Among All Nations

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Christian healthcare worldwide

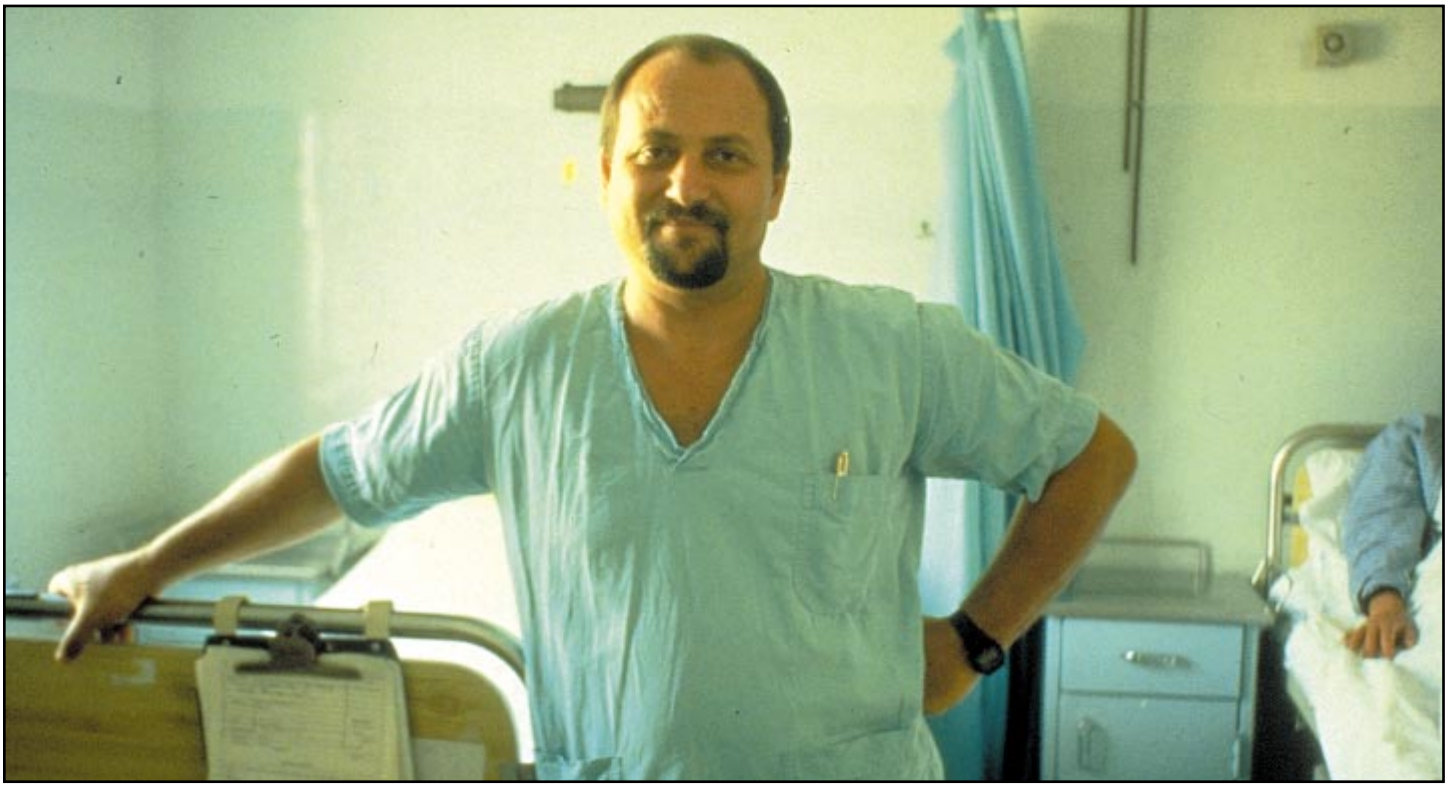

Photo: EMMS

What makes a doctor tick?

Increasing effort is being put into selecting, training, and controlling doctors while public confidence in them is declining, litigation is increasing and the media are reporting more failures in healthcare. The profession is pressed for more objectivity by a society that is increasingly driven by its feelings. We have objective selection of medical students, objective examinations, continuing professional development, evidence based medicine, management protocols and clinical governance. Doctors are to be re-accredited at intervals throughout their careers.

This pattern of control works well in business and industry. For medicine the ingredient lacking is motivation. Only 1% of recent medical graduates feel medicine is a vocation. The 99% are not be blamed - doctors are not a breed apart, genetically engineered for the task (at least not yet). They are the product of the culture and society for whose health they are responsible. When we point a finger at a doctor who has failed we point three fingers back at ourselves.

The personnel secretary of a Christian mission reported it was a privilege to interview medical candidates: 'they are looking for the opportunity to express their faith in the work they do'. They are people centred because they belong to a culture centred on the God who sent his Son to care for those he made to be like him.

Among All Nations is produced in partnership with the **Medical Missionary Association** and **Christians in Health Care** as the international section of *Triple Helix*. They also produce the magazine *Saving Health*, which has more articles on healthcare with mission, and a more comprehensive list of multidisciplinary service opportunities. Details on p15.

medical missions *look to the future*

John Martin reflects on the second 'Summit Meeting', arguably the biggest gathering of medical missions since the famous 1910 Edinburgh Missionary Conference

Top of the agenda at the meeting in London on 18th February was putting flesh on a framework document, product of the first 'summit' held a year ago. That meeting proposed creating a new umbrella organisation to bring new impetus to medical missions. Within weeks we can expect to see the birth of 'HealthServe'. Funding for its first year is already in place, and a Director is being sought - see p14.

The changing scene

Everyone agrees the mission scene is changing. The biggest change of all is that 'mission' is no longer 'the West reaching out to the rest'. Over a century and a half the modern missionary movement planted the Christian church in some form on every continent. In the last two generations what were once 'mission fields' have become churches in their own right. Most are led by their own people. Few depend financially on the West for day to day operational costs. It is widely recognised, moreover, that the West is now itself a 'mission field'.

Many third world churches are now missionary-senders. Dr David Barrett, author of the *World Christian Encyclopaedia*, believes that early in the new millennium the numbers of third world 'missionaries' will eclipse those from the West. It is estimated there are currently more than 1,500 third world missionaries working in Britain. If there was a major flaw in the blueprint for the 1999 Medical Missions Summit it was that the voice of the third world was nowhere to be heard directly.

Why medical missions?

All this change raises particular questions for medical missions. With political independence, many third world governments aspired to something approaching the British National Health Service. Missions were asked to hand over many of their hospitals and medical facilities. Soon, however, governments discovered that running these institutions was beyond their resources. In some places the outcome was an 'on-again off-again' relationship between non-governmental organisations, missions and government.

Now there are places where NGOs and missions effectively provide the only health service. It is a good question, however, whether this can be funded indefinitely. Moreover, money can be a source of tension. A Westerner suggesting a 'low tech' or low cost solution may sometimes be accused of seeking to deprive third world people of 'the best . . . which they are surely entitled to receive'. While some work reflects the character of mission work of earlier years, it is not always possible to maintain a distinctly Christian ethos. So where and how does the 'mission' part of it fit in the picture?

New questions

There are other factors in play. Are hospitals always the best base possible for medical mission work? A doctor-medical missionary based in Uganda told me recently: 'I could spend all my time at this hospital, doing operations, and prescribing treatment and medicines. But none of that addresses the root causes of why people get sick with illnesses that could be prevented.'

He is a keen convert to community-based healthcare, run in partnership with a team of local workers. What is certain is that it is often only Christ-like motivation that can lead a health professional with a family to accept the deprivations of working in an isolated third world situation rather than in an institution which as well as everything else confers status and prestige.

The spectre of AIDS carries an enormous threat to health care as we know it in the third world. It prompted one respected former missionary doctor to tell me: 'The AIDS epidemic could easily wipe out completely every semblance of third world healthcare'.

There have been times when Western-style healthcare, administered in an arrogant way, has received its come-uppance. In Nigeria in the 1920s some medical missions confidently told people there was no value in traditional remedies, or use of touch or prayer for healing. But then a virulent influenza epidemic defied even their ministrations. Out of the crisis came a breakaway African church that practises a combination of Western-style medicine and prayer for healing in a local form.

What is health anyway?

Experiences such as these have prompted some medical missions to engage in dialogue with local people about the nature of health itself. It is very easy for Western health professionals to arrive on a scene and immediately pronounce on what needs to be done. Some find themselves bewildered to discover that patients still die despite receiving the 'right' treatment.

Healthcare is both a science and an art. This is why, even in the West, a good GP will sometimes ask a patient 'How are you in yourself?' Sometimes third world patients are unable to conceive that they can be brought back to health without a 'touch' or even being prayed over. Can we learn something here from how Jesus worked with the sick?

Theological foundations

One issue somewhat absent at the Summit was consideration of the theological basis for medical missions. HealthServe is

rightly seeking balance between pragmatism and principle. Healthcare professionals are essentially practical people. Doctrinal statements can easily become a distraction or a source of unnecessary disagreement. So HealthServe, with a short doctrinal affirmation, is seeking to travel light. Nevertheless it recognises the need for sources of thoughtful reflection to help Christian health professionals, for example:

- to articulate cogent reasons for what they are doing, including the meaning of Christian 'witness' in day to day work, or in situations where formal Christian activities are restricted, even by the law of the land.
- to think through the ethical dimensions of the questions confronting Christian health professionals in their work, including how to adapt to another culture.

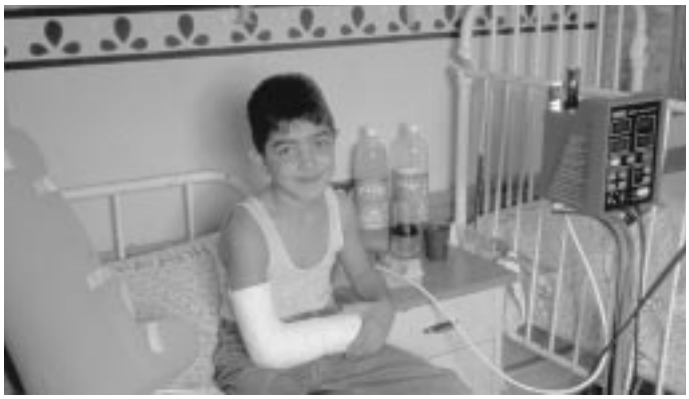

Photo: EMMS

Some key concepts

I would humbly offer the following as key concepts that underpin what medical mission is all about.

1. 'Incarnation'. Christ is the message. And he is the supreme model for what Christians seek to do in his name. When God in Jesus took human form he immersed himself completely in the life of a family, a community, a nation, and (even) a religion. 'That which he could not become he could not redeem' (Irenaus). Here is a radical vision for what mission is about and how it is done.

2. 'What Jesus did'. We get Jesus wrong if we think his work was fully accomplished over a long weekend (his death and resurrection). His life and ministry are important too. Sometimes the Gospels speak of the healing acts of Jesus as 'signs' of the coming rule of God. Sometimes Jesus heals out of the sheer goodness of his heart with nothing more said. People engaged in healthcare mission will sometimes be given opportunities to explain their motivation and it is worth having a ready answer. Equally the ministry of Jesus suggests that acts of healing, generosity and compassion can often be left to speak for themselves.

3. 'General revelation'. We do not 'take' Christ with us. He is already present as the creator and sustainer of all things, present in all that is good, and present by his Spirit, in his Church, and at work in the lives of God-fearers.

4. 'Presence'. This takes on special significance in places where opportunities to speak openly are restricted. Presence in other cultures is in itself beneficial. Third world Christians say that the presence of missionaries and 'tentmakers' reminds them of the missionary origins of their churches and that the mandate for mission never ends. Presence in the West of third world Christians often challenges timidity in witness and the tendency to 'privatise' matters of faith.

5. The 'Great Commission' (Matthew 28:19-20). This has often been misinterpreted by enthusiastic apologists for missions. In the Greek the imperative is not 'go', but 'make disciples'. The declaration assumes that followers of Jesus are a people on the move: 'As you go, make disciples'.

Conclusion

The emergence of HealthServe is a highly important development. Moreover it is good news for the UK scene for at least two reasons:

- More and more health professionals are being encouraged to seek out opportunities for electives overseas as part of their training and development. Without necessarily competing with other agencies HealthServe will be an important clearing house, identifying opportunities and helping those who go to be fully prepared.
- Christian health professionals are almost invisible. A major developmental job is needed to identify the Christian health professionals in this country and to discover what sort of support they need.

It all points to the need to find new approaches. HealthServe's first priority will be to enlist the help of churches to identify Christian health professionals, and link them up in interesting new ways. I wish it every success.

John Martin has broad experience of mission and is Associate Editor of *Triple Helix*

What can your church do?

You may be surprised how many healthcare professionals belong to your church. At my former church our mission committee identified the world of work as a key area of witness and ran a series of 'World of Work Seminars'. I shouldn't have been surprised that the biggest single sub-grouping was health professionals. But there were two sources of surprise. Several had hardly any contacts in the church at all and these seminars brought them 'out of the woodwork'. Worse, perhaps, was that some did not know that people they sat with in church week after week worked in healthcare.

1. Urge your church to plan a special service or event for *Health Care Sunday* (17th October). Make an effort to identify all the health professionals in your church. Have a special lunch or supper. Invite one or two to tell the entire congregation about the stresses and opportunities that form part of their everyday work. Pray regularly for them.

2. If a health professional from your church has worked overseas either on a short or long term basis, on their return gather other health professionals for a welcome home party. Before festivities start update the person on developments in the NHS and all the different professions.

Mental Health: Cinderel

In the first week of December 1998 a groundbreaking international workshop was held at High Leigh Conference Centre, run jointly by the Overseas Health Care Advisory Forum of the Churches' Commission on Mission and by the Evangelical Missionary Alliance. Of the 88 participants 52 were overseas nationals and several others were expatriates with overseas experience. John Lowther reports.

Photo: John Lowther

When the madness goes to the market place

A bright wintry sun poured through the windows as we met for the final session of the workshop. In prayer time, Peter Green chose the story of the healing of Legion and my thoughts went back not only to my patients who have exhibited similar excessive and destructive strength but also to our first session three nights before. Participants from a number of African countries, India and Nepal highlighted the breadth of the problems of mental illness in their countries, the few facilities and the valiant efforts of family to cope with the ill relative. But when 'the madness goes to the market place' their coping mechanisms fail. With violence and aggression or a 'David' dancing naked in public places, and in the absence of freely available anti-psychotic drugs, many patients end up as vagrants.

Photo: John Lowther

Church based projects

Examples of 'up and running' church based projects in Nepal, Malawi and Nigeria captured the imagination. I found particularly interesting the very innovative Nigerian project helping vagrant, chronic psychotic patients arriving at a village settlement. There they are able to come and go as they please, living and working side by side with mentally healthy compatriots. Because they are enabled to have treatment, many are eventually rehabilitated back into their families. As a result other families ask for their mentally ill relatives, still within the family fold, to be admitted for treatment. This has led to a community based service funded by national and local government sources but organised by the same Christian group.

Changes required

The workshop was a good blend of academic learning and participants' contributions of their own experiences. Professor Andrew Sims reviewed the changes in practice and advances in treatment which make it even more incumbent on Christians to provide for the care and treatment of people with mental illness. This will need efforts to change attitudes inside and outside the Church and programmes to train local staff in the variety of disciplines which need to co-operate in the care of the mentally ill. With the shortage of national professionals this still needs expatriate help.

Professional assessment: community choice

From her experience in Nepal Dr Christine Wright spoke of the necessity for a professional approach to assessing the needs of a population, and letting the local community give priority to those needs. One community considered an alcohol service essential and that led to a whole

lla in the developing world

series of rehabilitation measures and social changes. The professionals would have chosen a different priority! Dr Ewan Wilkinson - ex Malawi and with a public health background - gave valuable practical advice on the collection of data to optimise the usefulness of such assessments.

A biblical framework

From Singapore, Robert Solomon - doctor, theologian and pastor - brought a wealth of practical experience and academic learning as he discussed 'A biblical framework for mental health care'. He started with the Christian belief that we are:

- created in God's image which requires us to give to all the dignity we owe to God
- social beings made to live in community
- embodied beings - made of clay into whom God has breathed; bodies to be temples of God, not prisons

He then developed the implications of these beliefs for the Christian practice of mental health care and for the churches' support.

Traditional healers

Then came the necessity of acknowledging the role of the many types of traditional healers, who in Africa and Asia are the first line of treatment for the vast majority of the population. How do we co-operate with them and where do we draw the line? The issue is different for Westerners whose cultures largely ignore the spirit world - even though we acknowledge its existence Sunday by Sunday in our worship - but for colleagues in Africa and elsewhere the spirit world is an ever-present reality for the vast majority of their compatriots. The tensions of this dilemma for African Christians were obvious as delegates discussed the subject.

Photo: John Lowther

Of great help in assessing where to draw the line was the paper 'Challenge and opportunity - traditional medicine and a Christian response' by Brother Raphael Ngong Teh. Traditional medicine has so many components from straightforward herbalism to witchcraft. The debate is similar to the Western one about alternative medicine and its New Age connections.

Physical, mental, social and spiritual factors

Other speakers outlined ways of weeding out from general medical clinics patients with mental illness presenting with physical symptoms. Professor Ager quoted research findings from Israel showing that the support from a self-help group reduced the mental symptoms in women undergoing continuing severe stresses. He also raised the subject of the effect of such stressful experience on expatriates working in the developing world. We were warned of the danger of seeing mental illness solely in the context of the science of psychiatry and neglecting the role of global developments, local cultural understandings, and the input of Christian faith.

The global burden of mental disorder

- 12% of the global burden of disease in 14-44 year olds is caused by mental health problems
- 40 million worldwide suffer from severe mental disorder
- By the year 2000 there will be 23 million people with schizophrenia in the developing countries

Mental and physical health problems cause or complicate each other. No longer can healthcare afford to ignore this large slice of global health practice. Neither can the Church. Whether clinicians, administrators or other involved professionals we are all challenged to mediate God's presence to this unfortunate group of humanity.

John Lowther has mission experience, was a consultant psychiatrist and is now medical adviser to the Salvation Army International Headquarters

Nazareth Hospital: a unique mix

Medical student Rebekah Price on her elective in Israel:

The Nazareth Hospital was founded in 1861 and continues to be sponsored by The Edinburgh Medical Missionary Society. At the end of the British Mandate in 1956, over one million Palestinians became refugees and Nazareth became home for thousands of them.

In 1986 the hospital was recognised by the Israeli Ministry of Health and now all the Heads of Department have to be Israeli citizens or permanent residents in Israel. There are still expatriate staff and volunteers including the Hospital Director and Head of the Nursing School. The hospital continues to grow and a new Emergency Room is planned in 1999. It is reserved as a centre for casualties in the event of war.

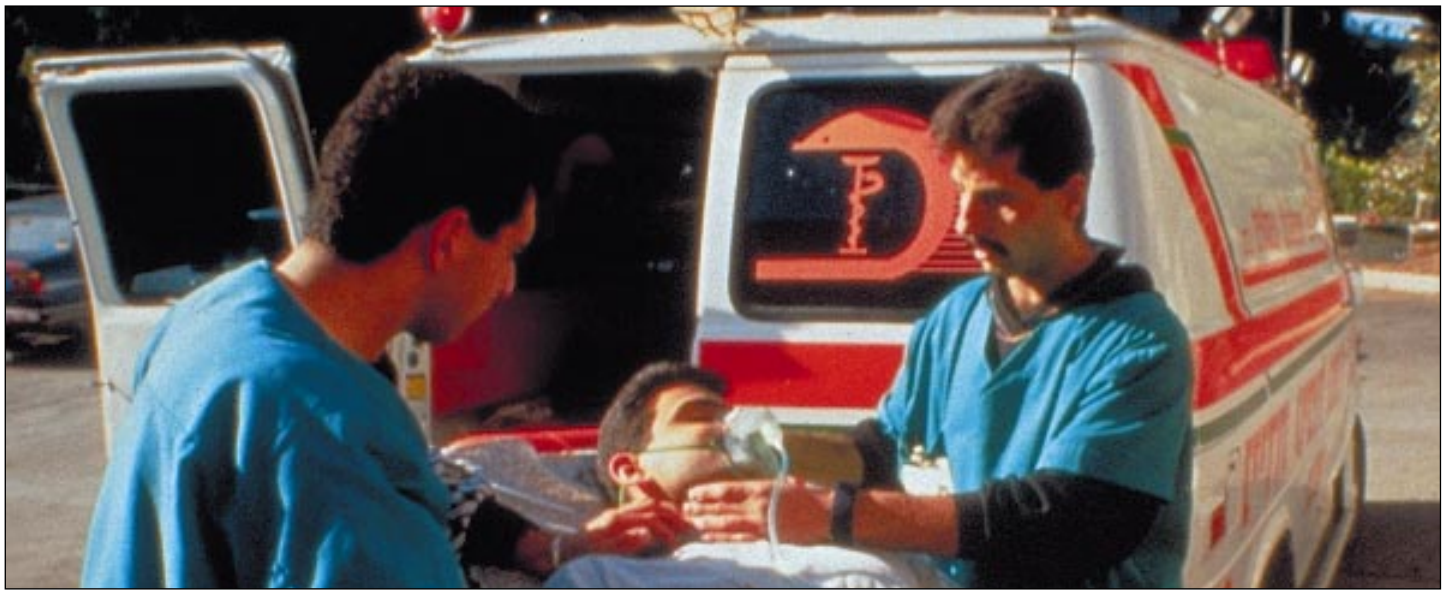

Photo: EMMS

The majority of the patients are Palestinian Arabs but Jews also visit the hospital from the newly built town of Nazareth Illit, a sharp contrast from the dusty, noisy maze of old Nazareth. The staff includes Christians, Muslims and Jews, including a number of immigrant Jewish doctors from Eastern Europe. Such a mixture of cultures working together in equality is unique in Israel and I felt privileged to be part of this working environment. Many of the Christian staff are Israeli citizens. There are worship services in the hospital chapel and weekly Bible studies.

I learnt much about this culture from observing the doctors and patients. Both Israelis and Arabs have an aggressive manner but patients seem very passive and untroubled by this. I was surprised at the medicalisation of childbirth - most mothers receive episiotomies, do not handle their babies after delivery, and seldom have their husbands present during labour and never at delivery. Afterwards the women were overjoyed to show me their infant and insisted I went away with pockets full of sticky sweet cakes, Arabic chocolate or pieces of fruit.

On the buses seats were filled with sleepy members of the Israeli Defence Force. The majority were in their late teens and the female contingent looked extremely glamorous in their figure-hugging khakis with an Uzi submachine gun slung over a shoulder.

We cycled up the Mount of Beatitudes and halfway around Lake Galilee, relishing in a freshwater swim in the lake to refresh us in the overbearing heat. We stayed in Jerusalem's Old City and soaked up the incredible atmosphere of this place, which has an almost tangible sense of destiny, visited Jericho, and swam in the Dead Sea - an extremely painful experience.

As we sought out in Bethlehem the site of the manger, it was no place of 'deep and dreamless sleep' because soldiers were guarding barriers on the road after the shooting of a young man.

Exploring the *souk* was a favourite activity in the early evening when the aromas of nuts, spices and coffee filled the cooling twilight air. One afternoon amongst the narrow cobbled streets and down stone steps I found the ancient synagogue. It is a simple building. Sitting inside I remembered a passage from Luke 4 where Jesus spoke in the synagogue at Nazareth about his priorities: not simply to stand and preach but to give the needy what they needed.

Rebekah Price was a final year medical student at Cardiff when she did her elective in summer 1998 with the help of an MMA grant