Mennonite Healthcare Fellowship

Mennonite Health Journal

Volume 15, No. 2
April 2013

This issue of *Mennonite Health Journal*

Welcome to this April 2013 issue of *Mennonite Health Journal*! This is the first issue to be published directly to the new journal display system on MHF's new website. Check it out at by going to the *Journal* home page (http://mennohealth.org/communications/journal).

- Spring (in the northern hemisphere, at least!) and the Easter season bring with them the reminder that often the most challenging "winter" experiences can be the most transformative experiences bringing us new life. With that in mind, here is what you will find in this issue of MHJ.
- MHF President, **Joe Longacher**, asks the question, "**What's in a Name?"** He reflects on the process by which the name "Mennonite Healthcare Fellowship" was chosen for the new organization birthed by Mennonite Medical Association and Mennonite Nurses Association. In a similar manner, he also introduces readers to the upcoming **Annual Gathering**, June 21-23, 2013 in Goshen, Indiana.
- **Harold D. Lehman** is one of the few persons still living who can reach back in adult memory to the days of a devastating world war in the 1940's. In his article**, "Conscientious Objectors and the Transformation of Mental Healthcare,"** he shows how those who were opposed to that war ended up transforming the mental health system in the U.S.
- Learning and serving in another culture can be both anxiety-producing and transformational! **Sarah Buller Phillips**, the most recent participant in MHF's Student Elective Term, shares **"SET Reflections"** on her recent SET experience in India.
- Traveling north from India, we come to **"Letters from Nepal"** by seasoned physician, **Theo Beels**. His story about a 12-year-old girl is illustrative of the theme of this year's Annual Gathering, **"Moral Dilemmas in Healthcare."**
- Mennonite Chaplains Association President, **Kenton Derstine**, brings the "Moral Dilemmas" theme back to the U.S. as he offers **"Reflections on *Escape Fire*"** (the documentary on the U.S. healthcare system). Might we as Mennonites have a key to a crucial "escape fire"?
- Finally, **Paul Leichty**, MHF Executive Director, reflects on "**Moral Dilemmas and Healthcare Ethics: The Future of ACHE."** ACHE is the Anabaptist Center for Healthcare Ethics which was active from 2001 to 2007. Can this unique Mennonite initiative be revived?

Published by
Mennonite Healthcare Fellowship
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Photographs supplied by authors unless otherwise noted.

What's in a Name?
by Joe Longacher

President's Column

Most of us are satisfied with the name we were given. However, I heard of a man who went to the trouble to change his name from Joe Pajaczkowski to Frank Pajaczkowski. When asked why, he replied, "I was getting tired of having people say, 'What do you know, Joe?'"

For most of us, our name is very important, linked as it is to our identity and often our history or heritage. It is easy to take personally, or sometimes dislike, comments or attitudes which appear to demean our good name.

Speaking personally, I haven't been tempted to change my name to Frank, even though I've also been greeted from time to time as was Mr. Pajaczkowski. I will admit, however, that I have wondered why someone with no particular distinguishing features is described as "an ordinary Joe," or why a common, not very healthy, and messy food had to be named Sloppy Joe!

Usually our name is what we make of it. The name of an individual (or a family) can evoke either positive or negative images depending upon the perceptions we have gained over time. The same is true for organizations and institutions, especially if we have the opportunity to interact with them or their members in significant ways. But what about a new organization? What meaning does its name have when we haven't had the opportunity for interaction?

After considering and discussing a variety of alternatives, the group charged with overseeing the formation of Mennonite Healthcare Fellowship (the Implementation Team) suggested that name to the parent organizations in 2011. There were reasons why the three words were chosen over other alternatives, reasons which relate to our purpose as well as our image. Let me share some of them with you.

Mennonite. The primary alternative considered for the first word was "Anabaptist." In some sense, that term would have more accurately defined our constituency as including a number of denominations with generally common beliefs, whether or not the name "Mennonite" is part of their denominational title. However, Mennonite was selected in part because a person who had done medical service in Africa noted that the word "Mennonite" was clearly linked to a set of beliefs and behaviors reflecting our basic theology. Mennonite did not carry the uncertainty or lack of understanding that the use of the theological term "Anabaptism" might engender.

Healthcare. The initial choice for the second word was "Medical," a natural consideration in view of our predecessors, Mennonite Nurses Association (MNA) and Mennonite Medical Association (MMA). But the Team felt that Medical was too limiting, for many persons linked only to nurses and physicians. "Healthcare" was thought to be a better term, obviously including the vocations traditionally associated with medicine, but much more inclusive of the broad variety of activities related to health. Healthcare can refer to treatment or prevention, can apply to an individual or a group, and can involve systems and organizations concerned with all aspects of health.

Fellowship. The third word chosen was also thought to be the best descriptor of the goals and activities envisioned for the MHF. Rather than the more formal or business-like terms "Association" or "Organization," "Fellowship" was selected, reflecting a desire to continue the

kind of interpersonal and family-oriented relationships valued by members of the MNA and MMA.

Annual Gathering. We have attempted to send a similar message in using the name "Annual Gathering," rather than "Meeting" or "Convention," for our yearly time together. While there will certainly be speeches and workshops, we want to emphasize the other aspects of that time, including worship, personal interactions, and dialogue.

There are additional words, not part of the formal title, which might be used in association with Mennonite Healthcare Fellowship, including "active," "relevant," and "growing." (There are other less positive words which I have chosen not to list!) Whether or not those words will be linked to MHF will, in large part, depend on our members. As members support, promote, and in other ways contribute to the organization, the organization, in turn, has the potential to contribute significantly to our members as they attempt to incorporate their faith into their vocation.

Mennonite Healthcare Fellowship: Will you lend your good name to its mission and vision?

Joe Longacher *was elected President of Mennonite Healthcare Fellowship in September 2012. He is from Richmond, Virginia and retired at the end of 2012 from a career in gastroenterology. Joe was part of the Implementation Team that gave leadership to the formation of MHF.*

Annual Gathering Considers Moral Dilemmas

"Moral Dilemmas in Healthcare" is the theme for the second Annual Gathering of Mennonite Healthcare Fellowship (MHF), June 21-23, 2013, on the campus of Goshen College in Goshen, Indiana. **Plenary sessions** will begin with worship led by Gwen and Les Gustafson-Zook with presentations as follows:

- Friday p.m. "Challenges of a Changing Healthcare System" Timothy Stoltzfus Jost
- Sat. a.m. "Don't Be Afraid: Anxiety in a World of Moral Dilemmas" Patricia Ebersole Zwier
- Saturday p.m. Panel discussion: "Healthcare Access for All: A Community's Response"
- Sunday a.m. "Healing as a Gift of God's Grace" Ervin R. Stutzman

Workshop presentations on Saturday:

- "Challenges of a Changing Healthcare System" Timothy Stoltzfus Jost
- "The Church's Mission in Healing and Health Care" Willard Swartley
- "Don't Be Afraid: We are a part of God's larger story" Patricia Ebersole Zwier
- "Everyone Deserves to Die Well" Glen E. Miller
- "Trauma and Spirituality" Lora Nafziger
- "Enhancing Our Compassion: The Spiritual Practice of Gazing" Dan Schrock
- "Transnational Partnerships for the 21st Century" Murray Nickel & John Martens
- "Dances of Universal Peace" Mary Martha Metzler

Registrations due May 31. Many more details including online registration are available on the Annual Gathering page (http://mennohealth.org/events/gathering/) All Journal readers are encouraged to join us!

Conscientious Objectors and the Transformation of Mental Healthcare

by Harold D. Lehman

The following article is adapted from a presentation given by Harold Lehman at the Harrisonburg, Virginia Regional Meeting of Mennonite Healthcare Fellowship on January 19, 2013.

Introduction

When I was 10 years old, my father took me along one evening to the chapel at Eastern Mennonite School to hear Peter Hartman talk about his memories of life as a young man during the Civil War. I remember how this elderly man with a cane described so vividly the hardships suffered right here in this community, whether by Confederate or Union troops. Sometime after the Hartman lecture, history professor Harry Brunk published the memories of Peter Hartman in edited story form as Reminiscences of the Civil War.

What does this have to do with tonight's topic? Actually two things: One is the importance of memory and the connection of memory and story. Memory is personal; story is public. Memory is time determined; story can be timeless. Memory is place determined; story may have no boundaries. Furthermore, a determinate of vocal expression of living personal memory is the age of the memory teller.

Uncle Pete in 1931 had a clear memory of events seventy years earlier, beginning when the Civil War started when he was fifteen years old. Tonight another old man stands before you to recall memories of World War II, which was raging seventy years ago. There is a time limit to the oral transmission of memory! The direct memory-tellers regarding the impact of conscientious objectors on mental health practices in World War II are a vanishing number! No Civilian Public Service men are present here tonight. Six such men currently live in our community; their CPS units are in parentheses: Richard Weaver (Harrisburg Mental Hospital), Cleo Weaver (Greystone Park Mental Hospital), Stuart Shenk (Harrisburg Mental Hospital), Harry Kraus (Staunton Mental Hospital), Laban Peachy (Howard, Rhode Island), and Merv Hostetler (Harrisburg Mental Hospital).

The following talk has three parts: (1) my memories of CPS experience (1942-46) and some basic facts about the CPS alternative during World War II; (2) the impact of conscientious objectors on Mental Health Service during World War II; (3) and the Mennonite Mental Health Story since World War II.

Personal Memories

Six of us left Harrisonburg on October 27, 1942, to open up CPS Camp 39 in Galax, Virginia, joined by four men from Archbold, Ohio, and six from Lancaster County, Pennsylvania. The number of men at the camp increased to 150 within two months. Our work included foresting jobs and building the Blue Ridge Parkway, including grading banks, and putting in culverts. What we were doing was interesting and worthwhile, but hardly work of national importance.

In April, 1942 the Galax camp closed and moved to Three Rivers, California. Meanwhile, word came through of openings at Greystone Park Mental Hospital in New Jersey and also a unit

at Vineland Training School in New Jersey. The unit at Vineland had a specialized requirement--open to ten men who were college graduates with two years of teaching experience. I just qualified. But on my way to Vineland I had to go by way of the mental hospital at Greystone Park, New Jersey. Leaving Galax, I had three days of furlough to spend a weekend at home and to report to duty at Greystone by that Tuesday morning. I took the Norfolk and Western Sunday night train out of Elkton and changed to the Penn Railroad at Harrisburg for the rest of the night's journey to Newark. Then I went by bus to the Greystone hospital, arriving by 9:00 a.m., hoping for some time to rest and settle in. But by 10:00 a.m. that Monday morning, I was told to report for duty at noon to the Medical Surgical Ward and was fitted with white trousers and jacket. Without a single word of orientation, there I was on the job with approximately fifty male bed patients.

What little I learned I learned very quickly from nurses and student nurses: how to change sheets, feed patients, tie on a camisole, particularly to wheel a patient to electric shock treatment. The first afternoon I was in the presence of a patient who died, something I had never witnessed before. Another shock was to find that the work day was 7:00 until 7:00, either on the day shift or the night shift, six days a week. Although my time in the mental hospital was short, I've always had great respect and admiration for the CPS men and wives who spent months, even years, as mental health hospital attendants working on this schedule.

Shortly, three of us who had been accepted into the new CPS Unit #92 were told to report to "Vineland Training School for the Feeble Minded" in Southern New Jersey to open up the unit. There I was stationed for the next three years. I will not take time to talk about this experience except to say that because it was a private institution, the CPS unit there came about only because Mrs. Eleanor Roosevelt, Pearl Buck, and Dorothy Canfield Fisher lobbied President Roosevelt for his permission to put a CPS unit there. Vineland Training School was an institution that was a leader in the care of, and scientific study of [what at that time was called] mental retardation. I was privileged to teach there for three years in the school and also served as unit leader for the last two years, from 1944 until July 1946. My wife Ruth joined me in January 1945, a month after we were married at her home.

General Background about Civilian Public Service in World War II

The sources for this information are *The CPS Story* by Albert Keim, which includes general information, an overview, and history of the CPS with the special attraction of photographs; a doctoral dissertation by Ted Grimsrud on four types of conscientious objectors and how they contributed; and *The Turning Point* by Alex Sareyan, which is a comprehensive treatment of COs and the mental health program. Some hospital units produced their own descriptive stories of their work and contributions, for example the Harrisburg Mental Hospital unit.

In all, there were 12,000 conscientious objectors assigned to 151 CPS base camps and units. The largest religious group was the Mennonites at 41units; next in size was the Church of the Brethren, followed by the Quakers. In all, the 12,000 men listed 201 different religious affiliations. Twice the number of COs in CPS, about 24,000 men, registered for non-combatant service in the military branches, and about 6,000 men went to prison rather than serving, mostly Jehovah's Witnesses. Others, who had registered as COs, failed their physical exams and consequently were not drafted.

All 12,000 men in CPS were inducted first into a base camp and worked for one of the federal agencies: Soil Conservation Agency, the National Park Service, the U.S. Forest Service,

etc. This was the design of the federal authorities: to scatter these men into places out of the public eye as much as possible. For instance, there were six base camps in Virginia, but not a metropolitan center in the group: Grottoes, Luray, Galax, Lynnhurst, Bluemont, and Bedford. Mental health service was not in the original CPS plan, but came later as I will describe shortly. About one-quarter of the men in CPS (3,000) served in 61 mental institutions. Hundreds of CPS wives and some other volunteers served as well. The Mennonite Central Committee administered 23 units in mental hospitals; the Brethren Service Committee administered 10, and the American Friends Service Committee (AFSC) administered 8. In Training Schools, the American Friends Service Committee administered 6, the Mennonite Central Committee administered 5, and the Brethren Service Committee administered 3.

Impact of COs on Mental Health Services during World War II (1941-46)

The first suggestions for establishing CPS units in state mental hospitals during World War II came from a group of COs then assigned to two US Forestry Services units in Massachusetts. In their attempt to seek more socially significant work they approached a YMCA secretary close by. He in turn addressed their concerns to the superintendent of a nearby state hospital. The idea was passed on to the Massachusetts Commissioner of Mental Health. After a series of lengthy negotiations, approval came for establishing a CPS unit at the nearby hospital. The unit was slated to open April 1, 1942, under the auspices of the American Friends Service Committee.

Less than ten days before the date, the American Legion in Massachusetts condemned the assignment of COs to the state hospitals as un-American. Instead, it recommended that COs be sent abroad to give aid to the wounded, bury the dead, and dig latrines.

At the same time as the Massachusetts event, the Brethren CPS administration made a similar effort to place CPS volunteers at Elgin State Hospital in Illinois. That project was deferred by the protests of the American Legion and the local labor organization. Meanwhile, the three service committees--Friends, Brethren, and Mennonites--were working with Selective Service for approval to place CPS units at mental health institutions. The first CPS mental health unit was opened in June, 1942, at Eastern State Hospital in Williamsburg, Virginia. Interestingly, it is also said that Williamsburg was the first state mental hospital in the United States. [Virginia] also saw the founding of the first permanent CPS base camp in May 1941 (seven months before Pearl Harbor) at Grottoes CPS #4.

Why were state hospitals and training schools in such dire shortage of staff and consequently so lacking for decent custodial care? Speaking foremost of attendant care: The war effort and better wages in civilian jobs (particularly those industries supporting the war efforts) drained much of the hospital staffs. Both the Keim and Sareyan books tell the story of the desperate need for hospital attendants at the Philadelphia State Mental Hospital, known as Byberry. In 1941 the hospital had 1,000 employees, but by October 1942 only 200 remained. Designed for 2,500 patients, the hospital held 6,000. There was one attendant for every 30 patients. It was into this setting that the AFSC established a CPS unit for patient care.

Within months the Quaker unit at the Philadelphia State Hospital became the center for the CPS movement to improve health care at the lowest level--on the wards. Four bright energetic COs published a monthly paper *The Attendant*, later called *The Psychiatric Attendant*. This paper was sent out widely to CPS units in mental health across the country. Its purpose was to empower readers at the attendant level toward better treatment for the mentally ill.

On May 6, 1946, *Life Magazine* published an exposé of conditions in US mental hospitals, which appeared under the headline, "Bedlam 1946: Most US Mental Hospitals Are a Shame or Disgrace," and was written by Albert Maisel, a science reporter for *Life*. One source was "A View from the Lion's Den," the journal or diary of Warren Sawyer from September 1942 until January of 1946. Out of the Byberry connections and work, the National Mental Health Foundation was formed and chaired by Chief Justice Owen J. Roberts. On May 6, 1944, the nation's big newspapers publicized this new organization, noting that 38 distinguished citizens had signed on as sponsors. By 1949, a National Mental Health Foundation week was established in April . These are two important developments in the mental health crusade. Among crucially important hospital units advocating for mental health care were the AFSC unit at Duke University Hospital and the AFSC unit at Connecticut State Hospital.

The Mennonite Mental Health Story

It wasn't until the Civilian Public Service mental hospital program began that Mennonites made their next major commitment to the care of the mentally ill. Some 1,400 men had volunteered for service in one of the 28 mental hospitals and training school CPS units under the sponsorship of MCC. Some 400 wives of volunteers also served in mental hospitals or training schools. (My wife Ruth, in fact, moved from the MCC office in Akron, Pennsylvania to join me at Vineland Training School.) After the war, from 1945 until the early 1960s, approximately 3,000 more Mennonite people served in I-W units sponsored by MCC.

In Sept. 10-13, 1944, I was one of the 29 unit leaders attending a conference at Sideling Hill CPS Camp. Ralph Kauffman, a psychologist from Bethel College, challenged the group "with the unique opportunities the Mennonite Church has in finding its conscience and attitude toward institutions and patient care and in particular the possibility of the church operating mental hospitals guided by religious principles." Some months later, in the spring of 1945, the MCC published a report: "Should the churches establish and maintain hospitals for the Mentally Ill?"

A positive answer to that question was on the move, but it took time, much deliberation, and expert planning. "By January 1946, the MCC in its annual meeting moved to recommend that plans be developed for the establishment of three Mennonite-sponsored mental health facilities: one in the East, one in the Midwest and one in the Far West of the United States." Eventually the first of the MCC-sponsored mental health services opened on a 105-acre farm at Leittersburg, Maryland and was renamed Brook Lane--a 23-bed facility when it opened.

The second of the three MCC-sponsored mental hospitals, a new facility at Reedley, California, was under the direction of Arthur Jost, who served there as administrator until his retirement in the late 1980s. This new center was named King's View. The third center under MCC, Prairie View, was built at Newton, Kan. The administrators were Myron Ebersole and Elmer Ediger. Later, two other hospitals were established under MCC: Oaklawn Psychiatric Center in Elkhart, Indiana, and Kern View Hospital in Bakersfield, California.

Finally, three Mennonite mental health facilities developed independently of MCC, but became affiliated with Mennonite Mental Health Services (MMHS), of which Elmer Ediger was a leader. These were the Eden Mental Health Center in Winkler, Manitoba; Philhaven Hospital in Lebanon, Pennsylvania, and Penn Foundation in Sellersville, Pennsylvania.

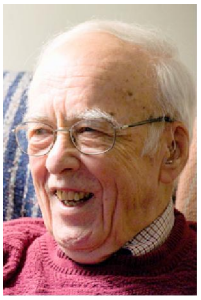
Gradually, the influence of Mennonite Mental Health Services grew and Mennonite Central Committee loosened its connections as the three mental institutions under MCC became able to administer their own programs with their affiliation to MMHS.

Summary

I would like to close my remarks with a tribute to the book, *The Turning Point* by Alex Sareyan. In 1988, in preparation for writing this book, Sareyan sent a questionnaire to men who had served in the 61 mental hospitals and training schools forty years before. His questions:

Reasons for Volunteering
Initial Fears
Hostility Experienced
Major Challenges Encountered
Reflections on the Positive Side
Effects of the Experience on Career Direction
Impressions of Former COs Who Made Return Visits to Institutions Where They Had Served

The results provided a good review of the long-term influence of the CPS experience in mental health and its effects upon the men and women who had these experiences in mental health service some 45 years previously.



***Harold Lehman**, Harrisonburg, Virginia, was educated at Eastern Mennonite College (3 years), Bridgewater College (1 year), and Madison College (3 summers), receiving his degree from Madison (now James Madison University) in 1942. At 91, he is the oldest living male graduate of JMU. In addition to his experience with Civilian Public Service, he taught in the public schools, taught and was Director of Eastern Mennonite High School, was Professor of Education and Registrar at Eastern Mennonite College (now University) and concluded a 45-year career in teaching with 19 years as Professor of Education at James Madison University.* Photo by Nikki Fox/Daily News-Record

MHF in Phoenix

The biennial **Mennonite Church USA Convention** is July 1-6, 2013 in Phoenix, Arizona. **MHF will be there!** Registration for Phoenix is now open; if you are coming, **please stop and visit us!** There are several opportunities:

MHF will have an exhibit in the Exhibit Hall near the large displays for Everence and MCC. If you are planning to come and have some extra time, your presence as a member of Mennonite Healthcare Fellowship at the exhibit table can be an encouragement for other healthcare workers to also stop and visit. Send an email to the MHF Office if you are interested!

Please plan to join us for a special reception for all healthcare professionals, Wednesday evening, July 3, 8:30–10:00 p.m. in Room 122A. Meet your Mennonite healthcare colleagues from across the country, hear about what is happening at MHF, and enjoy healthy late evening refreshments!

SET Reflections

by Sarah Buller Phillips

Traveling to India as a medical student has been a personal goal for several years. In college, I was very focused on completing my science prerequisites so that I could gain prompt admittance to medical school. Once in medical school, I identified fourth year as the ideal time to travel. I talked about doing an elective in India in broad, vague terms; I never took time to think about the impact of this type of trip. After months of planning, worrying, and praying, I have successfully travelled to and from India.

I spent the past five weeks at Herbertpur Christian Hospital, a mission hospital located in the northern Indian state of Uttarkarand. The hospital is situated at the foothills of the Himalayas and serves patients from the local communities as well as neighboring states. It is affiliated with the larger Emmanuel Hospital Association, which sponsors hospitals across northern India. Medical services include family medicine, general surgery, pediatric surgery, pediatric medicine, orthopedics, obstetrics/gynecology, ophthalmology, dentistry, and psychiatry. The hospital has four wards (male, female, ICU, and maternity), staffed by residents and teaching physicians. The attached outpatient clinic sees over 80,000 patients per year, and the hospital sees approximately 15,000 admissions annually.

As a fourth-year medical student and soon-to-be physician, I anticipated seeing patients and making medical decisions somewhat autonomously. Prior to arriving in India, I was told by multiple people that English would be sufficient to communicate. I learned very quickly that most communication with patients was done in Hindi. While the physicians, nurses, and hospital staff were conversational in English, our patients spoke only Hindi and most had never seen an American before. Many children would stare at me, especially when I visited the hospital's village outreach clinic; I found this incredibly humorous and loved waving and smiling at the kids.

My medical experiences at Herbertpur were primarily observational; at first, this felt like a regression in my medical education. However, I realized that I could still contribute to patient care and play a vital role in medical decision-making. Through my work with the family medicine residents, I was able to collaborate and offer suggestions for potential medications or necessary ancillary medical testing. My pocket medical texts, which are commonplace among American medical students, were a novelty for the physicians and residents. I was often asked about medication dosages and indications, and I became the go-to person for researching difficult medical questions. While my patient interaction skills did not improve, I was able to hone my physical exam skills and radiology technique. I encountered dozens of patients with tuberculosis and became much more confident in lung auscultation and deciphering chest x-rays.

I attend a Jesuit medical school. However, the religious influence seems to end at the crucifixes hanging in patient rooms in the hospital wards. At Herbertpur, the Christian influence permeated the entire community, and I truly felt that God was present in my everyday work. Each workday began with morning devotions; nurses led the group in Hindi Christian songs followed by a reflection given by a member of the staff. Physicians, nurses, and other staff alternated providing reflections, so each morning had a somewhat different theme and style of worship. While most of the devotions were in Hindi, I enjoyed spending thirty minutes of my day in worship with other Christians. I appreciated having a dedicated time to pray. At many points during medical school, I have tried to make morning devotions a part of my schedule. I am successful for a week or so, then revert back to my old habits of sleeping in or studying

before classes or clinic. It was challenging yet refreshing to be part of a medical community that made worship an integral part of each and every day.

Having never studied abroad or done overseas mission work, I found my Indian cultural education to be one of the most important aspects of my trip. Through discussions with friends at Herbertpur, I became more familiar with various customs of the Hindu, Muslim, Sikh, and Christian faiths. Family structure and marriage was particularly intriguing, as I was engaged and trying to plan a wedding during my elective. A young Hindu resident, Rashika, shared photographs and discussed the customs of her recent engagement ceremony in Delhi; I told her about my Christian wedding ceremony and the drastically different Western rituals of marriage. I learned about arranged marriages and love marriages in India and the vital role that extended family plays in these unions. It is amazing how my current life circumstances permeated my life in India; miles away from home I found my cultural questions to be shaped by my current concerns at home. It will be interesting to return to India in a few years; I imagine that my inquiries will be very different and I will learn more about a different aspect of Indian culture.

My time at Herbertpur demonstrated that faith and medicine truly can coexist. This has been a personal struggle for me, as I strive to live my life as a reflection of Christ while simultaneously respecting the sometimes conflicting views of my patients. In my patient encounters, I am reluctant to discuss faith and religion, although I cognitively recognize the importance of a belief in a higher power on one's health and wellness. I was able to work with the psychiatrist at Herbertpur, Dr. Raja Paulraj. Dr. Raja spoke with many of his patients about the intersection of mind, body, and spirit. Using a diagram of intersecting circles, Dr. Raja emphasized that when our mind or body is "sick", our spirit is also "sick." It is important to nurture all aspects of ourselves. Medication may help one's body or mind, but it does little for the spirit. It is important to invest in one's spiritual health; this can be done through organized worship or personal reflection. I think this perspective could easily be translated to Western medicine and is applicable to patients of all faiths.

On a more personal note, my trip to India served as a pilgrimage of sorts. My grandmother grew up attending the Woodstock School in Mussoorie, India, a Himalayan hill station about two hours from Herbertpur. On a free weekend, I was able to travel to Mussoorie and see Woodstock. It was incredibly surreal to see the place where my grandmother spent her formative years. I walked on the same stairs as she did, felt the same banisters, and stepped into the same classrooms. My family and personal identity is tied to this foreign place, and this trip facilitated an even stronger connection between me and my grandmother. Both during my trip and upon my return, I was able to speak to my grandmother, creating connections that none of her children or grandchildren have been able to make. My grandmother is so proud of me, both for giving my time to those less fortunate than myself, but also for making her heritage a more prominent part of my own.

One of the most important lessons I learned was to trust myself. I was very nervous about my trip. I am a stickler for organization and appreciate an attention to detail. I found that "orientation" meant something different in India, and my ability to be flexible was essential. Travelling alone, I spent a lot of time with myself, which was valuable time to reflect, pray, and question my purpose in India. I became very good at asking others for help, something that I tend to avoid in America. It was a blessing to be a part of a community that valued personal and family time, and I slowly came to appreciate the absence of constant connectivity to the outside world and the slower pace of life. American medical education is fraught with doubt, and my

time in India provided me the courage and confidence that has been missing from my education. I feel empowered; I went to India, *alone*, and came back alive.

In looking to my future, I see overseas medical work as a way for me to share my gifts and talents with those less fortunate. I began this experience with an open mind; I concluded my trip with thoughts to my next journey. I feel called to work with an underserved patient population, and as a future family medicine physician, I will have ample opportunities to serve within my home community. However, international medicine has a unique way of putting the stresses and challenges of daily life into perspective. When the protocols and regulations of American healthcare are removed, medical care is focused more on the patient and less on the paperwork. I anticipate future international travel will play an essential role in keeping me excited about the changing American healthcare system.

Sarah Buller Phillips *is a fourth-year medical student at Saint Louis University, a Jesuit institution in St. Louis, Missouri. Sarah will begin a family medicine residency at Brown University in Providence, Rhode Island, in June 2013. After residency, she is interested in pursuing a career in urban, underserved medicine at a federally qualified health center. Her medical interests include mental health and lifestyle medicine. Since her travel to India, Sarah celebrated her marriage to John Phillips on April 6th. The couple will be moving to the Providence area in early June. Sarah grew up in Lenexa, Kansas, and attended Bethel College.*

Are you interested in SET?
Applications now accepted for 2013-14

Applications are being accepted between now and May 15 for the Student Elective Term (SET) Scholarship Program! Any MHF member who is in a masters or doctoral level program in a healthcare profession is eligible. SET participants spend a term learning and serving in cross-cultural mission/service setting in a developing country for at least 4 weeks (6-8 weeks recommended) and typically receive credit for the internship through their program of study.

SET scholarships are funded through the Mobilization for Mission Fund (MFM) with up to $2,000 per student available for travel and living expenses. **All students who are interested in SET for the 2013-14 academic year** should **fill out an application now**. For more information, visit the SET page at http://mennohealth.org/programs/student_term/

Letters from Nepal
by Theo Beels, M.D.

Theo Beels and his wife, Beth, returned earlier this year from three years of service at the Tansen Hospital in Nepal. Following is an edited version of two letters he wrote to supporters.

August 7, 2012

Dear friends,

Last week I was called to the Emergency Room (ER) to see Mina B. She is an 18 year old female who apparently came to our ER about three months ago because of rapidly progressive weakness in the legs. (The family lost the records.) Since there was the distinct possibility that the weakness would progress to involve the rest of her body, she was referred to the nearest full service Intensive Care Unit (ICU), five hours away from us, so that she could receive ventilator support if needed. The family did not follow that advice and took patient home instead.

About a month later she returned to our ER. (Her records were lost again, but one of our pastoral care workers remembered helping with referral.) At this point she was paraplegic and incontinent and had serious bed sores that could not be managed by the surgeon who saw her. Pastoral care made arrangements for her to go to Kathmandu.

Instead, the parents took her home again for an additional six weeks before finally going to the hospital in Kathmandu where she was referred to earlier. On arrival there, they were told that she could not be admitted because of severe pneumonia. She was sent to yet another hospital in Kathmandu, where admission to the ICU was advised. The family decided that they could not afford ICU care and traveled back to Tansen where I saw them in the ER. Along with them was a bag of medicines and two units of unrefrigerated blood that they apparently had been asked to purchase by the Kathmandu hospital before admission.

At this point the patient was severely malnourished, short of breath because of a large pleural effusion with a severely collapsed lung, unable to move her legs and in pain because of the largest, most horrible looking bedsores that I have seen in my life. Deep in the cavities over both hips and sacrum, one sees the bone exposed to the outside world. One of our surgeons saw her with me in the ER and we both agreed that at this point nothing surgically could be done. The family has no money and realistically Mina has only a very small chance to live for another year and virtually no chance to ever walk. So the following questions came up:

- Our charity budget, which some of you have contributed to, is limited. Is it ethical to use a large sum of that money for this one patient, who most likely will not have a good outcome?
- This patient will require intensive nursing care. Is it ethical to admit her so that less nursing care is available to other patients?
- If I admit her to our only isolation room, we will increase the risk to other patients by putting patients with sputum positive tuberculosis in their midst. (In theory these patients wear masks but are not always compliant.)

I broke the rules of rational thinking. All of us who saw her were overwhelmed by the misery of this 18 year old girl and her family. True, they did not follow “medical advice” but that was a result of financial concerns. She now lays in our isolation room, is getting morphine, intense nursing care for her wounds and we are trying to figure out what to do with her

hemorrhagic pleural effusion, providing high protein feedings, emotional and prayer support. These are the patients for whom our hospital exists.

Could we have done things better? Yes, I believe so. If it had been clear from the beginning that the parents were not prepared to take her to the referral hospital, we should have admitted her right at the first visit. Unfortunately, patients and parents may say one thing and do another.

Thank you for your support!

Shalom
Theo

August 28, 2013

Dear friends,

Many of you have responded to the tragic case of Mina B, the 18 year old, paralyzed girl who presented with massive decubitus ulcers. Against my better medical judgment, I admitted her. She required morphine for pain control and intense nursing care. When she became progressively short of breath, she required a chest tube to drain air and pus from her chest. She got nutritional supplements because of her severe malnutrition, antibiotics, and TB meds. Her decubitus ulcers got worse and her hip bone started sticking far out of her wound as there was nothing to keep it in place. While on antibiotics she developed an abscess on her arm that required drainage by surgery. Ultimately she developed a pneumonia that did not respond to medication.

We discussed her situation with the family and gave them the option of taking her home. This is a common practice in Nepal as it is much cheaper to transport a live human being than a dead body. The family chose to leave her with us as, understandably, they felt that they could not care for her at home.

She died the next day.

During the several weeks that she stayed with us she was followed by our pastoral care team who supported her and prayed with her. During this time she confessed Jesus as her Lord and Savior and the head of our pastoral care department conducted a Christian funeral for her with full cooperation of her parents.

So, in retrospect, I am thankful that we had room to care for her. Although she departed early from this life, she did inherit eternal life. Thank you, Lord, and pastoral care!

Shalom,
Theo

Theo Beels, M.D. *is originally from the Netherlands where he did his medical school and family practice residency. He also did a rotating internship in Regina, Saskatchewan, and then in 1977 was sent for three years by Mennonite Central Committee to work for United Mission to Nepal. While in Nepal, he met his wife, Beth, and they were married. Since then, he has practiced in a variety of settings first in Kentucky and then in Grand Rapids, Michigan. He and Beth returned to Nepal in January of 2010 and served for three years with Interserve (http://www.interserveusa.org) in United Mission Hospital Tansen (http://www.tansenhospital.org.np) and Tansen Nursing School, respectively. Since returning to Grand Rapids, he works part time in a rehab unit of a nursing school in Grand Rapids.*

Reflections on *Escape Fire*

Kenton T. Derstine, D.Min.
President, Mennonite Chaplains Association

After viewing *Escape Fire,* the challenging documentary on the state of the U.S. healthcare system recommended as preparation for this summer's gathering of the Mennonite Healthcare Fellowship, several articles on a similar theme crossed my desk(top). The invitation to write this column was the stimulus for me to articulate my perception that the theme of each seemed to overlap with the others and offer a perspective on more than a few of the moral dilemmas within our healthcare system. Perhaps I can also identify some "escape fires."

The central thesis of *Escape Fire* is that it is more accurate to say that here in the U.S. we have a *disease management system* rather than a *healthcare system*. In short, our system is designed for intervention and management of disease processes rather than for disease prevention and health promotion. The result is that despite per capita spending that far exceeds every other country, the U.S. population is less healthy than that of fifty other nations.

Furthermore, the correlation between poverty and disease is striking. The *Wall Street Journal Live* recently identified and reported on the five "fattest" cities in the U.S.. The "winning" metropolis was McCallem/Edinburg/Mission, Texas with an obesity rate of 38.5% as well as the highest diabetes rate (21%) and the highest poverty rate (37.7%) in the country. Thus, poverty itself can be understood as not only a justice issue but a moral issue as it relates to health. In sum, the overarching moral dilemma of our healthcare system is how much is spent and how poor is the health of so many, especially the poor.

Dr. Dean Ornish suggests in *Escape Fire* that 70% of healthcare costs are driven by lifestyle choices. Furthermore, he asserts that many disease processes can not only be slowed, but actually reversed by "changing what we eat, how we respond to stress, how much we exercise and how much love and support we have in our lives." The latter point is consistent with much research in recent years that suggests that the quality and number of family and friend relationships is a significant predictor of emotional and physical health across the life span. It is commonly accepted that increased levels of stress proportionally compromise one's immune system. If we ask about the source of most persons' stress, the answer that is most commonly accurate is one's closest relationships. This idea, I think, should be especially intriguing to Anabaptist Christians with our historic conviction that faithful discipleship in the way of Jesus is most profoundly expressed in how we conduct ourselves in the day to day relationships in our families and communities.

As I was reflecting on this documentary the story of Roseto, Pennsylvania came to mind. First reported in various scholarly journals, I was reminded of this story when it appeared in the "Introduction" of Malcolm Gladwell's *New York Time*s bestseller, *Outliers: The Story of Success.* Roseto, PA became an enclave in the 1950s for a number of Italian Catholic families who had immigrated together and had established an extraordinary quality of cross-generational and extended family life in Roseto, the town they founded together. Significant to the life of this town was their common faith heritage sustained and shaped by their remarkable parish priest.

The nature of this town would have likely gone unnoticed except for a local physician who began to wonder how it was that the people of Roseto had few of the diseases common to

those from other surrounding towns. His curiosity stimulated a research project. Findings revealed that virtually no one under fifty-five had died of a heart attack or showed any signs of heart disease. For men over sixty-five, the death rate from heart disease was roughly half that of the U.S. as a whole. The death rate from all causes in Roseto, in fact, was 30 to 35 percent lower than expected.

A sociologist brought in to guide the research reported in amazement what he found. "There was not suicide, no drug addiction, and very little crime. They didn't have anyone on welfare…these people were dying of old age. That's it." Seeking an explanation, the researchers had to rule out the conventional factors of genetics, diet, exercise and quality of healthcare. They began to hypothesize about the "mysterious and magical benefits of people stopping to talk to one another on the street and of having three generations under one roof."

Gladwell described the challenge these Roseto researchers had in communicating their hypothesis. "No one was used to thinking about health in terms of *community*…they were not able to understand why someone was healthy if all they did was think about an individuals' personal choices or actions in isolation. They had to look beyond the individual. They had to understand the culture he or she was a part of, and who their friends and families were, and what town their families came from. They had to appreciate the idea that the values of the world we inhabit and the people we surround ourselves with have a profound effect on who we are." As the unique communal culture of Roseto broke down through the sixties and the next generation moved on and joined mainstream American culture, disease rates in the following generations reflected that of general society.

What might we learn from the story of Roseto? It would be reasonable to suggest that recreating such a world would be unthinkable. Probably so. However, "outliers" can serve to point toward what is proximately possible—they can point in a direction. Furthermore, we now have an increasing body of science that helps explain what was observed. Recent science and Roseto confirms that we need to look beyond diet and exercise—as important as they are—if we would address the issue of health holistically. Roseto offers the idea that life in community that includes meaningful inter-generational extended family life can make a difference for health. At the same time much recent research suggests that "loving relationships" are at least one component of a health-promoting lifestyle.

One such report that I found particularly intriguing appeared in the *New York Times* on March 15 and was entitled, "Family Ties that Bind." Included in the article was a brief summary of research done at Emory University stimulated by the observation that children who knew a lot about their families tended to do better when they faced challenges than children who knew little. To test this hypothesis they developed a measure called the "Do You Know?" scale that asked children from a random sampling of families to answer 20 questions. Examples included: Do you know where your grandparents grew up? Do you know where your mom and dad went to high school? Do you know where your parents met? Do you know an illness or something really terrible that happened in your family? Do you know the story of your birth?

They then compared the children's results to a battery of psychological tests the children had taken, and reached an overwhelming conclusion. The more children knew about their family's history, the stronger their sense of control over their lives, the higher their self-esteem and the more successfully they believed their families functioned. The "Do You Know?" scale turned out to be the best single predictor of children's emotional health and happiness. They then conducted a similar research project with this group of children after the Sept. 11 attack. Though the families they studied had not been directly affected by the events, all the children had

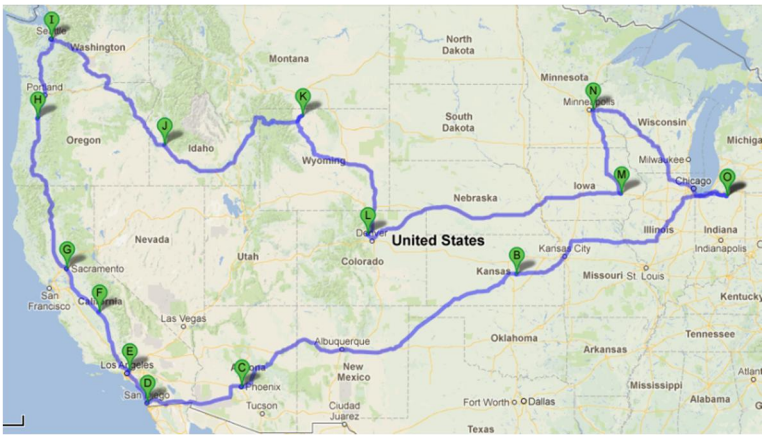
experienced the same national trauma at the same time. The researchers went back and reassessed the children. "Once again," the lead researcher observed, "the ones who knew more about their families proved to be more resilient, meaning they could moderate the effects of stress." The researchers concluded that "…the single most important thing you can do for your family may be the simplest of all: develop a strong family narrative…The answers have to do with a child's sense of being part of a larger family."

Escape Fire challenges to viewer to engage the effort to find a way forward through the crisis of health that our society faces. What might be the "escape fires" that will allow this firestorm to sweep over us without doing us all in? We are challenged to think outside the box—to think creatively and boldly for a way forward. What if we researched how the quality of community and relationships served health as deeply as we have researched the potential of pharmaceuticals and surgical interventions? What if we believed that the science of community and relationships demanded as much research, insight, and skill as brain surgery? Who better to embrace this challenge than Anabaptist Christians?

We have a word for the effort of growing in knowledge and wisdom and love after the manner of Jesus--discipleship. Perhaps we might have within the repository of our theology and history some answers that could show the way. The role of faith as a resource for shaping community and family life also has the effect of serving health. Might we offer this as an *escape fire* for ourselves and our society?

Kenton T. Derstine, D.Min. *is an ACPE Supervisor serving as Director of the Field Education and Clinical Pastoral Education (CPE) programs of Eastern Mennonite Seminary. As an accredited CPE Center, EMS has chaplain interns serving retirement communities and hospital systems in both Virginia and Pennsylvania. Prior to coming to EMS in 2000, he had served three different hospital systems, first as Chaplain Resident, then as CPE Supervisor, for eleven years. Kenton is currently serving as president of Mennonite Chaplains Association.*

MHF Executive Director on the Road



Since Executive Director, Paul Leichty is going west to Phoenix, he is planning some additional travel along the West Coast and then back through Wyoming, Colorado, and the Great Plains. Areas of particular interest are central Kansas; California (San Diego, Los Angeles, Fresno, and Sacramento); Albany, Oregon; Denver, Colorado; Iowa; and the Twin Cities, Minnesota. If you are interested in hosting a **small household reception or a Regional Meeting** in one of these areas, **please contact the MHF Office immediately!** Email info@mennohealth.org.

Moral Dilemmas and Healthcare Ethics
The Future of ACHE

Editorial by Paul D. Leichty, M.Div.
Executive Director of Mennonite Healthcare Fellowship

"Moral Dilemmas in Healthcare" This is the theme for this year's Annual Gathering of Mennonite Healthcare Fellowship (MHF), coming up June 21-23 at Goshen College. As the MHF Board and a special Planning Committee have worked with this theme, we have realized that there are many aspects to the theme and many directions that we could go in our explorations. Obviously, we won't be able to cover everything in one weekend. So one of the questions that will linger is how we can look at some overarching issues and use those as a springboard for exploring other issues.

On the national scene, there has been considerable controversy over the Patient Protection and Affordable Care Act (PPACA) passed by the U.S. Congress and signed into law by President Obama on March 23, 2010. Just prior to last year's MHF Gathering at Laurelville, Pennsylvania, the U.S. Supreme Court upheld most of the provisions of that law and this was a major topic of conversation for the weekend event at Laurelville. Now, many people have their sights set on January 1, 2014, when most of the remaining major provisions of the law go into effect. While some see this date representing a small but significant victory, others are focused on new dilemmas they foresee.

It is important to realize again that there are moral dilemmas, as well as legal, social, and economic dilemmas, that pushed the law into existence in the first place. Mennonite leaders, including leaders from the predecessor organizations of MHF recognized this for some time. As Mennonites have become increasingly involved in healthcare services and the healthcare system, it seemed important to create avenues for discussion and discernment on many increasingly complex healthcare issues.

One of the responses around the turn of the millennium was the creation of the **Anabaptist Center for Healthcare Ethics (ACHE)** in 2001. ACHE was formed as an association of Mennonite organizations and agencies and incorporated in 2003. Mennonite Medical Association (MMA) and Mennonite Nurses Association (MNA), the predecessor organizations of what is now Mennonite Healthcare Fellowship, were among the members of this association.

Under the leadership of Joseph Kotva, ACHE was largely responsible for developing resources, including a booklet called "Healing Healthcare," that propelled a wider discussion in Mennonite Church USA congregations about the issues in the U.S. healthcare system. During the 2005-07 biennium, Glen E. Miller gave leadership to the Mennonite Church USA healthcare access initiative that encouraged these discussions.

Unfortunately, a sustainable funding model for ACHE was never achieved. Staffing and the active work of ACHE ceased on May 31, 2007. From that time until the end of 2012, the corporate structure and some remaining funds were administered by one of the association partners, Mennonite Health Services Alliance. During that period of time major changes were taking place in most of the association partners. In addition to the merger of MMA and MNA to become MHF and the restructuring of MHS into MHS Alliance (now soon to become an agency of Mennonite Church USA), Mennonite Mutual Aid became Everence and AMBS changed from

"Associated" to Anabaptist Mennonite Biblical Seminary. Only Mennonite Chaplains Association kept the same name and structure.

In 2012, MHS Alliance and Everence initiated a discussion concerning what to do about the corporate structure of ACHE. They asked MHF to participate in that discussion. At a meeting in September 2012, it seemed clear to those present that healthcare ethics touches the mission of a number of Mennonite organizations, agencies, and institutions. The question was whether the corporate shell of ACHE should be kept alive and what direction the discussion of healthcare ethics should take in the Mennonite Church.

The other leaders at that meeting challenged MHF to think about whether healthcare ethics is "central" to the organizational vision/mission or just an "interest" of MHF. In response, the MHF Board affirmed that it is central to the MHF mission. It was part of the founding vision laid out by the Implementation Team that put together MHF and it is specifically mentioned on the MHF brochure. It remains a high interest among our Board and our membership and a point of attraction to new members as well. Finally, a prime illustration of its centrality is the theme for this year's Annual Gathering, "Moral Dilemmas in Healthcare."

While the MHF Board realized the centrality of healthcare ethics in MHF's work, they did not see their way clear to develop new programming while still in the start-up phase and having only two half-time staff persons. They suggested, instead, that the discussion of healthcare ethics be incorporated into existing forums. These would include churchwide conventions, Mennonite Health Assembly (MHA), and MHF's Annual Gatherings and Regional Meetings. MHF agreed to give some limited leadership to coordination and consultation on this mutual agenda.

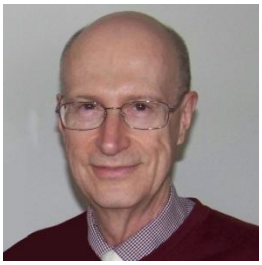
MHF also agreed to a plan to manage the financial assets of ACHE, using them to further the healthcare ethics agenda of the Mennonite Church as opportunities arise. This plan was approved by the association partners of ACHE and the transfer of assets was carried out in early 2013.

What this means for the immediate future is the following:

- **The ACHE Fund will be administered similarly to two mission funds** which were inherited from Mennonite Medical Association (MMA). Both the Mobilization for Mission Fund and the Steven Roth Fund were set up for specific mission-related purposes and the assets of those funds are tracked separately from the operating budget of MHF. When MHF members send in their yearly dues, they are given the opportunity to make additional contributions to MHF operations as well as to these funds. MHF keeps members informed about the assets in those funds and how they are being used. Designated contributions can be received from non-MHF-members as well. The MHF Board also follows MMA precedent and charges a yearly amount for administrative purposes that gets transferred from the fund to the MHF operating budget. This is now how the ACHE Fund will also be administered.
- **ACHE funds will be available to any of the association partners for projects that involve healthcare ethics.** The first such project is the MHF Annual Gathering in June. ACHE will help subsidize the expense for speakers and a larger meeting space so that the discussion of moral and ethical issues in healthcare can be broadened in the Mennonite Church and related groups.
- **MHF members and other interested persons will be given the opportunity to give feedback** to the MHF Board as to what they envision as the future of ACHE. This will happen first at the Annual Gathering in Goshen and the Mennonite Church USA

Convention in Phoenix in early July. Additional means for seeking counsel may also be developed. In addition, MHF members can speak with their contributions as to how much they are willing to contribute to replenish and sustain the ACHE fund. It is hoped that this method of operation could help determine over time whether this is, or leads to, a viable long term model and thus help answer the question of what to do with the ACHE corporate structure.

ACHE is simply a structure used to address a perceived need for a larger Mennonite Church discussion on healthcare ethics. It fulfilled a crucial purpose in the first decade of the new century. It seems clear that the "moral dilemmas" and other issues of Christian ethics related to healthcare have not gone away. Yet, the question remains on what the best means is to continue to discuss and come to discernment on those issues. Readers of *Mennonite Health Journal* are welcome to give their counsel at any time. Address your feedback to the MHF Office at info@mennohealth.org.



Paul D. Leichty, M.Div., *is Executive Director of Mennonite Healthcare Fellowship (MHF). He and his wife, Twila, live in Goshen, Indiana. Paul has been instrumental in founding and/or renewing a number of church-related ministries, including Anabaptist Disabilities Network (ADNet) and the Congregational Accessibility Network. He formerly served as a pastor of churches in Illinois, Indiana, and Pennsylvania and is currently active in music leadership at Berkey Avenue Mennonite Fellowship in Goshen.*