Mennonite Healthcare Fellowship

Mennonite Health Journal

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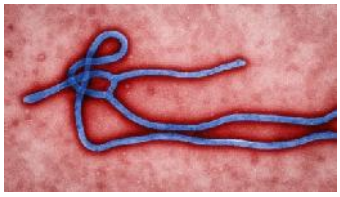
This issue of *Mennonite Health Journal* has a definite cross-cultural and international flavor as Mennonites look ahead to July 2015 when the Mennonite World Conference Global Assembly will be held in North America for the first time since 1990. Mennonite healthcare workers have a special opportunity to connect at the Mennonite Healthcare Fellowship (MHF) Annual Gathering 2015, July 19-21, 2015, just prior to Assembly Gathered in Harrisburg.

The lead article is entitled **The Burkitt's Lymphoma Story Parallels Mennonite Work in East Africa** and is written by Esther Kawira, a physician in Shirati, Tanzania. Her story comes on the heels of being honored in her home town by her alma mater, Goshen College, with one of its annual Culture for Service awards.

The Ebola outbreak in West Africa has made considerable news, especially after a case was reported in the United States. MHJ offers three perspectives on the situation:



1. **R. Michael Massanari**, a retired physician and educator who worked with infectious diseases and epidemiology during his career, gives us an overview of the medical aspects of Ebola.
2. **Beth Good**, Mennonite Central Committee (MCC) Health Coordinator, shares some reflections on how to respond.
3. **Donna Minter**, a psychologist from Minneapolis, Minnesota, gives some perspective in addressing the fear factor and psychological trauma, particularly in the large Liberian immigrant community in the Twin Cities.

Additional information on Ebola is being added to a special page at http://mennohealth.org/communications/topics/ebola/

Joyce Wilson, a nurse practitioner from West Virginia offers a powerful testimony to what the 2014 Annual Gathering at Laurelville meant to her in the context of her "cross-cultural" practice of a different kind, with teenagers in rural West Virginia.

Turning to a health issue that is truly global, Lyubov Slashcheva sets the stage for an extended discussion during the next year on **Climate Change and Global Health.** In the process, she issues us all an invitation to make our own contribution as we think about our attendance at the different Mennonite gatherings in 2015.

As the new President of Mennonite Healthcare Fellowship, **Eric Lehman** offers his first President's column as he reflects further on end-of-life issues that have been discussed at a number of Regional Meetings this fall.

In his **IMHA President's Column**, Murray Nickel offers a compelling analogy for encouraging international development work based on the torch from the 2010 Vancouver Winter Olympics. In the process, he poses a challenge and invitation to all readers of *Mennonite Health Journal*.

Finally, **Paul Leichty**, MHF Executive Director and editor of *Mennonite Health Journal* offers some comments on **Global Connections**, particularly in the context of the MHF Annual Gathering 2015 followed by Mennonite World Conference Global Assembly. He ends by introducing us to three confirmed speakers as well as workshop topics that are planned.

In the United States, this is the season of Thanksgiving. Mennonite Healthcare Fellowship, along with its partners in this publication, International Mennonite Health Association and Mennonite Chaplains Association, want to express our thanks for your readership and support. We love hearing from you, particularly by email at info@mennohealth.org.

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The Burkitt's Lymphoma Story Parallels Mennonite Work in East Africa

by Esther Kawira, MD

Early mission efforts. In 1935, two Mennonite missionary couples left Lancaster, Pennsylvania and headed for Shirati, in rural Tanzania, to start evangelism, along with education and health care. One member of that delegation, Ruth Mosemann, had received basic first aid training prior to departure. She set up a clinic and began to do what could be done with the resources of the time. She also snapped photos of some of those first patients. The photo on the right, taken in 1935 by Ruth Mosemann, may be the earliest known photo of child with Burkitt's Lymphoma. (Photo courtesy of Lancaster Mennonite Historical Society)

Identification of Burkitt's Lymphoma. Burkitt's Lymphoma (sometimes also referred to as "Burkitt Lymphoma") gets its name from Dr. Denis Burkitt, a surgeon from the United Kingdom working in Uganda. In the 1950's, Burkitt recognized a certain pattern of swellings in children, especially of the face and abdomen. This was eventually identified as a type of cancer, a lymphoma, which occurred in African children living in the "malaria belt" across central Africa. It was noted to be very rapidly growing. In fact, is still today the fastest growing cancer known to medical science. Being exquisitely sensitive to chemotherapy, which preferentially affects the most rapidly growing cells, Burkitt's Lymphoma became the first cancer to be treated and cured with chemotherapy alone, a discovery now applied to many other cancers.

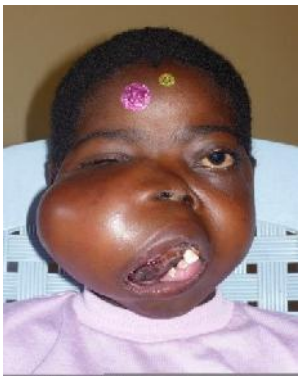
Internet graphics show the "Malaria Belt" on the left and the Burkitt's Lymphoma belt on the right.

Research and treatment at Shirati Hospital. In the 1970's, Dr. Glen Brubaker went as a missionary doctor from Lancaster to Shirati Hospital. He took great interest in Burkitt's Lymphoma, and started to make chemotherapy available to affected children there. In the 1980's, he also undertook major research to study the relationship between malaria and Burkitt's

Lymphoma. This involved using drugs to suppress malaria among children in the district and following the number of Burkitt's Lymphoma cases. His research showed a dramatic reduction in the cases of Burkitt's Lymphoma for the duration of the study.

Personal involvement. When I came to Shirati Hospital in the early 1980's, I learned about Burkitt's Lymphoma and participated in caring for children who were affected. In the 1990's, when Dr. Brubaker left Shirati, I inherited the work with Burkitt's Lymphoma children, both in treating them and continuing to keep the database of cases.

A new research project. In 2008, I was approached to participate in a major new research on Burkitt's Lymphoma that would look at the tumor using modern techniques, including genome sequencing. It would further delineate the relationship between Burkitt's Lymphoma and malaria, Epstein–Barr virus, and genetic factors. This study, funded by the National Cancer Institute (NCI) in Washington, DC is still being carried out in Tanzania, Kenya, and Uganda, and compares cases of Burkitt's Lymphoma with matched controls. Shirati is one of the main sites for enrolling the Tanzanian patients for the study.



Burkitt's Lymphoma patient before treatment (left) and one year later after treatment (right).

In 2013, I opened a health center in Sota Village, near Shirati, with facilities to house, feed, and care for Burkitt's Lymphoma patients during their three months of chemotherapy. Having them remain in a residential setting during treatment makes it possible to improve the care, treat complications quickly, and avoid default from care. Shirati Hospital refers patients to me, and also assists with biopsies. Chemotherapy drugs are donated, and additional donations help with other costs, making the treatment free to the patient and adult caregiver.

When the first Mennonite missionaries came to the Shirati area, a promise was made to the local chief. The missionaries pledged that along with the Gospel, they would bring modern health care and education. We continue to make good on that promise 80 years later. (Left) First two Burkitt's Lymphoma patients under treatment at Sota Clinic.

***Esther (Lehman) Kawira**, MD, is from Shirati, Tanzania, where she has worked as a physician*

for more than 30 years. She grew up in Goshen, Indiana and did her pre-medical studies at Goshen College in the early 1970s. During this time, she met Josiah Kawira, a student from Tanzania who was studying economics at Bluffton College (now University). Esther received her medical degree from Indiana University in 1977. In 1983, she and her family moved to Shirati, Tanzania where she worked at the Shirati KMT Hospital for over twenty years, seven of them as medical director. In 2012, Esther and Josiah established the Shirati Health, Education and Development (SHED) Foundation, dedicated to humanitarian, development and health work. From that base, they established the Sota Clinic, a village-based health care clinic overlooking Lake Victoria. The clinic specializes in Burkitt's Lymphoma research, imaging and ultrasound, inpatient services, male circumcision, prenatal care, childhood immunizations and outpatient malaria care. In addition to her direct medical care, Esther serves as a mentor and teacher to students from both Tanzania and abroad. The Kawiras have four adult children, all of whom currently live in the United States.

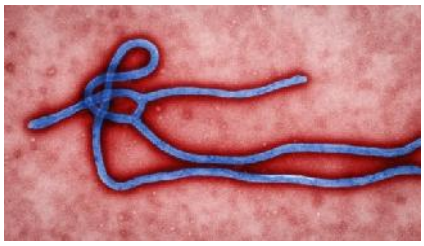
Ebola

R. Michael Massanari, MD MS FACP

[Author's note: This manuscript was prepared as a brief synopsis of the current Ebola epidemic. Space does not permit an elaboration of current protocols for managing exposures, patients, and transmission. CDC websites with pertinent up-to-date information are provided for the interested reader. It is important to recognize that recommendations for managing the epidemic are changing rapidly as experts acquire new knowledge in the course of the epidemic.]

Thus week by week the prisoners of plague put up what fight they could. …by this time the plague had swallowed up everything and everyone… (There was) only a collective destiny made of plague and the emotions shared by all. Strongest of these emotions was the sense of exile and desperation…. *The Plague*, Albert Camus

From time to time diseases emerge that are shrouded in mystery and threaten the well-being, indeed survival, of large segments of the population. Usually manifest as epidemics of infectious diseases, it is a lack of knowledge about the etiologic agent, its source, the mode of transmission, and effective management that amplifies fear and irrational responses to the outbreak, emotions that are compounded when healthcare workers are threatened in the course of the epidemic. Despite the scientific advances and technological sophistication of contemporary medicine, these epidemics continue to confound and challenge those who provide care. We need but recall influenza, Legionnaire's Disease, HIV/AIDS, SARS, and now Ebola among recent epidemics that serve as reminders that modern medicine is not invincible.



What is Ebola? Does it pose a significant threat, particularly to us who are healthcare providers? What can be done to prevent its spread and to manage those who have contracted the disease?

The Agent. The Ebola River is located in the Democratic Republic of Congo. It was along this river that the first outbreak of the disease that now carries its name was identified in 1976 and where a Belgian physician, Dr. Peter Piot, isolated the virus that caused the disease.

Five distinct Ebolaviruses (family Filoviridae, genus Ebolavirus) have been isolated, four of which are known to cause human disease. Recent evidence suggests that bats in several African countries serve as reservoirs for Ebolaviruses; however, it is uncertain how the virus is maintained in that species. The Ebolaviruses cause periodic epizootics in non-human primates. Humans probably contract the infection from bats or other wild mammals following which it is readily spread to close human contacts thereby initiating an epidemic. (Centers for Disease Control and Prevention, 2014) (http://www.cdc.gov/vhf/ebola/resources/virus-ecology.html)

Clinical Disease. Ebola is a rare, acute, and deadly infection. Clinical disease is typically manifest by abrupt onset of fever that occurs 8-12 days following exposure to an infected patient. Other symptoms may include chills, malaise, muscle pain, and loss of appetite. Because these symptoms are non-specific they may be confused with other infections, particularly where and when the disease is unsuspected.

In West Africa, site of the current epidemic, other tropical diseases must be considered, including malaria, typhoid fever, and pneumonia. As the disease progresses over the next five days patients may experience gastrointestinal symptoms including severe watery diarrhea, vomiting, and abdominal pain. Other symptoms include chest pain, shortness of breath, headache, and confusion. Evolving clinical signs include conjunctivitis, seizures, cerebral edema, and an erythematous maculo-papular rash over the neck, arms and trunk. Frank hemorrhage is unusual; however, petechiae, ecchymosis, mucosal bleeding, and bloody diarrhea may occur later in the disease course.

The more severe the symptoms and signs of the disease, the more likely the patient will die of the disease, usually between days 6-16 of the infection. Death usually results from multi-organ system failure or/and septic shock. Patients who survive generally have milder disease with resolution of fever around day six. However, survivors may experience a prolonged convalescence. The case fatality rate among documented cases in West Africa has ranged between 69-72%.

Pathogenesis. Ebola virus enters the host through mucus membranes, breaks in the skin, or in the case of health workers parenteral exposure via accidental needle sticks. The virus is particularly virulent, infecting an array of human cells, spreading rapidly to local lymph nodes and then to the liver, spleen, and the adrenal cortex. Liver involvement is associated with abnormal clotting while adrenal cell death is associated with reduced steroid synthesis and hypotension.

Although survivors generate an effective immunological response to the virus, it appears that the virulence of the agent is such that in fatal cases it overwhelms the host before the patient is able to generate an effective defense against the infection. Early laboratory abnormalities include reduced white blood cell and platelet levels. Striking elevations in hepatic and pancreatic enzymes are associated with cellular necrosis while abnormal coagulation tests signal disseminated intravascular coagulation. (Centers for Disease Control and Prevention, 2014) (http://www.cdc.gov/vhf/ebola/hcp/clinician-information-us-healthcare-settings.html)

Diagnosis. Several laboratory diagnostic tests are available to confirm the diagnosis following onset of symptoms and include ELISA testing, polymerase chain reaction (PCR), and virus isolation. Later in the course of disease, testing for IgM and IgG antibodies to Ebola virus can be used to confirm the diagnosis. (Centers for Disease Control and Prevention, 2014) (http://www.cdc.gov/vhf/ebola/diagnosis/index.html).

Because of the risk of transmission to health workers and laboratory personnel during specimen collection and processing, the Centers for Disease Control (CDC) has offered explicit guidelines for specimen handling. This brief overview of Ebola does not permit elaboration of these protocols. For more information the reader should refer to the following website: http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html. (Centers for Disease Control and Prevention, 2014)

Treatment. At the time of this writing, novel therapeutic interventions utilizing molecular knowledge regarding viral pathogenesis and host immunological responses are being investigated. However, current therapeutic recommendations rely primarily on symptom management and management of organ system dysfunction.

The critical importance of supportive care should not be underestimated. Recent observations from experts providing services in Africa suggest that excellent supportive care might significantly reduce case mortality rates because many patients die from lack of access to parenteral hydration when diarrhea and vomiting cannot be controlled. In addition to hydration, attention to proper oxygenation and management of associated infections is important. (Centers for Disease Control and Prevention, 2014) (http://www.cdc.gov/vhf/ebola/treatment/index.html)

Controlling Transmission of Ebola. The uncontrolled epidemic of Ebola in West Africa, the high case mortality rates, the lack of effective therapy, the risk of transmission to health workers, and more recently identification of isolated cases in the United States and Europe have sounded alarms around the world. To be sure Ebola is a disease with which to reckon. However, it is primarily persons in close contact with the patient and health workers that are at risk of contracting Ebola.

The infection is transmitted by direct exposure to the patient's blood or body fluids (i.e. mucus, urine, feces, sweat, semen, emesis, breast milk). Ebola is not spread via water, food, or airborne transmission. In Africa, exposure may also include contact with wild animals.

The good news is that access to appropriate equipment that provides protective barriers between the infected patient and contacts, along with proper disposal and sterilization of medical equipment will afford safe protection and prevent transmission. The bad news is that (i) contacts, including health workers, fail to suspect that the patient might be infected with Ebola; and (ii) contacts, including health workers, lack access to or fail to properly use effective barrier equipment to prevent spread of infection.

This brief synopsis of the Ebola epidemic does not permit a detailed elaboration of the protocols for managing persons exposed to and patients with Ebola infection. Perhaps the most important take-away messages for health workers who read this article are:

1. *Raise your level of suspicion*. Certainly, most patients with fever who seek acute care will neither be exposed to or have Ebola infection. However, in the event of unexplained fever and other symptoms suggestive of Ebola, be certain to include in your history queries regarding travel and/or exposure to travelers from Africa or to people who may have been infected with Ebola virus.
2. *Implement contact and droplet precautions*. Refresh your knowledge regarding contact and droplet precautions, where to access appropriate protective barrier equipment, and how to appropriately don and discard the equipment should you encounter a person reporting possible exposure.
3. *Report immediately to Public Health Authorities*. In the event you encounter a person who might have been exposed to Ebola virus infection, report immediately to the institutional infection control officer, to the local and state public health departments, and to the CDC (CDC's Emergency Operations Center at 770-488-7100). (Centers for Disease Control and Prevention, 2014) (http://www.cdc.gov/phpr/eoc.htm)

For more information regarding monitoring and management of persons exposed to Ebola virus infection, see **Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure**: http://www.cdc.gov/vhf/ebola/hcp/monitoring-and-movement-of-persons-with-exposure.html).

For more information regarding safe management of patients diagnosed with Ebola infection, see **Safe Management of Patients with Ebola Virus Disease (EVD) in U.S. Hospitals**: (http://www.cdc.gov/vhf/ebola/hcp/patient-management-us-hospitals.html).
For more information regarding infection control protocols for managing patients with Ebola infection, see **Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in U.S. Hospitals**: (http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html).

While it is unlikely that any of us as health workers will encounter persons exposed to or infected with Ebola virus, the threats associated with the current epidemic make it imperative that we avoid complacency and that we maintain vigilance and knowledge regarding appropriate and effective protocols for managing these encounters. Confronted with caring for patients with Ebola infection, we need not be overwhelmed by emotions of fear and despair, but rather render care with compassion and confidence that we can do so while protecting ourselves and those around us.

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R. Michael Massanari, MD MS FACP, is a retired physician and professor of medicine whose sub-specialty training included infectious diseases and epidemiology. Mike and his wife, Lois, currently live near Bellingham, Washington where their daughter Analisa and family reside. Although not currently attending a Mennonite Church, they maintain their lifelong ties with the church through their son Eric who is a Pastor and Chaplain with the Mennonite Church in Newton, Kansas. In addition to caring for grandchildren, they enjoy birding, traveling, reading, and participation in church and community choirs.

Responding to Ebola
Beth Good

Since the recent outbreak of Ebola in West Africa, there has been a plethora of information on the news and social media. Some information has been accurate and helpful and some has not.

It is no coincidence that the countries most affected by the Ebola outbreak also have weak healthcare infrastructure. The state of the health systems as well as limited human and material resources contributes to the difficulty in managing the spread of the disease.

The response of the faith community to the Ebola outbreak has been varied. Christian Connections for International Health (CCIH) has reported on the activity of several member organizations that are responding to the crisis. Other organizations are still monitoring the situation and gauging their response.

At the time of this writing, Mennonite Central Committee (MCC) has not initiated a response to Ebola in West Africa since the outbreaks are not in areas where MCC currently has programming. MCC continues to monitor the situation and the needs of our partners in the region.

In situations like the Ebola outbreak, MCC thoughtfully and prayerfully considers the needs of the situation and reconciles that need with local partnerships to determine our involvement. This thoughtful consideration strengthens the response to crises and the ability to do the most good and limit harm.

MCC is currently drafting guidelines for prevention measures that will be circulated to workers and staff that may travel near affected areas. The purpose of the guidelines is to respond to the outbreak in a proactive rather than reactive way.

The Ebola outbreak provides another opportunity for those of us living in relatively wealthy nations to examine the social determinants that lead to or exacerbate health disparities. While it is important to respond to crises, we also need to be diligent in working toward eliminating social and economic disparities in the long term.

Beth Good, PhD (candidate), APHN-BC, CNS, RN *is a nurse from Columbia, Pennsylvania and is serving on the MHF Board. She currently works as Health Coordinator for Mennonite Central Committee in the area of Public Health including awareness of HIV/AIDS, Sexual and Gender-based Violence, and community health. She and her husband, Clair Good, currently serve as co-pastors with Vision Columbia where she also established a primary care clinic in the church building to serve uninsured, low income patients. Beth is currently in the dissertation phase of PhD studies with an emphasis on women who have survived rape in conflict settings.*

"Fearbola" Is More Contagious Than Ebola

Addressing Psychological Trauma in Minnesota's West African Communities

by Donna L. Minter, PhD, Licensed Psychologist

Editor's note: This article originally ran on the www.themennonite.org blog.

Oh, to be a clever writer of *Late Night with Seth Meyers*! Published on YouTube October 10, *Fearbola: The Irrational Fear of Catching Ebola*, uses intelligent humor to shed light on the truth about Ebola's highly unlikely transmission in the United States.

According to the USA's Center for Disease Control and Prevention, Ebola is a physical disease that only spreads when a person is sick with the virus. You can't get Ebola through the air. You can't get Ebola via water. You can't get Ebola from food legally purchased in the USA. You can only get Ebola from touching the body fluids (blood, urine, saliva, sweat, feces, vomit, breast milk, semen) of a person sick with or who has died from Ebola, touching contaminated objects, like needles, and touching infected fruit bats, apes, and monkeys. As long as you don't engage in these behaviors, you will not contract the Ebola virus, you will not die from Ebola. Period. End of story, right? Unfortunately not.

While becoming sick from Ebola is highly unlikely, fear and anxiety is being spread by the media and politicians. As reported by Marino Eccher's front page Sunday October 26 St. Paul Pioneer Press article, in their fight against the Ebola outbreaks in their home nations, Minnesota's large West African communities have given food and money, held educational events, and offered health care services. As the disease ravages Africa, they're faced with the steep toll of intense loss. Over 4,800 people in Guinea, Liberia and Sierra Leone have died of Ebola, the most widespread in history. Many have lost family and more are inundated daily with public fears and stigma surrounding Ebola.

"We have to fight the psychological trauma," said Rev. Alexander Collins, executive director of the Liberian Ministers Association of Minnesota. The association, with more than 50 member churches, is partnering with the Minnesota Peacebuilding Leadership Institute (MNPeacebuilding) to train a community-based first-response team. Collins' congregations have been hit hard. One person lost 17 family members. Another has lost eight, including her husband and her mother. "We want to help them through the grieving process," he said. Additionally, Collins understands that the Liberian civil war has also left lingering unhealed psychological trauma for his people.

Rev. Collins and I met after several of his community members told him of their transformational experiences taking Strategies for Trauma Awareness and Resilience (STAR). The STAR training was created by the Center for Justice and Peacebuilding (CJP) at Eastern Mennonite University in Harrisonburg, VA in the wake of the Sept. 11 terrorist attacks. I took STAR for professional development in 2008 and introduced STAR to Minnesota in 2010.

Although Ebola is different than the 9/11 tragedy, the psychological trauma reactions are the same. Anytime somebody experiences a traumatic event, their body and brain go through the exact same process. STAR unpacks the full spectrum of trauma and teaches positive productive alternatives to revenge via restorative justice and conflict transformation informed by one's faith. It teaches the brain-trauma-behavior relationship and steers victims toward positive coping strategies creating a healing culture for those harmed and setting the stage for reconciliation. STAR is designed for leaders, care providers, professionals, and volunteers.

The STAR need is robust. In Minnesota, I have organized and taught twelve STAR trainings. Here STAR is offered for 27 hours of professional continuing education for mental health professionals, nurses, educators, and attorneys. In March 2014 I was hired by EMU to co-facilitate STAR in Fiji to address community and historical traumas. EMU's STAR program has trained thousands including Nobel Peace Laureate Leymah Gbowee and Somali President Hassan Sheikh Mohamud building a 13-year national and international reputation of success.

Now MNPeacebuilding is working closely with Minnesota's West African community leaders to raise $12,000 to become STAR trauma-informed and resilience-oriented empowered community first responders. To help, readers can make tax deductible contributions online at: https://givemn.org/organization/Minnesota-Peacebuilding-Leadership-Institute or checks made payable to MNPeacebuilding, PO Box 3717, Minneapolis, MN 55403. Readers wanting trauma healing in their communities should read the *Little Book of Trauma Healing* by Carolyn Yoder, take the STAR Training at EMU www.emu.edu/star or in Minnesota www.mnpeace.org, and/or sponsor a STAR training in their community.

Donna Minter, PhD, LP, *is a Neuropsychologist, Clinical Psychologist, and Forensic Examiner from Minneapolis, Minnesota as well as the Founder and Executive Director, Minnesota Peacebuilding Leadership Institute. Raised in the Mennonite/Anabaptist historic peace and social justice faith tradition, Donna has always had a passionate desire to find practical ways to build peace within her sphere of influence. After taking the Strategies for Trauma Awareness and Resilience-the STAR Training at Center for Justice and Peacebuilding at Eastern Mennonite University in October 2008, she realized that STAR's principles perfectly integrate her professional background and personal commitment to teaching positive productive alternatives to revenge via grassroots community trainings that are accessible to professionals and laypersons alike. She has degrees in social work, educational psychology, outdoor recreation, and earned her doctorate in clinical psychology in 1995. She completed her postdoctoral training in neuropsychology at the University of Minnesota Medical School in 1997 and her post-doctoral fellowship in neuropsychology in 1997. Her "day jobs" are as a neuropsychologist with the Minnesota Epilepsy Group in Saint Paul and the Wisconsin Forensic Unit. She sees the full spectrum of psychological trauma in her work as a neuropsychologist and when conducting court-ordered mental health evaluations in Minnesota and Wisconsin. She has taught individual and organizational assessment and evaluation and supervised students in a law and psychiatry clinic. As the founder and executive director of the Minnesota Peacebuilding Leadership Institute www.mnpeace.org she is committed to its mission to instigate, train, and support racially, sexually, culturally, ethnically, religiously, and economically diverse individuals and organizations to become trauma-informed and resilience-oriented for the empowerment of their*

communities in Minnesota, the USA, and around the world. She is the Lead STAR Master Trainer in Minnesota. She is an active member of Faith Mennonite Church in Minneapolis. She is married to Bruce Brunner and is the proud stepmom to three young adult women. She loves most any type of physical activity that gets her out in nature and takes her to distant places.

I'll Meet You There
by Joyce Wilson, FNP-C

A friend recently sent me a quote by Jelaluddin Rumi, "Out beyond ideas of right doing and wrong doing there is a field. I will meet you there."

The June 2014 Mennonite Healthcare Fellowship Annual Gathering at Laurelville was not what I had expected.

I was anticipating some workshops which would probably improve the level of service I provide, some continuing education credits, some interaction with health care providers and a little spiritual stuff sprinkled on top.

What I was not anticipating was to be challenged to my spiritual core, to be both emotionally exhausted and nourished by speakers and the music, to walk with others who know the path better than I, and to wander off the path and simply "be" for awhile.

At times it felt like an earthquake shudder, at times like a feather drifting in the breeze down to that field beyond. To help you understand where I am coming from, let me tell you a few stories.

Let me tell you about Jeremy. He came into my office clumsily and making a little more noise than was necessary. He slumped in the chair and looked as bored as most sixteen-year-olds I am seeing these days.

When asked why he was present, Jeremy pulled up his pant leg to show an infected wound running down his calf. I prescribed some antibiotics and told him to stop by the next day so I could check his leg. I smiled and patted his arm as a farewell and he mumbled something in return.

The next day Jeremy limped into the office. His leg was much worse. I told him I was sending him over to the hospital for treatment and I would need to contact his parents. He didn't know where his mother lived, somewhere out of state, he thought. He gave me the number where his father worked. I called and briefly described the situation and said he would have to take Jeremy to the hospital. The father said he couldn't and Jeremy would need to find another way to get there.

Jeremy is sixteen, doesn't have a car and has to find someone to take him to the hospital. **I'll meet you there …**

Let me tell you about Tristan. He came into the office with his head down. He sat still, staring at the floor. His clothes smelled of cigarettes. When asked why he was there, he said his teacher thought he may have lice.

In my mind, I could only guess at the classroom scene. Was he taken off privately to the side or was this a general announcement made so the entire class could hear? Either way, the embarrassment for Tristan was evident as he sat there refusing to meet my eye.

I prescribed the medication and explained that his mom would need to wash all of his clothes and bed sheets. He said that his mother was living with her boyfriend in Ohio now. I was afraid of where this conversation was headed. "And your father?" I asked. "In jail," he replied.

Tristan is fifteen and sleeping on a couch at a friend's house and then moving on to another friend's house. No one wants Tristan around too long. I asked where he had been sleeping the

past week. He gave me three names. I asked if he would like me to contact them. “No,” he shook his head. “I will take care of it.”

I’ll meet you there…

Let me tell you about Emily. I see her every day at exactly 9:45.

It’s amazing that Emily is able to actually attend school. In the past month, I have treated her for a cold, a twisted ankle, a sore throat, a fever, cramps, dizziness, coughing, a sore back, a broken finger and a sore toe!

Emily has no friends and there is a bully in her second period class who makes her life miserable. Emily is using me to skip this class every day! She knows that. I know that. But we both sit there and go through the motions of an exam. I have cured all of her ailments and sickness without prescribing any medicine. I am truly amazing!

I’ll meet you there….

Rumi knew a lot about right doing and wrongdoing I suppose, but I know more about infections and head lice than he ever will.

In reflecting on the impact of the Annual Gathering at Laurelville, I realize that even though the quotation passed on by my friend did not come from a Christian, I sensed something in it that was authentic to my own Christian faith.

I am a Christian because of Jesus; I want to be like him. I love the way that Jesus could touch humanity and God at the same time; he was the conduit. In being that conduit, Jesus taught us that we can have that conduit for ourselves and can be that conduit for others as we nurture our own connection through a relationship with Jesus. I respect that others find that connection through their own faith traditions.

Several years ago I read a book called *The Clan of the Cave Bear*, the first in a series of novels about prehistoric times. In the first part of the first book, there was the great earthquake that separated the continents and made the world that we know today. That is how I felt about the gathering at Laurelville. It felt like there was a big earthquake inside of me that has forever changed my landscape. There is some pain, but mostly it is just knowing that things have changed and there is no going back.

During the gathering, my emotions bubbled up and I felt them so much stronger than normal. All of my emotions were affected. If I was happy, I was ecstatic. If I was feeling spiritual, it was almost overpowering. The music lifted me to higher places.

All of the passages that were shared seemed to be just for me. There was the passage from Jeremiah telling the Jewish people to seek the peace of the city so they could find their own peace. There was John 1:14 where the Word became flesh and “moved into the neighborhood.” And there was the passage from Acts, where the leaders of the church told Paul that if he had a word of encouragement to say it now.

The words of encouragement that I heard at the conference were that God wants us to be safe. Getting out of the boat into the water doesn't seem safe, but out of the boat into the arms of our Savior is safe. We need to trust. We need to build our relationship with God and with those people in our faith community.

I know that I will draw on the words of encouragement, the music, and the support that I found at Laurelville as I trust that I will build community with the adolescents that I have been called to care for. I'm wading in.

Before the MHF Annual Gathering, I was a mid-level provider treating adolescents in a rural county high school. That is my job, but I am also a mother, father, brother, sister, priest, companion, friend, chauffeur, cook, mentor (and the list grows each day). I find lost mothers and send them home. I break fathers out of jail. I shampoo lice out of hair. I give a pretty good hug. Occasionally, I even prescribe a medicine.

Somewhere, way out beyond ideas of right doings and wrong doings, of broken fingers and broken hearts, of headaches and head lice, of cheaters and saints, of valedictorians and dropouts, of cigarettes and hugs, there is a field. **I'll meet you there…**

Joyce Wilson, FNP-C is a Family Nurse Practitioner who lives and practices in Barbour County, West Virginia where she works for the Belington Clinic. During the school year she practices at a satellite office in the county high school.

All Things are Connected
by Lyubov Slashcheva

If you turn to any news reporting source in recent weeks, you are likely to find an update on the latest viral activity of the Ebola virus, a discussion on California's acute water shortage, or an investigation on various acts of violence near and far. The headlines blur together into that of which Wendell Berry suggests Nature continues to convince us--that "all things are connected; the context of everything is everything else." (Berry, 2009)

As Anabaptists, we might respond by echoing the standards that Doris Janzen Longacre offers in the introduction to a denominational favorite, *Living More with Less:* **"Do Justice. Cherish the natural order. Nurture people."** (Longacre, 2010)

Though it is less clear how we ought to respond as healthcare professionals, Colin Butler, an Australian global environmental/public health scholar, suggests that "doctors have a duty of care to think ahead, to think in a precautionary manner, and to sound warnings in the interest of their patient, whether an individual, a population, or the whole planet." (Butler, 2014) Just a month ago, in collaboration with over 55 international experts, Butler published a compilation of scholarly resources on **Climate Change and Global Health**, addressing health concerns of populations vulnerable to climate change in their unique economic, political, and environmental contexts.

Butler's compilation suggests that climate change has primary, secondary, and tertiary effects on health. Primary effects include more extreme temperatures and mortality related to the effects of an increasing number of natural disasters. Secondary effects include factors such as vector-related disease transmission. Tertiary effects involve agricultural and social stability.

Butler and his colleagues discuss region-specific challenges, political realities, the use of resources, and the specific perspectives from various health disciplines. Yet they also empower readers with a practical discussion on actions for reform.

Another contribution to the topic of climate change comes from Ellen Davis, an Old Testament scholar at Duke Divinity School. She explains that "agrarianism is a way of thinking and ordering life in community that is based on the health of the land and of living creatures." She goes on to suggest the "logically perplexing but morally empowering paradox that the Bible is both grossly irrelevant in direct application to current economic problems and incredibly relevant in vision and principle for grasping opportunities and obligations to make the whole earth and its bounty serve the welfare of the whole human family." (Davis, 2008)

An invitation. Whether you're serving in a rural or urban location, in North America or abroad, I invite you into the conversation. These are just a few of the voices speaking to current realities as well as God's intent and vision for the world. I invite you to think about our role as Anabaptist healthcare professionals in responding to the way that climate change is affecting human health.

As Mennonites prepare to gather next summer from across the globe around the theme **"Walking with God,"** let us acknowledge that as journeying disciples we have not yet reached the goal. Our coming together in Harrisburg will provide members of Mennonite Healthcare

Fellowship some unique opportunities to engage in the topic of climate change and human health.

The **MHF Annual Gathering 2015** (July 19-21) will offer several workshop opportunities for discussion and learning more about this topic. In addition, the perspective of healthcare workers is welcomed and indeed important in a workshop to be held at the **Mennonite World Conference Global Assembly** (July 21-26).

If you would like to contribute to the team planning these workshops or have suggestions for additional resources or voices on the topic, please contact me, Lyubov Slashcheva, at lyubov.slashcheva@gmail.com. As we continue to approach next summer's gatherings, more detailed discussions will follow.

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Lyubov Slashcheva, BA, DDS Candidate

Raised in Virginia's Shenandoah Valley upon emigrating from Kazakhstan, Lyubov Slashcheva graduated from Eastern Mennonite University (EMU) with a BA in Biology. Interning with a dental/medical missions organization for four months in Honduras and Peru, she then settled in Richmond, Virginia to pursue dental education at Virginia Commonwealth University as a National Health Service Corps Scholar. She continues to be involved in tutoring/mentoring, local community service, and domestic/foreign mission efforts and has special interest in public health and geriatric/special needs populations. Lyubov passionately seeks to integrate her faith into the development of her career as an oral healthcare professional.

MHF President's Column

Eric Lehman, MD

While reading from the *Rejoice* devotional on October 1, I was struck by a quote from an elderly gentleman dealing with chronic back pain. He said, "It is my spiritual discipline to continue to live abundantly within the narrowing limits of life that come with aging." It struck me how this man could have the determination to live well despite his suffering. We are all challenged to live abundantly, but to do so under the duress of pain and advanced age is true grace.

The concept of living abundantly in the face of advanced age and disease is intriguing. At what point do we decide to give up attempts at life preserving therapy?

I know a man in his early 80s who was diagnosed with multiple myeloma over 2 years ago. He was deathly ill at the time of his diagnosis but achieved a partial remission with modern medical therapy. He had end-of-life discussions with family and friends and was ready to accept death. He continued with chemotherapy for a year until he developed a gall bladder infection and was deemed too ill for surgery. He chose against surgery, had supportive medical therapy and survived another near death experience. Weakened from this experience, he (with the support of friends and family) decided against more chemotherapy and entered hospice. Now, almost a year and a half later he still lives in his own home, cared for by his wife with the support of hospice. He is weak but still relates to visitors and family who visit and even occasionally can attend church.

Another man in his late 80s was diagnosed with advanced cancer. He and his family decide to pursue aggressive therapy with total parenteral nutrition and extensive surgery to attempt resection of a large tumor. Following surgery he developed multiple complications and required mechanical ventilation. His family was left with the decision to press on with continued life sustaining care. Eventually, they elect to decline further surgery and proceed with hospice care. He died in a hospice inpatient center within a week.

How is it that one man declines aggressive medical care and continues living while the other fights on to try to beat his disease and does not survive?

We are constantly challenged in medicine to make choices about life and death. We try to be good stewards of the resources God has provided for us on earth and realize that at some point we all will have to choose the type of care we receive at the end of our lives. We cannot predict outcomes but we know that God is with us in whatever situation we find ourselves.

This fall MHF has sponsored regional meetings with Dr. Glen Miller speaking on dying well. His book, *Living Thoughtfully, Dying Well*, challenges us to prepare for death so that we do not put an unnecessary burden on our families or the health care system to go to heroic lengths to keep us alive.

These events are part of MHF's vision to provide venues to communicate important topics to healthcare workers within the church so that they may be a more effective witness in health care matters. We encourage you as members of MHF to bring colleagues, friends and family to regional gatherings. Keep alert for regional meetings in your area coming up in the near future.

Another exciting gathering we are planning is the Annual Gathering 2015 to be held from July 19-21, 2015, just prior to Mennonite World Conference Global Assembly in Harrisburg, Pennsylvania. We will have the opportunity to share our journeys with healthcare workers from

around the world and also to help provide health care to those travelling to the conference. Another vital part of MHF has been its involvement in missions around the world and we hope to strengthen ties with international healthcare workers at this event.

***Eric Lehman, M.D.**, is a physician in family practice from Archbold, Ohio. He has been serving on the MHF Board since 2012 and became President in September 2014. Eric graduated from Goshen College in 1982 and Ohio State University College of Medicine in 1986. Following his residency, he has been serving the Archbold community in family practice medicine since 1989.*

Torchbearers

IMHA President's Column

Murray Nickel, MD

The Olympic Torch. Bombardier, an airline manufacturing company, was the proud designer and manufacturer of the Vancouver Olympic torch. The sleek white light saber was proudly carried by 12,000 torchbearers as it made its way from Olympia to the grand Olympic cauldron in Vancouver.

One of the Olympic torchbearers writes, "When my turn came to be handed the Olympic Torch, for half a second I pictured its entire story, from the forge to my hands, like a magic wand... Everyone wanted to touch and hold the torch, at one point there were so many hands on the torch and it was so beautiful! So moving!"

And then about passing the flame, "Together with the Olympic flame, John passed on to me his energy and his enthusiasm with such strength that I literally started to jump! I started to run holding the torch as high as I could. I [could] not put my hand down for a second..."

To be sure, it was incredibly exciting to carry the torch. But it was a profound privilege to pass it on, to be a part of the procession.

The torch connects three parties.

1. First, there are those who excel at their sport. These are the **athletes**.
2. The second group is the **crowd** in the stands who enjoy the feats of the athletes. They are the ones who enjoy the passing of the torch. The process leads them into the stands where they can support the fantastic feats of the athletes.
3. The third group are those who take part in the procession to the stadium. These are the **torchbearers**. No doubt they enjoy their moment of glory too. But they understand that the glory is in being part of something bigger. Because they see something bigger, they humbly but joyfully hand the spotlight to the next person.

Among the poor, the "athletes" are people with vision and talent who are able to move their family or their community forward. They are involved in a transformational process. The community looks to them for leadership. They understand the social dynamics in their communities and know what will work and what won't.

Torchbearers, on the other hand, might only be part of the show for a brief moment. But they hold the communities they visit in high esteem and feel privileged to have an opportunity to be involved. Bearing the torch draws attention to the good things that the athletes are accomplishing.

The **crowds** are linked to the impoverished community by the torchbearers. They are attracted to the message, and through the torchbearer's activity they have an opportunity to participate, supporting the athlete's actions with their cheers.

When I move among the poor I see many athletes. Unlike the Olympics, their cheering crowd is small. Maybe it's only a friend. Perhaps it's a few neighbors, maybe even a small village benefiting from the accomplishments of the athlete.

Back home, I see a crowd wanting to participate. It's a crowd that wants to be involved effectively with their resources. It's a crowd that wants to enter into relationship and cheer on the people who are making positive changes within their communities.

At International Mennonite Health Association (IMHA) we are looking for torchbearers. We need people who can help us make this link. We want to know more about the athletes, but we won't know unless someone bring us the news.

Have you travelled to or worked in a poor, underserviced community overseas? Have you seen inspiration and initiative? If you know athletes in these communities, consider joining IMHA. Help us honor them.

At IMHA we want to hear stories about these people. We want to post their stories so the cheering crowds can be a part of something bigger. Help us to be torchbearers.

Photo from http://www.ferniestanfordresort.com/blog/Olympic-Torch-Relay

To learn more about the work of International Mennonite Health Association, visit their website at www.intermenno.net where further contact information is provided.

***Murray Nickel, MD**, is President of International Mennonite Health Association (IMHA) and an emergency physician living in Abbotsford, British Columbia, just outside of Vancouver. He spent six years in Congo in association with Mennonite Brethren Mission and now travels back and forth between Congo and Canada two or three times a year. He has a special interest in human development and transformation in the context of the poverty.*

Global Connections

Editorial by Paul Leichty

Global connections are possible. We live in a world where global connections are possible on a scale that could hardly have been imagined fifty years ago. Developing countries which couldn't afford the infrastructure for land line telephones now have cell phone towers with the latest in cellular technology. People send emails and text messages from the remote corners of the world. Face-to-face conversations across many miles are increasingly common through Skype, Facetime, and other applications.

Global connections are a historic reality. Global connections have been a part of MHF from the beginning. Although the membership of Mennonite Healthcare Fellowship (MHF) is mostly from North America (and most of those from the United States), MHF has always had some members from other countries as well, making it an international organization.

In addition, many of our North American members have had experiences of working in developing countries as mission workers under a mission board or with Mennonite Central Committee (MCC). That work has established some very personal connections between healthcare workers in North America and those in developing countries.

MHF's Global Services interest group has been the most active of the Special Interest Groups that were established when MHF was founded. This is the group that processes requests for Student Elective Term and for the new Steven Roth Memorial Grant Program. The level of interest and activity in this group has been outstanding. All of these factors show that many Mennonites are keenly interested in global health issues.

Global connections are dwindling. However, with all of the possibilities for even greater global connections, I have the sense that our global connections are actually dwindling.

The personal connections with mission work in developing countries mostly reside among the retirees in our midst. Mennonite mission agencies have little need to call physicians and nurses trained in North America to serve the remaining mission hospitals which have their own national church connections and their own trained professionals.

As a result, while younger North American Mennonite professionals may have some overseas experiences, those experiences are usually short-term and happen during their student days. Thus, any global connections that are developed do not have deep long-term roots.

The future of global connections. What does it look like to develop global connections among Mennonite healthcare workers in the 21st century? Despite the possibility of greater connections through technology, there is a need for person-to-person and face-to-face connections that undergird our technological connections. Any forum in which international travel becomes the occasion for building personal cross-cultural relationships should be used to full advantage.

A unique opportunity for global connections. 2015 is a big year for Mennonites in general and Mennonite Healthcare Fellowship in particular.

North American Mennonites will be host to many international visitors

coming for **Mennonite World Conference's Global Assembly, July 21-26** in Harrisburg, Pennsylvania.

Some healthcare workers who have attended past Global Assemblies may remember a medical caucus within the Global Assembly itself. This is being largely replaced by MHF's pre-Assembly **Annual Gathering 2015**, held on Sunday evening through Tuesday noon, July 19-21.

Annual Gathering is wider in scope than past meetings within Global Assembly. Not just doctors and nurses, but therapists, educators, psychologists and other mental health workers, dentists and technologists, medical technologists, and chaplains are among those who are invited to this year's Annual Gathering. We encourage **all healthcare workers** from all backgrounds from around the world to attend this year's gathering and stay on for the Global Assembly!

To whet your appetite, here is some preliminary information on the plenary speakers and workshops which have been confirmed for MHF's Annual Gathering:

Theme: Walking Together for Healthy Communities

Plenary Session Speakers

Ann Thyle, MD., New Delhi, India
"Health Care Delivery to the Poor: A Personal Calling"
Dr. Ann Thyle is a Consultant in Anesthesia, Pain & Palliative Care for the Emmanuel Hospital Association (EHA), which includes several Mennonite hospitals among its members. Her work involves planning, fundraising and implementation of palliative care services in ten EHA hospitals, focusing mainly on people with life-limiting illness and based in rural north India where little or no palliative care services exist.

Shane Claiborne, Philadelphia, Pennsylvania
Shane's adventures have taken him from the streets of Calcutta where he worked with Mother Teresa to the wealthy suburbs of Chicago where he served at the influential mega-church Willow Creek. As a peacemaker, his journeys have taken him to some of the most troubled regions of the world – from Rwanda to the West Bank – and he's been on peace delegations in Afghanistan and Iraq. Shane is a founder and board member of The Simple Way, a faith community in inner city Philadelphia that has helped birth and connect radical faith communities around the world. He writes and travels extensively speaking about peacemaking, social justice, and Jesus. His books are translated into more than a dozen languages.

David Gullman, Broadway, Virginia
Dave Gullman is a chaplain and pastor in the Harrisonburg, Virginia area. He and his wife Debbie are parents of two children, John and Hannah. Hannah has Down syndrome and has opened many windows on the world of persons with disabilities. Dave is a pastor to over 130 individuals with disabilities at Pleasant View, Inc., an agency that serves people with disabilities in Harrisonburg and Rockingham County, Virginia where he has served for over 14 years. He also serves as a co-pastor to a small rural Mennonite church in Timberville, Virginia.

Workshops anticipated for **Annual Gathering 2015**:

- Health Care Delivery to the Poor: A Personal Calling -- Ann Thyle
- Spiritual Health/Disabilities – David Gullman
- Church Health Ministries – Linda Witmer
- Immigration and Refugee Concerns
- Climate Change and Global Health – Catherine Thomasson
- Kenya Mennonite Church's response to HIV/AIDS- Maurice Anyanga
- Gun Violence – J. Fred Kauffman & Curtis Book
- Maternal Health in Tanzania – Bwire Chirangi

I hope you will plan now to come to Harrisburg for the entire week of July 19-26. Mennonite Healthcare Fellowship has reserved a special block of rooms at the **Sheraton Harrisburg Hershey Hotel** for healthcare workers. Information for making your hotel reservations and further information on the registration process and more is now on the Annual Gathering web page at http://mennohealth.org/events/gathering/annual-gathering-2015/.

We look forward to the exciting **global connections** we can make at Harrisburg!

Paul D. Leichty, M.Div. *is Executive Director of Mennonite Healthcare Fellowship (MHF). Paul has served as a pastor, church musician, computer support person, disabilities advocate, and administrator/organizer of a number of church-related ministries. In addition to responsibilities at MHF, Paul is Executive Director of Congregational Accessibility Network and Director of User Services at Mennonite.net. He is also active in music at Berkey Avenue Mennonite Fellowship in Goshen, Indiana where he lives with his wife, Twila Charles Leichty.*