

A panel of CMF members discuss trends in twenty-first century medical mission



THE CHANGING SCENE IN GLOBAL HEALTH

key points

- The emergence of a truly global Christianity requires a shift in how we understand and talk about medical mission and the role of westerners in it.
- There are a huge variety of roles and contexts where there are opportunities for service, long and short-term.
- The traditional mission hospital is only one of many avenues open to today's Christian doctor with a vocation to work cross culturally. We probably need to mint new terminology to reflect this.
- It's possible to argue the case that Christian doctors who positively choose to work in tough UK contexts deserve to be thought of as 'missionaries'.

In the last century Christianity became a truly global faith, as Todd Johnson has pointed out: 'At the dawn of the twentieth century the statistical centre of global Christianity was near Madrid, Spain. In fact, at that time, over 80% of all Christians were European or North American. By 2010 the statistical centre had shifted well south of Timbuktu in Mali. This 100-year shift is the most dramatic in Christian history.'¹

The doctor with a call to cross cultural mission may no longer be European. Europeans will not necessarily lead medical teams. These medical teams will be composed mainly of nationals, working in situations that often don't look much like the traditional mission hospital.

To tease out more about the changing scene, *Triple Helix* put a series of questions to six CMF members. One has just begun to dip her toes into cross cultural mission. Others are early to mid-career. For the rest, involvement with cross-cultural mission has been a big part of a lifetime's work.

What big headline changes in medical mission have you observed during the span of your experience?

Andrew Tomkins (AT): The main headline change in 'medical mission' is that there are now many more ways for Christians to work in global health than *just* working in church-based hospitals or community health programmes. With a greater range of opportunities for Christian doctors now available for working in national government,

international agencies, NGOs and research and teaching organisations, the term 'medical mission' is not always appropriate. Some people, including myself, suggest a title of 'Christians in global health' rather like 'Christians in science' or 'Christians in sport'. Thus, 'medical mission' is just one of the many opportunities for Christians in global health.

Richard Vincent (RV): There is an expectation of shorter durations of service – sometimes much shorter. Plus an increasing readiness to work collaboratively with the local population; greater skills of listening to the local population are expected; a slowly broadening view of the global nature of health challenges.

Ted Lankester (TL): Fewer 'classic' self-described medical missionaries but many healthcare Christians are going abroad with a kingdom ministry to work in a variety of situations including humanitarian aid or teaching.

Huw Morgan (HM): A shift from hospitals initially run by ex-pat missionaries, now handed over to and run by national doctors and staff, with ex-pats being ordinary staff members or working in a consultative, advisory capacity. There is an increased emphasis on community healthcare and primary care clinics, in recognition of the fact that these have a much greater impact on morbidity and mortality than hospitals. However this is not a straightforward transition and there are many problems, not least funding. Then there is the emergence of teaching hospitals or university



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medical schools in developing countries – many of these need ex-pat missionaries to be faculty members when they start.

Emma Pedlar (EP): Compared to what someone like Helen Roseveare was doing some years back in the Congo, I would say the internet and technology have made a huge impact. I was working at the CURE hospital in Malawi where patients' stories were recorded and sent to prayer and financial supporters all over the world. Now mission doctors can be asking questions over the internet and getting quick replies, using technology to connect patients with specialist hospitals to perform complex operations or serving communities by providing centres of excellence and training the next generation.

Catriona Waitt (CW): There is a shift away from the long-term 'career' missionary towards short-term, focused projects. This can include very short-term work: for example week-long training or intensive 'stored up' operating lists of complex cases through to more medium-term work, like setting up a project or staff training staff. Often it's working oneself out of a role as national Christians emerge to take on leadership. But there is still a role for long-termers.

How big an impact has the emergence of local (national) Christian doctors had on the way medical mission is understood and practised?

AT: There are many more national Christian doctors now working in church-based (mission) hospitals and community health programmes and more with a specialist training. Thus the need for generalists from the UK is less and the need for training in specialties is greater.

RV: The impression that 'the west is best' hasn't faded by that much, I think. It often takes conscious effort by missionary health workers to resist being put on a pedestal.

TL: Global north missionary doctors and nurses and AHPs should ideally have an added value which they can bring rather than being a post holder – that can be wisdom, training skills, reconciliation skills as well as the purely medical.

EP: I think it's fantastic that 'missions' have become more indigenous. I suppose western medicine can be seen less as a white man's science if local doctors are practising it as well, and communities may respond better to one of their own sharing the gospel.

CW: In Sub-Saharan Africa there remains a shortage of skills, so a great benefit missionaries can bring is to train and equip national doctors. Furthermore, the Christian churches may be young and in need of focussed, systematic Bible teaching alongside the practical tasks.

Is a pattern emerging where doctors with a missionary vocation move in and out of a country, returning 'home' sometimes for considerable periods?

AT: 'Missionary vocation' is a term that's being

most commonly used to describe the motivation for Christian doctors as they work in 'medical mission'. There does not unfortunately appear to be widely used or accepted term to describe others who work as 'Christians in global health,' with an equal conviction that God wishes them to work in a particular type of work place. I'm not aware of a suitable term to describe Christian motivation of doctors who feel God's guidance and power in their professional lives in the UK. Perhaps 'Christian motivation in medical practice' is a starter – but there is plenty of room for more imaginative terminology. There are definitely new patterns emerging whereby doctors move from centre to centre, perhaps for clinical experience or teaching activity or research. Again a key issue is the need for professional validation to ensure that ongoing training and updating occurs.

TL: Yes, but from the US and some other countries the long term pattern remains. As far as the UK is concerned, the non-resident medical missionary is becoming a feature, for example with Medical Services International. They make a relationship with members of a hospital, medical school or health facility and work out a timetable with agreed topics over a three to five year period or longer.

HM: The old model of a doctor going from the UK to a developing country for ten to 20 years is increasingly uncommon. Many people go for one to five years, perhaps more than once in a career. Many ex-pat missionaries now work in national government hospitals and universities rather than mission hospitals, teaching and doing research. Direct links made possible by the internet have meant that recurrent short term visits to support, advise and teach are occurring without reference to 'mission agencies' which in the past controlled the flow of doctors to overseas Christian hospitals. PRIME's work is an example of this. International networking, perhaps at present mostly brokered by UK agencies (like PRIME) is increasingly enabling 'South to South' transfer of skills. For example, a surgeon in an Indian mission hospital taught a rural surgery course in Nigeria; a Christian Kenyan University teacher ran seminars on medical education on Uganda. Medical missionaries are increasingly not westerners but Christians from developing countries with a passion for extending the kingdom beyond their own borders.

What are the major trends affecting mission hospitals and how do you see their future?

What has been the impact of networks of primary clinics on how they work?

AT: Mission hospitals face different opportunities and challenges, according to where they are based. In some situations, mostly African countries, national governments pay a substantial proportion of the wages of staff and the costs of running services. Thus, they are able to continue to provide outstanding service, with a reputation of being a Christian mission hospital, while being supported

financially from a secular source. They can do extremely well. The paper on the scale of Christian-based healthcare which came out in *The Lancet* in July 2015² gives further information on this. Mission hospitals in rural areas and not supported by government face more of a challenge. Many of them are not able to be supported so well by private income from surgery. In India, in particular, some face considerable difficulties if they are not supported by national government. As to the impact of primary healthcare clinics, a key issue has been the focus for international funding on malaria, TB and HIV. Much of this funding has focused on community-based activities and there has been little money available for hospital care. A lot of Christian development agencies put much less emphasis on healthcare these days, emphasising holistic community participation and activity rather than provision of services. Thus 'medical mission' is less supported in the UK than it was.

RV: This varies enormously from place to place. There are very good reasons to focus on community services. That is where the health action is most effective, especially in prevention, education, working with church communities and giving support. These are less glamorous, less exciting, but the key to reducing illness. Governments generally think in terms of increasing the power, facilities, and size of hospitals and many give scant attention to community services. A Christian distinctive is to invert this priority.

TL: Mission hospitals will remain valuable (often under different names) providing they retain their God-given mandate to care for the most vulnerable. This does not, however, exclude others including private patients, providing they are well governed and managed. The means of reconciliation is built into their DNA so interpersonal problems don't fester. They support and connect with primary healthcare rather than despise it or fail to understand it. They need to work in cooperation with government, ideally having such an excellent or irreplaceable reputation that the government contracts out services to them or adopts/mandates them to become or serve as district or sub district general hospitals.

HM: I am personally encouraged to see more recognition that medical care is part of demonstrating the kingdom of God and has legitimacy in and of itself; that it need not merely be seen as a 'vehicle for evangelism', although good care by Christians inevitably has its own evangelistic impact. Doctors and healthcare workers need to be clear what their calling is (ie to care for the sick and all that that entails), and not act as evangelists-church planters, tasks where this can be done much better done by national Christians.

What new models of medical mission and medical missionaries have you observed?

How could these change perceptions about how we talk about medical mission?

AT: The 'new models' available for Christian

doctors in global health are multiple. They include: research, teaching, specialist care, policy development, provision of services for those who are neglected or despised. I think it's important to emphasise that there is a continuing vital role doctors to work in church based hospitals, both in the short and long-term. However, Christian doctors, particularly those in the early years of their career, need to be made much more aware of the many ways that there are of serving God within a great range of global health opportunities. Focusing on medical mission alone is too limiting.

RV: Idiosyncratically, I would abandon the terms 'mission' and 'missionary'. So, 'Next year, God willing, my wife and I will be working at X, [a Christian-faith-based -government] hospital-clinic in rural Zambia; we expect to stay there for at least three years and look forward to God's leading after that.' Serving abroad should undoubtedly garner considerable respect, prayer, and financial support where appropriate. For folks to leave their own culture for another can certainly be a major sacrifice. But maybe serving God in a very down-town practice in a 'western' city, or any place where frank opposition is experienced by a colleague on account of their faith, will have similar demands while not conventionally attracting the term 'missionary'.

TL: All healthcare missionaries must understand global health and be in tune with the sustainable development goals and universal health coverage. This is all about shifting healthcare to the community, home and neighbourhood and building on a primary healthcare model. Networks are critical to bring together all the health players within an area or bring together all those involved in similar themes, eg mental health, NCDs, palliative care, disability. Finally let's remember that the great commission and other verses in the Bible less often quoted imply that members of every congregation in every country town village or slum in every country have a mandate to preach and to heal. That means we will increasingly see those from eg the Chinese or Mongolian church being medical missionaries to Madagascar. It will lead to glorious and inglorious chaos making interconnection, communication and networks all the more essential. We must not forget miracles.

There are times in the evolution of many churches local and national where God chooses to do an Acts 29. We must be able to recognise and welcome it. Equally we must stand against all initiatives based on the prosperity gospel, and on the mistaken belief there is a dualism between the spiritual and the physical. There is an attitude that says taking ARVs is a sign you don't trust in God so you chuck them down the latrine and pray for a miracle. That's platonic dualism, not biblical Christianity.



Direct links via the internet mean that recurrent short term visits are occurring without reference to 'mission agencies'

Contributors

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references

1. Johnson T. Christian martyrdom: A global demographic assessment. November 2012 bit.ly/1Xo7Oq6
2. See News Review, 'A turning point in global health: the role of faith-based medicine' in this issue, p4