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Short-term Medical Teams: What They Do Well…and Not So Well

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In highlighting the problems associated with short-term missionary teams, Miriam Adeney uses the African saying, "When the elephant dances, the mouse may die" (2000, 56). If short-term teams are elephants, then medical teams may be the biggest elephants of all. However, even elephants have their place in God's creation.

Using short-term mission teams is now well established as a mission method, and the priority today is to help short-term teams accomplish their ministry for Christ most effectively (Corwin 2000, Parrott 2004).
Short-term medical teams take many forms and serve in many ministry settings. This article is limited to general medical teams. While even these teams are variable, many are fully equipped with personnel and head off to some location in the majority world to offer direct patient care to people. Teams may include a combination of physicians, nurses, physicians' assistants, allied health professionals and helpers. Patient care can take several days or several weeks, during which time the health workers dispense medicines from a traveling pharmacy.

Although the number of medical teams that travel each year is uncertain, it is thought to be substantial. The Christian Medical & Dental Association had forty separate medical missions scheduled in 2004 (Shealy 2004). MAP International provided medicines for 880 teams involving 15,840 missionaries in 2001 (Dohn 2003). Countless individual churches and parachurch organizations also send teams into the field. With all this activity, we are wise to consider what medical teams do well and what they do less well during a short-term medical mission trip.

THINGS SHORT-TERM MEDICAL TEAMS CAN DO WELL

Demonstrate Christ's love for a suffering world in a tangible and personal way. This strength alone may be sufficient justification for short-term medical teams. Today's medical missionaries follow in the long Christian tradition of healing ministries that began with Jesus himself. As modern ambassadors for Christ, team members have the opportunity to listen, touch and comfort in his name.

Make patients feel special. Through the medium of medical care, short-term teams can recognize and affirm their patients. When caregivers or a prayer team prays with patients, real comfort and healing can occur. The degree to which a medical team makes patients feel special may depend upon the adequacy of the language and cultural interpretation the team has available. Other factors may include the degree to which teams maintain a high quality of care, minimize possible adverse medical effects and have a patient-friendly system of management.

Treat every individual the same. In general, more cultural knowledge is a good thing. However, many short-term medical teams lack cultural awareness, thereby preventing them from distinguishing among different societal social strata. Consequently, these individuals treat every patient the same, thus affirming even the least of those among us. Although in general it is better for missionaries to have some knowledge of the culture in which they will be working, this lack of knowledge may occasionally be a paradoxical strength.

Provide team members with a spiritual high. The mission experience often profoundly changes team members. They may return from a trip with a sense of compassion for those who are less fortunate in wealth, health and education. Their faith may be strengthened by those who are poor materially but rich in faith. Reflection on their experiences may help them understand biblical texts in a new way. One description of a short-term medical mission program stated, "You need to go. You need to take your spouse, to take your kids (if you have them) and give them this mission

experience. It'll recharge your batteries, refocus your ideas about ministry and [it will] be a real spiritual revival" (Stevens 2004).

Provide a first-hand opportunity for team members to learn about conditions in the majority world and begin to understand underlying causes of poverty. While understanding the structure of poverty may require study beyond the short-term trip, face-to-face observation of conditions in the majority world as incarnated in the patients can provide a solid foundation.

Strengthen cross-cultural relationships. Relationships between the team (plus the sponsoring church, churches or organization) and the local church or faith community will form during a short-term medical trip. Team members may recognize the work the church is already doing in the majority world. Although there may be few financial resources, there may still be a solid foundation in faith and spiritual strength. Further ministry possibilities may emerge from these relationships.

Generate enthusiasm, energy and publicity. Short-term medical teams generate local interest. Depending upon the remoteness of the locale, the visiting team may provide the only live entertainment and diversion the people have seen for quite awhile. The local church may benefit as its presence becomes better known to those living nearby. We have seen the number of church members increase shortly after a short-term medical team visits.

Strengthen local relationships. Short-term medical teams may improve the relationship between the local church and the community. For example, a rift between a local congregation and the community arose as a result of an expensive new church building (built with donated North American dollars). The local community considered it a waste of resources in their poor neighborhood. After a visiting short-term medical team worked out of that building, community leaders now better understood the ministry of the church and its future plans for social ministries. The "lavish" building was now understood as it was intended—as a spiritual and social ministry center to be shared with the community.

Provide care for acute conditions. Short-term teams can provide services for people with uncomplicated acute medical problems. For example, many infectious diseases will respond quickly and completely when treated, thus alleviating suffering more quickly, avoiding complications and conceivably saving a life. Other treatments can include analgesic and symptomatic care for sprains and strains and reassurance and decongestants for a worried cold sufferer.

Provide short-term relief care. There is evidence that people with certain chronic medical conditions (such as arthritis) feel better and have fewer days of pain and disability for at least a month after receiving palliative care from a short-term medical mission team (authors' unpublished data).

Distribute vitamins and simple pharmaceuticals. Those in the majority world may not have a medicine cabinet with basic self-administered medications (aspirin, acetaminophen, ibuprofen or decongestants) present in adequate supply. As one Guatemalan pastor once told us, "In the rural areas here, aspirin is still a miracle drug."

Collect a lot of people in one place at one time. Ill people, healthy people, children, parents, adolescents, church members, members of other denominations, the unchurched…all may appear when a short-term medical team visits. This gathering may provide the local church with unique opportunities to teach and evangelize.

Offer second opinions. For the "worried-well" (healthy people who are concerned they have a medical problem), a second opinion from a short-term medical team may relieve anxiety. However, second opinions also have drawbacks, as we will discuss in the next section.

THINGS SHORT-TERM MEDICAL TEAMS DO LESS WELL

Provide care for chronic diseases. While a one-time evaluation of a patient with a chronic disease (for instance, hypertension or diabetes) may have some value, the nature of those diseases requires long-term care. The impact of short-term medical teams is limited in this area. Also, the quality of care by short-term medical teams may be compromised by many factors (Dohn 2003). In addition, the risks of complications are greater for patients with chronic or complicated medical conditions. One rule of thumb is that a short-term team should treat conditions that the caregivers would feel comfortable and confident treating in their usual practice settings if: (1) the physical

environment was suboptimal (no privacy, poor lighting, noisy, inadequate physical examinations, etc.); (2) the present and past medical history was considered unreliable due to language and cultural barriers; (3) they were seeing the patient for the first (and only) time; (4) no laboratory or other testing was available; and (5) there would be no follow-up to assess response to therapy or adjust management (Dohn 2003). Following this guideline, teams would still be treating the simple acute conditions mentioned earlier, but would limit their expectations for providing care for chronic conditions.

Screen for chronic diseases. This could be valuable or not. Screening for disease is generally the first step in making a proper diagnosis. If the rest of the process is not present, then screening may not be worth the effort. When a new diagnosis can be made by a short-term team, the patient may be well-served if therapy is available. However, screening for disease when no treatment is available is of limited value (and some would say ethically questionable). Arranging follow-up care for poor patients with local Christian physicians (who may already be committing significant time to caring for the poor) may be taking advantage of physicians who may be barely subsisting themselves. If the team is arranging local follow-up care, adequate remuneration for the physician’s time and for any necessary supplies should be planned into the budget.

Provide care for macroparasitic infections. Macroparasitic infection (worms) is common, easy to treat and likely to recur. In fact, if the source of the worms is still present, mass treatment of a community will likely result in a mini-epidemic with increased abdominal symptoms as people reacquire the worms. After everyone has been treated, the level of infection will return from the epidemic level back to previous levels found in the community (Anderson 1992, 13-23, 433-466). On an individual level, treating a child for worms is good; on a community level, treating many people may have unintended consequences.

Offer second opinions. Second opinions may be less helpful for people who are ill. While some cases are straightforward, others may not be. Compared to the short-term team, the local physician who made the original diagnosis (1) may be more familiar with local diseases and possible diagnoses, (2) may have had the advantage of getting laboratory tests, (3) may have been previously following the patient and (4) may already have a further diagnostic plan underway. Short-term teams may unintentionally create doubt about a local medical practitioner’s competency; create confusion for the patient; interrupt or delay treatment or further diagnostic plans; and generally get things messed-up (Dohn 2003). In trying to formulate a second opinion, we would do well to be cautious and remember that we are practicing (literally) in foreign territory. Even the team’s advance publicity may cause problems. When people hear that a short-term medical team is coming and want to get a second opinion or treatment from the North American doctor, they may wait for the team’s arrival. Appropriate care may have been delayed while waiting for the team and those patients will have suffered the consequences.

THINGS SHORT-TERM MEDICAL TEAMS DO EVEN LESS WELL

Teach patients. Patient education might seem to be a perfect activity for short-term medical teams. It can be done with simple materials, it takes advantage of the team’s ability to attract people and it holds the possibility of producing a long-term impact if patients change health-related behaviors. However, cross-cultural teaching is not that simple (Livermore 2004). Simply providing information is rarely sufficient in and of itself to change behavior; rather, change requires adopting a new mindset and initiating a new lifestyle. This is difficult to accomplish even in the best of circumstances (Shaffer 1990).

Language barriers must also be overcome. Even with materials in the appropriate language, cultural barriers may exist. A diabetic listening to recommendations for meals based on a North American diet may find little useful information. Their diet may consist largely of foods unknown to the North American and an assumption of three meals a day may be unrealistic. The individual may be so poor that he or she only eats every other day. Perhaps the North American “teachers” could learn more about local strategies for dietary control from the diabetic “students” than the other way around. If the roles were reversed, the missioners might find themselves introduced to exotic fruits and vegetables and new methods of cooking.

Just as in long-term missions, characteristics such as naive realism, ethnocentrism and cultural bias will interfere with effective teaching. These and other characteristics as related to short-term medical teams are well-described elsewhere (see Montgomery 1993). In contrast to long-term missions, short-term teams are less likely to have had significant cross-cultural training. Cross-

cultural issues are a major impediment to effective health education (Fountain 1990).

Problems that arise when patients cannot understand simple instructions concerning how to take medications raise questions about the simple patient education that teams are already trying to perform (Dohn 2003). More attention to educating patients about the medicines they are being given (and ensuring that those medicines are properly labeled) may do more to improve the mission and maintain an acceptable quality of care than trying to add a separate patient education component.

Improve people's overall health. Nearly all interventions used internationally which attempt to improve poor people's health lack evidence-based foundations (Buekins 2004). Short-term teams are no exceptions. Short-term medical teams have not been shown to improve overall health (Montgomery 1993, Dohn 2003). Perhaps the most obvious reason is that they simply do not have the time or opportunity to have an effect on health status. Long-term mission goals generally require a long-term mission strategy. There is only so much a short-term team can accomplish. The desire of some short-term medical teams to provide "continuity of care" is another sign of the confusion between long-term and short-term mission. Perhaps those short-term medical missioners who are truly interested and motivated to provide continuity of care are being called into long-term health missions. We should encourage those individuals to discern the Lord's call on their lives. If they are not called to long-term mission, we should help them accept the limitations of short-term missions.

Another reason health status is not improved by short-term medical teams is that Western curative medicine generally adheres to a narrow pathophysiological view of health in which the emphasis is on disease, diagnosis and treatment. According to Tony Atkins, "In the West, we generally view health in negative terms. If we are not ill, we are healthy" (1990, 7). The Bible presents a more expansive, wholistic and integrated concept of health (Mosley 1990). According to Daniel Fountain, "For adequate healing to take place, the many factors involved in a particular illness—physical, social, emotional and spiritual—need to be addressed in concert" (1999, 116). One definition of total health from MAP International is "the capacity of individuals, families and communities to work together to transform the conditions that promote, in a sustainable way, their physical, emotional, social, economical, environmental and spiritual well-being" (2004). In contrast, short-term medical missions operate as relief ministries based in the Western curative medical model. While mission teams can provide some medical care, it may not be possible to "provide" health for people. Improving health is a long-term transformational development ministry (Van Reken 1990).

An expectation of all short-term mission teams is that they somehow serve and relate to the program and goals of an ongoing local ministry (May 2000). This expectation should apply to short-term medical missions as well. Concentration should be placed on maximizing the quality of patient encounters and on the publicity and enthusiasm the team creates in the community. The local faith community can further their mission for Christ by capitalizing on the goodwill and energy generated by the short-term team's work.

Teams concerned with long-term health improvement might consider supporting local health development programs and efforts to strengthen the indigenous capacity for health-care. It must be noted that national or regional governmental authorities may react negatively to the team's presence. There may be a sense of embarrassment that foreigners are addressing deficiencies in the healthcare system. This embarrassment might either motivate authorities to provide better healthcare or it may cause them to try and obstruct the team's efforts. Another response might be relief that someone is taking care of the people in the area, thus justifying the authorities abandoning their plans for health development. While these "macro" effects are beyond the control and planning of the short-term medical team, they can impact the health status of the people in the area.

Local faith communities may harbor the unspoken hope that visiting teams will eventually support the local church's long-term ministries. Rather than having the local church try to grow ministries on their own, the short-term team (or its sponsoring church or organization) could enable the church to accomplish those ministries. This may mean forming a partnership, donating financial resources and taking a subservient role (Smith 1992, Parrott 2004). Also, while patient education may be problematic, professional peer education can be productive in the long run, though short-term medical missions may not be the best forum for this activity.

GROWTH FOR THE MEDICAL MISSIONARY AND THE OVERALL TEAM
Short-term medical missions provides team members with excellent educational and spiritual growth opportunities. The sentiment that "we came to give, but we received so much more" is common among short-term mission participants. Maximizing the spiritual experience for participants should be a priority for medical mission trips. Even if spiritual growth is not a cognizant goal of the participants, group leaders should be aware of growth opportunities. Many medical mission team members will begin to question whether the mission is just "band-aid" medicine during the trip itself. Team leaders must be prepared to lead their teams through a spiritual journey, take them to a deeper understanding of mission and mission issues and capitalize on the experiences during the trip. It may be useful to have clergy on the trip, though many health professionals with experience in missions can do this well. However, if it is true that a surprising number of missions pastors have little or no cross-cultural mission experience (Parrott 2004), then making the most of the educational and spiritual opportunities could be a challenge.

Medical teams may spend the preponderance of their preparation efforts on the logistics of the trip. Indeed, a medical missions trip is more complicated and difficult to organize than the average mission work team. However, providing team members with preparation in cross-cultural and missiological concepts may be a responsible stewardship choice considering the investment in time and resources that go into most medical mission teams. Help is available for medical team leaders who want to better prepare their teams.1

The list of things that teams could do well does not mean that all teams doing those things are doing them well. Nearly anything we do can be done better. Redefining the mission to include more of those things that a short-term medical team could do well (instead of concentrating only on that which it does poorly) would probably produce a better mission trip and more satisfied missioners. Most of the things that short-term medical teams could do well are related less to medicine than to relationships—relationships with patients, with the local people, with the local church and with the Lord. An editorial about missionary medicine cautions us not to think of medical technology or techniques more highly than we ought. "Ultimately, it is the missionary doctor or nurse's reflection of Christ which will be important to his cause" (Smalley 1959, 95).

Endnote
1. Check out these two comprehensive cross-cultural health ministry programs: Global Health Training Program, Peeke School of Christian Mission(King College, Bristol, Tennessee, www.king.edu/Academics/Schools/pscm/cghc/index.asp) and School of Intercultural Studies (Fuller Theological Seminary, Pasadena, California, www.fuller.edu/swm).

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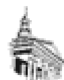
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