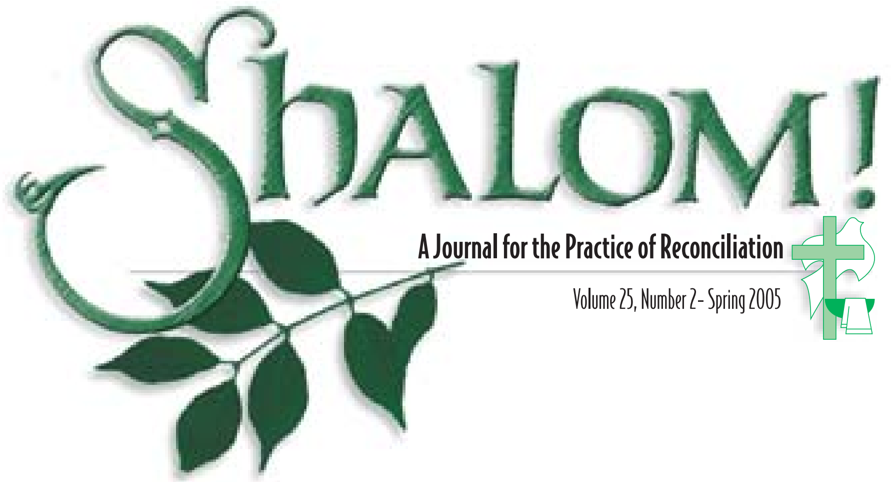


Volume 25, Number 2 - Spring 2005

Health and Wellness

This edition on "Health and Wellness" has particular significance for me. Since October 2004 I've been living with a diagnosis of colon cancer, and from November to May, I went through a course of chemotherapy treatment after having major abdominal surgery in September to remove a "suspicious polyp." The cancer was caught relatively early with a routine colonoscopy for people my age, which I had already put off for longer than I should have, and my prognosis is mostly positive. I am a cancer survivor! I am also now a walking "poster woman" for the importance of colorectal screening, by the way. God has been good, and my congregation has prayed and cared for me in many practical ways. I've been blessed with an ever-widening circle of people who have prayed for me—truly a humbling experience.

As you might imagine, a cancer diagnosis and joining the ranks of cancer survivors has changed my life. Not only have I received a harsh reminder of my mortality much earlier in life than I expected; I have also had to endure the sometimes debilitating effects of toxic chemicals dripped into my body every two weeks for six months, and I will always have the specter of a return of my cancer looming over me. I have also been depressed and anxious, although not to extent that Ray Bailey describes in his article. My situation is clearly not as grim as many others, but it has not been pleasant. And, the stress accompanying my illness has been compounded by the decline of my mother and her eventual death at age 93 in February, and by another family situation we've been dealing with for a number of years.

Many people told me early on in my cancer journey to "take care of myself." This is hard for me, schooled as I've been in self-sacrifice, thinking of others as better than myself, and in self-reliance and being responsible. So I've been thinking a lot about how I can reframe those old messages into other messages that are equally biblical and help me understand the importance and legitimacy of taking care of myself. This is what I came up with:

- I am made in God's image, like every other human being in the world. That means I am of inestimable worth in God's eyes.
- Both the Old and New Testaments tell us to love our neighbors as ourselves. Jesus himself said it. If we don't love ourselves and take of ourselves, how can we truly love our neighbors?
- Jesus took time for himself; he went away from the crowds to replenish his own soul and body.
- As part of God's creation which God has entrusted to us to care for, I need to make sure that I care for myself as well. It's part of a full view of the creation mandate, as Arlene Miller says in the lead article on page 2.

The next step for me, and perhaps for some of you, has been to think intentionally about just how to take care of myself. I'm not going to share my whole list, but I've included things like: learn to say no to new commitments unless I am really passionate about getting involved that way; take time for journaling, writing, reflecting on my own journey; nurture relationships with and spend time with friends; exercise and eat healthfully (now that I am regaining my energy after six months of feeling awful every two weeks); allow myself to grieve various losses I've had recently; when things are particularly stressful, give myself permission to take time out to whatever I want to do—take a day off, go somewhere, vegetate, etc.; learn more about accepting myself as a child of God, loved by God for who I am apart from what I do and how I perform; graciously accept people's offers of help without feeling guilty or that I don't need or deserve the help. I know these ideas sound simple and are not exactly profound, but they are helping me with my own health and wellness at a time in my life when this is really important.

In this edition of *Shalom!,* there are other stories of health and wellness, including another person's journey with colon cancer. The issue of depression is dealt with from two different perspectives; I invite your response. Health and wellness is a huge topic, and once again, only covered in part. However, I am pleased that the articles range from personal stories to challenges about health care access not only in the United States but in other places in the world. In relation to health and wellness, I am reminded of Jesus' words in John 10:10 when he said he came to give abundant life. Complete abundant life, including life with Jesus in it, is perhaps only possible as we care for our own bodies as well as think about how we can care for the bodies of those who don't have ready access to the kind of health care many of us enjoy.

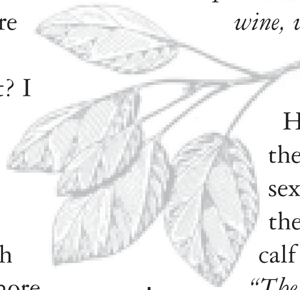
Harriet S. Bicksler, editor

The Church and Health

By Arlene Miller

Before starting to write I checked my email. One of the messages from the Prayer Ministry at my church concerned someone who was going to have medical tests. We were asked to pray for good results and peace for the family. This request was similar to the majority of those from the Prayer Ministry. Are we concerned about health in the church? If requests for prayer are a measure indeed we are.

Is this a recent development? I recalled the many injunctions against smoking, drinking and dancing I heard as a child. While these have been cited as evidence of past church legalism I think they were more. Knowingly or not these preachers and teachers were telling us that the Lord cares about our bodily health. The injunction against smoking was usually associated with 1 Corinthians 6:19, *"Do you not know that your body is a temple of the Holy Spirit?"* One elderly visiting minister called cigarettes *coffin nails*. That was before scientific research told us indeed that was the case.



Drinking was also on the list of forbidden things. Prohibition and reformers who railed against the personal and social effects of alcoholism and excess drinking influenced church leaders. Again our early teachers turned to Scripture for support. *"Do not get drunk on wine, which leads to debauchery. Instead be filled with the Spirit"* (Ephesians 5:18).

How did dancing fit into this theme? Usually it was linked to sexual looseness. The dancing of the Hebrews around the golden calf was sometimes referenced. *"The people were running wild and. . . out of control"* (Exodus 32:25).

While today we may smile at what seem like simplistic admonitions, our parents were onto several things. First, of all God does care very much about the way we care for our bodies. Caring for our physical bodies is an extension of the creation mandate to care for the earth and make it flourish (Genesis 1:28). Our bodies are earthy. Second, human life is holistic; we are embodied spirits, inspirited bodies. The earthy and spiritual aspects of our being cannot be separated and what happens to one impacts the other. Their tearing apart at death is a result of living in a fallen world. Third, because Christ redeemed us we belong to him and are indwelt by God's Spirit. We are to honor God with our bodies (1 Corinthians 6:20).

Many health problems we face are linked to smoking, drug use, excess alcohol, and undisciplined sexual activity. The popular media now warns us about these things in the name of science, not religion. While having scientific support is useful we in the church should also provide a more foundational appeal. Better yet, we should appeal to our love for Christ and his ownership of our bodies and spirits.

We are right to be concerned about a return to legalism if by that we mean that we are totally responsible for our physical "salvation." Doing all the right things does not guarantee perfect health. A current TV commercial tells us that high cholesterol comes from two things: what we eat and our family genes. We can work at what we eat but we are stuck with our genes. Further, there is still much we do not understand about illness, such as why some people are struck with heart disease for which there is no family history. Consider the non-smoker who develops emphysema. And then add the realities of accidents, epidemics, and natural disasters. A legalistic approach to health only adds guilt to the problems of those who are already burdened with illness.

As we are often reminded, we live in the "meantime" between Christ's resurrection and his return. We do get sick. Many live for years with chronic illness sapping their own physical and spiritual strength and of those who love care for them. Some of us recover from an illness like cancer and wonder if and when it might return.

So practically how can we in the church be concerned about each other's health? Here are some ways I have seen.

Some churches have a person on staff, usually a nurse, who gives leadership to health concerns. Others have a committee of professional persons. Sometimes aspects of this role are part of a deacon's ministry.

A common activity is taking blood pressures before or after services. Doing this gives opportunity to discuss other health concerns and offer encouragement to continue disciplines of diet and medication. Sometimes this person is responsible to make visits to members in the hospital and give spiritual support as well as help prepare for discharge. Often discharge instructions are complex and overwhelming. Having someone from the church who understands and can help interpret helps to smooth the way home. This person can check on progress in the following weeks and months.

Caregivers, family and friends need much support and often assistance. This work is emotionally and often physically demanding. Having someone from the church who knows the situation important. Helping the caregiver to know about outside resources for help is an important service. If it becomes necessary to make arrangements for care

Shalom!

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in another setting such as a nursing home, a person from the church can help in the process.

Some of us know we should do better but put it off till later. Health fairs can be fun ways to encourage people. Planning and conducting a fair takes work and commitment. Inviting outside exhibitors to come, setting up fun things for kids (and adults), determining contests and prizes, and doing a hundred other behind the scenes work takes time and effort. Sometimes it is best to target specific groups such as women's health, or kid's safety.

What some early church leaders overlooked was the struggle involved in overcoming addictions like smoking and alcoholism. Churches can either provide support groups like Alcoholics Anonymous, and Alanon or encourage members to be involved elsewhere. Relay for Life, sponsored by the American Cancer Society, offers those with cancer and survivors as well families and friends an opportunity to do something tangible.

Parents need help and support in talking with their children about sexual issues. A physician in my own church who sees sexually active teens and the health problems resulting has a burden to provide information and support to parents and their children.

At my own church the Health Ministry Committee keeps several First Aid Boxes supplied. We also loan durable equipment like wheel chairs and canes that have been donated to the church. A nurse who works in a local blood bank encourages members to give blood regularly.

There are many ways to structure a health ministries program. The important thing is that churches care for the whole person, and not only spirits.

Arlene Miller is retired from teaching nursing at Messiah College, active in Nurses Christian Fellowship, appreciating time to read for pleasure, and an active member of the Elizabethtown Brethren in Christ Church in Pennsylvania.

Surviving Clinical Depression

By Ray L. Bailey

My late uncle, Rolland Stiefel, used to joke, "I was born in the Depression and I've been depressed ever since!" Watching his clown-like antics and constant stream of limericks and laughs, you would never know he was blind. Just like me; looking at me you would never know I was depressed.

Oh, not depressed over my favorite TV show being cancelled or unhappy with the color of my SUV, but downright sleep-stealing, black-morning, breakfast-choking, suicide-considering depressed. At 52, in my prime with a good job, nice house, happily married with two lovely grandchildren, and a good 401k, how could I be depressed?

There are no easy answers for the cause of "clinical" depression. As with most people, mine was a confluence of life events: I suspected, but never knew with any certainty, that a traumatic event in my childhood inhibited my ability to handle stress. The death of Mallie, my beloved 14-year-old Golden Retriever still grieves me (if you are not a pet lover you may not understand this one). On top of that, a diagnosis of Type II diabetes and later a car accident while commuting to work resulted in atrial-fibulation heart condition. As a functioning adult I could handle these issues as a normal part of life.

Then came the primary trigger pull—work stress! As Senior Network Administrator I am responsible for the networks, servers, and telecommunications for a $100+ million a year manufacturing company spread around the globe. Work-weekends, late night calls, on-call pagers and cell phones, week-long trips to integrate new companies into the network, in a never-ending series of changes, upgrades and fix-its! Being transferred to the headquarters office added a one-hour commute (each way) across the Twin Cities!

Does this sound like your life? Fill in the blanks with your own list, and see what it all adds up to! I never intended for my life to get so messy; it built up one step at a time. Needless to say, one day while commuting to work, I ended up in the hospital with no clear idea how I got there.

As a good Brethren in Christ boy, I was raised that we are "perfected" in Christ. Having taken the "Core Courses" my intellect understands the theology of our Pietistic/Holiness heritage. Yet somehow, the Holiness lessons I learned in my heart meant I had to be "perfect" in this life and my Pietistic side told me I had to be separate and private. Tying this together with church services that were largely sanitized of any unsavory confessions, the imprint left was we could only show our shiny outsides at church and never show our dirty laundry. I perceive that this may be a reaction from my parent's generation, which had seen too many "show and tell" confessions in church where sins were excessively and inappropriately confessed. Combine this with our western culture ideals of individualism and performance-based character and an "avoidance of any appearance of sin" is created.

As a result I became good at "stuffing" my emotions, avoiding conflict at every turn, confessing to God, yet showing only the good side to other people. I conformed to the honest-dishonesty pervading the church; we talk about God healing the nasty stuff in our lives, but woe to them that actually have the temerity to reveal what they are experiencing! We are permitted to publicly confess minor sins, but never the deepest darkest nasty stuff!

This is the stigma I now face! As one who is emerging from a debilitating depression, there is the added burden of the stigma of mental illness. I am now publicly branded as an "imperfect" person. I was not able to live up to the expectations that God is able to fix all the ugly internal stuff while I remain shiny and perfect on the outside!

Yet is my mental illness any different than your illness? Is my collusion of faults and life experiences any different than yours? Overeating? Lustful thoughts and actions? Pain of past experiences? Betrayal to or by others? Failure at work? Medical conditions that debilitate? Are God's forgiveness and healing powers any different for me as for you? So why a stigma?

Another aspect that troubles me is the connection between medication and faith. I know God never abandons me, and even in my darkest hours, I never doubted that I was born-again. Yet for two years I prayed to God without ever feeling God answered me. Is it my lack of faith? Is God teaching me a lesson? Am I unworthy? Why am I the one he won't answer?

God started talking to me about a week after I started anti-depressant medication. Once again I felt a corresponding link of assurance I had previously experienced. My psychiatrist tells me my anti-depressant medication allows my mind to function normally so I have a chance to develop skills to handle stress in new ways. It is working and I can again communicate with God in the way I am accustomed.

Is my faith drug related? No…but it feels that way and it bothers me.

I am healing yet the consequences of having a serious depression are generating even more problems at the very time I am trying to eliminate them! I am learning to handle things one day at a time and some days are better than others. God is faithful and I continue to be his child whom he loves very much.

I don't have any pat answers for you. What I would ask is for honesty. The church I attend has recently changed its motto: No Perfect People Allowed! I like that. Only God can make us perfect, and until then I am a work in progress. Like my Uncle Rolland used to say, "I may be blind, but I can still see!" I am learning to be like him. I may be in a depression but I can still see Mount Zion!

Ray Bailey is currently moving from Minnesota to New York with his wife Mary. He also served for 12 years on the BIC Board for Media Ministries helping with technical issues. Ray can be contacted at Ray@raybailey.net.

A Christian Counselor's Perspective on Depression

by Dixie Yoder

Mental health is a phrase we hear often in our culture. This phrase was generally used in the past in connection with "nervous breakdown." Currently, "mental illness" is most commonly linked with depression and anxiety; conditions that have been labeled as "medical disorders."

The stigma attached to these emotional struggles has lessened in recent years as more people are affected and have become increasingly open to discussing the problem with a personal counselor or in a group setting. As a biblical counselor, I have spent the past fifteen years guiding Christian men and women into a way of understanding "mental health" that often opposes the standard cultural approach.

It seems to me that the problem within the body of Christ as a whole is currently not so much that we can't or won't talk about the problem of depression and anxiety (along with all of the attendant problems of drug and alcohol abuse, violence and divorce, to name just a few) *but that when we do acknowledge and talk about the problems, we offer the same surface solutions as the "world out there" offers.* We live in an "instant" and "quick fix" culture that has taught us to shy away from the hard work of renewing the mind and crucifying the flesh, and to reach instead for a pill bottle that will make us feel better immediately.

The Church in America has largely bought into the cultural myth that all depression and anxiety has a physical "first cause"—the highly promoted *chemical imbalance in the brain*. As a result, almost at the first sign of emotional pain, a drug is prescribed that may deaden some of the emotional symptoms but will not heal the biblically inaccurate thought patterns of fear and unbelief that ultimately lead to depression.

There are certainly some physical problems (hormone or blood sugar imbalances or thyroid malfunction) that may lead to or amplify depression and anxiety. These are legitimate medical conditions that can be detected by medical testing. However, these are the exception, not the rule. The predominant root of depression has a *spiritual* first cause, not a physical one. Here is the typical development of depression:

Expectations, both realistic and unrealistic expectations (denoted by the words "should, shouldn't and ought") that are not fulfilled.

- The result is disappointment, anger and grief.
- This produces fear that we will not have "enough of" whatever it was that we were expecting.
- If these emotions—disappointment, anger, grief and fear—are not dealt with in a biblical manner, the resulting bitterness, desire for revenge, resentment, ingratitude and a restless inability to enjoy even the good things in life, will culminate in depression.

Swirling thought patterns in an agitated mind that races out of control *will always produce an imbalance in the chemicals in our bodies.* Living almost continuously in "flight or fight" mode will cause the adrenal glands and acid producing glands to work overtime as they try to prepare us to deal with the situation at hand that seems threatening.

The shame of the church is not that believers sometimes struggle with depression and anxiety. Great men and women of the Bible faced life situations

that seemed insurmountable, and we read in Scripture how they dealt with the upheaval in their emotions. If they had lived in our day, every one of them would have been diagnosed with one of our present day "disorders." For example:

- Peter: Emotionally Unstable Personality Disorder and Attention Deficit Hyperactivity Disorder. Solution: He went out and wept bitterly over his failure, but chose to believe the absolute sufficiency of what Jesus provided. He preached: (2 Peter 1:2-3 Amplified), "May God's favor and peace, which is perfect well-being, all necessary good…and freedom from fears and agitating passions and moral conflicts, be multiplied to you in the full, personal, precise, and correct} knowledge of God and of Jesus our Lord. For His divine power has bestowed upon us all things that are requisite to life and godliness…"
- Martha: Generalized Anxiety Disorder. Solution: Luke 10:41-42 (Amplified): "But the Lord replied to her by saying, "Martha, you are anxious and troubled about many things; There is need of only one or but a few things. Mary has chosen the good portion, that which is to her advantage, which shall not be taken away from her."

We read about Moses, Elijah and David and their struggles with depression, hopelessness and fear. Their solution was always to put their hope and trust in the faithfulness of God who promises to provide all that is needed in every situation.

What would our Bible sound like if Isaiah had believed that medication rather than knowing God and renewing the mind is the answer? He might have prophesied about the coming Messiah in this way (Isaiah 61:1-3): "The Spirit of the Lord is upon Me, because the Lord has anointed me to bring the good news of the latest antidepressant to the afflicted; He has sent me to bind up those who feel brokenhearted because of low serotonin levels; to proclaim liberty and the freedom of Zoloft to prisoners of anxiety…to bring the comfort of Paxil to all who mourn, to grant those who mourn a new miracle drug, giving them a prescription to take away their sorrow, Prozac instead of mourning, the mantle of Ritalin instead of a spirit of fainting…"

The Bible has a great deal to say about the calmness of mind that makes it possible to experience the peace that is the inheritance of God's children.

The ultimate solution to the anxiety and depression produced by life in a sinful world is *growing up in our understanding* of the power and perfect love of God toward his children and *resting in that love*.

Believing that the love of God and the Word of God are sufficient for every need is not an instant fix, but is the only permanent solution. In Isaiah 26:3-4 we read, "You will guard and keep in perfect and constant peace the one whose mind, both its inclination and its character, is stayed on You, because he commits himself to You, leans on You, and hopes confidently in You. Therefore, trust in the Lord. Commit yourself to Him, lean on Him, hope confidently in Him forever; for the Lord God is the everlasting Rock of Ages."

Dr. Dixie Yoder is founder and executive director of Infinite Grace Ministries, Inc. and an ordained Brethren in Christ minister with many years of experience in biblical/pastoral counseling. She is the author of The Church Snatchers, The Ultimate Identity Theft*, a study of why so many believers have a life experience that is very similar to that of their unsaved neighbors. She is also active in the Bethany BIC Church in Thomas, OK.*

Reflections on Health and Wellness in Zambia

By Esther Spurrier

The couple had traveled hours by bicycle to reach the hospital with their sick child. But just as John was beginning to examine the child, he breathed his last and died. It was heartbreaking to watch the father bundle the corpse-that-had-so-recently-been-a-child on his back and begin the long, sad journey home for burial. No nearby hospital or clinic, no ambulance or 911 service. How far (in distance or time) are North American readers of this magazine from their healthcare providers?

Global inequities in the availability of health care have been an issue for years. World Health Organization's Alma Ata Declaration in 1978 touted "healthcare for all by the year 2000." In many parts of the world that goal seems less, not more, achievable now than it did then. The gap between haves and have-nots has widened. With the swift advance of technology in the developed world—along with the attitude that what is possible is necessary—the gap between what is routinely available in the "west" and what can be found in the rest of the world is widening. You might argue that here death is much more accepted as a part of life than it is in the west, but is it not an issue of Christian compassion that we work harder to achieve a better balance in available health care around the world?

Zambia's per capita budget of $5/year for health care does not go far in providing what is needed to relieve suffering and promote disease prevention among its 10 million people. That was true even before the HIV/AIDS pandemic, and it's even a greater challenge now. Even with significant input from non-governmental organizations, health institutions and programs struggle to remain even minimally staffed, equipped and supplied. Recently a North American emergency medicine physician and his physiotherapist wife considered funding and staffing a five-year project to base a helicopter at Macha to fly patients into the hospital and healthcare professionals out to outlying areas—even more marginally serviced. While the offer was

very tempting, John's response was that this seems an unjustifiably large outlay of capital when the hospital does not have running water all day, and such things as gauze and antibiotics are frequently in short supply. Christian compassion and justice lead us to believe that the intermediate steps should not be jumped over in the race to bring technology to the developing world.

Access, cost, technology, supplies, staffing—all these are daily issues of life in Zambia. And pressures by international banking institutions add to the struggle. For the past two years, Zambia has not added teachers and healthcare workers to its civil service rolls in its effort to qualify as a "highly indebted poor country" to have some of its national debt forgiven. This stipulation has caused great hardship for schools and health providers, and that hardship is passed down the line to the general population of potential students and people seeking health services. Thus Macha has had to use some of its precious little operating budget to pay nurses in order to maintain even minimal levels of staffing.

At Macha patients are charged about $2 for an outpatient visit or a week in the hospital including lab tests and most medications. But people still line up at administration for exemptions, unable to pay even this small amount.

Having made great strides in the treatment of children with malaria, malnutrition is now the leading cause of death in children under five years of age at Macha Hospital, ironically, at the same time obesity is becoming the premier health issue for North American children.

Both infant and maternal mortality are high in Zambia. Macha Hospital trains lay persons chosen by their communities to be community health workers (for primary health care) and traditional birth attendants in order to spread out the availability of health services and try to save lives.

World banking institutions and drug companies have recently combined forces in an effort to stop India from making the generic drugs much of southern Africa has come to depend on as affordable (evidently copyright and patent laws are being violated). Therefore, the antiretroviral therapy for AIDS sufferers, now available at about US$8.50/month (and even at that cost out of the reach of most of our rural people), will go to $50 or more if generics are not available.

HIV/AIDS has put increased pressures on an already overworked health system. If medicines are in short supply, who decides who will get and who will not? Life expectancy, 57 in the 1970s, has declined to about 35 years for both men and women because of deaths from AIDS.

Alcoholism and drug abuse, primarily smoking dagga (marijuana), are widespread and likely fueled by despair. Brewing beer has traditionally been a way for old women to earn a little money, and men and old women have been the main consumers. Now we see more young men becoming addicted during their school years and later feeling unable or unwilling to break free. Aggressive advertising by breweries and marketing their product in rural areas have made commercial alcohol more widely available.

Tobacco is another health care issue, though few in our area can afford to be consumers. However, an influx of displaced farmers from Zimbabwe has made growing tobacco a booming industry in Choma District and elsewhere. We see land once used for growing food now used to grow tobacco that will likely be shipped to Asia. The agreement with the government says these farmers must cultivate as many hectares in food as they do tobacco, but that is not obvious to us as we pass by their farms. Tobacco also debilitates the land. This becomes a food security issue as the country struggles with intermittent drought and famine.

Traditional medicine and the ways it interfaces with both western biomedicine and Christian faith remains a challenging issue for medical missionaries. We certainly do not want to equate faith in western medicine with faith in God. We do want people to see Christian compassion in the provision of medical care for people of our catchment area and beyond. And we do take opportunity to tell them the truth of God who revealed himself in Jesus Christ.

We see changing patterns in the ways missionaries (not necessarily BIC) access health care. In the 1970s and 80s, there was much more expectation and willingness for missionaries to get care locally (a number came to Macha for routine care, surgery, baby delivery). Now there is much more of a trend to go to a developed country or back to their homeland for care. We are challenged with what it means to live in solidarity with our community: to accept the limitations our Zambian brothers and sisters live with or to insulate ourselves with personal supplies and resources not available to them? Some people may second-guess some actions and attitudes of early missionaries, but we cannot fault their willingness to take risks, go into the unknown and trust God for the

EDITOR'S NOTES

2005 subscription campaign: So far in 2005, we have received about $4600 in contributions, which added to the balance left over from 2004 will come close to covering our expenses for the year. Thanks for your generosity! If you haven't yet contributed this year, please do so as soon as possible in order to continue to receive *Shalom!* The basic subscription price is $15.00 (or $20.00 Canadian), although we welcome additional tax-deductible contributions.

Upcoming topics: The Summer 2005 edition will be on "Water"—the ways in which this valuable life resource is used and misused around the world. If this is an issue in your community, please consider contributing an article or some reflections on what you see as a Christian response to water issues around the world. At this point, the Fall 2005 is scheduled to be on "Creating a Safe Space for Dialogue on Difficult Issues," although this is subject to change, in light of other topics also on the horizon, like "Immigration," "Gender Issues," "Marriage," and "The Global Church."

outcome. Current candidates and sending agencies seem less willing to risk, needing trial runs, assurances and guarantees of support systems in place. Is that one reason for the rise of extreme leisure activities in the west? Have we too much insulated ourselves from risk in normal life?

When we returned to Zambia in 2001 after 14 years away, we found a number of Dutch doctors helping out in rural areas. These were paid by their government on a par with their homeland colleagues, making this an attractive short-term option. During the intervening years, the practice has changed: the Dutch government now pays a generous top-up in salary and benefits to Zambians willing to make a three-year commitment to work in a rural area. Macha has benefited from this program, and perhaps such programs will mitigate the diaspora of Zambian professionals to countries where better salaries and working conditions can be found. (UK and Australia actively recruit Zambian nurses with attractive offers to augment their countries' nursing shortages; is this a justice issue?)

We heard on the radio yesterday of a U.S. government initiative to begin a global health service, patterned after the Indian Health Service and other public health programs. Doctors who volunteer would receive a "modest" $100,000/year. It's ironic to hear this in an era when mission agencies are declining in their recruitment/support for such compassion ministries. Rather than reinvent the wheel, could the government partner with and augment faith-based cross-cultural compassion efforts?

We also followed by radio the debate on the treatment of Terri Schiavo and its appeal to moral and ethical principles. Do not similar moral and ethical principles apply to the access of health care for disadvantaged people around the world? What does it mean for us as Christians to live in solidarity with our global brothers and sisters?

Esther Spurrier, along with her husband John, serve as Brethren in Christ missionaries at Macha Hospital in Zambia. Their home congregation is Dillsburg BIC in Pennsylvania.

Treading Water

By Patrick Cicero

For well over a decade, providing sufficient health care to all Americans has been one of the hottest political topics in the United States, yet we do nothing about it. Currently, more than 40 million Americans are uninsured and the number is growing. It is growing in part because employers are cutting benefits in order to remain competitive in a globalized economy. It is growing because governments (federal, State, and local) are cutting public assistance because of swelling budget deficits. Whatever the cause, the effect of not having access to primary health care is devastating on all classes of people, but it is especially problematic for the poor.

A few months ago, a couple came into my office because their house was being foreclosed. When I inquired about why they had missed their payments the answer was simple: James got sick and they could not afford for him to go to the doctor; because he did not get primary medical attention, his situation worsened and he ultimately had to have emergency surgery that laid him up for months. James lost his job and without it they were unable to keep up with their mortgage payments. Because they did not have health insurance, they also faced an astronomical medical bill. Because they did not have health insurance, James could not get the primary care that he needed to diagnose his illness. Because they did not have health insurance, James and Ann faced the potential loss of their home.

I have heard this story countless times and it varies very little. James and Ann are like millions of other individuals in the United States. They both work full-time jobs earning barely above minimum wage. They work long, hard hours which means that they are too "rich" for Medical Assistance (the name for Medicaid in Pennsylvania – the federally subsidized health insurance for the poor), but also do not receive health insurance benefits from their employers. They are the working poor and they have nowhere to turn when it comes to health insurance. It is only getting worse for people like James and Ann.

Take the recent budget proposal of Pennsylvania's Governor Ed Rendell as an example. On February 9, 2005, Governor Rendell proposed a budget that would greatly overhaul Pennsylvania's Medical Assistance (Medicaid) system by imposing service caps, expanding and increasing co-payments for services, restricting eligibility. In announcing these changes, Governor Rendell promised that no one who is currently on Medical Assistance will be thrown off. While this is technically true, the Governor's budget proposes cuts to Medical Assistance that would prevent about 8,000 individuals per year from qualifying for these services. The individuals who would be affected by the proposed changes are those who use unpaid medical bills to "Spend down" to become eligible for Medical Assistance.

The "Spend down" is a tool for individuals whose income is slightly higher than the qualifying income for Medical Assistance, but who are permitted to use their medical bills as a deduction in order to qualify. The program provides much needed relief to individuals who have very high medical bills from hospitalization, surgery or other expensive medical procedures. The "Spend down" option allows these individuals to access medically necessary care while saving them from the loss of their home or bankruptcy and ensuring that providers are reimbursed for the care that they provide.

Currently, individuals can only deduct paid medical bills that were incurred in the three months prior to application.

However, they can use unpaid medical bills incurred at any time prior to application. The Governor proposed placing the same three month retroactive time limit on unpaid medical bills that currently exists for paid bills. This proposal would reduce the number of "Spend down" eligible individuals by 8,000. It includes individuals like James and Ann who through the use of "Spend down" are able to get their medical bills paid when they incur these emergencies.

Because James and Ann were savvy enough to come into my office when they did, we were able to get their medical bills paid through these "Spend down" provisions, although under the new budget proposal these bills would have fallen outside this three-month lookback period. Fortunately at the time they came into my office, James had returned to work and through some creative advocacy we were able to negotiate a solution with their mortgage company. However, nothing has changed for James and Ann. They are treading water. They still work long hard hours for little pay. They still don't have medical insurance through their employers and now that James is back to work they once again make too much money to qualify for Medical Assistance. If one of them gets sick, they will not be able to afford to go to the doctor. If it becomes bad enough, they may miss work and be fired. They will be back to where they were when they came into my office only this time the mortgage company is less likely to forebear and negotiate and I am afraid that they will lose their house.

Though the lack of health insurance hits the poor particularly hard, they are not the only ones who are treading water; many middle class families are one catastrophe away from being in the same situation as James and Ann. Think about it. Two-thirds of all Americans get their health insurance from their employer or their spouse's employer. What happens when the employee providing the health insurance gets sick, really sick, so sick that they cannot go to work for months? How long will the employer allow the employee to stay on the health insurance plan? Federal law protects employees for a modest period of time, but there is a limit. It is a Catch-22. A person who is too sick to go to work can't get the treatment they need because they lost their health insurance when they lost their job. The unfortunate reality of health care in the U.S. is that until and unless we develop a system where one's access to basic medical care does not depend on the generosity of one's employer we are all treading water and hoping for the best.

Patrick Cicero is a legal aid attorney who lives in Harrisburg, PA with his wife, Helena, and their dog Pappy and are expecting their first child in June! They are both active members of the Harrisburg Brethren in Christ Church. We welcome him as the new writer of the "Midnight Musings" column and thank Megan Scott for her excellent writing for the past two years.

Disparities in Health Care in America

By Bethany Spicher

"Of all the forms of injustice, discrimination in health care is the most cruel" (Rev. Dr. Martin Luther King, Jr.).

Here in Washington, D.C., within a five-mile radius of the White House, there are two very different neighborhoods. To the northwest is Georgetown, an upscale residential and shopping district, and to the southeast is Anacostia, a low-income, primarily African-American area, which includes an entire ward without a single grocery store.

The national infant mortality rate is 6.9 deaths per 1,000 live births. In Georgetown, the rate drops to 1.2. In Anacostia, it is 20.1

The health disparities in these two neighborhoods mirror the injustices in our nation's health care system as a whole. The United States' medical technology may be the envy of the world, but in areas like Anacostia across the country—particularly in areas segregated by race or ethnicity—health indicators rival those of developing nations.

According to researchers at the Virginia Commonwealth University, mortality data from 1991-2000 reveals that medical advances saved 176,333 lives. Yet resolving the disparities in death rates only between whites and African-Americans over the same time period could have prevented 886,202 deaths.

"The prudence of investing billions in the development of new drugs and technologies while investing only a fraction of that amount in the correction of disparities deserves reconsideration," said the study's authors. "It is an imbalance that may claim more lives than it saves."

People of color in the United States tend to live shorter lives and suffer higher rates of disease than whites. Differences in health status have complicated causes, some of which are related to income, employment, housing and education disparities, as well as the geographic segregation evident in medically under-served areas like Anacostia.

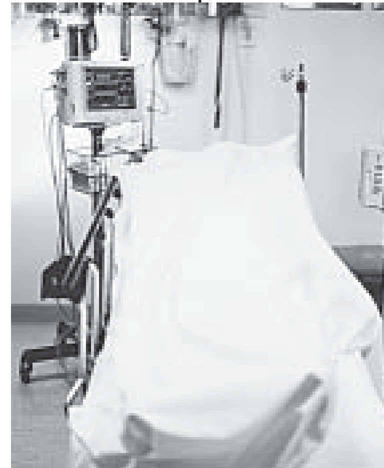
In addition, people of color are more likely to be uninsured than whites; and without insurance, are less likely to receive appropriate health care, if any. Thirty-four percent of non-elderly Latinos, 29 percent of Native Americans, 22 percent of African-Americans and 20 percent of Asian-Americans were uninsured in 2003, compared with 13 percent of whites, according to the Kaiser Family Foundation.

Yet, disparities in health *status* cannot be explained away by income level or insurance coverage. In hospitals, clinics and nursing homes across the country—even when services are paid for by public programs such as Medicaid and Medicare, or guaranteed through a managed care system—disparities in health *care* persist. For example, African-Americans are nearly one and a half more times more likely to be denied authorization through their managed care system for care after an emergency room visit than whites, according to the Alliance for Health Reform.

Physicians for Human Rights has documented additional inequities, all of which take into account income level and insurance coverage:

- The length of time between an abnormal mammogram and the follow-up test to determine the presence of breast cancer is more than twice as long for African-American, Asian-American and Latina women than for white women.
- When hospitalized after a heart attack, African-Americans are 13 percent less likely to undergo coronary angioplasty and 33 percent less likely to undergo bypass surgery than are whites.
- African-American and Hispanic patients with bone fractures in hospital emergency rooms are less likely than whites to receive pain medication.
- African-Americans are less likely then whites to receive drug therapy for HIV/AIDS.
- African-American patients are nearly twice as likely as whites to undergo above-knee amputation.
- Among preschool children hospitalized for asthma, only 7 percent of African-American and 2 percent of Latino children, compared with 21 percent of white children, are prescribed medication to prevent further asthma-related hospitalization.

Evidence shows that health care providers—who are overwhelmingly white—are subject to prejudices that, along with the power implicit in the provider/patient relationship, institutionalize racism in the U.S. health care system.



In an incident documented by Harvard Medical School students, a resident referred to an African-American patient by her first name, removed her bedclothes and examined her without drawing the curtains in a two-bed room. In the next room, a white woman was called “Mrs. Jones,” carefully draped and given the same examination with the curtains drawn. In similar cases of discrimination, many patients of color delay or forgo seeking medical treatment again.

For recent immigrants to the United States, racial/ethnic health disparities are compounded by issues of language access and legal status. Though U.S. law requires that health care providers who receive federal funding provide language services to patients with limited English proficiency, many do not comply. One fifth of Spanish-speaking Latino patients report not seeking medical treatment due to language barriers, according to the Alliance for Health Reform.

In addition, 1996 welfare reform legislation prohibited even documented immigrants from receiving federally-funded Medicaid for five years after their arrival. Some states use their own funds to provide health care for immigrant children or pregnant women, yet even those who are eligible are often afraid that seeking care will jeopardize their chances for citizenship.

For the residents of Anacostia and communities of color across the country, the health care system is broken. And hope for its repair seems far away, especially now as Congress debates cuts to Medicaid, which covers nearly one in five non-elderly African-Americans, Latinos and Native Americans.

But there are signs of change on Capitol Hill. For the first time in 2003, Congress commissioned a study of health disparities by the Agency for Healthcare Research and Quality. In the last session, the Senate introduced the bi-partisan Closing the Health Care Gap Act to expand health insurance coverage and address health care barriers for people of color. Both chambers introduced the Immigrant Children’s Health Improvement Act, to allow states to use federal funds to provide health care for immigrant children.

With “moral values” all the rage in the capital, now is a good time for us as people of faith to encourage our legislators to reintroduce legislation that addresses health care injustice. Invite your senators and representatives to reintroduce last session’s good legislation and to support – not cut – public health programs. You might even invite them to take a walk across the bridge to a neighborhood called Anacostia.

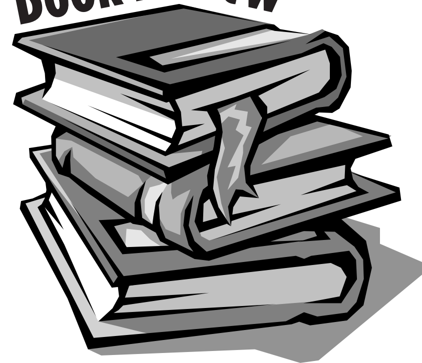
For additional information:

- *The Right to Equal Treatment*, Physicians for Human Rights, 2003.
- *National Healthcare Disparities Reports*, Agency for Healthcare Research and Quality, 2003 and 2004.
- *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, 2002.

Bethany Spicher is a legislative associate in the Washington Office of Mennonite Central Committee U.S. Check out the Washington Office’s web site at http://www.mcc.org/us/washington/index.html

Gilead: A Balm that Heals

By Lois Saylor



Reverend John Ames is 76 and facing death. How will he spend his remaining days? In this issue on health and wellness, the novel *Gilead* can take us on a tour of a fictional life and help us ask the question, "Am I living well and using well what God has given me even at the end of life?"

Gilead, a novel by Marilynne Robinson, is centered on one man in a small and perhaps dying town who preaches and pastors in a small congregation as did grandfather and father before him. If we listen we can discover once again that the small worlds we inhabitant are infinite. It is a soothing work full of grace and peace, intriguing insights that shows us the sacredness of our humanness and this material world in which we live and breath and must exercise our being.

The setting of the novel is Gilead, Iowa, in 1956, but the life story of Reverend Ames takes us back to the fiery preachings of his abolitionist grandfather who sanctions and uses violence to fight slavery. It concerns the conflict between Ames' gun-toting grandfather who saw visions of the Lord and his pacifistic father who rejects that a call to serve the Lord can be a call to war. It ends with the current day conflicts of racial issues so that we see a time in American history between the fight for freedom for slaves and the beginning of the civil rights era.

All that is happening, but the main focus of the book is smaller (or in another sense larger). The focus is what Reverend Ames has learned in all the conflicts and beauty that life has given to him. Reverend John Ames is 76 and facing his approaching death. He does not feel as if he is dying despite some of the limitations that he is experiencing. Contemplating his physical death he writes, "Well, this old body has been a pretty good companion. Like Balaam's ass, it's seen the angel I haven't seen yet, and it's lying down in the path." Contemplating this body he knows and the mystery of how we will enter heaven, he writes, "What of me will I still have?"

Early in life John Ames lost a daughter and a wife. He lived out the long years afterward by devoting himself to his congregation, his study of the scriptures and theology, writing and praying which become the same thing for him, and service to God. Of those long years of living alone he says, "Now that I look back, it seems to me that in all that deep darkness a miracle was preparing." The miracle is the young wife he takes in old age and the seven-year-old son to whom he is writing this letter. For the book is in the form of a letter to his son to tell him all the things he will not be alive to share as time and situations would warrant. This is how John Ames faces his dying days. He continues in this routine of preaching, writing, and praying in the church sanctuary in the quiet hours of the early morning and by writing to his young son.

Through these letters we learn about his life and his fathers' lives and the soft wisdom he wants to pass on to a son he won't be able to raise into manhood. The past conflicts of his fathers haunt him, but another ghost from the past turns up in flesh and blood – the wayward son of his aging and sickly best friend who is also facing death. This prodigal son has a sordid history that is slowly revealed while Reverend Ames watches as the younger man maneuvers his way into the hearts of his wife and young son. Will he die only to turn his life over to this man who he has good reason not to trust? How can he pastor this fellow who comes to him asking about predestination and if people can really change? How does he live well now? How does he do the right thing now? Does he reveal the past to his wife and son so they are warned away from this character? Should he take to heart his wife's belief that people can change?

Gilead is an intimate book both small and vast in scope. It is full of the delights in life and the fears too. Life is good. Life is difficult. Life can be cheapened and thrown away. It looks at all these things and also scrutinizes faith in action. It tackles theology and is littered with biblical references. It sermonizes. It questions. And it is an American novel and particularly explores American Protestantism. It is rich and warm and poetic in its prose; and in this novel there is the humming of the old hymn:

There is a balm in Gilead
To make the wounded whole
There is a balm in Gilead
To heal the sin sick soul

Sometimes I feel discouraged
And think my work's in vain
But then the Holy Spirit
Revives my soul again

If you can not preach
Like Peter
If you can not pray
Like Paul
You can tell the love of Jesus
And say, "He died for all."

Characters in the book find this balm and readers too can "find a balm" in *Gilead.*

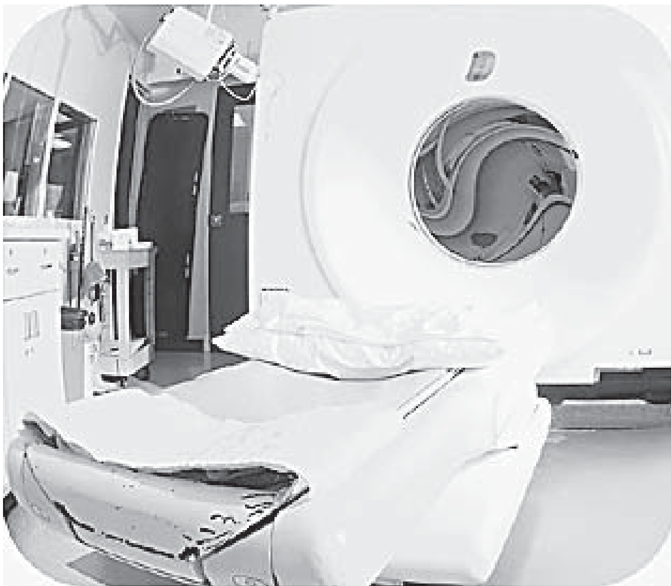
Lois Saylor is on the Shalom! editorial advisory committee, and recently has been leading the BIC Women in Ministry and Leadership Council as the Council finds its way in the wake of Janet Peifer's death. She is also an active member of the Elizabethtown Brethren in Christ Church.

embracing me. I felt like I was in the ever-loving arms of my Saviour. A peace descended in my life. Yes, I had many anxious moments when my humanity got in the way but that peace which passes all understanding has been a major strength and comfort in our walk and has never left us

I wrote about coincidences earlier, that they occur when God wishes to remain anonymous. I prefer to call them God-incidents and many occurred in my fight with cancer. Pastor Leonard Chester lives across the street and is a friend of a cancer specialist who has a worldwide reputation. That friendship led me to a major cancer research facility and a surgeon who is on the cutting edge (pun not intended) of recurrent colon cancer. He agreed to take my case. During the pre-operative time I received more chemo along with radiation. There were many obstacles to getting these procedures done quickly but every time we encountered difficulties it seemed somebody cancelled an appointment and I got their time. What could have taken five months was reduced to three months. Finally the day arrived for surgery. The surgery had been moved forward. The surgeon and I had not signed the consent forms. Because of this I was able to pray with my doctor immediately before the surgery. The operation lasted over 13 hours and it was closer to 16 hours before Anne Marie saw me in the trauma centre. Pastor Brian Lofthouse, our spiritually adopted kids and Anne Marie's sister Fran provided support for Anne Marie. I understand that things were a little tense after 10 ten hours of waiting with no word on my progress. Prayer, coffee and chocolate and a visit from the surgeon eased the tension. God just knew my family needed to get a report. It was expected that I would require three weeks in hospital for recovery. I was ready for release eight days later. Many of the staff including my surgeon commented on my attitude and my speedy recovery. The doctor has commented since on the effect of faith on my journey with cancer. Today, five years later, I remain cancer free.

Anne Marie's turn:

John did not mention that we did not ask, "Why us, God?" Life is not fair and cancer is no respecter of gender, age, personality, possessions, and the list goes on and on. Cancer affects those who follow the Lord Jesus Christ and those who do not. His followers have hope. I was told that if I had enough faith, my husband would be healed. My faith could move mountains. God is sovereign. Pray believing that healing will happen. And it will, in God's way. Faith is believing that it is God's provision for us in all.



Things I have learned:

- Face the facts and be prepared in all that preparing encompasses; be prepared for the emotional impact that living and providing support for your husband/wife; it takes a toll.
- Talk to someone outside your marriage about your feelings and fears. We all experience anger, frustration, fear and tears. If someone tells you they have never experienced these emotions they just might be suffering from the "Pinocchio syndrome." Let's face it, these feelings are normal and human, but it is when they take over our lives we get into trouble.
- Get into the Word! The enemy would have you believe that you are alone, God has done this terrible thing to you, you can't handle it, you are too weak. Recognize the lies. God is not the author of chaos and confusion. I, Anne Marie Griffith, have learned these lessons well and you can too!
- I know that I am not writing to the uninformed; please, however, accept this as a gentle reminder. An American poet, Edwin Markham wrote, "Ah, great it is to believe the dream as we stand in youth by the starry stream; but a greater this is to fight life through and say at the end, the dream is true!" In youth, cancer is not part of our dreams. As Christ followers we know we have been washed in the blood of the Lamb; heaven is not a dream, heaven is truth. "Blessed Redeemer, full of compassion, Great is Thy mercy, boundless and free; Now in my weakness, seeking Thy favor, Lord, I am coming closer to Thee "(Fanny Crosby 1820-1915). It is my prayer that each one of you reading this article will as John and I have, come closer to God through adversity.

John and Anne Marie recently left their pastoral position with the Riverside Community Church (Brethren in Christ) in Fort Erie, Ontario, and are waiting for what God now has in store for them.

Shalom!
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Knowing Reality

By John Griffith

Anne Marie and I were baptized 10 years ago, three days after our 35th wedding anniversary. We quickly became involved in the community of Upper Oaks and eventually found ourselves at Riverside Community Church in Fort Erie assisting in the Bishop's office. We decided the best way to understand our conversion (at our "young age") was to take the Core courses. Little did we know that God would place a call on our lives to pastoral ministry. We've learned that coincidences occur when God wishes to remain anonymous. I will write more about that later. Five years ago we completed our oral examinations and were granted our pastoral licenses.

Three weeks later we sat in a doctor's office and heard that I had colon cancer. We swallowed and left the office and drove directly to our pastor's office where we cried and tried to come to grips with our new reality. You can understand we felt devastated. The same doctor who gave us the diagnosis had six weeks earlier questioned my need for a colonoscopy. The first message of this article is: if you are over fifty, male or female, insist on a colonoscopy. Most colon cancer is treatable and survivable if it is caught in the early stages.

The Riverside community became an integral part of our life from the get-go. Pastor Todd prayed and counseled with us. From the outset we did not believe this was God's wrath being outpoured on us but rather the effect of being human, living in the fallen world. That night a family that had become very close to us came to visit. They treat us as second parents and they are our spiritually adopted children; they consoled us and insisted that we talk to a doctor who was a member of our congregation. Dr. Craig spent two hours the next day explaining what colon cancer was, the different stages, and the survival statistics. Reality is so scary but it gets rid of supposition and myth. Craig continued to monitor my progress and was a constant source of advice and encouragement. The next day, Sunday, we were the focus of a prayer circle; the prayer had begun in earnest for my recovery. The road to recovery would be lengthy and at times even more frightening but the sustaining prayer from the community and from the conference has never diminished. I often reflected on the comforting words, "Even when I walk through the dark valley I will not be afraid for you are close by me." The 23rd Psalm has always been a favourite of ours but it was the continuing prayer that strengthened me during some of the more stressful times.

Four weeks later I had my initial surgery, followed up by chemotherapy. My worst fear was realized, as the cancer had spread beyond my colon and I was in the third or most serious stage of colon cancer. It was during this time of chemo when my blood count was extremely low and I was feeling totally exhausted that God touched me. Gradually I began to feel very warm. It was as if somebody was

continued on page 11