INTRODUCTION TO
SHORT-TERM MEDICAL MISSIONS (STMM)

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Arnold Gorske MD, FAAP
INTRODUCTION TO SHORT-TERM MEDICAL MISSIONS (STMM)

OBJECTIVES

1. Explore the Phenomenon of STMM—Resources, References & Evidence-Based (E-B) Guidelines
2. Review the Current STMM Controversy
3. Review the Biblical Mandate for STMM and Christ's Holistic (Mind Body Spirit) Approach to Healing
4. Compare the Biblical & Scientific Evidence for Christ’s Holistic Approach to Healing vs the Primary Care Medicine-Based Approach
5. Describe Healing and the Biblical & Scientific Requirement for Faith—What do STMM Teach Patients to Believe?
6. Describe the Need for Integration of E-B Holistic Primary Care and Community Health Evangelism.
INTRODUCTION TO SHORT-TERM MEDICAL MISSIONS (STMM)

PART I
EXPLORE THE PHENOMENON OF STMM:
RESOURCES, REFERENCES & EVIDENCE-BASED (E-B) GUIDELINES
Missions

Missions are an integral part of CMDA. CMDA mission trips break down barriers that would otherwise obstruct the Gospel from reaching many around the world.

Our mission efforts reach out to those who rarely, if ever, are treated for medical or dental health concerns, and we provide educational training so that local healthcare providers can offer better care after a team leaves.

We also offer scholarship opportunities for students who would like to serve on the mission field, but do not have the funds available to complete their medical degree.

For more information on these programs, please browse through the links below.

• **Global Health Outreach** - Medical and Dental Short Term Mission Trips
• **Medical Education International** - Teaching Opportunities
• **Healthcare to the Poor** - providing training and technical assistance to new and struggling health centers
• **Pan African Academy of Christian Surgeons** - African Surgical Degree Program
• **Center for Medical Missions** - Supporting Medical Missions Around the Globe
• **Scholarship Programs** - Student and Resident Mission Trip Scholarships
• **International Student Missions Opportunity Booklet**

[www.cmda.org]
Important Links

- [GHO Trip Calendar](#)
- [GHO Urgent Needs](#)
- [Continuing Medical Education](#)
- [GHO Trip Evaluation Form (PDF)](#)
- [GHO Payment](#)
- [Apply for a GHO Trip](#)
- [A Week With GHO - At a glance](#)
- [GHO Testimonies](#)
- [Health Education Program for Developing Countries](#)
- [Overseas Medical Professional Liability Coverage](#)
- [Handbook for Short-Term Medical Missionaries by Bruce Steffes](#)
By Dr. Bruce and Michelle Steffes

“This handbook is an excellent resource to both those who may be considering missionary service and those who have made a decision to serve and are preparing to leave on their assignment.

Virtually every conceivable subject or question which might present itself to someone preparing to go to the mission field is addressed in a clear, concise, and helpful manner. Especially noteworthy is the way Dr. and Mrs. Steffes have thoughtfully addressed possible needs which spouses and children of short-term missionaries might encounter.

This highly informational book is well organized, easy to read, and complete in content. If you have a question concerning life on the mission field, you will likely find the answer you seek in this book.”

DOWNLOAD FREE
www.cmda.org/go/gho

UPDATED CHAPTERS AVAILABLE AT:
www.brucesteffes.net/handbook
a Guide for those contemplating a period of short term medical service overseas.

DOWNLOAD FREE www.healthserve.org

HealthServe is a ministry of: Christian Medical Fellowship (CMF)
6 Marshalsea Road
London
SE1 1HL
United Kingdom
www.cmf.org.uk
Global Health Outreach Manual and Audiotapes

David Stephens M.D. & Gene Rudd M.D.

Can be purchased from:

www.cmda.org
Dear Global Health Outreach Missionary

We would like to present this book to you as a gift. Over the next week or two you may be transformed. Although much at home hasn’t changed, you will soon look at your own culture from a different perspective. This resource is a valuable devotional tool that we hope you will use to grow in Christ, and effectively share your vision to encourage others in prayer and participation in taking the Gospel to the lost.

Our hope is that this book will be a source of encouragement and guidance to you as you work through your experience. We want you to integrate the experiences and ministry in which you have been involved into your life. Don’t just put this experience in a box labeled “Missions Trip” and forget what the Lord has shown you.

Thanks for making an eternal investment in the lives of others through Global Health Outreach. More than anything else, our prayer is that you will continue to serve Christ, share Christ, and grown in Christ. May the Lord bless you during your service and time of transition. We look forward to many more missions together.

Global Health Outreach
PO Box 7500
Bristol, TN 37621-7500

Phone 423-844-1000
Fax 423-764-1417

Email: gho@cmda.org

www.cmda.org/go/gho

Pre-Field, Field, and Reentry
Devotional and other STM Resources
Can be Purchased from: www.DeeperRoots.com
and Numerous Other Missions Websites
They heard the singing and wouldn’t stop knocking until the doors were opened.
1. Coordinating Office for Global Health
2. Diseases & Conditions (A-Z Index)
3. Travelers Health
   - Destinations
   - Vaccinations
   - Diseases
   - Mosquito and Tick Protection
   - Safe Food and Water
   - Illness and Injury Abroad
   - References
   - Resources
   - Travel Medicine Clinics
   - Yellow Fever Vaccination Clinics
4. Links to U.S. State Department Travel Site:
   - Passport Services and Travel Warnings and
   - Consular Information Sheets for specific countries.

www.travel.state.gov
CURATIVE (DRUG-BASED) PRIMARY CARE REFERENCES


2008 (3rd Ed) Comprehensive. Includes WHO Guidelines & Protocols

www.cmda.org

DOWNLOAD FREE www.refbooks.msf.org
COMMUNITY (PREVENTION-BASED HOLISTIC) HEALTH CARE

Setting Up Community Health Programs: A Practical Manual for Use in Developing Countries (3rd Ed)  
Ted Lankester  
Book may be ordered through:  
www.hesperian.org

Multiplying Light & Truth through Community Health Evangelism (2nd Ed)  
Stan Rowland  
Book may be ordered through:  
www.lifewind.org

COMMUNITY HEALTH GLOBAL NETWORK  
www.chgn.org
This program enables short term medical teams to have a long term impact by introducing desperately needed evidence-based health education services to the community.

The goal is to provide the very best lifesaving information necessary for use by team physicians and nurses, as well as for host-country pastors, physicians and their communities.

It enables the integration of Primary Care and Community Health and is used at all three levels of the WHO "Ideal Health Care Pyramid": Hospital, Clinic/Health Center, and Family/Church/Community.

Disclosure/Conflict of Interest Validation:
The Authors and GHO receive no royalties or compensation of any kind related to the "Health Education Program for Developing Countries" or its website www.hepfdc.info
ADDITIONAL MISSIONS WEBSITES
MISSIONS JOURNALS/INFORMATION/TRAINING

Crossnetwork Journal  crossnetwork.org

Evangelical Missions Quarterly  www.emqonline.com

Network for Strategic Missions  www.strategicnetwork.org

The Luke Society  www.lukesociety.org

MISSIONS TRAINING/CONFERENCES

CHE (Community Health Evangelism) International Network  www.cheintl.org

ECHO North Fort Myers, Florida  www.echonet.org

Global Health Training Program King College, Bristol, TN  www.king.edu

Global Missions Conference  www.medicalmissions.com

West Coast Healthcare Missions Conference  www.healthcaremissions.org
STMMs & E-B HIGH QUALITY LIFE-SAVING CARE

DISASTER RELIEF
1000 DEATHS/DAY
KURDISH REFUGEE CAMP
NORTHERN IRAQ
END OF FIRST GULF WAR
MAY 1991
DISASTER RELIEF

Numerous Areas Where STMMs Provide E-B HIGH-QUALITY, LIFE-SAVING Care

IRAQ 1991

MALNUTRITION & SEPSIS

IRAQ 1991

MEASLES IMMUNIZATION VITAMIN A PROPHYLAXIS
Again Numerous Areas Where STMM Routinely Provide E-B HIGH-QUALITY Care
STMM – THE CONTROVERSY

• There are numerous areas where STMM provide high quality (safe and effective) care. Specialty services such as Dental, Optometry, and Surgical specialties in particular relieve the suffering of countless patients. This is especially true when combined with teaching of host country providers and patients. Drug-based Primary Care can also be lifesaving under certain conditions, such as relieving or assisting Host country providers in their hospitals or long term clinics, or in selective disaster relief situations.

• However, our attempting to provide drug-based care in the STMM primary care setting is of recent onset and it is very unique.

• Unfortunately, Short Term Missions (STM) in general, and STMM Primary Care in particular, are being increasingly criticized. And they are being criticized by our own Long-term, in-country physician, community health, pastors and other missionary colleagues.

• STMM are by their very nature short-term, so it is our in-country missionary colleagues who are best qualified to evaluate the safety and effectiveness of our STMM Primary Care on their patients and their communities. And the criticism is being reported in our own Missionary Journals and websites and in our highly acclaimed community health and evangelism texts:
Study Questions Whether Short-Term Missions Make a Difference

Missionaries don't keep giving after they return; hosts prefer money to guests, Calvin sociologist finds.

by Abram Huyser Honig | posted 6/20/2005 11:00AM

Discussion: Day One | Day Two | Day Three | Day Four

Short-term mission trips to foreign countries are an integral part of the evangelical Christian outreach scene since it has been vacated and the number keeps rising.

Praises and critiques of the trend tend to be propitious either as miraculous recruiters of long-term mission workers or as third-world dependency.

But a new study, to which I contributed the literature, seeks to tear off the mask.

According to Kurt Ver Beek, professor of sociology and third-world development at Calvin College in Grand Rapids, Michigan, traditional humanitarianism might sound odd to those familiar with the subject in the last 15 years. A well-known sociologist in the subject. Most of these studies significantly increase participants' spirituality, for missions, likelihood to become career missionaries.

But in his survey of 127 North American short-term mission participants, those who had experienced notable life change compared to pre-departure were much higher.

Why such different conclusions? Ver Beek ascribes methodology. Many previous studies involved terminators soon after their trips—while they were still taking on the account of other people's misadventures, the hum of good intentions and interviews, he writes.

Few checked reports of increased giving against records, and almost none solicited opinions from

Globalized Short-Term Medical Missions (STMMs).

Dr. Apollos Landa, MD, MSc CIIDC LSITM

www.lukesociety.org

The STMMs appear as a sort of “Global Resources vs. Global Needs” mobilization in response to the depressing illnesses and poverty of the most exposed sector of Two-third world population. Multidisciplinary health teams emerged to outreach target communities with identified needs to address. They were either local or internationally based, state or privately supported, secular or religiously facilitated. They intended, in periodical campaigns, to bridge the
October 2000
What Have We Done?
Jim Lo

AND MANY OTHERS

October 2000
First, Do No Harm
Richard Slimbach

Each year tens of thousands of women and men from North America participate in short-term mission trips sponsored by local churches, mission organizations, and Christian colleges.¹ This short-term avalanche of travelers—destined for Mexico or Haiti, to lend a hand, to “prayer walk,” minister to the elderly, reach out to young adults for missions—has been drawing criticism of late.

The projects are started by churches or organizations, soliciting groups of 10 to 100 people with a crusade for the sick, the homeless, the poor, or the elderly. A recent appeal was made by a group of churches to save lost mission funding.

From modern to primitive, it is a reshaping of the world, but with a twist. It was believed that those who have created the culture—those who “own” the culture—would tell us how to do things. The so-called “short-termers” would consult the people about their problems, with strong and great intentions.

Church leaders need to make their mission trips meaningful. Missionaries need to help them understand the culture.

1. Tourists or spiritual participation?

¹ Short-term Medical Teams: What They Do Well, and Not So Well
"Short-Term Medical Missions: Enhancing or Eroding Health?"

Missiology. v. 21 no. 3. (July '93) pp. 333-341. Montgomery, Laura M.

Summary:
Case study of two medical mission trips (one to Central America, one to Mexico) concludes short-term medical missions cause negligible improvement and may even damage public health.

Major critiques: teams uninformed about local culture, underlying causes of poverty and poor health; short-term volunteers not suitable promoters of preventative measures; short-term missions band-aids instead of real solutions, make patients dependant on outsiders; insufficient or nonexistent follow-up to short-term trips.

"These potential or real disadvantages and short-comings of short-term medical missions have little if anything to do with local health conditions or delivery systems, but everything to do with worldview and cultural assumptions about health, poverty, and assistance that inform their design and implementation." –p. 338

"Some advocates for short-term missions often justify them in terms of the inspiration or the awareness they provide for participants. Indeed, a few do commit to lifelong service as a result of their participation. Christians should carefully examine this type of means-ends reasoning. Is a model for servanthood which essentially is oriented to the needs of the server rather than to the served the biblical model of servanthood? Is a mode of service which is informed by ethnocentricity an appropriate one with which to socialize potential missionaries?" –p. 339
“When health services are received by villagers, they are mostly curative. But 80% of village disease problems are preventable through such measures as health education and vaccinations against major diseases...

Curative medicine seeks to cure existing diseases, rather than preventing them in the first place. This approach is expensive and narrow and ineffective in reaching the masses.

It is like a fireman waiting around to put out fires, when taking measures to prevent fires in the first place would be better, less costly, and far more effective.” Page 4
“If an outside change agent (i.e. STMM) is viewed as a supplier of goods (i.e. relief), it is very difficult to switch to a developmental, self-reliant process.

At another location where we were requested to train the people in how to start a CHE program, the people had been involved in an outreach to orphans through a relief ministry for two years.

They were also running a clinic and dispensing free drugs, clothing, and food. When we began to teach about self-reliance–that the people need to help themselves–nothing happened.

The people were used to getting things free and having things done for them by others. The reasoned, “Why should we do anything for ourselves?”

Eighteen months later the project was still trying to overcome this dependence attitude.” p82
HOW IMPORTANT IS
HEALTH TEACHING VS
“RUNNING CLINICS & CURING ILLNESS”?

“Many health program staff spend most of their time running clinics and curing illnesses. They give health education only if there is time left over. Such an approach will never improve the health of a community. Health teaching with the active involvement of the people is probably the most important of all community health activities. It must be the top of our priority list and should take place on all appropriate occasions, not only in the clinics but in schools, in meetings or whenever community members and health workers come together.” p38
“BEWARE THE CURSE OF MALINCHE

Malinche was a Mexican who helped the foreign soldier Cortes invade Mexico and conquer the country. The Curse of Malinche is the belief that anything foreign or western is good and must be better than things made in our own country.

The Curse of Malinche makes poor people want to buy the latest drink, food, cigarette, or drug from the nearest ‘smart’ country...This in turn leads them deeper into poverty. P186

Each year drug manufacturers, especially multinational corporations, are developing new and more effective ways of persuading ordinary people that a whole range of medicines and injections are necessary...Two examples illustrate the pressures against rational drug use.

Example (1) recently one drug company offered Peruvian pharmacists a bottle of wine if they ordered three boxes of its cough and cold remedy.

Example (2) another company told doctors to suspect Giardia or amoeba in all cases of diarrhea and treat immediately with metronidazole In fact, this drug is only needed in a very small proportion of diarrhea cases.”
“One of our main tasks as community health workers is to educate the people about correct and incorrect use of medicine. If we succeed, communities will become healthy and self-reliant. If we fail, communities will become poorer, more exploited and more dependent...

The commonest reason why doctors over prescribe is this: Patients expect many medicines ... If they don’t receive them they seek out another doctor willing to provide them. p327

Unless the whole health team understands and practices the appropriate use of medicines at all time, community members will never be taught how to change their expectations. p331

It must be our aim to create awareness in the people so successfully that, when tempted by glossy advertisements or TV commercials promoting the latest health tonic, they refuse to buy it.” p332
DRUG-BASED VS EDUCATION-BASED STMM PRIMARY CARE Rx & THEIR EFFECTS ON LONG-TERM COMMUNITY HEALTH EVANGELISM (“The Pit of Ignorance” & “The Land of Knowledge”)

Drawings from “Setting up Community Health Programmes.”
Originally from “Where There is No Doctor”
Short-Term Medical Missions: Some Quality of Care Issues

Michael N. Dohn MD and Anita L. Dohn MD

The Journal for the Christian Health and Wholeness Network

November 2005 p31-45 crossnetwork.org
WHAT CAN WE LEARN FROM ALL OF THESE STUDIES & COMMUNITY HEALTH & EVANGELISM AUTHORITIES THAT WILL HELP US IMPROVE THE QUALITY OF OUR STMM PRIMARY CARE?

What is it that is chiefly responsible for our Poor Quality Primary Care?

Contrary to some beliefs, it is not our “Senders” or our “Goer-Guests”, or our Directors, or our Physicians, or even our often emphasized “cross-cultural incompetence.” What is chiefly responsible is...
THE STMM SETTING ITSELF

STMM PRIMARY CARE’S MOST CRITICAL QUALITY PROBLEM:
HOW DO WE PROVIDE MEANINGFUL, REASONABLE QUALITY (SAFE AS WELL AS EFFECTIVE) DRUG-BASED TREATMENT IN THE STMM PRIMARY CARE SETTING?
WHY PATIENTS ARE AT MUCH GREATER RISK OF SERIOUS HARM FROM OUR DRUGS IN THE STMM PRIMARY CARE SETTING

1. Lack of knowledge of the patient (Every Patient is a New Patient). This risk factor, alone, significantly limits the kinds of drugs even the very best physician, under ideal conditions, can prescribe safely.

2. Lack of adequate medical record, medication history, contraindications, etc.

3. Lack of adequate time for obtaining accurate and complete history.

4. Lack of adequate time /facilities for obtaining accurate and complete physical exam.

5. Lack of availability of reliable laboratory testing.


7. Confusion due to language and cultural differences. This risk factor, alone, significantly limits the number of patients/hour even the very best physician, under ideal conditions, can evaluate and treat safely.
8. Lack of patient’s familiarity with our medicines and their adverse effects. Lack of package inserts, patient medication guides, black box warnings or other informed consent information that is legally required in our country.

9. Lack of adequate time for counseling by either the physician or the pharmacist.

10. Increased risk of drug interactions and drug overdose: Because our medicines are donated, patients often deny they are taking any medicines or have medicines at home in order to be certain they will receive ours. The frequent use of traditional medicines also increases the risk of adverse drug interactions.

11. Increased risk of accidental ingestion: Lack of knowledge of child safety requirements by patients. Lack of safe storage area in home. Lack of child-safe containers.

12. Lack of poison control centers, emergency medical systems and intensive care units for timely and appropriate treatment of accidental ingestions.
14. Lack of availability of follow up if patient develops adverse side effects. Neither the prescribing provider nor the dispensing pharmacist will be available if there are any adverse effects to the treatment.

15. Lack emergency medical systems and intensive care units for timely and appropriate treatment of adverse effects. For example, the NSAID deaths/year (16,500 due to GI complications alone, in arthritis patients alone, in the USA) would be much higher in countries without emergency medical systems and surgical ICUs.

16. Local in-country health care providers and pharmacy personnel usually have little knowledge of our drugs and their adverse effects and lack the resources to help our patients.

For These Reasons
In the STMM Setting,
The Harm of Treatment Outweighs the Benefit For Most Drugs...

and the STMM Pharmacy is by far Our Highest Risk Area for Poor Quality Care as well as Patient Harm.

What Does the WHO Have to Say about our Drugs?
CORE PRINCIPLES

“THERE SHOULD BE NO DOUBLE STANDARDS IN QUALITY”

“GUIDELINES FOR DRUG DONATIONS” WHO 1999

*Collaborating Partners for these International Standards & Guidelines included the Churches’ Action for Health of the World Council of Churches.
“The quality of our work and service is more than just a part of our professional persona; it is an important part of our witness for Christ.”

“We are commanded to be excellent… Jesus healed the sick because he loved them … Love does not reach out with leftovers.”

“People don’t care if you are a good person until they know you are a good doctor”
THE STMM SETTING ITSELF

STMM PRIMARY CARE’S MOST CRITICAL QUALITY PROBLEM:
HOW DO YOU PROVIDE MEANINGFUL, REASONABLE QUALITY (SAFE AS WELL AS EFFECTIVE) DRUG-BASED TREATMENT IN THE STMM PRIMARY CARE SETTING?

HOW CAN STMM MEET EVEN MINIMAL INTERNATIONAL STANDARDS & GUIDELINES?
HOW CAN WE RESOLVE OUR DRUG-BASED STMM PRIMARY CARE PROBLEMS?

• As noted previously, our attempting to provide drug-based care in the STMM primary care setting is of recent onset and it is very unique.

• Published reports from our long-term in-country missionary physician and community health & evangelism colleagues are very highly critical. The criticism concerns the adverse effects of our drug-based approach on the spiritual and psychological, as well as, physical well being of their patients.

• Nearly all conclude that providing meaningful, adequate quality (Safe as well as effective) drug based primary care treatment in the STMM setting is not possible, and that our STMM efforts should be abandoned.

• Contrary to the above published reports, we strongly believe it IS possible for STMM not only to provide and teach high quality primary care, but culture-changing community health & evangelism services as well.

• However, we do agree that it does require a change in procedures and adoption of relatively recent WHO (and AMA) E-B programs to integrate Primary Care with Community Health (and Evangelism) Services. What does the WHO have to say?
"Irrational use of medicines is a major problem worldwide. It is estimated that half of all medicines are inappropriately prescribed, dispensed or sold and that half of all patients fail to take their medicine properly." WHO Medicines Strategy-2004

- E-B guidelines report only 15% of treatments are proven to be beneficial, even when prescribed, dispensed, and taken under study conditions.

- Adverse effects are the third leading cause of death even in developed countries.

- The ADDITIONAL risks of significant Patient Harm inherent in the STMM Practice Setting and its Double Standards.
INTERNATIONAL STANDARDS AND PRACTICE GUIDELINES

• Care provided by medical missions must meet the legal requirements and medical standards and practice guidelines of the host country. In nearly all cases, medical standards for host developing countries are based on World Health Organization (WHO) international standards and guidelines.

• The WHO constitution and additional documents available through www.who.int delineate the authority of the WHO and its 193 member countries. “WHO’s mandate comes from the constitution adopted by member states and the primary audience it serves is composed of governments, more specifically, the ministries or agencies concerned with health.”

• The WHO requires that practice guidelines be “systematically developed evidence-based statements which assist providers, recipients and other stakeholders to make informed decisions about appropriate health interventions”

• Until relatively recently, very few standards and guidelines were available, and those were rarely enforced. Over the past several years, numerous WHO international standards and guidelines have been established for the care of patients in developing countries. And those involving primary care now emphasize the “integrated” approach.
WHAT SHOULD WE IN STMM PRIMARY CARE BE DOING IF OUR GOALS ARE TO:

• SAVE THE MOST LIVES AND PREVENT THE MOST SUFFERING

• COMPLY WITH THE REQUIREMENTS OF “THE GREAT COMMISSION”.

• PROMOTE JESUS’ MESSAGE FOR A BELIEF IN GOD FOR HEALING VS OUR CULTURE’S DRUG-ADVERTISING MESSAGE FOR A BELIEF IN DRUGS.

• SUPPORT OUR HOST COUNTRY PHYSICIANS’ & PASTORS’ COMMUNITY HEALTH GOALS & EVANGELISM MINISTRIES (A MEANINGFUL, LONG-TERM, CULTURE-CHANGING DIFFERENCE).

• MEET INCREASING WHO STANDARDS AND GUIDELINES FOR PROVIDING INTEGRATED, HOLISTIC, HIGH QUALITY, SAFE AS WELL AS EFFECTIVE PRIMARY CARE

WHAT WE SHOULD BE DOING IS THIS...
COMMUNITY
(PREVENTION-BASED HOLISTIC)
HEALTH CARE
THE PROBLEM IS:

COMMUNITY HEALTH
(If it is being done at all)
IS BEING DONE HERE

PRIMARY CARE IS
ONLY CURATIVE CARE &
IS BEING DONE HERE

and

WHO "Ideal Health Care Pyramid"
WHAT IS NEEDED IS:
INTEGRATION OF PRIMARY CARE & COMMUNITY HEALTH & AT ALL LEVELS OF CARE

INTEGRATED HIGH QUALITY (SAFE & EFFECTIVE) HOLISTIC (CHRIST CENTERED) HEALTH CARE

WHO "Ideal Health Care Pyramid"
INTEGRATED PRIMARY CARE & COMMUNITY HEALTH EVANGELISM

AN EVIDENCE-BASED, HOLISTIC (CHRIST-CENTERED) APPROACH TO MEANINGFUL, HIGH-QUALITY STMM PRIMARY CARE

Evidence-Based Download Free www.who.int

TEACHING

TOUCHING
As this approach may not be familiar to many STMM, it is important to review the evidence for adopting this approach from both the Biblical standpoint and the WHO and the Scientific Evidence-Based (E-B) Standpoint.
PART III
THE BIBLICAL MANDATE FOR STMM
“THE GREAT COMMISSION”
“Go therefore, and teach (or make disciples of) all nations, baptizing them in the name of the Father, and of the Son, and of the Holy Spirit: Teaching them to observe all things whatsoever I have commanded you.”
Matthew 28:19-20

FIRST AND FOREMOST, IF WE WANT TO FOLLOW CHRIST’S MANDATE AND EXAMPLE, WE MUST TEACH.

WHAT ARE WE TO TEACH?
WHAT ARE WE TO TEACH?

THE GREAT COMMISSION

“Go therefore, and teach (or make disciples of) all nations, baptizing them in the name of the Father, and of the Son, and of the Holy Spirit: Teaching them to observe all things whatsoever I have commanded you.”
Matthew 28:19-20

Of all of the Commandments, Which did Jesus Teach was the Most Important?
THE MOST IMPORTANT COMMANDMENT
& HOW JESUS DEMONSTRATED IT

“Love the Lord your God with all your heart and soul and mind and...

Love your neighbor as yourself ”
Matthew 22: 36-40
Mark 12: 28-31

CHRIST’S APPROACH TO MISSIONS & HEALING REQUIRES THAT WE TEACH AND DEMONSTRATE CHRIST’S LOVE
(WHY STMM INTEGRATED HOLISTIC PRIMARY CARE IS NEEDED & WHY COMMUNITY HEALTH ALONE IS NOT ENOUGH)
“Jesus’ mission was not chiefly a crusade against disease ... but rather a ministry to individual people, some of whom happened to have a disease. He wanted those people to feel his love and warmth and His full identification with them. Jesus knew he could not readily demonstrate love to a crowd for love usually involves touching.” Dr Paul Brand & Phillip Yancey “Fearfully & Wonderfully Made”

It was not the curing of physical disease (He could have just prayed and healed the whole crowd), but the Demonstration of the Most Important Commandment that was important. Christ and His Followers Demonstrated this Love through Touching.
STMM-THE BIBLICAL MANDATE

CHRIST’S HOLISTIC (BODY, MIND, SPIRIT) APPROACH TO HEALING—

THE ESSENTIAL IMPORTANCE OF TOUCHING

Matthew 8:3
Jesus reached out his hand and touched the man. "I am willing," he said. "Be clean!" Immediately he was cured of his leprosy.

Matthew 8:15
He touched her hand and the fever left her, and she got up and began to wait on him.

Matthew 9:29
Then he touched their eyes and said, "According to your faith will it be done to you";

Matthew 17:7
But Jesus came and touched them. "Get up," he said. "Don't be afraid."

Matthew 20:34
Jesus had compassion on them and touched their eyes. Immediately they received their sight and followed him.

AND NUMEROUS OTHERS
The use of medicines for healing existed for many centuries before Christ. However Jesus chose not to use medicines for His STMM team’s healing.

Mark 6:12-13 Jesus Sends Out the Twelve:
“They went out and preached that people should repent. They drove out many demons and anointed many sick people with oil and healed them.”

Luke 10:9-17 Jesus Sends Out the Seventy two:
“Heal the sick who are there and tell them, 'The kingdom of God is near you’… The seventy-two returned with joy and said, “Lord, even the demons submit to us in your name.”

Again, Jesus’ Holistic Integrated Approach to STMM Primary Care Healing demonstrated His teaching and relied on a belief in a loving God (not a belief in drugs) for healing.

Is Jesus’ Teaching and His Holistic Approach to STMM Primary Care Healing still applicable today?
Although Randomized Controlled Trials (RCT) quantifying Love & Faith & the Holy Spirit and the resulting healing effects are not possible, there is an overwhelming abundance of non-RCT evidence that Jesus’ teaching and methods are as relevant today as 2000 years ago.
And The Current (Fall 2008)

Physician Literature Reports that Even...

Apologetics Series

Miracles are Possible

by Robert W. Martin III, MD, MAR

Note: This is the sixth article in this series on apologetics. The pages are divided for ease in creating for personal study discussion in a group setting, or for distribution to colleagues and staff. Installation seven is scheduled to appear in the Spring 2009 issue.

I. Introduction

"Bob, you are a basic science researcher and physician, how can you believe in (biblical) miracles?" asked a skeptical colleague. "You cannot believe in miracles and call yourself a scientist. That is schizophrenic!"

For the post-modern mind in general and unbelieving scientists/scholars in particular, nothing seems more ridiculous than to suggest that biblical miracles can occur and did occur. "Ridiculous" to one mind, however, may be "reasonable" to another.

II. Credibility of Miracles – Why Hume Was Wrong

Miracles are very different from natural laws. Miracles are unusual and irregular acts of God that occur in the world. A miracle does not violate or contradict the natural law of cause and effect; it is a new effect, introduced by a supernatural cause on a special occasion in the natural world that is truly unique and has theological, moral, doctrinal, and teleological dimensions.

In contrast, natural laws describe the usual and orderly way the world operates. Natural laws describe naturally caused regularities; a miracle is a supernaturally caused singularity. This doesn't mean miracles are violations of natural laws or that all singularities occurring in nature are miracles.

Of a theistic God exists, then the miraculous has already occurred in cosmic history. In fact, the only way to show that miracles are impossible is to disprove the existence of God. Despite this simple argument, arguments against miracles still deserve to be addressed:

"David Hume proved miracles are impossible over 100 years ago."

Hume argued that natural laws describe regular occurrences, established by uniform human experience. Miracles violate natural law and are rare, contrary to human experience. Since wise persons base belief on the greater evidence for regular occurrences, they should never believe in miracles, unless the evidence is greater for the miracle than for uniform experience.

Hume's first logical fallacy is a "category mistake." Miracles deal with irregular singular events that aren't even in the same category as repeatable natural events. Hume's next logical fallacy is to "beg the question" (argue in a circle) in favor of naturalism. He assumes that only natural explanations can be believed because only natural causes exist. He is essentially arguing that miracles cannot occur because miracles do not occur.

Christian's argue that miracles are "exceptions to," not violations of, natural laws. Natural laws deal with regular events, not singularities like miracles. Consider the resurrection. According to Hume, the uniform experience of mankind tells us Jesus' death and burial back to life. But Hume mistakenly adds evidence by looking at the number of times something did not occur instead of weighing the evidence of a singular event by considering the circumstances and witnesses.

It doesn't matter how many people have not come back from the dead. What is the evidence that Jesus DID come back from the dead, and what evidence supports this event? Is it "probable" (only selecting experiences of some people who have not experienced a miracle) and "circular reasoning" (presuming to know in advance that all possible experience past, present, and future will confirm naturalism to assume that all experience against miracles is uniform. Christianity claims over 500 reliable witnesses in a historically reliable book, the Bible!

Finally, if Hume's argument is correct then even evolutionists cannot believe the central premises of their naturalistic view, since the "big bang," spontaneous generation of first life, macro-evolution, and our solar system have happened only ONCE. Singularities do occur!

III. Possibility of Miracles – Questions & Answers

"Scientists only believe what I can prove scientifically."

There are several problems with this frequent comment. First, the comment itself is self-defeating, because it cannot be proven scientifically! You cannot put this statement in a test tube and evaluate its truthfulness because it is a philosophical statement about science.

Second, fact/data do not interpret themselves. Every scientific approach uses data with a predetermined set of assumptions (i.e., worldview) that implicitly or explicitly affect their interpretation. A good example of this is the macroscale debate discussed in our next article.

Third, the Christian asks, "Which investigative science are you referring to?" The idea of a Creator and miracles seems improbable to most scientists. Therefore, they are not even recognizing the distinction between operation (empirical) and origin (speculative/forensic) sciences. Both sciences require that their explanations be comprehensive and non-contradictory, but they differ in their use of other principles to investigate and explain either repeatable natural laws (operation/empirical science) or singular events (origin/forensic science).

Revisiting this valid distinction between operation and origin sciences removes the seemingly incontrovertible arguments against miracles that have been raised and persist over the centuries.

"What do you mean by Operation Science?"

Operation science is empirical science that employs repetition and observation. It deals with the way things operate now by studying regular and repeated phenomena through experiment (repetitive observation). The conclusions are falsifiable (if the cause does not always yield the same result) and have predictive value of what will happen in future experiments. This is the "science" most people are acquainted with.

"How does Origin Science deal with singular events?"

Origin science deals with past singularities. Since historical singularities are not observed regularly or repeatable, they must be reconstructed by evaluating the evidence that remains. Examples include murder, crimes, archeological finds, origin of the universe, first life, and miracles. Furthermore, conclusions are either plausable or implausible and are not falsifiable (because they cannot be repeated and observed, since they occur only once)

Origin science employs the four principles of consistency, comprehensiveness, causality, and teleology. First, all theories must be logically consistent or non-contradictory with all other elements of one's scientific views. For example, you cannot hold that the cosmos was both created and new-created.

Second, the scientific explanation must be comprehensive enough to explain the known facts. While anomalies may exist, no indisputable data can be neglected in theory construction. Usually, the most comprehensive explanation is the correct one.

Third, the principle of causality states that everything that "comes into existence" had a cause. This is true for unobserved as well as observed events. All forms of investigative science are based on the principle of causality. A primary cause is the first cause that explains singularities that happen once and have no natural explanation. Secondary causes are natural causes and laws that govern the way things repeatedly operate. While natural laws regulate the operation of things, they do not account for the origin of all things. For example, motors function in accord with physical laws (secondary causes), but physical laws do not produce motors; intelligent minds (primary cause) do.

Fourth, the principle of uniformity affirms that certain kinds of causes regularly produce certain kinds of effects and the cause of certain kinds of events now would be produced like events in the past ("the present is the key to the past"). Since we do not have direct access to the past, we can "know" the cause of events only by analogy with the present. Repeated observation reveals that intelligent (primary) and natural (secondary) causes regularly produce distinctive kinds of events. For example, waves produce certain naturally occurring patterns (secondary cause) on beaches. But when we observe "Rob loves Deb" etched in a beach, we do not believe that the waves (secondary cause) produced these words because they demonstrate a complex (unrepeatable) and specific order (i.e., specialized complexity). Therefore, an intelligent (primary) cause was involved.

"Accepting miracles invalidates the scientific method?"

Miracles are singular events that are not repeatable, therefore, the scientific law is not invalidated. The key is to use the correct scientific method, origin science!

Further, this argument falsely assumes that no matter what happens in the world, it must be a natural event. Attempting to use the principles of operation science (repetition and observation) to evaluate singular, unrepeatable events is analogous to performing brain surgery with tools designed for repairing car engines.

If an event is irregular, once forever, and has specified complexity (intelligent design is manifested in it) you do not need a naturalistic explanation. In fact, an honest intellectual recognizes that intelligent cause best explains what has taken place.

IV. Summary

Miracles are possible and credible. The existence of theistic God demonstrates the probability and reality of miracles. Arguments against miracles fail because of logic, fallacies and lack of recognition of the difference between origin and operation science.

Robert W. Martin III, MD, MAR
Lives in Lapeer, Indiana, where he practices Dermatology and Dermatopathology. He is married, with four children. He has served on the faculty of John's Hopkins, Case Western Reserve, and now Indiana University and Purdue Pharmacy School. He has a practice in Religion from Southern Evangelical Seminar. He has a practice in Water (Volume III: A Guide for the Health Professional). Available via OCM's website, "Billions of Bolivar" is a collection of Norman Geisler's twelve-part "Classical Apologetics" approach published after Paul's apologia in Acts 17. Dr. Martin may be reached by email at: robertm@cmich.edu
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He said to them, "Go into all the world and preach the good news to all creation...And these signs will accompany those who believe:...they will place their hands on sick people, and they will get well." Mark 16:15-20

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Therefore I tell you, whatever you ask for in prayer, believe that you have received it, and it will be yours. Mark 11:24

Never the less, most doctors & patients (including most US Christians) do not believe that the Holy Spirit & Faith & Love can still heal.―And because of scientific “modern” medicine, Jesus & His teaching are now irrelevant.

In the year 2008, Is Jesus’ teaching and healing treatment truly better than our modern scientific drug-based primary care treatment?

WHAT DOES SCIENTIFIC EVIDENCE-BASED MEDICINE HAVE TO SAY?