

Healthcare Missions Conference PROCEEDINGS TABLE OF CONTENTS

SPEAKERS	ABSTRACT	PAGE
Gil Odendaal, PhD	✦ THE CHURCH AND SHALOM	NS
Bryant Myers, PhD <i>Fuller Theological Seminary</i>	📖 ✦ SHALOM, HEALTH, HEALING AND WHOLENESS: THEOLOGICAL REFLECTIONS	3
Beth Snodderly, D. Litt et Phil and Brian Lowther <i>William Carey International University and Roberta Winter Institute</i>	📖 BLESSED ARE THE SHALOM-MAKERS: THE ROLE OF THE HEALTH PROFESSIONAL IN THE CHURCH	3-4
Erin Dufault-Hunter, PhD <i>Fuller Theological Seminary</i>	📖 ✦ "JESUS WEPT": WHY CHRISTIAN CARE NECESSITATES EMBRACE OF TRAGEDY	4-5
Elizabeth Conde-Frazier, PhD <i>Eastern University</i>	📖 HOSPITALITY TO SHALOM IN A CROSS-CULTURAL CONTEXT	5-6
Bryant Myers, PhD <i>Fuller Theological Seminary</i>	📖 ✦ THE WHOLE GOSPEL: HEALTH AND HEALING AS CHRISTIAN WITNESS	6
Meredith Long, DrPH and Debbie Dortzbach, RN <i>World Concern and World Relief</i>	📖 ✦ HIV/AIDS, BROKENNESS AND SHALOM	7
Cynthia B. Eriksson, PhD, Ashley M. Wilkins, PhD student and Jude Tiersma Watson, PhD <i>Fuller Theological Seminary</i>	📖 ✦ BURNOUT, RELATIONSHIPS, AND SHALOM	8
Dave Scott, PhD <i>Fuller Theological Seminary</i>	📖 ✦ WHERE DO CHILDREN FIT IN THE PURSUIT OF SHALOM?	9
Katy White, MD and Kathy Henry, PA <i>Los Angeles Christian Health Clinics</i>	📖 ✦ SHALOM IN URBAN HEALTH CARE	10
Ana Wong-McDonald, PhD <i>The Salvation Army</i>	📖 ✦ RESTORING SHALOM: MINISTRY OF RECONCILIATION FOR EMOTIONAL TRAUMA	10-12
Chisoo Choi, MD <i>Korean American Missions Health Conference</i>	THE KOREAN AMERICAN HEALTH MISSION MOVEMENT	NS
Mike Solderling, MD <i>Campbell University</i>	📖 ✦ SHALOM WITH UNCOMPROMISING STANDARDS: ACCEPTING NOTHING LESS THAN EXCELLENCE IN HEALTH RELATED MISSIONS	12
Rebecca Gagne-Henderson, RN <i>Healthcare @ Home</i>	📖 THE EVIDENCE OF A CREATOR WITHIN THE DYING PROCESS: A MAGNANIMOUS DESIGN	13-14

Grace Tazelaar, RN and Carolyn Newhof, RN <i>Nurses Christian Fellowship</i>	📖✦EMPOWERING TOWARDS SHALOM: THE LAY HEALTH MOVEMENT	14
Terry Dalrymple MDiv and Jody Collenge, MD <i>Global CHE Network</i>	📖✦COMMUNITY HEALTH EVANGELISM	15
Arnold Gorske, MD <i>Health Education Program For Developing Countries</i>	📖✦COMMUNITY HEALTH SCREENING AND EDUCATION (A CHURCH-BASED APPROACH TO THE QUEST FOR SHALOM)	16-17
David Campbell, DDS <i>Los Angeles Christian Health Centers</i>	📖✦PROMOTING SHALOM THROUGH DENTAL MISSIONS AND HEALTHCARE	17
Micheal McLaughlin, MDiv and Steve Baker, MD <i>Christian Medical and Dental Association</i>	📖✦SPIRITUAL INTEGRATION WITH PATIENTS DURING CLINICAL ENCOUNTERS	18-19
Mark Dahle <i>La Jolla Lutheran Church</i>	📖✦THE SAD TRUTH ABOUT PRAYING FOR HEALING Mark Dahle, La Jolla Lutheran Church	19
Doris Arrington ART-BC, HLM, Licensed Psychologist <i>Notre Dame de Namur University</i>	📖✦ART, IMAGE, AND SYMBOLS AS SHALOM IN THE CHURCH	20-21
Peter Yorgin, MD and Ben Rodriguez <i>Maranatha Chapel and Iglesia mi Refugio</i>	HOW CAN HEALTH PROFESSIONALS PARTICIPATE IN HEALING OUR CHURCHES AND COMMUNITIES?	21-22
Greg Seager, RN <i>Christian Health Service Corps</i>	✦HEALTH MOVEMENT: SHALOM, THE CHURCH AND GLOBAL HEALTH BEST PRACTICES	22
Rana Herro, PhD <i>San Diego Christian College</i>	✦MANAGING THE TENSION BETWEEN SCIENCE/MEDICINE AND FAITH	23-24
Sheldon Wermes <i>Medsend</i>	✦THE POWER OF MEDICINE TO OPEN CLOSED HEARTS, MINDS , AND BORDERS TO THE GOSPEL	24-25
John Tannous, MD <i>H.O.M.E.S. International- Kunming International Clinic</i>	✦CHARITY PROJECTS IN ECONOMICALLY DEVELOPING COUNTRIES	25-26
Peter Yorgin, MD and Ben Rodriguez <i>Maranatha Chapel and Iglesia mi Refugio</i>	✦SHORT TERM MEDICAL MISSIONS; INTERNATIONAL GOERS, SENDERS AND HOST RECEIVERS	26-27
Rick Donlon, MD <i>Christ Community Health Services</i>	✦THE CHURCH, HEALTH AND SHALOM	NS

📖: CHAPTER IN THE HEALTH AS SHALOM BOOK; ✦: WILL BE PRESENTED AT THE 2012 HEALTHCARE MISSIONS CONFERENCE; NS: NONE SUBMITTED

SHALOM, HEALTH, HEALING AND WHOLENESS: THEOLOGICAL REFLECTIONS

Bryant Myers, PhD; Fuller Theological Seminary

Shalom is a relational term the Bible uses to describe the peace, health, wholeness and joy of what God intends for individual human beings in their relationships with God, with their bodies and minds, with each other and with God's creation. The purpose of this presentation is to present a theological framework for a biblical understanding of shalom's health and wholeness and then relate this frame to the practice of healing and health care missions.

To build this theological foundation for health and wholeness, three things are needed. First, we need a clear Christian anthropology – who are human beings; of what do they consist; what were they intended to be and do; and how do we, or does God, help us overcome the fact that we cannot be and do as God intended? This anthropology is derived from a theology of creation. Second, we need to explore the theological ideas of shalom and salvation as they relate to our Christian anthropology. Finally, we need to explore the implications of this theological framework in terms of its consequences for the theory and practice of Christian health that seeks healing and wholeness.

At the center of this proposal are three key conclusions. First, human beings were created by God as relational beings, not autonomous individuals. Second, human beings are inseparably mind, body and soul; all three are essential to human wellbeing. Third, human beings were always intended for health, wholeness and flourishing; that was and remains God's intention for all human beings, even as we live between the resurrection and the second coming of Christ. Finally, this drives us to understand health, wholeness and flourishing relationally and holistically: when all of our relationships work for the wellbeing of our body, mind and soul, we flourish as human beings as God intended. This is the essence of shalom.

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BLESSED ARE THE SHALOM-MAKERS: THE ROLE OF THE HEALTH PROFESSIONAL IN THE CHURCH

Beth Snodderly, D.Litt. et Phil; William Carey International University and Brian Lowther; Roberta Winter Institute

The purpose of this chapter is three-fold: FIRST, to equip the reader with a theological framework for the role of the local church, a community living and demonstrating the reign of God. SECONDLY, this chapter aims to provide a theological framework for viewing health missions as part of a cosmic battle with an adversary who actively works against and distorts God's will for *shalom* among

humans and creation. FINALLY, the authors of this chapter call for the local church to recognize and support the crucial role that health practitioners have in the ministry of the local church, both locally and globally, as it engages in this cosmic battle.

Something is wrong in this world. “Nature, red in tooth and claw,” is a pattern acted out at all levels of life, from micropredators (disease caused by microbes) to macropredators (social diseases caused by humans, such as war and human trafficking). Intelligent evil is at work, distorting God’s original good purposes. Creation itself is groaning, even at the microbial level, waiting to be delivered by the free choices of the body of Christ, through whom God has chosen to work in this world (Rom. 8:18, 19). God’s intention at the end of history is to restore *shalom* relationships among humans and throughout creation (Isa. 54:23; Rev. 21:4). In the meantime, Christ’s followers serve as God’s display window (Stetzer 2012, 189) for what God’s kingdom is meant to look like.

When Jesus said, “Blessed are the peacemakers” (Matt. 5:9), he was describing the role believers are to have as children of God, taking over the family business of bringing *shalom* to this broken, diseased, war-torn world. In this cosmic war, an adversary is battling against God’s will for God’s people and creation. The famous hymn, “A Mighty Fortress Is Our God,” shows Martin Luther’s awareness of this “ancient foe” who seeks “to work us woe.” “Satan is his name, i.e. an adversary. ... He is the prince and god of this world” (Luther 1999, 37:17).

What is the role of health practitioners in the church, then, to those in harm's way in this war-torn world? In this chapter we would like to challenge missions pastors and senior pastors to recognize that health practitioners are an integral part of the ministry of the local church, a sign of God’s kingly rule to the world around it, both locally and globally (Newbigin 1986, 134). People are being wounded physically, psychologically, and spiritually by activities instigated by the adversary. As health workers go where people do not expect to see God at work, taking Jesus into the world (Stetzer 2012, 6), they are doing the work of the Church, giving the world a “foretaste of the restoration of creation to its true harmony ... and of man to his true relation to the created world” (Newbigin 1954, 67).

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“JESUS WEPT”: WHY CHRISTIAN CARE NECESSITATES EMBRACE OF TRAGEDY

Erin Dufault-Hunter, PhD; Fuller Theological Seminary

As a health care worker, one faces the reality of the tragic with startling regularity: cholera devastates already fragile communities; babies are born only to die; diseases ravage families and communities; youth perpetuate a cycle of violent abuse learned from our culture; the poor cannot afford preventative care; all of us face our own death – usually, a slow, protracted one. How can Christian workers here and in other cultures witness to the hope we have in Christ amidst such

suffering? And as importantly, how can health care workers develop practices that sustain our own hope and strength as we care for others amidst such sorrow?

Christian hope differentiates itself from mere wishful thinking or dishonest denial by its willingness to see reality: The world is filled with seemingly unbearable tragedy and crushing heartache. But it is also a world loved by God, who does not abandon us to meaninglessness and sorrow. Rather, God enters into our every corner of our lives, including profound illness and shocking sorrow. As his body, we are aware that we participate in offering his healing presence.

But as health care providers, this task of entering into suffering can be overwhelming. Indeed, given that we may have many patients, are scrambling to save those we can, and often must detach in order to heal the broken bodies before us, we might well ask if we should even allow ourselves to sense the impact of tragedy. In order to be better healers, should we not practice disinterestedness and reasoned objectivity?

This seminar considers how health care providers, who see some of the worst of the human condition, might develop spiritual practices that support their ministry as healers. In particular, the seminar considers the necessity of practicing the age-old discipline of lament as modeled not only by the psalms but particularly by Christ in the Gospel of John. In this text, we will consider how and why Christ – the One who raises the dead – gives himself to grief over loss of a friend. We will discuss how such practices are not only ways of honestly interceding and presenting our patients to the Great Physician. They also nourish us in honest hope, habituating us to the patience by which we all must live amidst a deeply fragile, bent, and vulnerable world.

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HOSPITALITY TO SHALOM IN A CROSS-CULTURAL CONTEXT

Elizabeth Conde-Frazier, PhD; Eastern University

This chapter will address the question of how we equip health workers with a theological framework and spiritual practices for cross-cultural ministry. It will be an adapted version of the chapter which Conde-Frazier wrote for the book *A Many Colored Kingdom* (Conde-Frazier 2004). This chapter will explore the cross-cultural encounter, for both the health worker and the guest (patient), as the two parties move together from hospitality to shalom (Lingenfelter 1996). The spiritual practices which are involved in the journey are hospitality, encounter, compassion, passion and shalom. As a means of illustration, a case study will be presented from the Watts Christian Health Center (Voss 2009).

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THE WHOLE GOSPEL: HEALTH AND HEALING AS CHRISTIAN WITNESS

Bryant Myers, PhD; Fuller Theological Seminary

The mission of Christian mission is to declare the good news of Jesus Christ, his death and resurrection, to the ends of the earth. This is what Christians were told to do. The purpose of this paper is to explore the meaning of this commission when it comes to healthcare in mission. The modern West, the origin of medical science, dismissed God and religion as relevant to science and medicine about 300 years ago. Modern science no longer needs God as part of the explanation for what it discovers that improves human life.

This creates a challenge for healthcare in the context of Christian mission. The practice of healthcare – medical and psychological – does not point to God and announce the gospel of Jesus Christ directly. In fact, medical practitioners in most cases are expected not to refer to such things in their professional work. So how does healthcare mission become missional?

One option is to do healthcare professional work five days a week and do Christian mission on the weekends or on special non-professional occasions. Sadly, this reflects a modern worldview in which the spiritual (mission) is radically separated and disconnected from the material (medicine and psychology). This approach makes medicine functionally atheistic and turns Christian healthcare professionals into functional schizophrenics.

As a contribution to struggling with this dilemma, this paper explores the following questions:

- * When are we witnesses
- * To whom or what are we witnessing
- * The two-tiered worldview framework of Paul Hiebert
- * A different approach to proclamation from Lesslie Newbigin

The paper concludes with a proposal and a challenge. The proposal is to reframe evangelism as the second act, the explanation for the healing or prevention of disease. Let the activity of God provoke the question to which the gospel is the answer. The challenge is to recover the activity of God and God's spirit as part of the explanation for why medicine and psychology work.

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HIV/AIDS, BROKENNESS AND SHALOM

Meredith Long, DrPh; World Concern and Debbie Dortzbach, RN; World Relief

In spite of the advances made through increased access to improved levels of care that is prolonging the lives of those infected with HIV throughout the world, HIV positive men and women still suffer the rendering of relationships to themselves, to others, to their communities and to God. Those of us who are called to minister to those affected by HIV must first of all Be with God before we are able to bear witness to his gospel as sign, as deed and as word. We face our own brokenness as we encounter the moral issues related to AIDS, questions of sexuality and sexual practice and of guilt and innocence. We face the darkness of responding to a fatal disease that uniquely transforms pathways that God intended to bring life and fullness into dark channels of sickness and death. We must face suffering that affects all of life. We are able to witness to the Kingdom of God only as we walk in the company of the wounded but whole Christ.

Gospel as Sign We point to Jesus and his kingdom as we provide sanctuary, a truly safe place from which those affected by HIV and AIDS can face their brokenness. We provide belonging for those who choose to join a family of shalom and we restore the dignity of purposeful vocation to those who join in the mission of God.

Gospel as Deed How can an incurable disease be healed? Our core beliefs are foundational to prevention. Men and women who respect themselves and one another as equal, valuable and morally responsible bearers of God's image resist the destructive gender dynamics that drive the epidemic. They become more passionate and powerful advocates for access to early treatment for the poor and preservation the fragile international commitment to fund that treatment. Those who embrace God's gift of dominion or self-efficacy are better able to maintain protective behaviors as part of a community that values restraint. Faith-based hospitals and care providers provide disproportionate access to compassionate testing and treatment among the poor and marginal. Other followers of Jesus enable reconciliation of broken relationships, release from guilt and self-condemnation to those affected by HIV and AIDS and gently care for them, respecting their dignity and reflecting Jesus' compassion. Finally, only in the Kingdom of God is hope for life and after death rooted in the character, love and power of God rather than chance or the earned merit of the dying.

Gospel as Word Only within the Kingdom of God do words achieve their true healing power. Words of lament, of power, of correction and instruction, words of inclusion, of forgiveness and restoration, and of compassion and hope, timely spoken in love, are words of true healing and salvation, of life eternal.

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BURNOUT, RELATIONSHIPS, AND SHALOM

Cynthia B. Eriksson, PhD, Ashley M. Wilkins, PhD student and Jude Tiersma Watson, PhD; Fuller Theological Seminary

Burnout is evidence of marred relationships with self, other, community, and environment. The psychological construct of social support provides scientific evidence for understanding the protective or restorative power of relationships for Christian ministry workers. The chapter will demonstrate the ways social support and burnout reflect the enactment of shalom (and non-shalom) through empirical research and theological, missiological, and psychological reflection.

We violate God’s plan for Shalom when we do violence to ourselves and others. While this statement may seem extreme, we would contend that the experience of burnout represents a violence of self-deception and expectations of others that extend beyond capacity for health. The psychological literature identifies that burnout is an experience of work fatigue that is unique for those whose occupation or service centers on caring for the needs of other human beings, such as physician, teacher, psychotherapist, nurse, child care worker, and missionary. The responsibility of engaging with the physical and emotional needs of others can lead to seasons of burnout characterized by emotional fatigue, disconnection from those one seeks to serve, and limited sense of achievement in one’s work (Maslach, Schaufeli, & Leiter, 2001).

Yet, just as burnout is connected to the experience of relational stress in work, one of the most important components of healthy engagement in work is supportive relationships. Social support as a psychological construct represents both the experience of being supported (emotionally and practically) as well as supporting others (Cutrona & Russell, 1987). Support from personal relationships and support from organizational relationships have been associated with reduced burnout in humanitarian aid workers (Eriksson et al., 2009) and other health care workers (Maslach et al., 2001).

The theological and missiological importance of human relationship is undeniable; Myers’ (2011) framework of Shalom is based on whole relationships within self, others, and environment. This understanding of health and wholeness is a foundation for asserting that pursuing ministry should include the pursuit of a healthy awareness of one’s own capacity (e.g. not serving out of a “Messiah complex”), as well as supportive awareness of the needs and limits of colleagues. The presentation offers a call to organizational and personal commitment to relationships that challenge the cultural assumptions of productivity and progress as the final goals of work and ministry. These relationships recognize the seasons of hard work and sacrifice, while also reflecting the Shalom of healthy team, organizational, and personal relationships.

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WHERE DO CHILDREN FIT IN THE PURSUIT OF SHALOM?

Dave Scott, PhD; Fuller Theological Seminary

While global statistics on child mortality show improvement, the 7.6 million children under five who die each year is still short of the Millennium Development Goal target. Christian NGO's and local church outreach efforts are a key part of this push, who demonstrate their commitment to the widow and orphan by making the needs of poor children a focus of their pursuit of *shalom* in their communities. Occasionally these efforts have resulted in unexpected church growth as well, as demonstrated by the church planting movement that was established as a byproduct of the effort to reduce child mortality in Cambodia by the Hope Project during from 1994-2007 (Penner 2007). This phenomenon is a fascinating case study and provides an opportunity to enhance the existing theological frameworks for work with children at risk (McConnell, Orona, and Stockley 2007), building on both Myers' (2011) understanding of poverty and Fielding's vision for combining medical ministry with church planting (2008).

Yet despite these exciting gains in the lives of young children at risk, it is paradoxically concerning that there has been comparatively minimal engagement by the healthcare community in understanding and addressing the substantial challenges that children that are "in crisis" experience. Children in crisis are best represented by prototypical groups like street children, child soldiers, child laborers, sexually-exploited children and children affected by HIV/AIDS. These children in crisis tend to exist on the edges of their societies, marginalized and functionally or actually orphaned. They are also more likely than their peers to have experienced physical or psychological trauma. Children in each of these categories face significant medical needs on a regular basis. Yet, although a significant amount of research and literature has been developed by Christian psychologists considering the emotional needs of these children, relatively little has been studied or published from a purely medical perspective to discuss the provision of basic medical education and care, and very few medical professionals can be found among the ranks of those committed to full-time engagement with these young people (Huang and Tang 2006).

In light of these observations, Christian medical professionals have the opportunity to lead the way in meeting these needs: to understand the health concerns of children in crisis worldwide, to develop creative, church-based solutions to seeing those needs met, and to make the kind of lasting commitment to the health of these children that will move them closer to the place of *shalom* God desires them to inhabit.

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SHALOM IN URBAN HEALTH CARE

Katy White, MD and Kathy Henry, PA, Los Angeles Christian Health Centers

We as healthcare providers working among the urban poor reflect on “shalom.” We share a story of shalom experienced in the office context between patient and provider. Then we present a picture of “kingdom health care” modeled on the principles and practices of Jesus laid out in Scripture. Kingdom health care is holistic, focused on the poor and those with the least access to health care (Hoffman 2009), incarnational, and rooted in the community of the local church and the broader community of like-minded believers (CCHF, 2012). Then through further story we reflect on the shalom that is possible as a healthcare provider ministers by living in an underserved inner city neighborhood “after hours.” We offer perspectives on barriers and breakthroughs in this context where evidence of success is often slow to emerge, such as poor understanding of the impact of poverty (Bloch, 2011), distance from others’ pain, ongoing suffering and overwhelming need, and our own need for healing. We share successful models of clinics, which are agents of shalom and community transformation over many years, and offer hope for the reader to participate in kingdom health care.

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RESTORING SHALOM: MINISTRY OF RECONCILIATION FOR EMOTIONAL TRAUMA

Ana Wong-McDonald, PhD, The Salvation Army

Globally, more than one billion people have been affected by extreme violence in the form of war, ethnic conflict, torture and terrorism. Research suggests that one in seven people experiences trauma worldwide (Mollica 2011). For people living in war zones, it can be 100% of exposure. In the United States, trauma is part of life and history, ranging from the fear of fires and earthquakes in California to the shootings in Colorado, and to the September 11 terrorist attack in New York. Seventy percent or 223.4 million Americans have experienced some form of traumatic event at least once in their lives (Rosenthal 2012). Among public mental health patients with severe mental illness, up to 98% have been exposed to trauma, with most having experienced multiple trauma (Mueser 2004).

Regrettably, trauma is the expectation and not the exception among the majority of people we meet and serve.

Trauma is extreme stress that threatens life, bodily integrity, or severe loss for oneself or another. The event is experienced as sudden, terrifying, and overwhelming beyond the victim's ability to cope. It mars the individual's definition of self and severely impairs one's relationship to God, others, the community, and the environment. In short, it shatters shalom (Wolterstorff 1983) as the person can no longer dwell in peace with all of his or her relationships.

With over 18,000 participants in the United States, the Adverse Childhood Experience (ACE) Study is the largest research study of its kind to examine the health, social, and economic impact of trauma before the age of 18 (Felitti et al. 1988). Early life trauma was examined in 10 categories including trauma in the household environment, neglect, emotional, sexual, and physical abuse. The key finding of the study is that participant who experienced 4 or more categories of trauma had been found to have higher incidences of the following ailments in adulthood. Thus, the root cause of many physical, mental, and social ills has been traced to trauma.

- a. Neurobiologic ailments such as disrupted neuro-development, rage, hallucinations, depression panic and anxiety, multiple somatic symptoms, sleep problems, impaired memory, flashbacks, dissociation
- b. Health risk behaviors including smoking, severe obesity, suicide attempts, alcoholism, drug abuse, promiscuity, self-injury, eating disorders, interpersonal violence
- c. Disease and disability including heart disease, cancer, long disease, emphysema, asthma, liver disease, skeletal fractures, HIV/AIDS
- d. Social problems such as homelessness, prostitution, delinquency, violence, criminal behavior, inability to sustain employment, re-victimization, and
- e. Poorer life expectancy: Adults with high ACE scores had double the death rate compared to adults with an ACE score of zero. Children exposed to 6 or more died at age 60, whereas children without ACEs died at age 79.

In addition to the myriad of health, social, economic problems that trauma brings, it disrupts a believer's relationship and trust with a loving God, shatters a person's identity and the sense of existing, robs the victim's sense of safety in the environment, and destroys trusts and connections with others and the community. This chapter explores the repercussions of trauma as it shatters shalom in all aspects. A scriptural-based approach of restoring shalom will be discussed within the context of counseling and treatment.

To restore shalom treatment must be holistic and multifaceted to include: Restoring emotional and physical safety, psychoeducation, spiritual education, immediate and ongoing spiritual support, reinterpreting the trauma in light of scripture, restoring one's identity from God's word, re-establishing spiritual activities, forgiveness, seeking a new and meaningful role in society, re-engaging with the environment, with others, with the family, and with the community. The essence of shalom is the ministry of reconciliation, beginning with God who reconciled us to himself through Christ and gave us the ministry of reconciling the lost to Him, restoring His image within the self, reconnecting with others and mending what was broken in relationship with the world (2 Cor 5:18-19).

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SHALOM WITH UNCOMPROMISING STANDARDS: ACCEPTING NOTHING LESS THAN EXCELLENCE IN HEALTH RELATED MISSIONS

Mike Solderling, MD; Campbell University

It is generally accepted that upwards of 2 million Christians participate in short term "missions" trips each year and this author estimates that approximately 15% of these teams have a medical component associated with their work. Using this conservative figure we can safely say that some 300,000 health care professionals participate in cross-cultural health related missions activities. Considering that those suffering from physical disease in underdeveloped countries will readily (most of the time) spend a day away from work in order to be seen and examined by a visiting western health care worker this provides the Church with an incredible opportunity to be a true witness to the reality of the risen savior. However the explosion of short term health related missions has also been sharply criticized for adopting an approach that lends itself to getting short term results (as many patients seen and treated as possible) at the cost of long term community transformation.

In this chapter we will explore briefly the history of "medical missions" from its biblical roots to the first documented sending of a western trained physician to work in the fledgling field of medical missions to the present day situation regarding medical missions globally. We will explore the biblical mandate of excellence in all we do in the name of Christ. We will also discuss the uncompromising standards expected from health care providers in the developed world, "first do no harm," and I will then develop the argument that we should accept nothing less than the highest of standards in our present day health related missions activity. Finally we will discuss what can be done to assure that the short term health related activities we are planning or in which we will be a participant are conducted with the highest of standards.

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THE EVIDENCE OF A CREATOR WITHIN THE DYING PROCESS: A MAGNANIMOUS DESIGN

Rebecca Gagne-Henderson, RN, Healthcare @ Home

"A good scientist understands three things – what we know, what we don't know, what we believe."

-Otis Brawley

Can faith based medicine also be evidenced based medicine? This is the clarion call of Otis Brawley (2012), the Chief Medical and Scientific Officer and Executive Vice President of the American Cancer Society. My answer to this is, emphatically, "yes". It could be argued that every medical text, every medical discovery and every successful medical intervention is the evidence of God. Science is the study of God's handiwork. Indeed, the human body has been fearfully and wonderfully made (Psalms 139:14-18) and God has a plan for all things. There is no boundary between science, technology and faith, save the one created by the hubris of some in the scientific community and the lack of vision in some religious leaders.

As health care providers in the mission field, or any other health care setting; whether chaplain, nurse, physician, psychologist or social worker, it is difficult to watch helplessly as our patients die. We sometimes writhe in our inability to rob death of the end to this material, "mortal coil" (Shakespeare, 1603). It is painful to see the families' grief and it is hard to know how to help. These situations may lead us to question our clinical skills, and our place in God's plan. Each member of the health care team is subject to doubt, sadness and fear (Tillich, 2000).

Knowledge of the physiology of our death is a window into the intricacies of God's work. It reminds us that we are never alone and that we are never forsaken. God keeps His promises. It is lamentable that in our training as providers and clinicians we are not taught the processes of death, but only to thwart, many times in futility, these processes.

There remains great controversy and strife regarding the ethical and moral aspects of the decision to withhold or withdraw artificial nutrition and hydration (ANH) for the seriously ill and dying patient. While medical bio-ethicists have concluded that the withdrawal/withholding of ANH is not unethical, the catholic document Ethical and Religious Directives for Catholic Health Care Services (ERD) is ambiguous, stating that while the avoidance of futile care should not be employed, that removal of technology should not be removed to cause death (USCCB, 2009) (CHA, 2009). While this controversy has been smouldering since the Kathleen Quinlan case in the 1970's and was blown open in 2004 by the Schiavo case (Emmanuel, 1998), the controversy has remained unsettled.

An understanding of the correlation between the way our bodies are designed to die and God's mercy is integral to humankind's understanding, the improvement of our patients' and families' acceptance of the loss of a loved one and to bringing meaning and purpose to physical death (Psalms 145:8-10).

This chapter will explore the recent history of this controversy; the physiology of death, dehydration and starvation; the scriptural evidence of how this mechanism fits into God's plan; and compare the Judeo-Christian and secular worldviews of this phenomenon. Finally, the chapter will approach how this knowledge can provide an opportunity to witness to those we serve and how this knowledge can be a source of *Shalom* to patients and families while firmly giving all the glory to God.

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EMPOWERING TOWARDS SHALOM: THE LAY HEALTH MOVEMENT

Grace Tazelaar, RN and Carolyn Newhof, RN; Nurses Christian Fellowship

The Parent Child Program at Cary Christian Center in Cary, MS was one of the first lay health programs in the United States to document impact on the five year average infant mortality rate. (Boelens, Kooyer, George, & Newhof, 1997) The mothers enrolled in the pre-natal and parenting education classes are regularly visited by trained women from the community who assess the home environment and follow up on education practices. They serve as a resource to the mothers and are available by phone to assist with parenting information. While the significance of the reduction in infant mortality was not statistically significant, because of the small population size, the program has anecdotally positively transformed the leadership of Cary Christian Center, the home visitors, and the community. Additionally, national news media has taken notice and reported on the program. (Serrano, 2009). This program has been used as a model for other lay health programs around the country. (George, 1997) (Tazelaar & Pyper, 1999)

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COMMUNITY HEALTH EVANGELISM

Terry Dalrymple, MDiv, and Jody Collenge, MD; Global CHE Network

There is an urgent need for integrated community health initiatives that are community based. Consider the following facts: 21,000 children die each day before the age of five, most from preventable causes (Child Mortality Report, 2011). 780 million people do not have access to clean drinking water (WHO/UNICEF, 2012). 2.5 billion people lack access to improved sanitation facilities (WHO, Global Health Observatory Data Repository, 2012).

The church is uniquely positioned to respond to this need. The church in many places is the only institution with the capacity to mobilize enough volunteers to do what is needed in the area of community health. When children are dying from preventable causes and the church has the capacity to prevent those deaths, the church must respond. This is something that followers of Christ must do.

Biblical health, or Shalom, may be defined as harmony with God, self, others, and the environment. The World Health Organization's definition of health is not far from the Biblical concept, aside from the absence of any reference to God or spiritual well-being. WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946). As Christians, we affirm that there cannot be a state of complete well-being apart from Christ who forgives our sin, gives us new life, and restores us to right relationship with God. Health from a Christian perspective is a state of complete physical, mental, social, *and spiritual* well-being.

Community Health Evangelism (CHE) is a breakthrough mission strategy that seamlessly integrates evangelism and discipleship with disease prevention and community-based development. The goal of a CHE ministry is to help restore harmony or Biblical Shalom in lives, families, and communities. Through these ministries people become followers of Jesus, churches are planted, and communities are lifted out of cycles of poverty and disease.

CHE has grown to become a worldwide movement that involves hundreds of churches, denominations, missions agencies, and faith-based organizations all across the globe. In this chapter, we will describe how to implement an integrated community health program, identify transformational indicators used to measure the success of a program, describe the outcomes and impact of successful CHE programs in different contexts around the world, and provide access to resources and collaborative partners to help readers initiate their own CHE programs.

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COMMUNITY HEALTH SCREENING AND EDUCATION (A CHURCH-BASED APPROACH TO THE QUEST FOR SHALOM)

Arnold Gorske, MD; Health Education Program For Developing Countries

Most patients we see in both developed and developing countries, are suffering from diseases that are preventable. The World Health Organization (WHO) emphasizes the following as one of the most important problems in both developed and developing countries: "Misdirected care. Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden." (World Health Organization 2008, xiv)

Community Health Screening & Education (CHS&E) was developed to assist communities, both urban and rural, in the US as well as developing countries, in their efforts to resolve their most important healthcare problems (Save the most lives and prevent the most suffering). It is based on national and international evidence-based standards and guidelines which were often developed and/or strongly influenced by our Christian missionary mentors.

Although primarily focused on the 70% of the disease burden that is preventable, CHS&E enables high quality assistance in curative care areas as well. There is much concern about the harm of using drugs in the short-term mission (STM) setting. However, there remains a tremendous need for qualified STM doctors, pharmacists, and other providers in this collaborative, Biblically-based approach which also preserves the benefits of the provider-patient healing relationship, *without* the harmful effects due to drugs

CHS&E's *evidence-based* approach also enables the integration of Personal/Primary Care and Public/Community Health, at *all three* WHO "Health Pyramid" levels of care: 1.Hospital, 2.Clinic/Health Center, and 3.Family/Community. This remains *the key* to community transformation and the success of healthcare systems in both developed and developing countries. This approach was developed by the Christian Medical Commission (CMC), formalized in the Declaration of Alma Ata -co-authored by CMC member Carl Taylor, and its critical importance is now being re-emphasized by the WHO. As reported in the special edition of *The Lancet*, "Alma Ata- 30 Years On" 13 Sept 2008, "The future of health care generally, and primary care specifically, depends on the integration of personal health care and public health at the level of the local community." (van Weel 2008, 871ff)

Lack of implementation of these Biblically-based guidelines has resulted in a world-wide "Slow-Motion Disaster." (Rosenbaum 2011, 2345 ff) This global epidemic of non-communicable diseases primarily due to obesity and smoking recently resulted in the second ever UN General Assembly on Health in its 67 year history. The Director General of the WHO reported "In the absence of urgent action, the rising financial and economic costs of these diseases will reach levels that are *beyond the coping capacity of even the wealthiest countries in the world.*" (Chan 2011)

WHO *evidence-based* reports have also confirmed that the lifestyle changes required to prevent this pending world-wide health and economic disaster may be best accomplished in a *religious* setting. (World Health Organization 2009)

Illustrated screening and education materials demonstrating the evidence-based standards and guidelines of the WHO and our missionary mentors have been developed to address the most critical healthcare needs in both the U.S. and developing countries. All of the materials and guidelines referenced are available free for downloading through www.hepfdc.info "Health Screening" and related links, and most are available in multiple languages. So although the healthcare problems addressed remain the leading causes of premature death and unnecessary suffering in nearly every community in every country, it is emphasized that organizations and communities *already have access to the resources* to begin to resolve those problems.

And most important, CHS&E enables the local Church, *regardless of size or resources*, to re-assume its responsibilities for the provision of Biblically-based, holistic (Body, Mind, Spirit) health and healing for its members, its community, and its country.

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PROMOTING SHALOM THROUGH DENTAL MISSIONS AND HEALTHCARE

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The opportunity for the church to reach out to the lost through dentistry is great. Every community has a great sense of "felt" need for dentistry, and this sense of need attracts rich and poor, overseas or *intramuros*. Christ in his earthly ministry and the church over the years have used healthcare in missions to address "felt" needs, while introducing the gospel to deliver shalom. Christ exaggerated his goal, by comically ignoring the "felt" need of the paralytic lowered through the ceiling. He instead delivered his forgiveness, to the bewilderment of the crowds in Mark 2. Christ was highlighting his preaching goals, which were being overlooked, but deserved fuller attention. Then, he resumed healing. While healthcare missions are popular, they regularly overlook addressing forgiveness and salvation, as we get involved in the gritty details of delivering healthcare in missions. To provide and promote shalom, the church must address physical, relational and spiritual wholeness. If an imbalance exists in this calling, then needs will persist and the Great Commission will have failed in that context. Initial discussion will revolve around the balance of social service missions with evangelistic missions, while the final discussion will revolve around transitioning from evangelistic missions to embrace church building concepts, which are best equipped to promote Christ's ministry of forgiveness and fulfill the promotion of relational wholeness in shalom.

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SPIRITUAL INTEGRATION WITH PATIENTS DURING CLINICAL ENCOUNTERS

Michael McLaughlin, MDiv and Steve Baker, MD; Christian Medical and Dental Association

Healthcare is often compartmentalized or reduced to the physical, mental, emotional and spiritual components of a patient, with the greatest emphasis placed on the physical. Yet overwhelming evidence demonstrates that when treated as a whole, including the spiritual, better health outcomes often result (Farr et al., 2007). General consensus now agrees that the best practices of medicine address all the needs of a patient including her physical, emotional, mental and spiritual needs (Puchalski et al., 2001). Many Christian docs are convinced that the single best opportunity to address a person's spiritual needs is the encounter between a physician (or other healthcare worker) and a patient. At the same time, and as observed by the popularity of CMDA's Saline Solution Conference in the 1990s, most Christian providers desire to increase their skills in order to address the spiritual needs of patients. We believe that it is the obligation, even the duty of Christian providers regularly to seek training to hone their skills in order better to meet all the needs of their patients (Koss-Chioino et al., 2006).

Objective: We will present our approach to addressing spiritual health, including how to introduce the topics of God, prayer, the Bible and even Jesus Christ with patients in a clinical setting with the goal of training and honing the skills of clinical providers in attendance."

Method: Among the best practices where *spiritual integration with patients during clinical encounters* occurs today is the New Heights Clinic in Vancouver, WA. Steve Baker, MD, is the founder and director of New Heights Clinic. New Heights is committed and intentionally trains and disciples medical and dental students, both in the Vancouver clinic during the academic year and in Papua each June and August, even taking small teams of students and docs to serve patients without any healthcare.

The training of the next generation of Christian doctors desiring to address all the needs of their patients, including their spiritual needs is the primary goal of New Heights Clinic. The Christian Medical & Dental Associations has committed to training Christian doctors and healthcare providers to represent Jesus Christ in the practice of medicine and dentistry. The Saline Solution Conference, created by Walt Larimore, MD and Bill Peel, ThM and produced by CMDA, has had perhaps greater impact on the lives of USA Christians in healthcare than anything CMDA has done (Larimore et al., 2000).

Conclusions: Medicine and spirituality often provide alternative explanations for many of life's deepest and most mysterious phenomena. As a result, historically there has been tension between these two domains of understanding. And yet, when properly understood, that human beings are a unit, greater than the sum of our parts, and that when one's spiritual needs are addressed along with the mental, emotional and physical concerns, better health outcomes result. Agreeing with this current assessment, and convinced that not all approaches to spiritual care are equal, that in fact Christianity

alone is true and therefore must be included in excellent medical care, we offer this training to physicians committed to Jesus Christ.

We predict that this session will improve the skills of healthcare providers in attendance to address the spiritual needs of their patients and encourage them to address the spiritual concerns of their patients more readily.

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THE SAD TRUTH ABOUT PRAYING FOR HEALING

Mark Dahle, La Jolla Lutheran Church

The sad truth about praying for healing is this: it sometimes works. You sometimes meet people that doctors have given up on, offer one quick prayer, and have them come to a state of full recovery. I've seen it with my own eyes. Many times. In many cases the healing has been instantaneous or within 24 hours. Early in my ministry I saw a group of novice prayer partners go to the home of a stage-four cancer patient whose doctors had given up hope. People in the group prayed based on what they read in the Bible, but with *no* life experience to back it up. None. Perhaps to the surprise of the group, the cancer went away and never returned. In another case, I went to a community, prayed for people, and returned a year later. In the first year, a woman had come to me for prayer but had not mentioned back pain. I could feel something in my back when I talked to her, so I asked if I could pray for her back. The prayer took maybe 60 seconds. Tops. A year later when I saw her, she told me that before I prayed for her, pain had kept her flat on her back one or two weeks a month. After the short prayer, she had a full year with no recurrence. I could go on and on, with story after story, of people who had tried lots of treatments without success, got prayer for 30 seconds, and were completely healed. Prayer sometimes works. Spectacularly.

But that's only part of the story. The sad truth about praying for healing is that it *sometimes* works. We want prayer to be like a light switch that is reliable: any time we talk to God we always get what we ask for. But it's not like that at all. Prayer is much more like watching a great hitter in a game of baseball. If he goes up to the plate, you never know what will happen. Often he'll strike out. But if you watch long enough, you'll see an amazing play. Prayer has that same level of long-term predictability and short-term unpredictability. In the short term, you never know if you're going to swing and miss or connect. In the long term you know if you stay in the game, you'll have lots of strike outs but many, many great plays.

This chapter will include the following points:

- prayer works
- but it only works sometimes
- you can't predict what will happen before you pray
- why it's worth persevering
- A few tips for people who want to get started

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ART, IMAGE, AND SYMBOLS AS SHALOM IN THE CHURCH

Doris Arrington, ART-BC, HLM, Licensed Psychologist, Notre Dame de Namur University

Individuals live in images, think in them, create them, are ruled by them, and destroy them. All this is a matter of course, the course of natural life. Wickes (1976, p. 310)

This chapter will focus on art, images and symbols as Shalom in the church. It will illustrate how art and images bring Shalom, completeness, wholeness, health, peace, welfare, safety, tranquility, prosperity, perfectness, rest, and harmony into worship and the church.

Symbols, plentiful in the Bible, (i.e. Tree of life, (Genesis 2:9); salt, (Luke 14:34); vine and branches (John 15:5) are chosen on a daily basis by all individuals as part of their everyday selections of clothing, objects d'art, modes of transformation, and cultural heroes and heroines. Collectively, people in a given society show the values of their society in their symbolic expressions of customs, and traditions (Billig & Burton-Bradley, 1978). Symbols reflect, not only the attitudes of the times but instill in people courage to "defeat the enemy or...to motivate themselves for success in other endeavors" (p. 69, as cited in Arrington, 1986). Visual symbols and pictorial images facilitate daily communication by synthesizing thoughts, memories, and experience.

Early psychologists who focused on adult personality believed that individuals constantly search for more elaborate and refined symbolic outlets. Science and technology have not freed humans from their dependence on symbols; indeed, it might be argued that they have increased humanities' need for them. This is seen today in the games and tools available to children and adults (i.e. I Pads, I phones, Droids, laptops, movies, TVs, Kindle's, tattoos, and tweeters). Because symbols express blocked or distorted thoughts, ideas, and feelings (Horowitz, 1970; 1975; Rhyne, 1980) as well as creativity (Cirlot, 1962) they provide alternatives to linguistic limitations in societies. Visual communication provides a three way experience of visual perception, cognitive connection, and verbal expression. Art, images and symbols help the multicultural and global church; male and female, young and old, literate and illiterate, rehearse, remember and share the biblical stories of a heavenly father and salvation (CIVA, 11).

Art therapy, [with its art, images and symbols] is based on the belief that the creative process involved in the making of art is healing and life enhancing. Through creating art and discussing the process, one can increase awareness of self, cope with symptoms, stress and traumatic experiences, enhance cognitive abilities, and enjoy the life affirming pleasures of creative activity. In addition to what a person says about their artwork, the imagery is a 'tangible record' (Wadeson, 1980, p. 284) that can reconcile conflict, solve problems, and alleviate anxiety. (2005 Calendar, Magee Rehabilitation, Jefferson Health System, Philadelphia, Penn). Creating images assist individuals in identifying and labeling feelings, and, in

knowing the difference between feelings and actions. Creating and selecting images crystalizes and etches in lasting form the recollection of personal experiences, dreams and fantasies.

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HOW CAN HEALTH PROFESSIONALS PARTICIPATE IN HEALING OUR CHURCHES AND COMMUNITIES?

Peter Yorgin, MD; Maranatha Chapel, and Ben Rodriguez; Iglesia mi Refugio

Jesus gave his disciples the authority to, "...heal those with diseases and to preach that the Kingdom of Heaven has come near" [Mt 10: 5-16]. The disciples were initially directed to seek people in near-by communities, share the gospel and heal, which is in effect, bringing Shalom. Shalom is the complete restoration of right relations between man and 1) God, 2) one's own body 3) one's own mind, 4) one's own neighbors/community and 5) the diverse unreached communities of the world [Mt 28:19]. While Shalom is not achievable this side of heaven, the church is called to evangelism, discipling, pastoral ministry and mission, thus moving our communities toward Shalom in all its facets. The work of mind and body restoration seems uniquely suited to health professionals. This abstract reviews some of the practical ways that churches can engage congregational health professionals in ministry.

We have utilized a model (BICEPS) of church-based health efforts to bring greater Shalom to congregations with health professionals. *B: biblical-based health teaching*: While the importance of a personal relationship with Christ is essential for the restoration of a right relationship with God, all pastors should take the opportunity to teach health-relevant topics to their congregations including: 1) Old Testament Jewish laws regarding foods, health and sexual purity, 2) understanding miraculous healing, from the perspective of Jesus's healing ministry, 3) the centrality of faith in healing and 4) the body as a temple. *I: individual care*: All Christian health professional have an opportunity to minister those in their congregation and local community who have physical needs, while providing counseling and guidance. Congregational or parish nursing is a formal program of individual care (Monay et al. 2010; Pravecek 2005). *C: classes*: Each Christ-following health professional knows important health information about diabetes, hypertension, healthy diets, addiction cessation, and end of life decision making, etc. that should be shared with the congregation. *E: event-based programs*: Health screening and education fairs for adults and children are a means to bring together the community, churches,

government, Christian non-governmental organizations (NGO) and health professionals to provide 1) preventative education, 2) screening for health problems and 3) management advice and care for diseases(Boyes 2001; Lawson and Young 2002). *P: prayer ministry*: The combined prayer ministry of elders, deacons and health professionals should be visiting the sick, anointing them with oil, and asking God for healing. *S: support*. Health professionals often need guidance and training so that they can effectively combine their faith and health training/experiences. Many health professionals provide human-powered care for those in need and find themselves emotionally and physically wounded. Pastoral counseling and re-training can restore wounded healers to effective Christ-centered service(Foyle 2010).

Churches that share evangelism and health-related ministries can achieve better health and effectively reach-out to their community through the sharing of their health ministry. Importantly, health ministry and missions can be multiplied from one congregation to another thereby spreading health and Shalom.

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HEALTH MOVEMENT: SHALOM, THE CHURCH AND GLOBAL HEALTH BEST PRACTICES

Greg Seager, RN; Christian Health Service Corps

In recent years there has been a tsunami of short-term healthcare volunteers going into the developing world; both faith-based and humanitarian. Recent estimates tell us that 29% of students enrolled in medical schools participate in some type of short-term global health project prior to graduation. Nursing schools are also beginning to follow suit. Yet, few churches or educational institutions have any knowledge of what constitutes best practices in global health.

This workshop will review known best practices for global health ministry and in the process will seek to answer three primary questions.

What was the role of the “Health for all” movement and the Declaration of Alma Ata in shaping global health ministry best practice?

How do we identify best practices in global health ministry?

Are practices that support both patient safety and human dignity realistic and attainable in short- term initiatives?

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MANAGING THE TENSION BETWEEN SCIENCE/MEDICINE AND FAITH

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Our modern society has a deep trust in Science. Many people believe science represents the empirical, the hard facts. All things can be proven experimentally including life. In 1953 Stanley Miller tried to demonstrate how life first emerged on earth. He conducted an experiment where he mimicked the early atmosphere. He pumped hydrogen methane ammonia and small amount of water in a glass apparatus, and then sparkled the gases with an electrical discharge to simulate lightening. Five days later, he was able to collect amino acids in the bottom of the glass. Miller's experiment prompted people to believe that life can emerge without any external assistance from naturalistic circumstances. God was out of the picture (Strobel, 2004). People who have faith or believe in God are considered weak, irrational and foolish. However, can science serve God? Will I become a bad scientist if I believe in God, and can I become a bad Christian because I am a scientist? Where is the truth?

As Nobel Prize winner Linus Pauling stated, Science searches for the truth. The basic definition of Science is "to know". Science is not Truth by itself. God is Truth. "Jesus answered: I am the way, the TRUTH, and the light" (John 14:6). "With my great power and outstretched arm I made the earth and its people and the animals that are on it, and I give it to anyone I please" (Jeremiah 27:5). Science and medicine are investigating tools allowing us to understand the truth in God. God invites us to seek, to investigate, to understand His wisdom and praise Him for His creations. "God said, come let us reason together" (Isaiah 1:18); "From knowledge of God's work, we shall know Him" (Robert Boyle).

Science explains how things work however God explains why things are. We investigate to understand. And we seek understanding to love God and glorify Him, and to love His people and serve them. Professor Donald Mackay said: *"Obviously a surface meaning of many passages could be tested, for example, against archaeological discoveries, and the meaning of others can be enriched by scientific and historical knowledge. But I want to suggest that the primary function of scientific enquiry in such fields is neither to verify nor to add to the inspired picture, but to help us in eliminating improper ways of reading it. To pursue the metaphor, I think the scientific data God gives us can sometimes serve as his way of warning us when we are standing too close to the picture, at the wrong angle, or with the wrong expectations, to be able to see the inspired pattern he means it to convey to us."* (Witham, 2005).

To do Science, we apply the scientific method, which is a logical and biblical method to reason. It starts by an observation, followed by the emergence of a hypothesis that needs to be tested in a

controlled experiment in order to draw conclusions. Yet it is not complete. We propose you start any enquiry by praying and asking God to lead you to His truth. Ask Him to become your coworker, your collaborator. Read scriptures and look through His eyes before making any observation. Discern between God's truth and man's words. It will set the basis, the rationale for your hypothesis. Trust as if God is in control but work as if you are in control while performing the experiment. Learn about God's Truth while drawing the conclusion and reflect on how to apply it to serve His people. Your lab is your mission field but remember your role is to serve not to save. Finally, offer thanksgiving and praise, giving credit to the Lord for every answer you have.

Coming back to Miller's experiment, our modern geochemists refute the idea that the atmosphere of the early earth contained hydrogen since it is too light to be held by the earth gravity, it would have escaped. In our days, the scientific community believes that the early earth atmosphere consists of what comes out of volcanoes, namely carbon dioxide, nitrogen and water vapor. Stanley Miller re-conducted his experiment using the correct components of the early earth, and failed to isolate amino acids, so did many scientists who tried to reproduce this experiment. Moreover all attempts to demonstrate that nonliving components arrange in one living cell or organism have failed. Science is unable to explain the origin of Life. Also, there is no conclusive evidence that all living organisms have descended from one origin (DeYoung, 2005; Parker, 2006).

Then why can't scientists be more scientific and recognize God's supremacy and intelligent design? The simple answer would be that the latter rejected God and His Spirit is not dwelling in them." But when He, the Spirit of truth, comes, He will guide you into all the truth"(John 16:13). So let us chose God and know Him.

Through His Spirit, God has given us visions. Vision sees what is not and knows that by faith it can be. So dear reader/scientist, I invite you to pray before observing and hypothesizing. Read the scriptures and be full of the Spirit of wisdom and truth that God has sent you. And let God be your microscope, through which even the smallest can be seen.

For the LORD gives wisdom; from his mouth come knowledge and understanding. He holds success in store for the upright; He is a shield to those whose walk is blameless, for he guards the course of the just and protects the way of his faithful ones. Then you will understand what is right and just and fair—every good path. For wisdom will enter your heart, and knowledge will be pleasant to your soul. Discretion will protect you, and understanding will guard you (Proverbs 2:6)

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THE POWER OF MEDICINE TO OPEN CLOSED HEARTS, MINDS, AND BORDERS TO THE GOSPEL

Sheldon Wermes; Medsend

The global need for the most basic healthcare is profound, with half of the world's population underserved and a disproportionate lack of services for women and children. Wars, famines, epidemics and natural disasters deepen the plight of those with little or no access to healthcare as do human trafficking and other forms of cultural enslavement. Spiritual oppression is also a growing reality as countries close to Christian evangelism and more than 200 million Christians worldwide suffer imprisonment, abuse and sometimes death because of their faith.

Medsend was developed to train healthcare professionals to minister to these needs. As healthcare missionaries, they are often welcomed in areas that are not open to other types of evangelists. As compassionate Christians, they seek and care for those who are the most vulnerable, desperate and otherwise forgotten. By caring for physical health needs, sharing the gospel and training and empowering national believers, MedSend grant recipients can bring transformative change to individuals and communities that are hard to reach with other methods of evangelism and humanitarian programs.

MedSend empowers Christian healthcare professionals to serve spiritually and physically needy people in the U.S. and around the world in Christ's name. We do this primarily by awarding grants that release them from the financial burden of making educational loan payments while they serve FULL TIME. Without MedSend, these healthcare professionals would need to spend years working in the U.S. to pay off their educational debt before answering God's call to serve and many would never make it to the mission field at all. From the inner cities of the U.S. to remote regions that are closed to other forms of Christian witness, MedSend grant recipients are empowering people to make the changes necessary to improve their health, living conditions, and spiritual well-being.

MedSend partners with individual donors, churches, foundations and sending agencies so that we can enable growing numbers of Christian healthcare professionals to bring urgently needed hope and healing to the hurting people of the world. Today, seventy-five (75) mission boards and sending organizations rely on MedSend to provide the educational loan repayment grants that enable Christian healthcare workers to answer God's call to serve in places of great need. MedSend is the only ministry that focuses exclusively on career medical missionaries and enables their service by removing the obstacle of educational loan repayment. MedSend has raised nearly \$15 million dollars to support this mission and we have awarded 500 grants, which have made it possible for physicians, dentists, nurses, veterinarians and other healthcare professionals to serve in more than eighty (80) countries around the world.

MedSend run mission hospitals and clinics and develop innovative health outreach programs. The impact of their work is staggering, as it is common for grant recipients serving in hospitals and clinics to see at least 5,000 patients per year. In addition, the average tenure of a MedSend missionary is eleven years, with many continuing to serve many years after MedSend has paid off their educational loans. This longevity has led to truly effective and transformational ministry. For example, MedSend grant recipients have founded or co-founded comprehensive ministries including: a ministry in Malawi that provides free or low-cost HIV/AIDS care to more than 6,000 per month; a ministry in Honduras that includes a medical clinic, children's home and programs in nutrition, agriculture, early education and church planting; an orphanage and crisis pregnancy center in Romania.

We will discuss more the power of medicine in opening closed Hearts, minds, and borders to the Gospel; we will address the following topics:

- The biblical foundations of medical missions with scriptural references.

- The exceptional power of medicine in evangelism with video interviews from our people in the field giving their testimony and examples of “a day in the life”.
- “About MedSend”: we will present the newest MedSend missionaries who will need sponsorship before they can go to the field.

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CHARITY PROJECTS IN ECONOMICALLY DEVELOPING COUNTRIES

John Tannous, MD; H.O.M.E.S. International- Kunming International Clinic

Operating charitable clinics presents a myriad of challenges. Overwhelming physical need, understaffing, and constant financial demands are all pressures inherent in operating medical clinics focused on serving the poor. In many settings, nations are experiencing rapid national development and financial growth. Unfortunately, in these rapidly developing countries, the needs of the poor remain vast and relatively unaltered by the overall national progress.

The Kunming International Clinic is located in Yunnan province of China. Using this charity clinic as an example, we will examine the unique challenges of serving the poor in China as the nation surges forward economically. National progress brings not only new complex challenges, but also unique opportunities for those interested in serving the poor and marginalized via health care. By integrating educational and economic benefit to a charity clinic, the poor can receive care both physically and spiritually healing in a holistic setting.

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SHORT TERM MEDICAL MISSIONS; INTERNATIONAL GOERS, SENDERS AND HOST RECEIVERS

Peter Yorgin, MD; Maranatha Chapel, and Ben Rodriguez; Iglesia mi Refugio

Well-planned God-inspired short-term medical mission trips (STMMT) yield tremendous opportunities to promote the gospel (Romans 1:16) while at the same time meeting the felt needs of the unreached. When done well, the fruits of STMMT are new believers in Christ Jesus, who are discipled by newly-created or restored churches, more educated and empowered indigenous Christian health professionals, and a healthier people (physical, emotional and spiritual) with a greater capacity for self- and community- care. STMMT that effectively engage in mission outreach should be a model for the indigenous church so that they also go and spread the gospel through mission, thereby facilitating multiplication of the church. The case presentation (Yorgin and Rodriguez 2012) demonstrates that prayer should be the starting point for any church seeking to conduct STMMT.

Churches are presented with many mission opportunities. These opportunities, even if fully actualized, will yield vastly different outcomes. Therefore, only the best opportunity should be selected consistent with church STMMT vision. In selecting, one needs to manage the tension between the greatness of the human need within an area of service and the practical aspects of serving. Greater cost, language unfamiliarity, longer length of service time and more challenging locations generally translate into fewer STMMT members. Before committing to launch a STMMT, one should sense a calling to a people group. An exploratory trip to meet partners and the people group, assess resources and conduct advanced planning is most helpful. Good partners should share a similar theological perspective, a passion for the Lord and sharing the gospel, have a full-time presence in the country, have sufficient contacts and resources in-country and exhibit bi-directional transparent stewardship of financial resources. Great spiritual discernment is needed to determine how best to reach the people group. STMMT which focus on works, without sharing the gospel, and those which share the gospel, but do not address the felt needs of people, fail to reach the full potential of God's loving will (DeYoung and Gilbert 2011). STMMT leaders need to commit to discipling and, in the case where the team recruits unbelievers, evangelize team members.

Adherence to Best Practices in Christian Short Term Health Missions (*Best Practices in Global Health Missions* 2010) including the guidelines dealing with dependency is strongly advised. Each STMMT must determine how best to work within the local church and people group so that dependency issues do not arise. The early church mission (Biblical) model can be summed-up by local family support of missionaries (Luke 10:7) with missionaries committing some of their time/effort to self-support within the community. In such a model, both the people group and missionary have equal status. Most modern churches have abandoned this approach and have adopted an approach where the STMMT pays/donates to live within a community, whether within the church or a local hotel. Many STMMT cover the costs of the local community health project, whether education or direct clinical care. The unanticipated impact of this model can be dependence, which disempowers the local church. STMMT leaders can avoid dependence, in part, by sharing the costs of any project with the local church or choosing an early church model.

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That God will open our minds and hearts to his Word and that we will learn from his servants who have gone before us!

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