

Short-term Medical Teams – What they do well . . . and not so well

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In highlighting the problems that short-term teams may produce, Adenay (2000, 56) uses the African saying, “When the elephant dances, the mouse may die.” If short-term teams are elephants, then medical teams may be the biggest elephants of them all – but even elephants have their place in God’s creation.



Short-term mission teams of all sorts are now well-established as a mission method, and the priority now is to help short-term teams accomplish their ministry for Christ in the most effective manner (Corwin 2000, Parrott 2004). Towards that end, we offer some thoughts about what short-term medical teams do well and also what they do less well.

Short-term medical teams take many forms and undertake many different ministries. We are limiting our comments to general medical teams – specialty and surgical teams are a different discussion. While even general medical teams are variable, they typically have a fully-equipped team that goes to a location in the 2/3’s world to offer direct patient care to people. Teams may include some combination of physicians, nurses, physician assistants, allied health professionals, and helpers. They may see patients during several days or several weeks, dispensing medicines from a pharmacy that they brought along, before returning to their country of origin.

No one knows how many such medical teams travel every year, but the number is likely substantial. The Christian Medical & Dental Association alone had 40 separate medical missions scheduled in 2004 (Shealy 2004). MAP International alone provided medicines for 880 teams involving 15,840 missionaries in 2001 (Dohn 2003). Countless individual churches and para-church organizations also send teams into the field. With all this activity, let’s consider what these teams are able to do well and also less well during a short-term medical mission.

Things that short-term medical teams can do well –

- **Demonstrate Christ’s love for a suffering world in a very tangible and personal way.** This strength alone may be sufficient justification for short-term medical teams. They follow in the long Christian tradition of healing ministries that begins with Jesus himself. As modern ambassadors for Christ, team members have the opportunity to listen, touch, and comfort in His name.
- **Make the patients feel really special.** Through the medium of medical care, short-term teams can recognize and affirm the patients that they see. When caregivers or a prayer team pray with the patients, real comfort and healing can occur. The degree to which a medical team makes patients feel special may depend to some extent upon the adequacy of the language and cultural interpretation that the team has available. Other factors may be the degree to which teams maintain a high quality of care, try to minimize possible adverse medical effects, and have a patient-friendly process (Dohn 2003).

- **Treat everybody the same.** In general, more cultural knowledge is a good thing. However, for short-term medical teams, their lack of cultural awareness may prevent them from distinguishing among the different social strata within the society in which they are working. Consequently, they treat everybody the same, affirming even the least of those among us. This can be a paradoxical strength of these teams.¹
- **Provide team members with a spiritual high.** The mission experience often profoundly changes the team members. They may return from the trip with a sense of compassion for people who are less fortunate in wealth, health, and education. They may find their faith strengthened as they see people who are poor in material terms, but rich in faith and relationship with the Lord. A biblically-based reflection on their experiences may open up new vistas and understandings of the Bible texts. A recent description of a short-term medical mission program said, “. . . 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 be a real spiritual revival . . .” (Stevens 2004). The spiritual benefits for members of short-term teams are well-recognized.
- **Provide a first-hand opportunity for team members to learn about conditions in the 2/3’s world and begin to understand the underlying causes of poverty.** While understanding the structure of poverty may require study beyond the short-term trip, face-to-face observation of the conditions in the 2/3’s world as incarnated in the patients is a good beginning.
- **Strengthen cross-cultural relationships.** Relationships between the team (and its sponsoring church, churches, or organization) and the local church or faith community are bound to form during a short-term medical trip. Team members may recognize the phenomenal work that the church is already doing in the 2/3’s world with a foundation in faith and spiritual strength, but few financial resources. 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 that 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 in the time 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) that the local community considered as a waste of resources in their poor neighborhood. After a visiting short-term medical team worked out of that building, community leaders confided that they now had a better concept of the ministry of that church and its plans for social ministries there. The “lavish” building was now understood as it was intended: as a spiritual and social ministry center to be shared with the community. Rift repaired.



- **Provide care for acute conditions.** As some examples: there are many infectious diseases that will respond quickly and completely when treated, probably alleviating suffering more quickly, possibly avoiding complications, and conceivably saving a life; a little analgesic and symptomatic care for sprains and strains helps a lot; reassurance for a worried cold sufferer, along with some decongestant, can be a real blessing for that patient. Short-term teams can provide good service for people with uncomplicated acute medical problems.
- **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.** People in the 2/3's world may not have a medicine cabinet with basic self-administered medications (aspirin, acetaminophen, ibuprofen, or decongestants, for example) that are present in a goodly supply in homes in North America. As a 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 . . . they may all appear when a short-term medical team visits. This gathering of people may provide the local church with unique opportunities to teach and evangelize.

- **Offer second opinions.** For the "worried-well" (healthy people who are concerned that they have a medical problem), a second opinion from a short-term medical team may relieve anxiety and allow them to return to their lives. However, second opinions also have a down-side as we discuss in the next section.

Things that short-term medical teams do less well –

- **Provide care for chronic diseases.** While a onetime 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) and the risks of complications from medical care are greater for patients with chronic or complicated medical conditions. One rule of thumb is that a short-term team should treat those conditions that the caregivers would feel comfortable and confident to treat in their usual practice settings if: the physical environment is sub-optimal (no privacy, poor lighting, noisy, inadequate physical examinations, etc.); the present and past medical history must be considered unreliable secondary to language and cultural barriers; they are seeing the patient for the first (and only) time; no laboratory or other testing is available; and there will 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.

- **Screening for chronic diseases.** This could be valuable, or not. Screening for disease is generally the first step in a process to make a diagnosis. If the rest of the process is not present, then the 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 unfair advantage of those physicians who may be barely subsisting themselves; adequate remuneration for the local physician's time and for any necessary supplies should be planned into the team's budget if they are arranging local follow-up care.
- **Provide care for macroparasitic infections.** Macroparasitic infection means worms: very common condition, very easy to treat, and very likely to recur. In fact, if the source of the worms is still present, mass treatment of a community for worms will likely result in a mini-epidemic with increased abdominal symptoms as people reacquire the worms.² The level of infection will eventually return from the epidemic level back to the previous levels that were present in the community before the team treated everyone (Anderson 1992). On an individual level, treating a kid for worms is a good thing; on a community level, treating lots of people for worms may have unintended consequences.
- **Offer second opinions.** Second opinions may be less helpful for people who are ill. While some cases are straight forward, others may not be. Compared to the short-term team, the local physician who made the original diagnosis may be more familiar with the local diseases and all the possible diagnoses, may have had the advantage of getting laboratory tests, may have been following the patient for awhile, and may already have a further diagnostic plan underway if the diagnosis is in doubt. 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 a bit 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 a significant time 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 that 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, takes advantage of the team's ability to attract lots of people, and holds the possibility of producing a long-term impact if patients change their health-related behavior. However, cross-cultural teaching does not work that well (Livermore 2004). Simply providing information is rarely sufficient in itself to change behavior; rather, change requires adopting a new mindset and initiating a new lifestyle – difficult to accomplish in the best of circumstances (Shaffer 1990).

Also, language barriers must 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. Her diet may consist largely of foods unknown to

the North American diet and an assumption of three meals a day may be unrealistic; she may be so poor that she only eats about 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 missionaries might find themselves introduced to some exotic fruits and vegetables, as well as learning about some new cooking methods.

Just as with 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 (Montgomery 1993). In contrast to long-term missions, however, short-term teams are less likely to have had any significant cross-cultural training or to even be aware of these issues. Cross-cultural issues are a major impediment to effective health education, even to the extent that the issues are addressed in books seeking to improve long-term health missions (Fountain 1990).

Problems with the instructions given to patients with their medicines raise questions about the adequacy of 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 state of health.** Nearly all interventions used internationally in attempting to improve poor people’s health lack evidence-based foundations (Buekins 2004), and short term teams are no exception. Short-term medical teams have not been shown to improve people’s 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 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 missionaries 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 and not delay becoming long-term missionaries in health ministries. If not called to long-term mission, then we should assist those people to accept the limitations of short-term missions.

Another of the reasons that 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. “In the West, we generally view health in negative terms. If we are not ill, we are healthy” (Atkins 1990, 7). The Bible presents a more expansive, wholistic, and integrated concept of health (Mosley 1990). “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” (Fountain 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” (MAP 2004). In contrast, short-term medical missions operate as relief ministries based in the Western curative medicine 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. Of those things that short-term medical missions can do well, concentration should be placed on maximizing the quality of the patient encounters, and on the publicity and the enthusiasm that 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.³ Local faith communities may harbor the unspoken hope that visiting teams will somehow eventually support the local church’s long-term ministries and not just expect the local community to be the facilitator for the foreigners’ short-term mission trip. Rather than trying to figure-out how to do it themselves, the short-term team (or its sponsoring church or organization) could enable the local church to accomplish those ministries (this may mean forming a partnership, sensible contribution of 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.



Short-term medical missions provide the 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 the possibilities and ready to take advantage of them. Many medical mission team members will begin to question whether the mission is just “band-aid” medicine during the trip itself. Team leaders ought to be prepared to lead their teams through a spiritual journey, take them to a deeper understanding of mission and mission issues, and generally capitalize on the experiences during the mission trip. It may be useful to have a clergy-person along on the trip, though many health professionals with experience in missions can do this well. However, if the recent observation 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 mission trip is more complicated and difficult to organize than the average mission work team. However, also 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 in these areas.⁴

The list of things that teams could do well does not mean that all the teams doing those things are doing them well. Nearly anything we are doing can be improved. Thoughtful and intentional efforts to

improve the quality of the ministry and of the health care that the team provides should be a part of every team's process (Dohn 2003).



We are nonplussed by e-mail saying, “I am coming to the Dominican Republic with a short-term medical mission team for a week and I want to know what I can do to make a lasting improvement in the health of the people there.” The short and honest answer is, “Nothing.” However, 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 missionaries. Most of the things that short-term medical teams could do well are related less to medicine than to relationships⁵ – relationships with patients, with the

local people and local church, and with the Lord as the participants' spiritual journeys proceed. An old 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).

Endnotes

1. We are not arguing that short-term medical teams should avoid cross-culturing training. Short-term teams that are more culturally knowledgeable, aware, and open would always be the better alternative.
2. Beyond the theoretical and biological considerations, missionary anecdotes indicate that gastrointestinal complaints increase during the month or two after short-term medical teams visit and treat everyone in the community for worms.
3. Short-term medical teams may have effects that reach beyond their own actions. National or regional governmental authorities may react (perhaps unpredictably) to their presence. There may be a sense of embarrassment that foreigners are addressing deficiencies in the health care system. This embarrassment may motivate authorities to provide better health services or prompt a response in which authorities try to end the embarrassment by obstructing the team's efforts (directly or indirectly). Another response might be characterized as a sense of relief that someone is taking care of the people in that area, thus justifying the authorities abandoning their plans for health development there with the effect that long-term improvement in health status of the people there is delayed. 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 that the team visits.
4. The sources of help constantly change and are different now (January 2009) than when this was written. One website that can lead you to conferences and other resources is:
<www.healthcaremissions.org> [last accessed 31 Jan 2009]
5. If the benefits are predominately relational and not medical, this raises the question whether the same ministry goals might be accomplished with a non-medical short term mission team at a lower cost and without the risks (such as medication reactions and other side-effects of medical care).

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