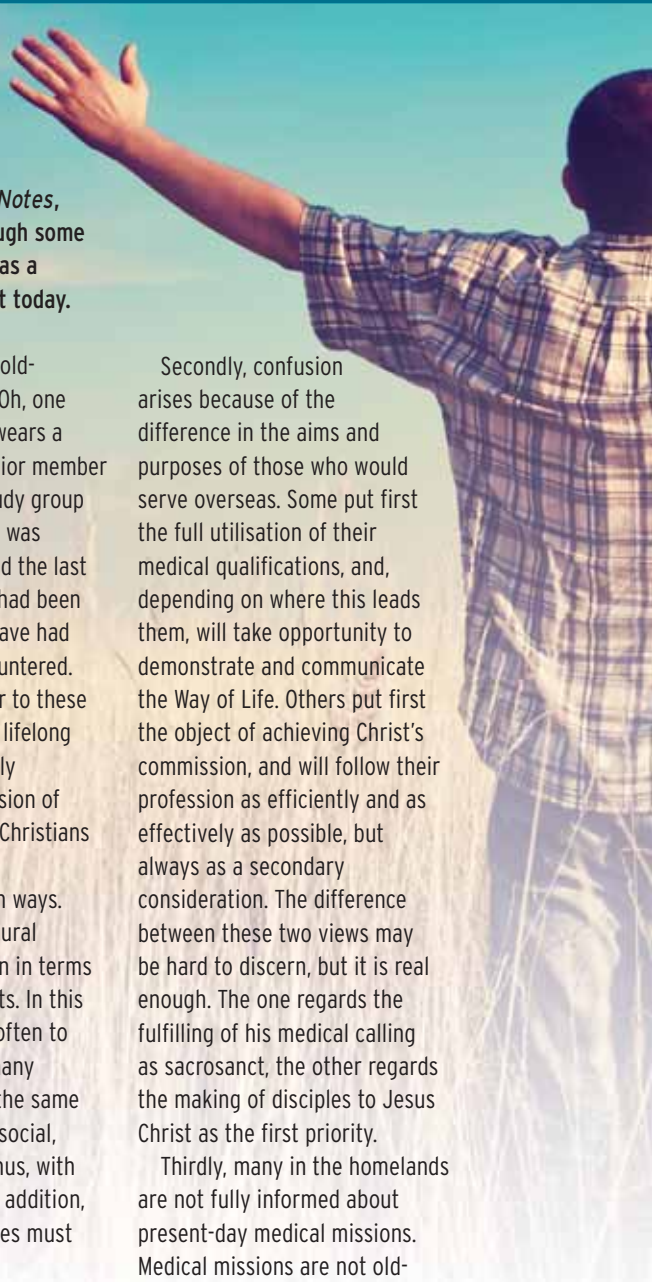
Christian medical service overseas

Keith Sanders describes our main focus



Keith Sanders was General Secretary of CMF in the 1980s, having previously been a medical missionary in India. This article is reproduced from *Clinical Medicals' Notes*, published by CMF in the 1960s. Though some examples may be a little dated, it has a message that is still just as relevant today.

'What do you mean by "the old-fashioned missionary"?' 'Oh, one who joins a Society, and wears a topi!' Such was the appraisal of a senior member of a University CU in a missionary study group of 1962. The subject under discussion was 'preparation for overseas service', and the last avenue of foreign service envisaged had been that of a missionary. This 'missions have had their day' attitude is frequently encountered. Yet at the time a previous contributor to these notes writes that 'too many consider lifelong medical missionary service as the only possibility'.[1] It is apparent that confusion of thought often reigns in the minds of Christians considering service overseas.

Confusion has arisen in three main ways. First, there is an unfortunate but natural tendency to judge the world situation in terms of what are merely local requirements. In this both missionaries and missions are often to blame. It needs to be realised that many countries (and even districts within the same country) differ considerably in their social, political, and economic standards. Thus, with a variety of religious environment in addition, the types of Christian medical services must vary accordingly.

Secondly, confusion arises because of the difference in the aims and purposes of those who would serve overseas. Some put first the full utilisation of their medical qualifications, and, depending on where this leads them, will take opportunity to demonstrate and communicate the Way of Life. Others put first the object of achieving Christ's commission, and will follow their profession as efficiently and as effectively as possible, but always as a secondary consideration. The difference between these two views may be hard to discern, but it is real enough. The one regards the fulfilling of his medical calling as sacrosanct, the other regards the making of disciples to Jesus Christ as the first priority.

Thirdly, many in the homelands are not fully informed about present-day medical missions. Medical missions are not old-

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fashioned, but people at home have old-fashioned ideas about them. Accounts of medical heroics and penknife surgery, with pith helmets and savages, still tickle the fancies (and to a lesser extent the pockets) of many churchgoers at home. But an intelligent reading of missionary literature will reveal a very different picture. Confusion of thought can lead to misdirected or ineffectual activity. Alternatively, it can result in a period of lethargy. In order to avoid such confusion therefore I would suggest that the Lord's command, known as the 'great commission', be our lodestar, the fulfilling of it our overall objective.

Some basic considerations:

a. None can legitimately doubt but that all Christians (not excluding any in the medical profession) are included in the commission to 'go therefore and make disciples of all the nations...teaching them to observe all that I have commanded you...'.[2] Needless to say, not all are to go abroad, but all must be related to the fulfilling of this command. 'This is not the hobby of a few enthusiasts nor yet an optional extra; this is the mission of the Church of Jesus Christ.'[3]

b. Each one of us must teach others the Lord's commands. We dare not rely on our professional conduct alone as the means of bringing others into obedience to Jesus Christ. All of us, whether college lecturer or rural hospital worker, must look for and take opportunities to instruct others in the faith. There are several very good reasons for this, besides the fact that it is the expressed will of God:

(i) Christians are made by being taught – 'teach all nations'.

(ii) Mimed Christianity, that is the non-vocal variety, does not by itself produce conversions. That we must be a Christian example in the way we work and behave

goes without saying, but we must communicate the faith by word of mouth at some stage. Not to do so plays into the hands of non-Christian governments, and suits the devil. The majority want Christian service without the Christian message. They want the demonstration of integrity, without themselves having to conform to the One who is the Way, Truth and Life.

(iii) To rely on the 'teamwork' idea, having doctors, teachers, and evangelists, each contributing their part, may lead to a false sense of achievement. The patient primarily comes to see the doctor, and if the doctor is not able or prepared to start the patient on the road to God, then, in many instances, the chances[4] are that no other Christian will get the opportunity to do so.

(iv) If we ourselves do not communicate the gospel, it is hardly likely that the people whom we are training as medical workers will do so either, and so much of our effort will again be wasted as far as the building of an indigenous church is concerned. Dr Cochrane's quotation needs repeating: 'To my way of thinking, when we get to heaven we will be much more highly commended by our Lord for having made true disciples of some of our African brothers (as he commanded us to do) than for having provided good education and medical care to all the Southern Cameroons at the expense of failing to make disciples of the Africans.'[5]

(v) There are few things which keep one more spiritually alive and balanced than teaching others the gospel.

c. Just as the social and economic standards vary from country to country, so also does the current need of the Christian community; which need should direct us as to the type of service to be undertaken. Our contribution, as foreigners, will therefore vary considerably in different countries. In some instances, as in Kenya, there is a well-established African Church, and Christians are to be found in all levels of society. A strategic need, therefore, is for suitably qualified personnel to take the teaching posts in the medical colleges, and head up other hospitals, with the district work being done by Africans, educated in their own country. Such places as Vellore in India also demonstrate the importance of training Christian medical personnel. On the other hand, there are many more countries and areas where the rural type of work needs to be done by the foreigner, to open up areas to the gospel and to win the confidence of people, and so more firmly establish a local Christian community.

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The holding of teaching and administrative posts by Christians is not a first essential in every circumstance. Christian educational centres and hospitals catering for non-Christian students in a non-Christian country (in India at least) have contributed little to the establishment of the church.[6] This does not mean that highly qualified personnel are not needed

in such countries – they are, but they may be best used not in colleges, but in rural community medical work, where their Christian testimony vitally contributes to the establishing of an ongoing Christian community. Later, with the growth of the church, the expatriate Christian doctor may be led to higher administrative positions, and may ultimately lose his title of 'missionary' as he enters government service. One of many examples of this adaptation is seen in the late Dr Patrick Dixon of Rhodesia. First a rural missionary doctor, working in a mission hospital, then ultimately a medical director under government employ, with a large African state hospital named in his memory. This was still the same man, with the same calling of God, but, as circumstances changed, he was found adaptable.

d. An important fact to remember in the evangelisation of Asian and African people especially is that the individual largely moves with the community, be it the family or the clan. Thus, in helping to establish a Christian community we ought to try to put ourselves in a position where we can reach the family as well as an individual. It is inconceivably difficult for a student to change his religion when none of his family knows what he is talking about.

e. Christian medical service should not be a compromise with mediocrity, but rather making the full use of the facilities and equipment available, without neglecting our obligation to teach others the commands of Jesus Christ.

f. The capacity and interests of the individual will help in determining the kind of service to be undertaken. AJ Cronin's newly qualified doctor, whose heart was set on becoming a neurosurgeon, was disappointed when told that his was the temperament for general practice. But how much better to be given the honest opinion of one who by much experience is qualified to judge. It takes different qualities to make a good general practitioner from those needed for a research worker, yet both are needed in medical missions. God often directs someone to a particular country by giving him a special interest in that land.

Does he not equally guide in professional specialisation? A man who hates obstetrics and loves pathology need not feel that he must become an obstetrician, if he wants to go overseas. Furthermore, as a rule, opportunities for postgraduate qualifications should be taken. But a word of warning. The experience you need is mainly found in the place where you are to go. It is possible to spend several years at home, chasing different specialised posts in order to obtain a good all-round preparation and then, as all too frequently happens, end up by not going abroad at all. ■

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6. McGavran DA. *The bridges of God, a study in the strategy of missions*. London: World Dominion Press, 1955