Mennonite Healthcare Fellowship

Mennonite Health Journal

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This issue of *Mennonite Health Journal*

Hearing a presentation in person and being on site to share and discuss the experience with others is the ideal way for Christian healthcare professionals to interact. Mennonite Healthcare Fellowship wants to especially encourage you to come and participate in the **Annual Gathering 2014** which is highlighted in the first article in this issue. (p. 2)

At the same time, we can't all be at the same place at the same time! Thus, *Mennonite Health Journal* presents both summaries of significant events as well as written versions of some of the key presentations at those events.

The lead article, **Empowering Patients: New Paradigms for the Urban Underserved,** grows out of a Regional Meeting presentation by Nathan and Rochele Beachy, physicians in Cleveland, Ohio. (p. 3) **Faith & Healthcare** by Beth Good, was presented originally in a Regional Meeting in Harrisonburg, Virginia. (p. 13) Short reports on these and other Regional Meetings are also presented for information and as a way to encourage other regions to hold their own meetings. (p. 11)

In addition to these more recent meetings, those persons who have attended MHF events in Goshen, Indiana during the past year have probably heard about Dr. Glen E. Miller's upcoming book on preparing for death. That book was published earlier this year and MHJ is pleased to present a book review by Mark Derstine, a chaplain in Pennsylvania. (p. 15)

Mennonite Healthcare Fellowship also cooperates with other Mennonite organizations in the annual **Mennonite Health Assembly** (MHA). MHF Executive Director, Paul Leichty, reports on MHA 2014 held in Kansas City in March. (p. 7) A second report (p. 9) comes from **Mennonite Chaplains Association** (MCA) President, Kenton Derstine, on the chaplains' track of MHA.

In his editorial column, Paul Leichty reflects on **Healthcare and Mission** as he connects the upcoming Annual Gathering 2014 with an even bigger set of events in 2015 as MHF's Annual Gathering is held just prior to Mennonite World Conference Assembly Gathered.

Finally, two presidents reflect on the value of participation in general. Joe Longacher, President of MHF, urges us to go first to the places where we will most likely find the resources—in this case, resources for integrating faith and practice. Murray Nickel speaks to the value of listening to folks at the grassroots level whether in a North American town or city or in a sprawling city or small village in the Congo. May you find blessing as you read this issue!

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Faith at Work: Practicing Our Profession
A Call to Annual Gathering 2014

Mennonite Healthcare Fellowship (MHF) will hold its **Annual Gathering 2014** on the weekend of June 13-15, 2014 at Laurelville Mennonite Church Center, Mt. Pleasant, Pennsylvania. The theme for this yearly event for Anabaptist healthcare workers and their families is **"Faith at Work: Putting our Beliefs into Practice."**

The Annual Gathering will focus on how Christian faith calls, moves, guides, and sends healthcare workers into their everyday work world. Featured speakers include Scott Holland, pastor, teacher, and narrative theologian who currently teaches at Bethany Theological Seminary; Tim and Jen Leaman, a physician and social worker living in the Oxford Circle neighborhood of Philadelphia, and J. Melvin Janzen, a chaplain in the University of Virginia Health System.

Worship and music for the event will be led by Jim and Angie Clemens of Dayton, Virginia. Each plenary session will begin with an engaging worship experience featuring music in a variety of styles. Jim and Angie are involved in composing, engraving, and teaching music in the Harrisonburg area and between them play a variety of string, wind, keyboard, and percussion instruments.

Following the Saturday morning plenary session, three workshop sessions will give attendees the choice of a variety of topics related to the "Faith at Work" theme. Workshops will explore "Mission, Intercession and Neighboring;" the overseas experiences of medical students through MHF's Student Elective Term; "Faith, Food, and Health" including gardening in both rural and urban settings; spiritual struggle in the midst of illness or injury; and the differences in approach toward mentoring or facilitating the development of emerging healthcare professionals. Participants will also be given the opportunity to help MHF leaders shape the future of the organization to better serve its members toward the mission of the integration of faith and professional life.

After time for recreation, relaxation, and fellowship on Saturday afternoon, the evening's plenary session will feature a panel of persons sharing their experiences in living out their faith amidst the challenges and opportunities in a variety of contexts. Panelists include a physician in transition, a social worker and coordinator of a community program, and graduate students in both the medical and dental fields. Saturday's activities conclude with a traditional ice cream social, followed a hymnsing led by the Clemens.

A Children and Youth Program for ages 0-18 is planned to coincide with all plenary and workshop sessions. Theresa Wolf from Johnstown, Pennsylvania, is coordinating the Children and Youth Program using a wilderness journey theme.

Further information and registration is found on Mennonite Healthcare Fellowship's website at www.mennohealth.org/gathering. New members are welcome to register. Inquiries are also welcomed by phone at 1-888-406-3643 or by email at info@mennohealth.org.

Empowering Patients
New Paradigms for the Urban Underserved
Nathan Beachy, MD

Editors Note: This article is based on a based on presentation given by Nathan Beachy, MD, and his wife, Rochele Beachy, MD, at the MHF Regional Meeting held on March 29, 2014 in Dalton, Ohio. See biographical statement at end of article for more information.

A story is often told of a group of water rescue workers who came to a rapidly flowing river. They immediately found a person who had fallen in and was in danger of drowning. Putting their skills into action, they proceeded to rescue the person and bring him to safety. No sooner than the man was safe and sheltered, there came the cry of another individual in the same desperate straits in the midst of the river rapids. So naturally, they rescued that person as well.

Based on their experience on day one, the rescue workers decided to stay around for another day and make sure others were safe. Sure enough, by mid-morning they pulled out two additional people and by the end of the day, four more. The rescue workers decided that a full-fledged rescue station was needed and so they established a permanent presence in that location. The work continued, as with compassion and care, this tiny group of persons rescued more and more people from the churning stream.

One day, after a particularly grueling stretch of one rescue after another, one of the workers got up and walked out. "Where are you going?" the rest yelled. "There are still many more people to be rescued!" "I'm going upstream," the worker yelled back. I want to find out why so many people are falling into the river in the first place!"

"Going upstream" is a metaphor for new paradigms that are emerging in America today, especially in the area of healthcare. In the United States healthcare system, we spend at least 30 percent more than any other healthcare system in the world although study after study tells us how much money and effort we could save if we would "go upstream" and focus as hard on preventing illness as curing it. Going upstream would include immunizing all our children, being sure that pregnant mothers were well nourished, getting a reasonable amount of exercise, and recognizing that tobacco, alcohol, sugar, and most junk foods are slow poisons.

At the Mennonite Health Assembly in Atlanta in 2003, Dr. David Hilton was the keynote speaker. Dr. Hilton had spent ten years in rural northeastern Nigeria doing several surgeries a day and watching over 90-100 inpatients. He said that he had a moment of clarity when he looked at the health of the community in year ten and realized that the people he served were no healthier than when he arrived. Yes, he had helped some individuals, but the general health of the population had not changed.

It was then that he looked at the definition of health from the World Health Organization (WHO). WHO defines health as a "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This has been WHO's definition since 1946 and it has not changed.

Some years later Dr. Hilton lived and worked in Geneva where he had many contacts at WHO. He discovered that despite the definition cited above, he could not find anyone there who even knew anyone that was working on the sense of well-being. Everyone was working on a specific disease.

Why do I tell you all of this? What does it have to do with empowering patients in underserved urban areas?

I knew that I should really find ways to look upstream. Yet, during the day I was busy seeing patients at an office a few miles from our house on Cleveland's east side. Often, I wasn't finished documenting what I did until late into the evening. (Thanks to electronic medical records, the documentation can now be done at home.) Yes, I did try to listen very intentionally to each of my patients per Dr. Hilton's statement that listening well may be the most important thing we do. But I was so busy "operating the rescue station" that I didn't have time to look "upstream."

A year and half ago I was presented with the opportunity to do health care in a different way. I moved from a satellite MetroHealth facility to the MetroHealth Medical Center. Rochele stayed at the satellite office we shared with 4-5 other providers and although she had a full patient panel often took on the patients I had cared for during the previous 15 years. This was a mixed blessing. I often heard about the difficulty "my patient" had caused her, but also heard through her that I was deeply missed. I had initially suggested that she come join me at the main campus, but it was apparent to us both after a few months that we (mostly Rochele) were needed and deeply appreciated in our community. Not everyone gets to hear that while they are alive.

My new work resulted from a grant called MEDTAPP (Medicaid Technical Assistance and Policy Program) which was initiated by Ohio Governor John R. Kasich as a way to spread Patient-Centered Medical Homes (PCMH) to urban underserved areas and attract primary care providers to work in those areas. My job was to implement a PCMH model. I was seen as having expertise because I had studied the PCMH model after hearing Dr. Doug Eby speak at a Mennonite Medical Association / Mennonite Nurses Association convention in Colorado.

Doug has been in Anchorage, Alaska for over twenty years and works for the Southcentral Foundation, an Alaska Native-owned nonprofit health care organization. Southcentral Foundation assumed responsibility for the healthcare of native Alaskans in their region from the Indian Health Service in the late 1990s. They have implemented a healthcare system that exceeds the PCMH model and is recognized internationally and nationally, winning the Malcom Baldridge award for healthcare in 2011. I call it PCMH 8.0 when I discuss it with medical students and residents.

In the summer of 2012, Rochele and I were able to go to Southcentral Foundation's conference on the Nuka system of care and in good Mennonite Your Way fashion, stayed with Doug and his wife Rosene (who happens to be my second cousin). So from here on, if you read something compelling in this article, Doug or someone at Southcentral Foundation probably said it first.

As I moved to MetroHealth and started work on the MEDTAPP grant, we researched novel ways to deliver care outside the normal office visit. These included shared medical appointments or group visits, team based care, using behaviorists as an integral part of the care team, home visits, and focusing on "superutilizers." Here, I would refer you to some of the work that Dr. Jeff Brenner has done in Camden, New Jersey which was highlighted in a New Yorker piece by Dr Atul Gawande called "The Hotspotters" " (Gawande, 2011).

Our approach was to do all these things at once: to have group visits of super-utilizers with a team based approach using behaviorists incorporating the principles of a PCMH. Those principles include:

- Patients having a personal physician
- Healthcare with a "whole person" orientation
- Increased quality of care
- Increased access to care
- Care that is integrated and coordinated among all providers
- A different payment model

One caveat is that our "different payment model" was that the grant paid our salaries and we were not able to bill Medicaid; however, we were implementing all the other items on the list to some extent.

Our team was two full time physicians, two full time social workers, a program coordinator who had been a medical assistant prior to this assignment, and a registered nurse who is a care coordinator. We also use a dietician especially for a diabetes group, a yoga instructor for chronic pain, and additional guests as well. Medical students are often part of the group for a month or two and they are required to give a presentation to the group on a medical issue.

We used our electronic medical records to find out which patients had high emergency department and/or hospitalization rates. Our social workers contacted them and did an interview and invited them to come to group visits. We had to contact approximately 30 patients to get a group of 5-10 patients. The groups were divided by condition, namely COPD, chronic pain, and two diabetes groups. They meet weekly for 6 weeks and then have a week off and then we repeat.

We have seen marked reductions in hospitalizations and emergency department visits. Other things that we are measuring include self-reported depression, anxiety and self–efficacy scores all with validated standard scales such as the PHQ-9. We have seen marked improvement in every parameter.

What do we do in the groups?

The first thing that we do is to make sure the group is a place where patients' control is recognized. We review the WHO definition of health and state that this group is about finding "health" or "well-being" in the context of their chronic condition. We discourage providers from wearing white coats or ties as a way to "level the playing field." We have the group set the rules, which usually include being respectful of each other, no interrupting, no cursing, etc. We also make sure that everyone knows the importance of maintaining confidentiality. We have some topics that we touch on with every group such as optimizing sleep patterns, mindfulness, forming habits, and the science behind habits.

There are other topics that are condition-specific such as inhaler use for COPD patients, yoga for the chronic pain group, and a diabetic diet for the diabetes groups. However, many topics we discuss are generated by the groups. They may want more information on garcinia cambogia, for instance, so we do research from a credible source and give them the information they need to make a decision.

Why does this work?

Dr. Eby has a graph that he shows with **acuity**, or how sick a person is, on the X axis and **control** over decisions that affect one's health on the Y axis. Then there are two lines on the graph one representing the patient (or "customer-owners" as they call them in Alaska) and the other line representing the healthcare system. What the lines show is that when acuity is high the

system/doctor is in control. This would be in the emergency room, the operating room, or in an acutely ill hospitalized patient. However, when acuity is low, which is most of the time, the doctor is not in control at all. It is the patient who has the control, albeit influenced by their culture, their family, and all the other things they encounter on a daily basis.

Often in outpatient medicine, because of the way we as medical professionals are trained, we still act like we are in control. We may see a patient once every three months for 10-15 minutes and we tell them to eat right, exercise, and take their meds correctly, and then we expect that they will do it just like we said. That just does not usually work, in my experience. When we consider that 70 percent of healthcare is delivered as outpatient care and yet we use a model of delivering care that does not take into account the truth that the patient is in control, it is no wonder that we get less than optimal results. In the groups, I have discovered that patients are much more likely to believe each other than me, because the other person knows what they are going through in a way that I cannot. I am there to serve as a referee and make sure that what people are taking away from the group is accurate and useful in some way.

The inpatient high acuity situations are often handled in a very proscribed fashion. That means there are protocols and we assume we just have to get the protocols right, improve them, break down every step, and figure out the most efficient way to carry out that process. This has been likened to throwing a stone at a target. In that situation it is all about doing it the same way every time. We should gauge our arm velocity, our release point, and the angle of our arm so that it is as close to identical every time. That works well in those high acuity situations.

In the outpatient setting, where most healthcare happens, it is a different situation. This can be likened to throwing a bird at a target, and as soon as you release the bird, it can go anywhere it wants to. That means that our jobs are much more about coaching and making the target more attractive. One of my medical students suggested to me that we could just throw the bird really hard. It seems to me that is what our health system already does in many cases. If our "birds" don't fly straight to the target that we (the healthcare providers) have determined should be their destination, then we call them noncompliant and the opportunity to significantly improve their health fades.

Partnering with our patients to map out their health journey is time-consuming, but is likely to give better results in the long run. The other thing about birds is that they travel in flocks and we ignore the power of groups to change behavior at our peril. One of my favorite African proverbs is this one: "If you want to go fast, travel alone; if you want to go far, travel with a group." Empowering patients is thus, not so much about struggling to get individuals into compliance as it is in building together more healthy communities.

Citation:

Gawande, A. (2011, January 24). The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? Retrieved May 13, 2014, from The New Yorker: http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande?currentPage=all

Nathan and Rochele Beachy *have been practicing Family Medicine the past 20 years at MetroHealth, the county hospital in Cleveland, Ohio. Prior to that they served a 3-year term with Mennonite Central Committee as rural physicians in Panyam, Nigeria. They returned to Nigeria for 6 months in 2003 to work at Faith Alive, an HIV clinic in Jos. They are members of Lee Heights Community Church and have three children: Jared 24, Marita 22, and Caleb, 20.*

Report from Mennonite Health Assembly

Paul D. Leichty

Mennonite Healthcare Fellowship (MHF) often gets confused with other entities that have "Mennonite" and "Health" in their names. As Executive Director of MHF, I often explain it like this:

Mennonite Health Services (MHS) has created an **Alliance** of **organizations** that generally serve their local communities with health-related ministries but seek to retain the values and connections with the larger church.

Mennonite Healthcare Fellowship (MHF) is an organization of **individuals** seeking to integrate their faith and professional life wherever they work and serve.

Once a year, these organizations come together in an event called **Mennonite Health Assembly** (MHA). This year, MHA was held on March 6-8, 2014 in Kansas City, Missouri. MHS takes the lead in planning MHA. However, MHF also has representatives on the MHA Planning Committee as does Mennonite Chaplains Association (MCA), whose report can be found elsewhere in this issue. Everence provides financial support for MHA.

While Mennonite Health Assembly tends to shape its program around the leadership and governance needs of the member institutions of MHS Alliance, there is always something useful for individual healthcare professionals as well. This year's theme of "Pioneers, Partners, and Pathways" provided some particularly interesting content.

Myron McCoy, President of the nearby Saint Paul School of Theology brought the opening keynote address against the backdrop of the story found in Genesis 12 of Abram as a pioneer. McCoy proceeded to discuss how his institution stepped out into the unknown and built new partnerships in order to better meet the leadership needs of its church constituency.

Friday's luncheon presentation by Teresa Cutts was of particular interest to healthcare practitioners, particularly in light of changing paradigms being accelerated by the implementation of the Affordable Care Act. She talked extensively about the Congregational Health Network model implemented in Memphis in which hospital, churches, and the community as a whole entered into partnerships which resulted in building long-term relationships with community residents to serve their healthcare needs in a holistic way. She stressed partnerships built on trust and covenant and recognizing the need to operate in two modes of language: both "hospitalese" as well as the faith language of the persons served. As people of faith she asked the audience to consider the question, "How can we partner to create the Beloved Community of Health?" She also made reference to a larger study of this type of model outlined in a "Health Systems Learning Group Monograph" available online.[1]

The final plenary presentation was given by Rick Stiffney, CEO of Mennonite Health Services, who spoke about pathways to the future. He used the imagery of the Apostle Paul on the road to Damascus as his conversion experience led on a pathway to a transformed reality,

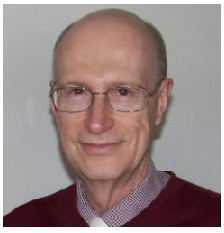
[1] Health Systems Learning Group Monograph. Accessed on May 16, 2014 at http://www.methodisthealth.org/files/faith-and-health/HSLGembargoedmonographApril42013.pdf

going from being blinded to having the scales fell off of his eyes. Stiffney referred to several ways of considering the metaphor of "pathway" in the work of guiding healthcare-related institutions into the future. Pathways as **strategy** helps to consider which way we will forge into the future. However, pathways as labyrinths invite reflection and deeper search for meaning. Pathways are thus seen as an invitation to spiritual reflection as we pay attention what God is up to in our journey.

Workshops were also an integral part of Mennonite Health Assembly. One of particular interest to individual practitioners was by Jeanette Nisly, a nurse currently living in Oregon, entitled "Health Promoters as Practitioners: Lessons from Guatemala." Nisly shared from her Masters program work at Eastern Mennonite University in which she studied the results coming from a program in which she herself participated. In this model, where there were only eight physicians in a large but remote region of Guatemala, an organization related to the Catholic Church was able to train lay "health promoters" whose work had a demonstrably positive effect on the health of the people in the villages it served at only a fraction of the cost of traditional systems.

A new feature at MHA this year was called "Open Space" which allowed Assembly participants to talk together about topics of their own choosing. MHF took advantage of this time to invite Dr. Joseph Duerksen to share his reflections on 100 years of Mennonite health work in India. Duerksen himself served in India for many years and is still involved in the leadership of the Emmanuel Hospital Association, which directs the work of many small Christian hospitals in the country. His talk and slide presentation was a fascinating blend of history, culture, and the practice of medicine in India.

Next year, Mennonite Health Assembly will be held March 5-7 in Cincinnati. MHF wishes to express its appreciation to Don Tyson of Harrisonburg, Virginia for his work on the MHA Planning Committee, first on behalf of Mennonite Nurses Association (MNA) and then for MHF. Current MHF members on the MHA Planning Committee are Wanda Thuma-McDermond and Carol Spicher.



Paul Leichty *is Executive Director of Mennonite Healthcare Fellowship (MHF).*

Mennonite Chaplains Association

President's Reflections

Kenton T. Derstine, DMin

"Pioneers, Partners, and Pathways" was the theme of the recent Mennonite Health Assembly held on March 6-8, 2014 in Kansas City, Missouri. Within the larger Assembly and paralleling focused workshops for other professional disciplines were a series of workshops especially intended for chaplains. The gift of this Assembly for chaplains and especially these workshop settings was the opportunity to (1) become more acquainted with the pioneers in our field, (2) enrich existing partnerships and envision new ones, and (3) stimulate our imagination regarding future pathways in ministry.

Our series of workshops opened with a session designed as an "open space" for each chaplain to report on a "best practice" that had become an effective piece of his or her ministry. Emerging for particular discussion was the effort among the various retirement communities to provide ongoing grief support to families following the death of a loved one. The grief resources developed by Rebecca Hauder were highlighted and are being utilized by several communities. Chaplain Bob Keener reported on the "Celebration of Life" ritual practiced at Menno Haven immediately following the death of a resident that includes available staff and family. Variations on this practice were discussed and stories shared indicating the value of such a practice for all involved. Chet Yoder of Garden Spot Village reported on his offering a free and open forum called "Faith Crumbs and Coffee" for discussion of issues and questions related to faith.

This "Best Practices" session was roundly applauded not only as a time of cross-fertilization where the group could learn of the pioneering efforts of colleagues, but as a time to become more deeply acquainted and build partnerships as friends and colleagues.

Following this initial time was a session roughly billed as our Business Meeting for Mennonite Chaplains Association (MCA). It included various elements that highlighted our partnerships and explored future pathways for MCA. Those gathered were blessed to have Nancy Kauffmann, Mennonite Church USA Denominational Minister as a special guest through these workshop times. Her presence signified her confident assurance of the awareness of and support by denominational leadership for chaplains. One practical aspect of her role is the call process for pastors. She inquired regarding the value of developing a Ministerial Leadership Information form designed especially for persons seeking positions as chaplains as well as institutional search committees.

Paul Leichty, Executive Director of Mennonite Healthcare Fellowship (MHF) described the emergence and mission of this new organization intended for all healthcare professionals. A warm invitation was extended to all individual chaplains to consider joining MHF and to attend the Annual Gathering to be held at Laurelville Mennonite Church Center in June on the theme, "Faith at Work: Practicing Our Profession." Further discussion explored how membership in MHF is an opportunity for chaplains to more actively embrace their identities as healthcare professionals and to become partners with others around shared concerns arising from our common faith perspectives.

A highlight for many of us was Rebecca Hauder's workshop, "Mending the Body, Mind and Spirit: A Wholistic Approach to Grief and Loss." Rebecca can be considered a pioneer in the area of grief and loss as she has developed materials and a program for institutions and congregations to provide comprehensive and sustained support to the grieving. Attention was called to her website at www.resourcesforgrief.com to learn more.

Finally, chaplains gathered at Mennonite Health Assembly also gave time to explore the pathway ahead for Mennonite Chaplains Association as an organization. While there are over 200 names on MCA's email list, there are fewer than 30 actual members and fewer still who attend the annual meeting at Mennonite Health Assembly. MCA's purpose as an organization is to be "… a network of chaplains and pastoral caregivers called by God as followers of Jesus Christ, committed to the Anabaptist faith perspective, providing fellowship, support, collaboration, collegiality, educational opportunities, and resources for ministry."
As the current President of Mennonite Chaplains Association, I believe this is lofty and worthy purpose, one that should not be abandoned. Yet the question remains as to how to fulfill this mission. Drawing upon the theme of the overall Mennonite Health Assembly in Kansas City, it is clear that MCA cannot develop this vision without "Pioneers, Partners and Pathways." MCA will need hear and support the Pioneers among us, to grow our partnerships with chaplain colleagues and, as an organization, more actively build partnerships with others. The time in Kansas City accomplished each of these. Much more work lies ahead. I invite you to please contact me or anyone on the Executive Committee with your ideas about how Mennonite Chaplains Association might better fulfill its mission.

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 and is a member of the Mennonite Healthcare Fellowship Board of Directors.*

Regional Meeting Reports

A Busy Spring for Regional Meetings

Paul D. Leichty

March 2014 was a particularly busy month for Mennonite Healthcare Fellowship Regional Meetings. Here are reports on what happened:

Iowa City, Iowa – March 5, 2014

Mennonite Healthcare Fellowship (MHF) held its first Regional Meeting in Iowa on Wednesday, March 5, 2014, at the home of Nyle and Lauralee Kauffman near Iowa City. Ten persons gathered for a delicious home-cooked dinner and heard Paul Leichty, MHF Executive Director, share about the work of MHF. Participants in the meeting also shared briefly about their own work.

Newton, Kansas – March 9, 2014

Mennonite Healthcare Fellowship (MHF) held its first Regional Meeting in Kansas on Sunday afternoon, March 9, 2014 at Shalom Mennonite Church, in Newton. **Matthew Schmidt**, LSCSW, Executive Director of Health Ministries Clinic, was the featured speaker on the subject of **"Integrated Health Care: One Mind, One Body, One Patient."**

Health Ministries Clinic, a Federally-Qualified Health Center, has instituted a model of integrated care that involves multiple health care providers working together with a patient-centered focus, often bringing several disciplines together into a single patient encounter, with the goal of capturing the patient in their current visit. Schmidt detailed the benefits of the integrated model, and several of his staff members also commented on how it is being implemented at Health Ministries Clinic, which is in Newton. Several dozen attendees from a variety of disciplines showed keen interest in the model which involves the ongoing collaboration between behavioral health, medical, and dental services.

Paul Leichty, MHF Executive Director, also shared briefly about MHF's mission to be an interdisciplinary community of Anabaptist health professionals. Refreshments were served following the presentation.

Harrisonburg, Virginia – March 21, 2014

Mennonite Healthcare Fellowship held its most recent Regional Meeting in Harrisonburg, Virginia on Friday, March 21, 2014, at Martin Chapel, on the campus of Eastern Mennonite Seminary. Beth Good provided the evening presentation entitled “Public Health and Faith.” (See elsewhere in this issue for a summary of the content of her talk.) Approximately 90 persons attended the meeting which included a discussion time with the speaker and refreshments following the presentation. Good is the Health Coordinator for Mennonite Central Committee (MCC) for global health projects. Her work has primarily been with HIV/AIDS and other public health issues. The subject of Beth’s PhD dissertation is sexual gender-based violence in conflict-affected settings.

Dalton, Ohio – March 29, 2014

Mennonite Healthcare Fellowship (MHF) held its first Regional Meeting in the Kidron, Ohio area on Saturday evening, March 29, 2014, at the Das Dutch Kitchen in Dalton. Almost 50 persons enjoyed a delicious meal funded by a small group of MHF members.

The featured speakers for the after-dinner program were Nathan & Rochele Beachy, physicians in the Cleveland area, speaking about **"Empowering Patients: New Paradigms for the Urban Underserved"** (See article based on their presentation elsewhere in this issue.)

Shorter informative reports were given by Dr. Olivia Wenger of New Leaf Clinic for Special Children and Mark Leinbach, Director of SpringHaven Counseling Center in nearby Mount Eaton.

MHF Board members were also present, having had their Board meeting during the day at Kidron Mennonite Church. Vice-president Eric Lehman welcomed the group gathered who came from a variety of disciplines. Paul Leichty, Executive Director of Mennonite Healthcare Fellowship rounded out the evening by encouraging attendees to join MHF and come to the Annual Gathering in June.

Special thanks goes to Elton Lehman and his committee for planning a unique Regional Meeting!

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Faith & Healthcare

Beth Good, PhD (candidate), APHN-BC, CNS, RN

I recently attended an event for someone who was retiring from a church leadership role. During the service, I was surprised to learn that this person had started out in a different "secular" career, but left that for a "higher calling." When this statement was made, spontaneous applause broke out. I wondered what we were applauding. I could absolutely applaud the excellent job this person had done in the years of service in church leadership. But did the applause somehow reflect our attitude that the only true and honorable "ministry" is through church leadership?

I am not saying that a person who starts in one career direction should never change, or that church leadership is not a worthy endeavor. I also have no desire to question this particular person's call to change career paths. My only question is, "Is church leadership the only faithful ministry?"

This question has been a dilemma for me over the past several years. I am a nurse. It is my "calling" (higher or otherwise). When I wash and dress the malodorous wounded feet of a man without a permanent home, it feels like holy ground to me. When I work with international partners who are helping to prevent mother-to-child transmission of HIV, it feels like a "higher calling."

Historically, the lines between ministry and a vocation in the care of the sick appeared less dramatic than they do today. Though the details are disputed, many historians agree that in the fourth century some of the first hospitals were built due to the influence of Christians responding to the care of the poor and the ill. The care given in these early hospitals prompted Emperor Julian to remark, "Now we can see what it is that makes these Christians such a powerful enemy of our gods. It is brotherly love which they manifest toward the sick and poor."

Fast forward to the 18th and 19th centuries that brought significant changes in healthcare and the use of a more professional system for treating and curing illnesses. It was also was the beginning of an unfortunate rift between the work of the body and the spirit. (Risse, 1999). Before the civil war, a pastor was most likely the first person one would go to for care. John Wesley, best known as a preacher and founder of the Methodist tradition wrote extensively about the medical treatments he employed in caring for the sick as he traveled for ministry (Rogal, 1978).

Industrial growth and immigration brought with it a myriad of serious social issues of which healthcare was just one of the problems facing the most vulnerable. The churches responded with many hospitals bearing the name of the denomination that sponsored them.

It is only in the last 30 to 40 years that healthcare has shifted in the United States from a social service for the most vulnerable to a $1.7 trillion industry (US Census Bureau, 2013). In developing countries, however, church-based health centers still may provide up to 70% of care (WHO, 2007). Even in the United States, many who are unable to afford healthcare rely on faith-based clinics.

Healthcare is part of our history and our future as people of faith. Health-related professions may be our job or our calling…or maybe it is both.

Citations:

Risse, G. B. (1999). Mending Bodies, Saving Souls: A History of Hospitals. New York: Oxford University Press.

Rogal, S. (1978). Pills for the Poor: John Wesley's Primitive Physick. Yale Journal of Biology and Medicine, 81-90.
US Census Bureau. (2013, 4 21). Health Care Industry Statistics. Retrieved from Statistic Brain: http://www.statisticbrain.com/health-care-industry-statistics/
WHO. (2007). Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa. Washington: WHO.

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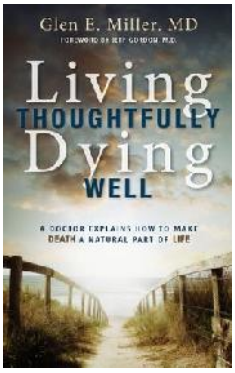
Book Review: Living Thoughtfully, Dying Well

Reviewed by Mark Derstine, MDiv



Living Thoughtfully, Dying Well:
A Doctor Explains how to Make Death a Natural Part of Life

By Glen E. Miller, MD, MATS
Herald Press, 2014

Reviewed by
Mark Derstine, MDiv

Although each of us knows that death is inevitable, there continue to be powerful emotional barriers to talking about and planning for our own death. It is much easier to put time and effort into how our financial assets are to be handled when we die than to plan for how we want ourselves to be treated in our dying. Despite the increased use of advance directives for expressing medical treatment wishes, an increasing desire in the medical profession to honor an individual's treatment choices, and even with more awareness and acceptance of hospice care at the end of life, the pressure to continue fighting against death in the face of all odds has not diminished in our society.

A recent report by the Pew Research Center's Religion & Public Life Project found that today 31% of U.S. adults said doctors should do everything possible for a patient, even in the face of incurable illness and pain. What is so surprising about this statistic is that it is nearly double the percentage who expressed this view compared to a study done 23 years earlier in 1990. The same study also found that the majority of U.S. adults (66%) still say that there are circumstances when a patient should be allowed to die. However, the never-say-die view calling for nonstop aggressive treatment had increased across every religion, race, ethnicity, and level of education. (Pew Research Center, 2013)

It is this concern that Dr. Glen Miller addresses so helpfully in his recently published book, *Living Thoughtfully, Dying Well: A Doctor Explains how to Make Death a Natural Part of Life*. What makes Miller's presentation in the book so helpful and influential are the multiple "insider" perspectives from which he shares.

First, Miller shares out of his own **personal** insider experience as a survivor of two heart attacks, a cardiac arrest, and bypass surgery. Because of these experiences, he lives with thankfulness for each day but also at peace in the preparations he has made for his death. In the sharing of his own story and numerous stories of others facing difficult medical decisions, it is possible for readers to discover and evaluate their own values in making end of life decisions.

Miller also shares from his extensive insider experience and expertise in the **medical profession.** His work as a doctor specializing in internal medicine has given him experience in relating to patients and families in illness and death. Furthermore, his work in hospital administration and personal service in the United States and several other countries enable him to speak to both the amazing advances in medical treatment as well as how these ever increasing options for prolonging life can rob individuals and their family members of experiencing a dignified death.

While Miller is supportive of the continued advances in medical treatment, his great concern is that there is a critical point when facing a terminal illness that the attention should be focused on dying well rather than being subjected to continued medical and life support procedures. Miller states that doing more is not always better in health care. In fact, doing more can harm patients, generate excess costs, and defy patient preferences. Miller helps us see how this is especially true in our time of dying when we may often suffer from too much medical care.

There is another important insider perspective that Miller brings to his concerns about dying well. This is his **clear Christian faith** that informs his personal and professional life. In fact, Christian faith undergirds all of his life and thus, also, his approach to death. While he is clear in the book about sharing his faith and values from an Anabaptist/Mennonite orientation, he includes numerous faith stories and perspectives from other Christian traditions as well. In one chapter, he shares various ministry approaches to care for persons who are dying as practiced among Catholics (Benedictine Monks), Eastern Orthodox, Mennonite, and Pentecostal faith communities.

Miller states, "The thesis of this book is that everyone deserves a good death and a good death requires planning." Miller recognizes that how and when one dies may often be beyond an individual's control. Death may come within a few minutes of a catastrophic event, or it may occur after many months or years of cancer or other chronic illness. Yet his conviction is that however death occurs, we can often affect the experience of dying for ourselves and family members by how we have planned and prepared in advance. If we wait until we face a health crisis and are suddenly caught up in the pressure of making medical treatment decisions, we will be unprepared for making choices which reflect the values and theology that have guided our life. Planning for a good death is really what Miller means by "Living Thoughtfully."

Planning for a good death means being able to talk about death. Miller has written this book to get us talking about death--talking with our spouses and other closest family members and talking with others in our church communities. How does our Christian faith affect our health care decisions? When is it appropriate to say "no" to more medical tests and treatment options that may prolong life briefly but diminish the quality of life and our ability to experience a good death with those we love? Questions and suggestions for discussion are provided at the end of each chapter. These can be useful in facilitating conversations by families and by groups about choices and a good death.

So who can most benefit from the guidance and resources provided by Miller in this book? In my own experience of serving as a chaplain within a senior adult continuing care community, it is clear that when we reach this stage of life, we will be faced most directly with increased health difficulties and the reality of planning for our death. While I have experienced a greater readiness for many to do some pre-planning of funeral details, that is only addressing one's wishes for the arrangements after death occurs. Miller is addressing a much more important dimension of how we want to be treated in our dying.

I have often been saddened when these conversations have been delayed too long and such conversations are no longer possible due to age-related illnesses and dementia. Miller gives the amazing statistic that for 85 percent of elderly patients, a family member or another person will make end-of-life decisions for them. This makes a compelling case that often it is the adult children who need the resources of Miller's book to take the initiative in initiating these difficult conversations with their aging parents. Best of all is when older and younger generations read

and learn from this book together so that dying well becomes a source of renewed faith and love together in Christ.

Pew Research Center. (2013, November 21). Views on End-of-Life Medical Treatments. Retrieved from Pew Research Religion & Public Life Project: http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/

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Healthcare and Mission

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

The theme for this year's Annual Gathering is **Faith at Work: Practicing our Profession**. It is a theme that speaks directly to a key purpose for the existence of Mennonite Healthcare Fellowship (MHF), the integration of faith and professional life.

MHF's predecessors, Mennonite Medical Association (MMA) and Mennonite Nurses Association (MNA), had much the same purpose albeit from a different angle. Today, professional life is taken for granted and it is often the church which challenges the young professional to stay rooted in the church. In the 1940's, being a Mennonite and becoming a nurse or a doctor still carried with it the suspicion of worldliness which was placed on higher education in general. So although the church wished to retain its young adults, it was often up to the Mennonite student turning professional to convince the church that he or she could actually be a Christian (in the Mennonite understanding) in the midst of his or her development into a doctor or nurse.

One way for the early MMA and MNA members to make their case was to link up with the growing mission movement in the 20th century Mennonite Church. A key method of demonstrating the compatibility and thus the integration of faith and professional life was to become a medical missionary. While there was a recognition that not everyone was called to be an overseas medical missionary, that calling was still considered the pinnacle of the integration of faith and medical professions. A calling to medical mission was to be lifted up, encouraged, and financially supported by the whole membership of both organizations.

Mennonites who became physicians prior to World War II generally left their communities and the Mennonite Church. Following World War II, the growing movement toward relief and service through Mennonite Central Committee (MCC), as well as medical missions through the various mission boards, gave persons trained in medicine places to serve within the church structures. (Amstutz & Wiebe, 1989) Indeed, the annual mission board meetings were the early gathering places for missionary nurses that formed themselves into MNA. MMA also had some early meetings at the mission board meetings. (Brief histories of both MMA and MNA are linked from http://mennohealth.org/about/history/.)

Both MMA and MNA took steps to keep the importance of medical missions in front of their members. MNA took regular offerings at its yearly meetings which went for mission purposes. MMA began a Student Elective Term (SET) to encourage medical students and residents to do a term of service and learning in an overseas mission setting as a part of their education. To fund this initiative a Mobilization for Mission (MFM) Fund was set up separately from the main MMA operating budget in order to fund SET and other mission-related projects. SET alumni and others continue to give generously to MFM in its restructured format under Mennonite Healthcare Fellowship (MHF).

Two deaths sparked additional giving for missional purposes. In June 1964, Mary Jean Yoder had just graduated from medical school with the goal of following her father, Dr. Jonathan Yoder, into medical mission work in India when her life was cut short by a tragic automobile accident. An endowment fund was established in her name through Mennonite Board of Missions (later integrated into Mennonite Mission Network) with the cooperation and participation of MMA. It had the forward-looking goal of assisting international students associated with Mennonite mission efforts to obtain further education.

The untimely death of medical student, Steven Roth, in December 1990 sparked an additional mission fund administered by MMA which was first intended to assist new physicians to go from medical school and residency into the medical mission field, as Roth himself intended to do. However, the fund was little used, and in 2013, MHF merged it into the Mobilization for Mission Fund.

In order to utilize these funds, it was necessary to rely heavily on overseas medical mission contacts. The SET program usually placed students with mission hospitals which were established, supported, or at least known by Mennonite mission agencies. Students were usually supervised by physician preceptors who were missionaries from North America and could help bridge the gap for students between their North American medical education and the culture and norms of the mission location. The Mary Jean Yoder Memorial Endowment Fund relied on North Americans on location in international settings to refer deserving students for endowment funding.

As the 20th century came to a close, the changing paradigm for overseas missions meant fewer direct connections with Mennonite medical mission settings. Retiring medical missionaries were increasingly replaced with locally-educated natives, and control of the hospitals and clinics was turned over to the local and national churches. Returning missionaries still have maintained contacts with their prior overseas locations, but those contacts continue to fade in many places.

As mission boards and MCC let go of administrative control of medical mission facilities, the concept of medical mission itself has undergone a profound change. More emphasis has been placed on national workers serving in facilities controlled by the national churches. In turn, the North American Mennonite mission agencies have refocused their efforts on evangelization, church planting and development, and Biblical and theological teaching ministries.

This has meant that any ongoing cross-cultural and international efforts in specifically medical missions have become mostly driven by individual medical professionals working directly with an overseas institution. Sometimes these efforts spring out of cross-cultural marriages in which one spouse is from North America and the other from the country being served. In other cases, children who grew up in missionary families and themselves became medical professionals still maintain overseas contacts with the country in which they grew up.

Some of these former missionaries and children of missionaries now form the core group of International Mennonite Health Association (IMHA) which was initially formed after the Mennonite Brethren mission board took the conscious step to focus only on evangelism and church planting and let go of their medical missions. IMHA is increasingly inter-Mennonite in its scope and new leadership in the last few years is finding its way into new partnership relationships with creative community developers in under-developed overseas settings.

At the same time, there are less participants in the Student Elective Term (SET) program even though the program has been expanded to include graduate students in disciplines other than medicine. The reasons for this decline are unclear. Perhaps the interest hasn't been cultivated in the current generation of students. Perhaps with the transition to Mennonite Healthcare Fellowship the publicity hasn't been as good. There also appears to be increasingly less flexibility in graduate programs for overseas experiences like this, particularly for any period of time longer than four weeks. All of these may be factors.

What is clear, however, is that international awareness and a spirituality of service continue to inspire the current generation of Mennonite college students. Students are also more aware and thoughtful about relating across boundaries of class and culture. There is considerable

interest in partnership relationships which avoid the pitfalls of paternalism and Western domination.

As denominational mission agencies continue to cut back on specific programs in medical missions, the opportunity widens for new paradigms. These paradigms will continue to focus on people-to-people partnerships and doing "more with less." They will require more networking as individuals and small groups learn from each other.

I am convinced that Mennonite Healthcare Fellowship and its members can play a key role in advancing God's work in the world through international relationships that focus concern on the health and wholeness of all people. The MHF Board is considering how to most effectively build partnerships with other Mennonite agencies and entities as well as cooperate in larger Christian efforts as well.

A marvelous opportunity exists to advance the missional conversations and activities as North America hosts the Mennonite World Conference Assembly, July 21-26, 2015 in Harrisburg, Pennsylvania. Mennonite Healthcare Fellowship is taking advantage of this opportunity by scheduling its Annual Gathering 2015 immediately prior to this Assembly, on July 19-21 (Sunday evening to Tuesday morning). A "Coordinating Committee" is being formed to not only plan for the Annual Gathering but to coordinate our efforts with the larger Mennonite World Conference Assembly. We encourage MHF members to put these dates on your calendars, joining in prayer now and planning to be present in July 2015.

Citations:

Amstutz, H. Clair and Bernie Wiebe. (1989). Medicine. Global Anabaptist Mennonite Encyclopedia Online. Retrieved 15 May 2014, from http://gameo.org/index.php?title=Medicine&oldid=120770.

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Sutton's Law and MHF

President's Column by Joseph Longacher, MD

What does Sutton's Law have to do with Mennonite Healthcare Fellowship?

Among the many common experiences of American medical students is frequent reference to Sutton's Law by their professors and other teachers, and subsequently by themselves in training those who follow. The law is named after Willie Sutton, a notorious bank robber from New York, who, when asked by a reporter, "Why do you rob banks?" replied, "Because that's where the money is."

The law is promoted as a useful guide in clinical settings to diagnose the cause of symptoms of any kind. It suggests that the studies one might order should be those most likely to lead to the diagnosis, and since most conditions are common rather than rare, simple tests for frequently occurring diseases, rather than a search for the esoteric, are most likely to provide a correct answer. In other words, "Go where the money is."

How does this relate to Mennonite Healthcare Fellowship (MHF)? Perhaps it is a stretch, but as those of us in any type of healthcare profession need, and look for, ways to interact with other Anabaptist Christians whose beliefs are similar to ours, we do well to adhere to Willie Sutton's advice, at least figuratively. Where might we find "the money," that is, the places and ways to share our convictions and problems with like-minded practitioners?

The obvious answer (not surprisingly) is Mennonite Healthcare Fellowship! MHF membership provides direct access to others who have intentionally joined together for dialogue, fellowship and support—a rich resource to guide and nurture each of us as we live out our faith.

That happens in a number of specific ways, from articles and insights found in this journal, to interaction at the local level during one of our regional meetings, to the benefits experienced in a large group setting during our Annual Gathering, such as will take place at Laurelville this June. Those experiences confirm the wisdom of Sutton's Law as we seek out the most efficient, effective, and reliable way to meet our needs.

However, there is one problem: There is no Sutton's Law. Willie Sutton, during subsequent interviews and in the book he wrote about his career, denied ever having made the statement upon which the putative law is based. Yet, even if he didn't do so, the principle remains valid: We are most apt to find what we want and need in an easily accessible place with reliable resources, rather than through unusual or expensive efforts.

The story of Willie Sutton reminds us that wisdom can *sometimes* come in surprising ways from surprising sources. (Another famous line attributed to Sutton was that while he always used a gun to rob a bank, it was never loaded "because somebody might get hurt.") But for the *greater likelihood* that Anabaptist healthcare professionals will find spiritual sustenance and encouragement in their faith, "the money" will be in the Annual Gathering time together at Laurelville, June 13-15. Please join us if you can!

***Joe Longacher, MD**, is President of Mennonite Healthcare Fellowship and lives in Harrisonburg, Virginia. He retired at the end of 2012 from a practice in gastroenterology in Richmond, Virginia and was part of the Implementation Team that gave leadership to the formation of MHF. Joe has also served at the conference and denominational level and was a past president of MMA. He is married to Constance (Brenneman), originally from Hesston, Kansas, and they have four children and six grandchildren.*

Grassroots Development
IMHA President's Column
Murray Nickel, MD

Last week I went to a town council meeting. I don't usually attend these meetings, but this one was different. The agenda included a request to change a bylaw to allow for the building of a low-barrier home for persons in the downtown area who are homeless.

I was surprised by the attention that the meeting drew. The moment I entered the foyer, a woman stationed by a cardboard box bursting with green scarves accosted me. "Wear it if you're for the homeless." In the meeting room the seats were full and I was obliged to stand in the back with about fifty other latecomers. When the time came for questions, at least a hundred people pushed through the crowded aisles to line up at the microphone. For every businessman pleading with the council not to change the bylaws, two green scarf-wearers alleged that the council would be cold-hearted to prevent such a change. The meeting went on for hours; the paranoid business people and the scarf-wearers remained polarized.

Having worked among the poor overseas, it might seem obvious that I would be on the side of those with the green scarves. But I was conflicted. I knew some of these business people appealing their case at the microphone. I sympathized with their fears. Well into the question period, a man who works among the homeless came to the microphone. Shockingly, he wasn't wearing a green scarf. Did he forget to wear it?

In New York in the early 1980s the Times Square Hotel and its surroundings was known for peep shows and prostitution. The hotel was on the verge of being condemned and there were almost a thousand homeless people in the immediate area. Rosanne Haggerty, a resident of the community, decided something had to be done. She rallied fellow residents and local businesses to renovate the hotel in order to improve the aesthetics of the neighborhood while providing housing for those in need. Then she organized a group of community volunteers to spend time on the streets with the homeless to better understand their concerns. Now, decades later, the hotel fits nicely into the high priced surroundings with its gold-trimmed ceilings and marble lobby. Living there are 650 people who once frequented New York's homeless shelters and are now successfully blending into their community. Additional solutions were generated by the community as well.

If you visit the streets around Times Square today, the homeless are no longer there. The New York project was a resounding success. Others wanted to get in on the act. Governments, including mine, poured money into similar projects. However, they missed the key reason why the New York project was successful. In New York the solution was triggered by a community that worked together, not by money. In contrast, the green scarf troops rallied because of a massive government grant to build a building. Meanwhile, the business community was alienated. Is this why the man who works among the poor refused to wear a green scarf?

On my trips to Congo, I used to take my travelling colleagues to two Kinshasa health clinics. One clinic was started by a well-funded group from the outside, interested in meeting the health needs of the poor. The second clinic came from the vision and commitment of people with few resources from within the community. The first clinic was depressing to visit. It was empty, the staff were unmotivated and the management had other things on their minds. The second clinic, though, was inspirational. It was brimming with activity, the staff were committed and the management had a passion for the community. No doubt, a health clinic in a poor community is a good idea. Yet, if it is not triggered by the grassroots, its impact on community health may be limited. Seeing the man without the green scarf reminded me of an upside-down principle. Don't follow the money. Follow the people.

Image credit: Alex Butler, Abbotsford News, http://www.abbynews.com/news/243452721.html