills of Western medicine but also discernment on the part of the physician as well as a dependence on the working of the Holy Spirit.

Question #2: How can I ensure (as much as possible) that the medicines I prescribe (give out) will be used in the way I intend?

The distribution of medicines by both short- and long-term medical missionaries carries its own set of potential problems. Consider these issues:

a. Does the patient understand the dosage I have prescribed and the timing for taking those medicines?
b. If time is important to the prescribed medications, do they have a watch/clock? How do they indicate or measure time in that cultural context?
c. Will the patient "share" those medicines with others in his/her family, and, if they do, what is the potential harm?
d. Will the medicines be sold to meet some other more urgent need such as food or to pay off a debt?
e. If you give instructions in writing, can the patient, or someone close to the patient, read?
f. If you are working with oral learners, how should you "package" and "deliver" your instructions in a way that they will be understood and remembered?
g. What is the potential "harm" if the patient does not follow your instructions?
h. If there is potential harm if the medicines are not used correctly, do you simply withhold those medicines, even if the consequences of doing so are dire?

As a non-medical person, I would not pretend to answer the questions I have raised or the many I have failed to mention. But they are questions which will need to be answered. While the consequences of how they are answered are medical, the context in which they must be answered is cultural and the consequences potentially spiritual.

Question #3: How can I make sure that what I am doing interfaces with the larger community?

The tendency for North Americans is to "take charge." This is especially true of medical personnel. After all, they <u>are</u> in charge in the context in which they practice medicine in the U.S. As a North American culture, we are "doers," i.e., we believe in getting things done. Results are the important thing. In the process, we expect some confrontation. We believe in "meeting the problem head on." When working with others we prefer that "they say what they mean and mean what they say," and not "beat around the bush." After all, one is either a part of the solution to the problem or part of the problem! Time is money. If someone makes a mistake, he/she should take responsibility for it, "own up to it." We believe in equality, equal treatment and fair play. We don't like those who try to "pull rank." We expect cooperation from the locals, even if we do not agree on everything. Cooperation takes place for the sake of action, getting something done. It does not imply or demand agreement outside the task.

While there is nothing inherently wrong in the above characteristics, they can be problematic in working cross-culturally, especially when it comes to interfacing with the larger community. For example, in honor/shame cultures, saving face is more important than "telling the truth" or taking personal responsibility. In other cultures, confrontation is to be avoided at all costs; you always "couch" your statements in a way that will not offend, or you use a third party to deliver an undesirable message. <u>Results are not as important as relationships</u> and cooperation means agreement in "life," not just on one issue.

Of special concern is how the practice of medicine by Western missionaries, especially short-termers, affects local medical providers. Will the people prefer to see the Western doctor as opposed to a local doctor? If so, why? Is it because free medicines are being offered? Is it because medical services are free, as opposed to the local doctor who charges? What "damages" are done to the local pharmacists and doctors by our actions? Are Western doctors perceived to give better treatment? Are patients seeking a confirmation of what they have been told by the local doctors? If the local medical provider is a shaman (or healer), what are the repercussions for "outsiders" who come in, and for the people who access those services? If local people are hesitant to take advantage of medical attention offered by Western medical professionals, why? Have they been threatened by bodily harm, or exclusion from the community, or a "curse?"

At the macro level, do missionary physicians and dentists have the "permission" (blessing) of the local leaders to practice in their community? If they do not have access to those leaders, do they have someone who will "speak for" them, i.e., a

sponsor? What credentials are required by the government to practice in the host country?

What I am emphasizing is this: the cooperation of key persons in the community where Western medical missionaries serve is crucial. To avoid proper cultural protocol, or to ignore "important" people in the community, or to act in ways that are accepted in the U.S. but are culturally unacceptable in the host environment makes it difficult, if not impossible, to practice good medicine. At the same time, it can destroy the ultimate purpose of our being there, namely to share the gospel. If missionary medicine is to be a vehicle for reaching people for Christ as well as serving their physical needs, interfacing with the local community must be a priority.

Question 4: Is what I am doing benefiting (or being detrimental) to my indigenous ministry partner and his vision?

In most cases, Western medical missionaries are present at the request (or acceptance) of local Christians. That means "partnership." *True partnership exists when two entities, both of which are autonomous, agree upon a common goal, which has been established by both parties, and in which both parties make a contribution*. It is difficult for North Americans to enter into a real, cross-cultural partnership, especially when the other partner has less formal education, fewer resources and less power (control). Thus, it behooves the North American missionary doctor to diligently work to understand what the goals are of the local Christian leaders. We must work to show them that we consider them as equals in the task before us. No, they may not have the education and resources, but they are the ones who will live with the consequences of our presence long after we are gone. Make sure that they have a place to contribute and that the place reserved for them is not a menial task, which will lessen their influence in the community. *Our mission is to bolster their influence in the community, not diminish it*. We are serving on their turf and are present because of their good will. It befits us to take a servant's attitude, not one of superiority! Only then will we really benefit our international partner. You may ask, "If our presence is not beneficial to the local pastor or other Christian leader who has opened the door for us to be present, why have we not been 'uninvited?'" It most cases, the answer, unfortunately, is quite simple: money. The presence of medical personnel from the U.S., short- or long-term, represents dollars. By and large, North Americans are generous. They will respond to the needs they see, even if doing so is not in the best interest of good strategy. All too often indigenous leaders tolerate our North American presence simply because of the flow of funds which is badly needed in the local ministry.

1. *How do I get a good (accurate) diagnosis before I treat?*
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Four questions not easily answered, but critically important to the success of our medical ministry in cross-cultural situations.

[1]By culture I mean the integrated system of beliefs, values and customs and the social institutions which embody those beliefs, values and customs.

[2]The degree to which group members differ on dimensions of language, social status, religion, politics, economic conditions and basic assumptions about reality.

[3]Christianity Confronts Culture, 1987.

[4]http://www.beyondintractability.org/essay/trust-building

[5]http://hiebertglobalcenter.org/blog/wp-content/uploads/2013/04/Lecture-Note-36-Set-Theory-and-Conversion.pdf

[6]*Telling God's Stories with Power*, Wm. Carey Library, 2010.

[7]http://www.lausanne.org/en/documents/all/nairobi-2000/204-contextualization-and-spiritual-power.html

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CMM's 2014 Pre-field Orientation Conference for New Medical Missionaries

August 14-17
Jubilee Retreat Center
Abingdon, Virginia

If you are under appointment with a mission sending agency and will be leaving for your field before next summer, you should seriously consider participating in Orientation to Medical Missions, our 2014 pre-field orientation conference. During this three and a half day conference, we look at many of the issues you will face as a new missionary. Some of these include: World Religions and Their Effect on Medical Practice, Different World Views in Medical Missions, Lessons

Learned by First Term Missionaries, Sharing Christ through Healthcare, Working with the Ministry of Health, The Medical Missionary Family, Building Capacity in National Staff, Ministry in Closed Countries, Community Health, Playing God and Other Bioethical Issues, Addressing Fears and Taking Care of Self. This is not all inclusive, but it will help you understand that this is training you will not get anywhere else. It is specific to medical missionaries.

If you are interested, you can learn more at www.cmda.org/orientation or contact Susan at susan.carter@cmda.org. You need to register soon as registration will close when the retreat center is full.

Global Missions Health Conference

November 6-8
Southeast Christian Church
Louisville, Kentucky

Registration is already open for the Global Missions Health Conference - the largest healthcare mission conference in the U.S. If you have never participated, you want to put this on your calendar, load your car with friends and go to this life-changing event. You will find the breakout sessions informational, the plenary sessions challenging and the opportunity to chat with representatives of sending agencies and/or Christian training programs exciting. You can learn everything you want to know about the conference at www.medicalmissions.com/gmhc. Students are offered free housing in church members' homes. If you can only get there for Friday afternoon and Saturday due to your classes, it would still be worth going. It is often a life-changing experience! Find someone who has attended before and ask them about it. It really is a unique opportunity. I hope to see you there!

While at www.medicalmissions.com, be sure to spend some time learning of all the resources that are available any time you want them. If you are preparing for a life of missionary service, www.medicalmissions.com is there for you!

You Think About That!

You Don't Have to Come Back

"What is more, I consider everything a loss compared to the surpassing greatness of knowing Christ Jesus my Lord, for whose sake I have lost all things. I consider them rubbish, that I may gain Christ" (Philippians 3:8, NIV 1984).

In his book *The Insanity of God*, Nik Ripken (pseudonym) shares the story of a Russian pastor sent to a Siberian prison because of his faith. His wife and children followed him there to support him in his suffering, and they too suffered. One night, the wife and three children ate their last bread and rested in the knowledge that they were about to starve to death if God did not provide.

That same winter night God spoke to a church deacon 30 kilometers away and told him to get out of bed, hitch his horse to a sled and carry food to the starving family. The deacon then argued with God that it was too cold and too dangerous. God continued to command him to go. The deacon then exclaimed that there were wolves out there that could eat his horse and then eat him as well.

"I'll never make it back!" he cried out.

The Holy Spirit then spoke to him clearly, "You don't have to come back. You just have to go."
We doctors are geared to evaluate risk/benefit ratios. We evaluate patient problems, our solutions to those problems and calculate the potential benefit versus harm of our therapy. By weighing the risk against the benefit, we come up with a therapeutic decision that produces the best chance of helping our patients with the least chance of hurting them.

And we carry this line of thinking into our personal lives and into our lives of faith.

"God asks me to do this with Him. What will be the consequences? How much the cost? What will it do to my practice, my income, my relationships, my reputation, my family? I know where God is pointing but I hesitate, so that I might be certain the benefit is worth the risk. What if I never make it back?"

And God says to me, "You don't have to come back; you just have to go."

Dear Father,

Whatever the call, whatever the risk, help me follow.
Amen

Tea Mobile

by Judy Palpant

*Over tea we built trust. I was shown the social topography that I needed to navigate to become relevant and useful to the community. Operating at eye level...face to face.--Aaron Ausland writes of his early days in Bolivia with the Mennonite Central Committee in "Staying for Tea"**

She caught me red-eyed from crying, sweeping our cement floor. Embarrassed, I brushed the tears away and welcomed Christine into my home. We'd recently met upon our arrival in Lugulu, Kenya. I'd relegated her to the "acquaintance" category because her extroverted, bubbly personality contrasted with mine.

"What's wrong?" she asked as I poured chai into her mug.

"Ben and the pharmacist's son closed the hospital gate yesterday. No staff or patients could pass. Five year-olds! Someone ran to tell me," I answered. "Nobody wanted to cross the new American doctor's son. Since we arrived here, he's been acting out."

Christine followed with a few stories about her 7-year-old son Philip. Though not sounding as dramatic as mine, they helped.

Different personalities. Different cultures. Different mother tongues. She, a Ugandan refugee. Me, the new American missionary. Both living in a foreign country. Both mothers. Both believers. Over chai, we connected. As she prepared to leave, Christine invited me to pray with her every week and I gratefully accepted.

Like the tea leaves I threw into the boiling water to make chai that morning, we both found ourselves fighting inner battles juxtaposed with external circumstances. "The agony of the leaves," according to tea jargon, draws out the essence.

As Christine left, I prayed, "O God, give us all the staying power. We are tempted to jump. Let the fragrance of our lives be compelling."

Tempests within and without marked our transition into Kenya. In addition to parenting dilemmas, my husband found himself caught in conflicts between staff and administration at the hospital.

Before leaving the U.S., we attended orientation with the Mennonite Central Committee. They wisely advised us--"don't impose your ideas for change until six months have passed"--just live with and among the people. Work to see things from their perspective. We did. Like the quiet expectancy of an extended Advent season, we listened. We waited and watched.

We earnestly prayed for God's wisdom. Blue air mail letters flew between the U.S. and Kenya requesting friends and family to join us in these prayers.

Eventually, we invited the hospital administrator once a week to our home for a cup of chai. Away from the hubbub and pressure of the hospital, this African administrator and my husband, the American medical officer, talked face to face. Together they mapped out a strategy and hope for the future.

In his essay "Staying for Tea,"* Aaron Ausland describes the process: "...something else was happening over tea. I was becoming real to them. Mysterious behavior began to make sense, hidden problems were brought to light, bigger dreams and deeper fears were disclosed."

A cooperative spirit gradually emerged between staff and administration. Tensions eased. New curtains replaced rags on hospital windows--external evidence of internal changes.

What a boon, this cup of comfort served up in a culture that paused mid-morning and late afternoon. Once again, this beverage that has traveled the globe, invoked traditions of sharing.

Even in the hospital kitchen, the cooks made a large kettle of chai and carried it to the wards where patients and family members held out their cups to be filled. On the pediatric ward, the hum of voices rose as 20 to 30 worried and weary

mothers drank chai and conversed with one another. A dozen mothers of newborns on the maternity ward shared their joy. In the isolation hut, the cup of balm built a communal spirit.

Getting in step with this custom, we invited staff and friends for tea. We, in turn, savored cups of sweet, smoky chai steeped over charcoal fires outdoors and served up in homes built of mud and thatch. Or in wealthier concrete homes, milky chai mellowed over gas stoves under corrugated iron sheets.

No instant tea here. Over time, the upheaval calmed. From transition, we moved to living in community with locals and refugees, including Christine, who became a best friend. Like the mixture of tea leaves, boiling water, milk, sugar and spices, we were all thrown together. God took time to nurture and prepare the brew. Mutual indebtedness grew amongst us. And just as the cup of rich liquid carries its welcome aroma to the nose, the fragrance of Christ rose to touch hearts and build his kingdom.

*Volume 2, Article 1: Staying for Tea
www.kristafoundation.org/.../E00DABA6-3048-7C56-5F0A1486AB4EB59...
Aaron Ausland

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