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This issue of *Mennonite Health Journal* focuses on the theme of Mennonite Healthcare Fellowship's Retreat 2012: **Integrated Healthcare: Many Gifts, One Purpose**. Integrated healthcare can mean many different things. Readers will get a taste of some of the issues discussed at Retreat 2012, held June 29 to July 1, at Laurelville Mennonite Retreat Center.

Paul Leichty, MHF Executive Director, reflects in his editorial on the interaction between the societal concerns of professional healthcare providers which surfaced at Retreat 2012 and the personal and family concerns that come our way regardless of our profession. (p. 2)

The lead article by **John Wenger, D.O.** is entitled **Integrative Medicine: It's just good medicine.** Out of his experience in a two-year residency at the Arizona Center for Integrative Medicine, John commends an approach that emphasizes overall health and disease prevention and integrates conventional medicine with alternative therapies that have evidence of efficacy and safety. Read full article (p. 4).

At the opening plenary session of Retreat 2012, **Jone Friesen, R.N**., led a panel of persons who earlier gave leadership in the formation of Mennonite Healthcare Fellowship (MHF). Their reflections, entitled **An Integrated Anabaptist Healthcare Organization: The Gifts and Challenges for Mennonite Healthcare Fellowship**, are distilled into an article starting on p. 7

Stan Reedy, M.D., offers some further reflections on the timing and implications of the U.S. Supreme Court upholding the Affordable Care Act in his **President's Column.** (See p. 10).

Finally, we turn to "Integrated Healthcare" at a very personal level as we feature the heart of the Retreat 2012 Sunday morning sermon by **Jim Leaman, M.Div., M.A.,** called **Faith, Health and Community: An Integration.** Jim, who is Secretary of Mennonite Chaplains Association, draws on Jesus' own healing ministry as a model. Read full article (p. 11).

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Integrated Healthcare
Reflections on Retreat 2012

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

As I reflect on Mennonite Healthcare Fellowship's first "Convention Retreat," I am grateful to be a part of the very important conversations in the church surrounding health and healthcare in our society today. This year's theme, "Integrated Healthcare: Many Gifts, One Purpose," focused on healthcare in the United States. As it turned out, the landmark Supreme Court decision essentially upholding the Affordable Care Act (ACA) was announced the day before we gathered.

In our Saturday morning session, Jane Hiebert-White, Executive Publisher of the Health Affairs journal gave us a good overview of the implications of this decision and its impact on the ongoing movement in the U.S. toward healthcare reform. Doug Schwartzentruber's Saturday evening presentation gave us further insight into the benefits of a multi-disciplinary approach to cancer care.

Underlying both of these presentations as well as the weekend as a whole was a key issue: the cost of healthcare. The financial costs of our healthcare system are a huge driving factor behind both healthcare reform and the movement toward more "integration," in all of the various ways in which that term is used.

Nowhere is cost a more complex and perplexing issue than at the end of life. Our current medical technology gives us unprecedented means of prolonging life. As Christians who recognize the God-given value of each human life, we want to do everything possible to bring our loved ones back to health and wholeness.

Yet, what is possible today is also very costly. The debate rages about who is ultimately going to pay those costs. The discussion brings up hard questions about whether it is worth hundreds of thousands of dollars to extend human life by a few months.

As I was absorbing the implications of the larger picture, what Jane Hiebert-White called "the 30,000 foot level," I couldn't help but think of back home and my neighbors across the street, at "ground level." They were facing agonizing situations and choices around end of life care that my own family was facing just a year ago at this time.

In both cases, our elderly fathers (89 and 92) ended up in the hospital and eventually on a ventilator in the intensive care unit, the latter situation despite the fact that most family members felt that neither father would have wanted this. Yet, in each case, it happened because of (a) the high value we as a Christian family placed upon the life of our loved one, (b) the judgment of the physicians that there was a good chance of full recovery with a good quality of life, and (c) the fact that Medicare and insurance were covering the costs.

Yet, as our fathers alternately improved and declined, we also became aware that, in the final analysis, their lives, and indeed, all of our lives, are in God's hands. Our belief in the resurrection means that physical death is not the ultimate tragedy, but rather, the gateway to eternal life. In light of our faith, we could not help but wonder, expressed out loud in our neighbor-to-neighbor conversations, whether the money to keep our fathers alive a few extra months wouldn't have been better spent on those who went without even basic healthcare.

In the midst of my family journey, I stepped into my role as Executive Director of Mennonite Healthcare Fellowship. And, in the midst of my work for MHF, attending important Board meetings, planning the Retreat, and scheduling important conversations, I was called home to be with my father in the last two days of his earthly life in late February.

Thus, in the midst of the Retreat, I realized that while I was learning and reflecting on the "30,000 foot" level, my neighbor, a physician and MHF member, was also on the "ground level," attending to his patients, his practice...and his own father.

As Christians, family members, and professionals, we deal with these hard issues on many levels. I feel privileged to be part of a Christian community that can encourage and support each other as we wrestle with these societal and yet very personal issues. I hope that MHF can play an important ongoing role in fostering that kind of community.

Paul Leichty is an ordained minister in Mennonite Church USA and Executive Director of MHF. He has also served in past and present roles as pastor, music minister, disabilities advocate, and computer support specialist.

Saturday Presenters at Retreat 2012

Jane Hiebert-White, Saturday morning presenter

Doug Schwartzentruber, Saturday evening presenter

Integrative Medicine
It's just good medicine
by John Wenger, D.O.

In 2001, the Institute of Medicine stated, "The US healthcare system is in need of a change. Healthcare today harms too frequently and fails to deliver its potential benefits routinely. As medical science and technology have advanced at a rapid pace, the healthcare delivery system has floundered. Between the care we have and the care we could have lies not just a gap, but a wide chasm." Dr. Andrew Weil writes, "Imagine a world in which medicine was oriented toward healing rather than disease, where doctors believed in the natural healing capacity of human beings, and emphasized prevention above treatment."

These statements should cause each of us to pause and take notice of our current state of affairs in healthcare:

- Heart disease is responsible for nearly 30% of global deaths.
- Well over 100,000 Americans die each year from adverse effects of pharmaceutical medications.
- Evidence shows that up to 80% of cardiovascular disease and up to 33% of cancers can be prevented by healthy lifestyle and diet.
- Americans spend more per capita on healthcare than any other people in the world, yet have some of the worst outcomes among developed nations.

The picture can seem quite grim and the future is uncertain. However, despite these realities, healthcare remains an exciting profession with growing and innovative opportunities to provide better care to our communities and to improve the health of our nation.

Our current healthcare system is geared toward intervention in established disease. This remains the foundation of medical training to this day. Unfortunately, people then tend to live with an expectation that medicine will fix the consequences of lifestyle. I would hold that **our long-term goal must be to shift our healthcare efforts from disease intervention to disease prevention and health promotion**. Many healthcare providers as well as people in society are developing a greater awareness and desire for this premise to be implemented into our system of care.

We are getting closer to that "tipping point" where alternatives and new approaches to healthcare are desperately needed. Yet, as Einstein reminds us, "To solve significant problems that we face requires a different level of thinking than we possessed at the time they were created."

An exciting and rapidly growing movement in healthcare is known as *integrative medicine*. **Integrative medicine is a healing-oriented medicine** that takes account of the whole person (body, mind, and spirit), including all aspects of lifestyle. It reaffirms the importance of the relationship between

practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing. Integrative medicine emphasizes disease prevention and adds many less toxic and more cost-effective means to address acute and chronic conditions.

Let us take a look at the defining principles of integrative medicine:

First, the patient and practitioner are partners in the healing process. That may sound obvious, yet I encounter so many patients that, when asked why they are taking a certain medication or why a certain test was ordered, state they do not know because their doctor never explained it. That directive style of care does not tend to facilitate a good relationship of trust and partnership between practitioner and patient.

All factors that influence health, wellness, and disease are taken into consideration including mind, spirit, and community, as well as the body. As the World Health Organization stated in 1948, good health can be defined as "...a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity." We are more than just physical beings and there are many facets to our health.

Appropriate use of both conventional and alternative methods facilitates the body's innate healing response. It is important to note that integrative medicine is not "alternative medicine." The term "alternative medicine" is often used to convey the idea of "in place of" conventional medicine. Integrative medicine uses conventional medicine fully alongside complementary and alternative therapies that have evidence of efficacy and safety.

Effective interventions that are natural and less invasive should be used whenever possible. A great example is the patient who presented to me with symptoms of anxiety. The patient was open to learning a breathing technique that is effective at decreasing the adrenergic surge associated with anxiety and brings improved balance between the sympathetic and parasympathetic parts of the nervous system. It worked very well for her and we were able to avoid an often used conventional medication that has side effects of sedation and addiction.

Integrative medicine neither rejects conventional medicine nor accepts alternative therapies uncritically. I believe that too many individuals in our healthcare system are closed-minded cynics. I would suggest that a better approach for us is to be open-minded skeptics. I also believe that our method of evaluation, the classic "randomized controlled trial," should be used more on a sliding scale approach. In other words, if an intervention has potential for great harm or cost, greater amounts of study and testing should be done compared to an intervention that has very little or no cost or harm. Good medicine is based in good science. It is inquiry-driven and open to new paradigms.

Alongside the concept of treatment, the broader concepts of **health promotion and prevention of illness** are paramount. Again, our long-term goal must be to shift our healthcare efforts from disease intervention to disease prevention and health promotion.

Finally, **practitioners of integrative medicine should exemplify its principles** and commit themselves to self-exploration and self-development. We as health care providers need to be on this journey, fully engaging ourselves towards better health and wellness as we interact with members of our communities.

During my two year fellowship at the Arizona Center for Integrative Medicine, I have learned a great deal about nutritional health, botanicals and dietary supplements, mind-body medicine, and many complementary and alternative practices. I have studied integrative approaches to women's and men's health, pediatrics, mental health, gastrointestinal disorders, cardiovascular disease, respiratory illnesses, cancer, and much more. It has expanded the scope

of my practice and enabled me to provide a wider array of interventions as I bring health and healing to the patients I serve.

For some of us, it is challenging to think beyond our understanding of what is known or established. And yet, when we are pushed to rebuild our perceptions of what is possible, they are often bigger...expanded! As we deal with the realities of our current healthcare system and the type of care being delivered, I share this opportunity to explore integrative medicine. Hopefully, one day, it will simply be known as *good medicine*.

John Wenger *is a family physician in Harrisonburg, Virginia. He is married to Sandy Eberly Wenger; they have 4 children, 2 sons-in-law, and one grandson. John specializes in practicing integrative medicine and is passionate about paving the way to a new future in healthcare.*

Other Workshop Presenters

Clockwise from upper left: Jane Hiebert-White; Bernie Good; Pamela Brubaker, Jim Leaman, Ken Brubaker, and Chris Wood; Juliette Cutts and Don Carufel-Wert; Joe Martin, Todd Weaver, and Kristen Metzler-Wilson; Beth Good and Rebekah Good Charles.

An Integrated Anabaptist Healthcare Organization

The Gifts and Challenges for Mennonite Healthcare Fellowship

The opening plenary session of the first MHF Retreat on June 29, 2012 provided an opportunity to reflect on the significance of the new integrated Anabaptist healthcare organization. Jone Friesen, who served as consultant for the Implementation Team that led in the transition process led a panel of persons which included Beth Good, Rebekah Good Charles, and Joe Longacher, each of whom was a member of the Implementation Team from 2010-11 and served as co-chair of a Task Force. Stan Reedy, President of the first Board of Directors, offered some follow-up comments. The following represents reflections by Executive Director Paul Leichty based loosely upon the compilation of panelists' notes.

Mission Statement. *Mennonite Healthcare Fellowship (MHF) is an interdisciplinary community of Anabaptist health professionals that seeks to nurture the integration of faith and practice, provide opportunities for dialogue on health-related issues, and address specific needs through education, advocacy and service.*

Mennonite Healthcare Fellowship (MHF) was born out of a rich history of two previous associations of healthcare professionals. Both Mennonite Medical Association (MMA) and Mennonite Nurses Association (MNA) began in the 1940's as Mennonites became more engaged with the larger North American society, pursued higher education, and entered into a life of professional service.

The healthcare field in those days was made up primarily of doctors and nurses. MMA and MNA provided a means by which Mennonite healthcare professionals could reflect and act upon the implications of what it meant to be both Mennonite and professional. As Christians, family life was also an important component of their faith journey and thus both associations had a strong emphasis on supporting families as well.

In the first decade of the 21st century, it became increasingly obvious that changes in the larger society and the church were calling for changes in these associations as well. Among the most significant changes are the following:

- Doctors and nurses are no longer the only healthcare professions.
- Models of healthcare delivery are changing as individual healthcare professionals increasingly become part of larger healthcare systems.
- An increasing level of expertise is required in all healthcare professions leading to longer periods of education.
- It is no longer unusual for Mennonite young adults to enter healthcare professions but rather seen as a typical response to the desire of Christian young adults to live a life of service that will also financially support their families.
- Mennonites themselves are more diverse in the 21st century

By 2007, both MNA and MMA began asking, "How can we as Anabaptist organizations be relevant in today's world?" How can we more effectively reach out to a new generation of healthcare professionals who are not just doctors or nurses? They agreed to work together and in

2008 formed a study team to determine the feasibility of a new organization. In 2009, that study team presented a proposal for a new organization that would be multidisciplinary and have a global presence. Following a period of working out the details of implementation in 2010 and 2011, MHF was launched in June 2011.

So what is the vision for MHF? What are the opportunities and challenges presented with this vision? Examining the Mission Statement more closely helps us answer the question.

The vision: MHF is an **interdisciplinary community.**

- **The opportunity** is to develop the full range of professionals from many different viewpoints working together in an integrated, multi-faceted organization With the current technology, there are many creative possibilities for an interactive organization that truly spans the globe. **The challenges** are that the vast majority of current participants in MHF are physicians and nurses. Attracting other professionals will take work.
- **The opportunity** is to become a model for many voices in dialogue and collaboration between disciplines as we honor and value the different perspectives that each person brings. **The challenge** will be to make sure that each discipline maintains connections with their discipline group, with an equal voice that can then be fully integrated into MHF.

The vision: MHF nurtures **the integration of faith and practice.**

- **The opportunity** is to support and nurture each other in a common Christian faith that transcends professional boundaries and indeed learns from other professions in the practice of our faith in our professions. **The challenge** is to actually be open to the many voices around us, listening and truly hearing, being alongside each other, without being judgmental, as we struggle with the complex issues of healthcare today.

The vision: MHF is a vehicle for Anabaptist health professionals wherever they are located to **develop relationships, stay connected and dialogue** on pertinent issues and concerns on an ongoing basis.

- **The opportunity** is to have a global presence and develop relationships throughout the world around all aspects of service, education and advocacy. **The challenges** are to expand beyond mainstream North American Mennonite groups and use the previous strong mission emphasis to propel us into a mutual partnership in God's mission around the world.

The vision: MHF is a viable and dynamic resource to Anabaptist health professionals, other Anabaptist organizations and to the healthcare arena as a whole.

- **The opportunities** are virtually limitless! Many levels of involvement with each other, our churches, and other Anabaptist groups can be explored. **The challenge** is to make the best use of our resources of people, finances, and time to enable MHF as an organization to serve its members, the church, and our world.

When it comes to resources, Joe Longacher noted the saying that "if you want to know someone's priorities, read their checkbook stubs." He expanded the more narrow definition of

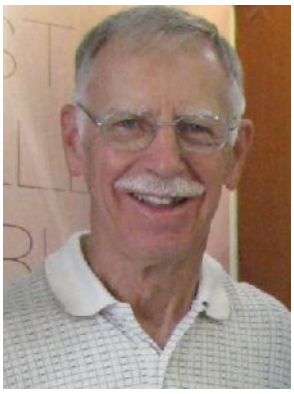
"checkbook stubs" to encourage all of us look at our expenditure of time and energy as well as finances. These are the ways in which we discover our true values and priorities.

Jone Friesen used her own story as an illustration of the vision for MHF. She came out of the Mennonite Brethren rather than the Mennonite Church tradition and from rural Oklahoma instead of one of the Mennonite centers in the East and Midwest. Even though she didn't know what the word "Anabaptist" meant and knew no other member of MNA or MMA, she was drawn to MNA because she wanted the connection with other Mennonite health professionals, to be part of the dialogue, part of the greater whole.

Joan's hunch is there are many other Anabaptist health professionals in the same situation, scattered throughout the world, who would be drawn to be part of a dynamic faith community of Christian healthcare professionals.

How will this happen? How will MHF live up to the vision set before us? How will we take advantage of the opportunities and respond to the challenges? Rebekah Good Charles reminded us that in the end, it will happen only by the power of the Holy Spirit in our midst. As the hymn we sang reminded us, "we are weak and selfish too." Our prayer is thus in the title line, "Holy Spirit come with power." (*Hymnal: A Worship Book* #26) May it be so!

Friday evening panelists led by Jone Friesen (top) were (L to R) Rebekah Good Charles, Beth Good, and Joe Longacher.



President's Column

by Stan Reedy, M.D., M.P.H.
President of the Board of Directors
Mennonite Healthcare Fellowship

"Integrated Healthcare" was our theme at the MHF Retreat 2012 at Laurelville Mennonite Church Center in Pennsylvania. The U.S. Supreme Court decision on the Affordable Care Act (ACA) was announced the day before Retreat 2012 began. It's hard to imagine a more timely pair of events.

Each of the workshops at the Retreat was connected in some way to initiatives that ACA has already set in motion. Many of the healthcare reform provisions of ACA are broadly based and have already affected millions of people (54 million by the AMA's count). Yet, there are two key ingredients that will produce improvements in health: (1) an emphasis on personal caring in the context of a scientific base, and (2) efficiently utilizing the skills of an integrated care team.

Integration of a growing number of treatment and prevention modalities was another key component of the Retreat. MHF is providing a place where different disciplines can share their approaches and learn to value the contributions of others.

MHF members can definitely expect to hear more about the implications of health resource allocation in coming months. Health professionals will be a focus of examination by both the government and the private healthcare industry and insurance companies for cost-effectiveness. As total spending soars well above 2 trillion dollars per year, and important health status indicators are second-rate, it is dawning on legislators that their failure to take action might result in national bankruptcy and disruption of the healthcare system.

MHF will establish better Internet tools for communication. One clear lesson from the Retreat is that within a short time, an in-depth discussion is difficult. We also want to find a way to record Retreat sessions and post them online.

The MHF staff and board are grateful for evaluation feedback and other comments. We are looking forward to next year's Retreat, June 21-23, 2013 at Goshen College.

Stan Reedy is the outgoing President of the Board of Directors of Mennonite Healthcare Fellowship, having served in that role since the inception of the organization. He and his wife, Janet, will be serving Mennonite Central Committee as interim country directors in Vietnam from August to November 2012.

Faith, Health and Community
An Integration

by Jim Leaman, M.Div., M.A.
Secretary, Mennonite Chaplains Association

The following article is adapted from the message Jim delivered at the Sunday morning worship service on July 1, 2012 at the Mennonite Healthcare Fellowship Retreat.

Jesus, in his ministry, modeled an integration of health care and spiritual care, as well as one that promoted emotional and relational wholeness. It was a ministry of shalom – the welfare of the totality of one's being.

The story of the healing of the man who was paralyzed illustrates the integrated healing ministry of Jesus. (Mark 2:1-12) In this account, we see, first, that **Jesus was in a house preaching the word**. His preaching was bringing the kingdom of God among the people. He invited the poor in spirit to experience the peace which could heal troubled lives. I have come to appreciate the healing aspect of the word, as it affirms who I am as a redeemed person in Christ. I am not under condemnation. I am God's beloved child in whom he delights. The transformation God's Spirit has begun in me, he will complete.

Second, the story presents **the power of community** – a small community of four persons – who brought a fifth person, their friend who is paralyzed, to Jesus. This community of four was creative, carrying their friend past the crowd spilling into the street, up the stairs on the outside of the house, tearing a hole in the brushwood and earthen roof, and letting their friend on his mat down through the hole to place him in front of Jesus. One creative way the community of Christ can bring healing to underserved persons, is to develop church-based health centers, where persons receive both medical and spiritual care.

A third aspect of healing in this gospel story is the **offering of forgiveness** by Jesus to the man. "Son, your sins are forgiven." Was the man a great sinner? When the disciples asked once about a blind man, Jesus replied that neither the blind man nor his parents had sinned, causing his blindness, but that this was for an opportunity to reveal the glory of God; and he healed the blind man. Forgiveness is a basic human need of every person. Jesus first forgave and freed the spirit of this man who was paralyzed.

Fourth, **Jesus physically healed the man**. "Get up, take your mat, and go home," Jesus said, and the man did just that. As chaplains, we have the privilege of working alongside the interdisciplinary medical, social work, dietary and life enrichment team to bring integrative health care to the residents we serve.

CPE teaches us to work at developing the practice of non-anxious presence with those we provide care for. A fifth aspect of healing in this account was **the non-anxious presence** of

Jesus in a context where the religious elite were exhibiting great consternation towards Jesus, who had declared forgiveness for a hurting man. Jesus stayed self-differentiated.

Finally, **the people praised God and worshiped** at the conclusion of this experience of integrated healing. "We have never seen anything like this!" they exclaimed.

The good news of God, creative community, compassionate forgiveness, the art of healing, "being present with," and worshipful awe are six aspects of the ministry of wholistic health care. *May you discover ways to partner joyfully in the integrative health care of Jesus where you are serving.*

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Jim Leaman is Lead Chaplain at Landis Homes Retirement Community in Lititz, Pennsylvania, serving primarily residents in Personal Care and Health Care. He is married for 43 years to Beth (Kling) Leaman and they have two married children and six grandchildren. Jim also enjoys bird watching, travel and following the political scene.

Scenes from the Sunday morning Communion Service at Retreat 2012.