A DIFFERENT WAY OF DOING MEDICINE

I was only fourteen when I decided I was going to become a medical missionary. In my fourth year of medical school, when it was time to decide where to spend my elective term, I assumed I would be going to Africa – back then I thought *all* missionaries went to Africa.

But I was surprised to learn that female medical personnel were most needed in Muslim countries, where many women died because there were no women doctors to attend them.

So I ended up doing my medical elective term at the Pennell Memorial Hospital in Bannu, north-west Pakistan. It was in a compound with high fences and armed guards. Women were not allowed outside the compound alone, and we had to cover every part of our body including our head. I have pictures in my mind of old rusty beds, surgical gloves hanging out to dry after use, hot sweet tea and lots of kids with thin mums. Women would travel great distances to come to this hospital, some even on horseback from Afghanistan, to see the famous obstetrician Dr Ruth Coggan.

Stomping on Baby's Bottles

I started to think about holistic health and doing medicine in a different way, after I witnessed a nurse at Pennell Hospital stomping a baby's bottle under her foot. Her strange action started making sense after I learned that bottle-feeding contributed to the malnutrition, infection, growth retardation – and even the death – of babies there.

Big multinational companies sold their milk formulas cheaply, and promoted bottle-feeding as the way of the West, until it became a common belief that good mothers bottle-fed rather than breast-fed. However, many poor village women watered down the formula to make it last longer, depriving their babies of the nutrition necessary for growth. Not only that, the lack of clean water and inability to sterilise bottles frequently led to infection and diarrhoea, then dehydration and death.

My brief time at Pennell Memorial Hospital taught me so much. I learnt the importance of preventative and community medicine. I learnt that even though curative hospital care was exhilarating and necessary, prevention is better than cure. I began to understand that people's health is more than physical, and that it is bound to their poverty, education level, status, economic means, gender and religious beliefs. In short,

I had begun to understand about holism.

I probably could not articulate it at the time, but it was there I first understood that being healthy is not as straightforward as I had previously thought. As I began to consider the type of medicine I wanted to be involved in, it was very clear that, even though I enjoyed hands-on healing, my future lay in primary health care, community medicine, teaching and training.

Theological study

I reached another turning point in my Christian journey in Pakistan. While visiting Multan Christian Women's Hospital I had the opportunity to go on an evangelistic ward round. The hospital evangelist would share the gospel with the captive audience of the patients' friends and relatives, who stayed there to care for, wash and feed the patient. I thought it was great that the gospel was shared, but I was uncomfortable with the division: doctors dealt only with the physical, and evangelists dealt only with the spiritual. I didn't want to restrict myself to being only a doctor; I wanted to share the message of Christ myself, and to teach from the Word of God. I realised two major things then: I did not want to do medicine full-time, and I was going to need more theological training than I'd previously thought.

So in 1990 I began full-time theological study, while also working part-time as a GP to help pay my bills. After I finished my theological training, I worked in churches and as an itinerant speaker, still juggling that with part-time GP work. During this time of doing two jobs I was able to reflect on the interaction of the physical, emotional and spiritual. I also did a counselling course which was based on an integrated understanding of the person. We are complex beings and being healthy is a complicated business. Our emotions, hidden or conscious, have a powerful effect on our wellbeing and our perception of the world, and the way we impact others.

Community development

When I applied to become an Interserve Partner, I was willing to go where I was most needed. That turned out to be Central Asia, where the church had grown exponentially since the fall of the Soviet Union, but leaders were young in years and young in faith. I would be serving there as a General Practitioner training other GPs.

This role was a concern to me. Even though the GP training programme was vitally important (it was part of a reform of the whole health system from being very hospital based to one that is more primary health care based), it was not the grassroots, community-based medicine that I wanted to do.

My first year there was focused on learning Russian, but I also attended community development training. This was another significant turning point, as I caught the vision of impacting

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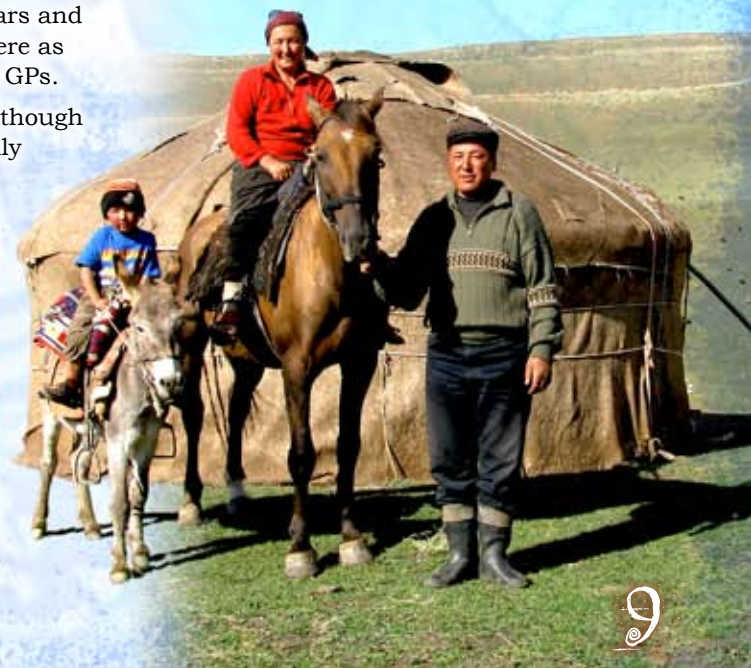

communities in a holistic and grassroots way, where they could be empowered not only to recognise their own problems, but also to solve them with local resources.

By the time my language learning ended, there was a breakthrough in my work situation: my organisation decided to start a community development department. It meant that I got the opportunity to work in a small team that, among other things, did health screening and trained village health workers. Working in the project team was quite a cross-cultural experience, with sometimes four languages needed for everyone to understand what we were going to do, or what we were thinking. I would say something in Russian, for example, then my Russian-speaking friend would translate it into the local language for my Korean colleague to understand, then she would say something in Korean to her husband, and he would then respond in English! It was a wonderful experience, but needed lots of patience.

Initially there were two doctors (myself and another) available to meet the villagers' needs: we would see patients in the morning, then move on to teaching the local health workers how to prevent and treat common problems. However, I came to realise that I was undermining what we were trying to achieve in the project: as long as there was a doctor available, people wouldn't bother to learn how to prevent the problems themselves. That is when I decided my main role would be to train and coordinate the work of our community development workers, rather than be directly involved in the community myself.

We had a few different ways of selecting communities and entering them. One involved doing health screening at schools and then presenting the findings to the parents at a public meeting. We then offered to help them, but made it clear that we offered training, not money. We began by training the people in identifying needs and problem solving. Our lessons covered many topics, such as physical health, income generation, agriculture, emotional issues and moral values like honesty and forgiveness.

Sometimes we were able to incorporate stories from the Bible in our teaching. One very powerful lesson on forgiveness was taught by using the story of the prodigal son, but adapting it to 'the prodigal daughter-in-law'. This seems to be the relationship with the most strain here, the one between the wife and her husband's mother. Wives go to live with their husband's family, and the wife has to do the bidding of the family matriarch – her mother-in-law. Most women are not free from this until they become mothers-in-law themselves. We saw many people recognise the destructiveness of unforgiveness after this lesson, and many were willing to do the homework we set them, which was to forgive someone!

Most of the communities we worked with knew we were followers of Jesus, and through years of interaction they developed a more positive understanding of Christianity. We

do this work not as a means to evangelise or plant churches, but because it is good in itself and demonstrates the love of Jesus to broken people. In many places around the world, however, the natural consequence of such holistic community development is that, over time, churches are planted.

TEE and discipleship

A great number of local church leaders, when surveyed, said the biggest need in their church was for discipleship. The local church is great at evangelism and church planting, but after people turn to Jesus there are many obstacles that prevent them from growing in their faith. Many groups are started in small and isolated communities as people respond to the good news, but without local leadership they often go for months without receiving any biblical teaching.

Theological Education by Extension, or TEE for short, addresses this issue. Group members can study the Bible wherever they are. Books of self-study material become the tutor. Someone needs to know how to be a facilitator or group leader, but basically the group learns together, has home-study tasks and practical ministry assignments.

In my last term overseas I was asked to help develop a TEE programme for one of the Bible Colleges. A few of my former students were keen to work with me on this, as they realised that TEE was the best way to help the church grow, especially in remote areas. Mars, a gifted church planter, used to be a

Muslim mullah until he encountered Jesus as he was saying his prayers. As Mars began small groups, he found he didn't have the time or resources to follow them all up. Now, through TEE, the groups are provided with the resources they need to grow in Christ.

We have a big vision for our TEE groups: we want to use them to address the needs of the whole person. We plan not only to offer theological training in these groups, but also to pass on life-skills and knowledge in the areas of health, parenting, intensive gardening, income generation and so on. It is our hope that group members will become lights in the community which others are drawn to and want to learn from. This is still in process as change is slow.

When there is harmony between people and God (the spiritual dimension), among people (the social dimension), within the person (the emotional dimension) and between people and their environment (the physical dimension), we have holistic health. Illness is a breakdown of these relationships. As Christians we work to reveal the reconciliation that Jesus achieved through His death on the cross. He is Lord of all and has reconciled all things in heaven and earth to Himself (see Colossians 1:15-20). If He is Lord of all, He is Lord of every aspect of this world and of our lives. That's holism.

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