MedSend®

BOUNDARIES

for Healthcare Missionaries:

God-Honoring Structure for a Thriving Life of Service

by Jim Ritchie

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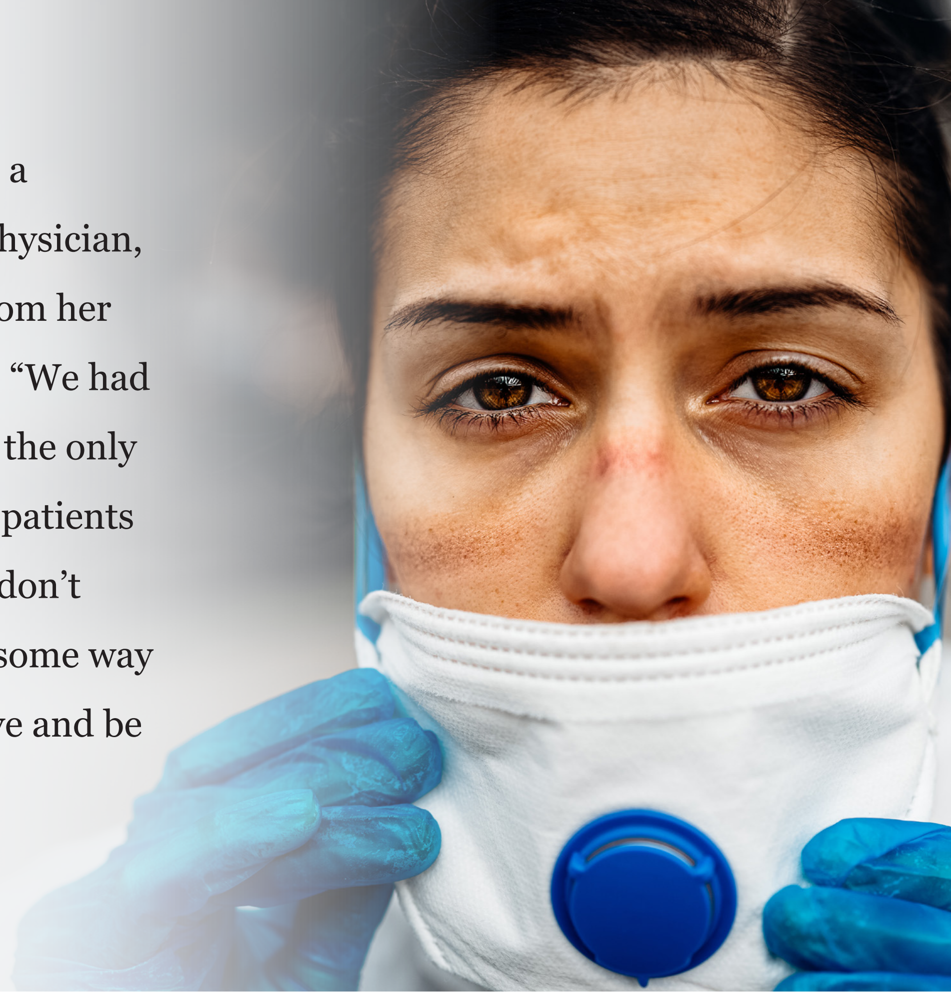
“I burnt out bad,” said a missionary family physician, recently returned from her first term of service. “We had no idea what it would feel like to be the only doctors in our region, with a line of patients that went on forever every day. We don’t want to quit. We have to figure out some way to have boundaries so we can survive and be decent parents to our kids.”



“My wife has always been all about missions,” explained a surgeon. “But she told me that she’s not going back to the field if I don’t get some boundaries. The truth is I’m not home much. But there are all these needy patients and now my partner is gone and I have a residency to run.”

An experienced missionary internist lamented, “We used to have fifteen doctors, but now we’re down to six. I cover both medicine wards and our ICUs, and try to cover peds as best I can. I’ve had to take on seven more committees, which I try to do after I get home from the hospital. I haven’t had time for morning devotions in a couple of months.”

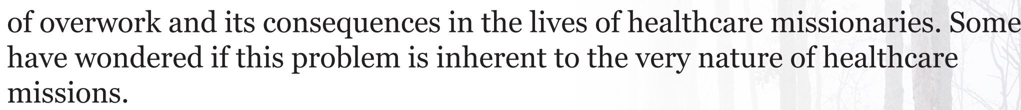
Another experienced healthcare missionary (HCM) said, “I knew I couldn’t keep going at that pace, so I made some rules for myself, some boundaries. But my colleagues resent that. My boundaries leave them with more work.”

One of the most respected leaders in healthcare missions confided, “Far and away, the most common reason our missionaries leave the field is overwork. How can we help doctors and nurses to stop burning themselves out?”

We healthcare missionaries go to the Field so we can serve. **We know of the profound need and we see that we have been blessed by God with the ability to meet that need.** We know that we can literally save lives and address deep spiritual crises in our patients and their families. And often, there appear to be no alternatives for our patients. If we don’t help them, they don’t get help.

But the demand for our services often requires more than a person can deliver. The patient queue goes on forever. The emergencies keep coming. The check-off list of duties is never completed. We can find ourselves exhausted, even though the work isn’t anywhere near completion.

Overwork and burnout may be the most common preventable reason healthcare missionaries leave the field and do not return. I have interviewed counselors with extensive experience caring for healthcare missionaries, member health representatives from large mission agencies, healthcare mission leaders, and many individual healthcare missionaries. Almost all are deeply impressed with the problem



of overwork and its consequences in the lives of healthcare missionaries. Some have wondered if this problem is inherent to the very nature of healthcare missions.

"I have to decide between burnout and moral injury," complained a missionary surgeon. "If I do everything that is asked of me, I will burn out. It's inevitable. No one can continue to work like this. But if I don't do everything that is asked of me, I will feel morally injured. I will be guilty of having failed someone at a time of great need. And if I have to decide between burnout and moral injury, I'll pick burnout every time. For me, being a medical missionary is a direct path to burnout."

Can that be true? Is it impossible to be a healthcare missionary without burning out?

Happily, it is very possible to be a healthcare missionary who not only does not burn out, but regularly experiences joy in practice. We know many of them. Invariably, these missionaries work within boundaries. God-honoring boundaries. Life-giving boundaries. Team-affirming boundaries. Patient-serving boundaries. Some of these boundaries have been structured by a schedule or a leader. Some have been put in place by the individual missionary. Frequently, the boundaries were put in place after the missionary had crashed or failed due to burnout and overwork. But then, instead of being seen as an obstacle to faithful service, these boundaries are seen as a structure to enable long-term healthy joyful service to many.

Boundaries have always been part of our practices, though we may not have thought of them in that way. We all have worked within clinic schedules, operating room time, work hour rules, patient load assignments, and other defined limitations. These limitations may not have been established to promote entirely healthy lifestyles, but they usually at least allowed survival. When we were in our training programs, the limitations had been established by other people, usually supervisors. We probably weren't present when the rules were written, but someone crafted them very deliberately. The rules took into account patient demand, but also considered pragmatics such as worker lifestyle.

When we go to the mission field, often the boundaries have not been established or clearly defined. Instead, patients' short-term needs tend to dominate the equation, and HCM's needs are subordinated. Unless boundaries are intentionally instituted, the tyranny of immediate needs will drive HCMs to overwork and burnout.

SOME USEFUL CONCEPTS ABOUT BOUNDARIES.

A swamp has no boundaries, no banks, no destination. The swamp is stagnant and breeds disease. **In contrast, a river has banks, has boundaries, and has a specific destination.** The river is powerful and life-giving. If we aren't willing to establish boundaries for our lives, our lives may look more like swamps. But if we are willing to establish boundaries, we may find more focus, more power, and more joy.

Boundaries sometimes are misconstrued as high stone walls with razor wire on top, preventing healthy interaction. But healthy boundaries aren't like that. On the other end of the spectrum, some attempts at maintaining boundaries may be likened to a line in the sand, crossed easily with impunity. But healthy boundaries aren't like that, either. **Healthy boundaries are like a lovely hedge with a gate.** And you control the gate to your boundaries. No reasonable person will crash through the hedge; they look to the gate to determine when it's appropriate to engage with you. If the gate is closed, a reasonable person will conclude that you are busy with something else. When the gate is open, they know you are happy to work with them.

VALUES AND BELIEFS

In order to wisely choose boundaries, it is helpful to consider the difference between values and beliefs as described by Stan Haegert. **Values** may be defined as one-to-three-word concepts, such as *devotion to patients,* or *industry,* or *honor*. **Beliefs** may be defined as sentences that describe attitudes toward values, usually including words such as "should," "must," or "ought." For instance, regarding the value of *devotion to patients,* a belief might be "I should maintain current medical knowledge for my patients." Another belief might be "I must work until I see every patient who wants to be seen."

Even if we agree that a given value is inherently good, we might not agree on beliefs that support the value. In subsequent sections, we will use these concepts of values and beliefs to clarify the debate.

CHRISTIAN CONCEPTS ABOUT BOUNDARIES

Surely, Christian healthcare missionaries should base their conduct on biblical principles whenever possible. So we must ask whether the Bible gives us guidance about boundaries. Happily, we see many examples.

Boundaries are based on God-given limitations. God is omniscient, omnipresent, and omnipotent. We human beings have none of those attributes. He has given us limitations. Adam and Eve were human, so they had physical limitations. They were given great laterality in Eden. God only really gave them one significant behavioral limitation. And when they defied that limitation, all the trouble started.

God gave us limitations in time and place and strength. We can't work forever. When we try to defy those limitations, we cause trouble for ourselves, our co-workers, and ultimately, our patients. When we embrace those God-given limitations and serve within them, we can thrive and find joy, and bring blessing to our co-workers and patients.

In Deuteronomy 32:39, God says,

> *"See now that I am He and there is no god beside Me. It is I who put to death and bring life. I have wounded, and it is I who heal, and there is no one who can deliver from My hand."*

That is a crystal-clear statement of sovereignty in the lives and deaths of people. **We human beings are not given that authority, but are given limited skills and abilities to heal.** When we embrace those limitations under God's authority, we can be very effective ministers of medicine. When we try to go beyond our limitations, we may think we are doing some good, but we would do well to remember God's sovereignty in life and death.

MOSES GOES TO BOUNDARY SCHOOL

Moses led the Israelites in the desert. In Exodus 18, Moses's father-in-law, Jethro, visited him and watched him conducting court proceedings for the Israelites from morning until evening. Moses had no boundaries regarding the important value of justice. Jethro said,

> *"What you are doing is not good. You will surely wear out, both yourself and these people who are with you, for the task is too heavy for you; you cannot do it alone."*

Jethro showed Moses the importance of sharing the burden with others and delegating. "So Moses listened to his father-in-law and did all that he had said." And it went well.

The value of justice was rightly important to Moses. His initial belief about justice was "I am the only one who can judge rightly," or "because I am the best judge I should do all the judging, even if it wears me out." Jethro also appreciated justice, but helped Moses with a new belief, "Justice can be delegated well," or "The most ideal arrangement for justice can be attenuated reasonably so we don't wear ourselves out."

JESUS ESTABLISHED BOUNDARIES

Jesus taught crowds and healed many. Some verses say that Jesus healed all of the sick who were with Him. But Jesus also slipped away at times. Jesus sometimes sent the crowds away. Jesus sometimes got in a boat to distance Himself from the crowds and to depart from the crowds.

> *Matt 8:18 Now when Jesus saw a crowd around Him, He gave orders to depart to the other side of the sea.*
>
> *Luke 5:16 But Jesus Himself would often slip away to the wilderness and pray.*
>
> *Mark 1:35-8 Very early in the morning, while it was still dark, Jesus got up, left the house and went off to a solitary place, where he prayed. Simon and his companions went to look for him, and when they found him, they exclaimed: "Everyone is looking for you!" Jesus replied, "Let us go somewhere else—to the nearby villages—so I can preach there also. That is why I have come."*

Some of the people in these crowds had walked for days to see him. And He sent them away. He did heal, and He did teach, and then He sent them away. Jesus had a figurative boundary hedge with a gate. At times, the gate was open, and at times, the gate was closed.

Let's consider Jesus's beliefs regarding the value of healing. He obviously loved healing and knew it to be an important sign that He was the Messiah. That said, Jesus did not appear to believe that he must continue to heal as long as anyone was asking for healing. Instead, He appeared to hold this belief: "I will spend much time and effort healing, but at times I will rest, and at times I will depart to do other things, and at times I will leave some people in order to go to other people who also need Me." As Christ-followers, isn't it legitimate for us to adopt His belief about healing?

THE PRACTICE OF SABBATH REQUIRES GOD-PRESCRIBED BOUNDARIES

God included the practice of Sabbath in the **Ten Commandments,** alongside the commandments not to kill or steal or commit adultery. Interestingly, God was remarkably verbose in addressing Sabbath in the Decalogue. In the NASB, the Commandment not to kill required only four words. But the Commandment to observe Sabbath required 104 words. Clearly, the practice of Sabbath is important to God and He wants us to understand it well.

Sabbath is wonderfully restorative, especially for those who are serving in difficult situations. An excellent example of the power of Sabbath restoration can be found with **Mother Teresa's Sisters of Mercy,** who served among the poorest of the poor in Calcutta. Working with the very poor is phenomenally difficult work emotionally. Abject poverty is much more of a problem than just lack of money. Poverty is accompanied by many other social ills, such as prostitution, malnutrition, and untreated illness. One might expect the Sisters of Mercy to have had a high attrition rate. But the attrition rate for those Sisters was remarkably low. Surely, part of the answer lies in their Sabbath practice, as described in Mother Teresa's words: "The sisters shall spend one day a week, one week per month, one month per year, and one year in six in the motherhouse, where in contemplation and penance together with solitude she can gather in the spiritual strength, which she might have used up in the service of the poor."[1] The sisters spent much time in one of the hottest spiritual fires on earth, and they were able to sustain that level

[1]Mother Teresa: Come Be My Light. Doubleday, 2007, p 344.

of effort by regular, reliable time away. Their time away was spent reconnecting with God, the Source of restoration and healing.

The Practice of Sabbath doesn't happen spontaneously. Active decisions are necessary to take the time to be refreshed from Sabbath. **In making these decisions, it may help to ask a clarifying question: Is there anything more absurd than a missionary who doesn't have time for God?**

CONTRASTING BIBLICAL IDEAS

We have been considering some biblical examples of God-honoring boundaries. Some other biblical ideas may appear to be contrary to the idea of having boundaries in our lives. However, when those apparently contrary ideas are better understood, they aren't contrary at all.

In seeking to understand these apparently contrary ideas, let's anchor our discussion around the value of 'faithful service.' We want to serve our patients and our God well. We can all agree that this is a worthy, God-honoring value. Now let's think about some beliefs that pertain to that value.

One such belief: 'Faith makes us tireless so we don't need boundaries.' Some verses seem to support this belief. For instance,

Isaiah 40:31 - but those who hope in the Lord
    will renew their strength.
They will soar on wings like eagles;
    they will run and not grow weary,
    they will walk and not be faint.

Philippians 4:13 - I can do all things through Him Who strengthens me.

When we take those verses out of context or original meaning, they may seem to oppose the idea of boundaries. But let's look more closely at the intended meaning of those verses.

The Bible contains many different figures of speech, such as narrative and poetry, promise and metaphor, principle and command. It is very important to understand the context and figure of speech in order to properly apply a verse. For instance, if we take an isolated verse from Ecclesiastes, "All is vanity," and try to apply that to determine our life's work, we may despair. But when we consider that the book of Ecclesiastes consists of the ruminations of a jaded ruler who departed from God's law and found his self-directed efforts to be fruitless, we can more properly understand and apply the verse, "All is vanity."

Isaiah 40:31 is a highly metaphorical piece of poetry referring to the certainty of our hope in God's faithfulness. It is *not* a promise about physical endurance. Wings have not sprouted from the shoulders of any of God's people, and the greatest saint of the Lord cannot run forever.

Philippians 4:13 also is *not* a promise about physical ability. Paul wrote it from *prison!* He didn't want to be in prison. He was not able to break down walls or bend bars or convince his jailor to release him. When we look at the verse in context, we can easily see that Paul was teaching that he had learned to be content in any circumstance. Paul was not teaching that we should expect to be able to work without rest.

THE "OX IN A DITCH" FACTOR

Another potentially misleading belief may be "Jesus healed on the Sabbath, so we don't need to observe Sabbath." A verse which, when misapplied, may appear to support this belief is:

> *Luke 14:5 - And He said to them, "Which one of you will have a son or an ox fall into a well, and will not immediately pull him out on a Sabbath day?"*

We have needy patients, who are surely more important than an ox in a ditch. Doesn't that verse give us freedom to "bypass" Sabbath for the sake of our patients?

To answer that question we need to understand the intent and context of the verse. The Gospels record in many places that Jesus taught regularly in the synagogue on Sabbath. He didn't bypass Sabbath, He observed Sabbath routinely. For instance:

> *Luke 4:16 - ...on the Sabbath day He went into the synagogue, as was His custom.*

The Gospels record only seven instances of Jesus healing individuals from illness or demons on the Sabbath. In six of the seven accounts, we clearly see Jesus observing Sabbath or festival activities, and in the remaining account, He is walking with His disciples:

> The demon-possessed man, *while teaching in the synagogue* (Mark 1:21-28, Luke 4:31-36)
>
> The man with the deformed hand, while teaching in the synagogue (Mark 3:1-6, Mt 12:9-13, Luke 6:6-10)
>
> The woman bent double, *while teaching in the synagogue* (Luke 13:10-17)
>
> Peter's mother-in-law, in the home of Peter *after teaching in the synagogue* (Mark 1:29-31, Luke 4:38-39, Matt 8:14-15)
>
> The swollen man, while eating in the home of a leader of the Pharisees, which we can surely assume was *consistent with Sabbath practice* (Luke 14:1-6)
>
> The crippled man at the pool of Bethesda, while in Jerusalem *for a Jewish festival* (John 5:1-18)
>
> The man born blind (John 9:13) while walking along in Jerusalem.

Jesus did not ignore Sabbath; He consistently observed Sabbath, and the healings occurred in that context. The healings on the Sabbath apparently were not routine. We only have seven accounts of individuals healed, out of approximately 150 Sabbaths during the three years of Jesus's earthly ministry. If we do a little math, that's roughly one Sabbath healing in an average of five

months' time. Surely, there could have been other Sabbath healings that we don't know about. But several of the Sabbath healings were recorded in multiple Gospels, so they would seem to be unusual and noteworthy events.

Importantly, what we *don't* see in the Gospels is Jesus healing *crowds* on the Sabbath. Actually, Mark and Luke make that distinction for us. In the account of Jesus healing Peter's mother-in-law on a Sabbath day, they record that *at sunset, after the Sabbath was over,* the crowds came and Jesus healed them. (Mark 1:32-34, Luke 4:40-41)

When Jesus taught about the "ox in a ditch factor," He was refuting the over-legalistic practices of the Pharisees which emphasized man-made rules instead of emphasizing compassion. Jesus was not teaching to disregard Sabbath. He was teaching to love compassion.

Jesus was not advocating for starting an "ox in the ditch service." He was referring to an unusual event, not an everyday event. Exceptions are not to dominate normal practice. If we think the importance of medical practice supersedes the importance of Sabbath, we have missed the point. A more appropriate belief may be, "Faith gives us hope and contentment as we work within our God-given limitations, including the blessing of Sabbath."

ADDITIONAL HELPFUL CONCEPTS

Now that we have identified clear endorsement of personal boundaries within the Bible and have clarified some misunderstandings, let us consider some **additional helpful concepts (not necessarily of direct biblical origin)** to understand the importance of healthy boundaries.

IMPAIRMENT FROM FATIGUE

Airline pilots are restricted to a limited number of flight hours before they must rest. The reasons seem obvious. Who wants to be a passenger in an airliner controlled by someone who is sleep-deprived? Truck drivers have similar statutory limitations. According to Department of Transportation regulations, truck drivers "may drive a maximum of 11 hours after 10 consecutive hours off duty."[2] Moderate sleep deprivation, corresponding to remaining awake until 1 a.m., has been shown to produce impairment in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication.[3] If we smelled alcohol on the breath of a colleague who was on his way to operate on a patient, we would stop him. We should think of ourselves in the same way when we are sleep-deprived, and arrange, as much as possible, to set up system boundaries so our workload is manageable with decent sleep.

ONGOING MASS CASUALTY

A good working definition of **"mass casualty"** is a situation in which the demands of patient care overwhelm the ability of the available staff to provide standard of care. When a mass casualty, such as bus crash, occurs, we must adjust our system and adjust our expectations. We need to triage, or "sort" patients in order to do the best we can for the greatest number of patients. Inherent in the idea of triage is that we make the best decisions we can with very limited information, knowing that we will make some mistakes. Some patients with significant injuries will have to wait until we treat the patients with immediately life-threatening injuries. And, perhaps most difficult, some patients will be triaged to "expectant" category, meaning their injuries are unsurvivable, will require too many assets to treat successfully, or will require assets that could be probably be used to save several other lives.

Medicine in the developing world typically would qualify as an **ongoing mass casualty.** The demands of patient care consistently overwhelm the ability of available staff to provide standard of care. Accordingly, we must adjust our system and adjust our expectations. Though we want to provide standard of care for all, we simply can't. We have limited information, and we make the best decisions we can, knowing we will make some mistakes. Some patients with significant illness will have to wait. And some patients will be triaged to a palliative category, because we don't have the assets or the funds to provide curative treatment.

FOCUSING ON WORK LEFT UNDONE

We tend to focus our attention on **work left undone.** We may have worked all day and compassionately cared for many patients. But at the end of the day, if there are patients still waiting to be seen, we tend to be burdened by the needs of those remaining patients. We find it very difficult to send them away, even if this only means a delay of a few hours, and even if we have cared for the great majority of the patients, and even if we did not promise that we will care for everyone who comes to the hospital.

But if we do not work sustainably, we will burn out and will not be available to take care of *any* of those patients. We must learn how to focus our self-assessment on the good work we have done and the good work we will be able to do in the future because we are making good decisions about our ability to work in healthy and sustainable ways. Actually, even in the most capable Western hospital, we have to tell many of our patients that we are not able to help them in the way they wanted. Also when we are away from the facility at meetings or on home assignment, we are not caring for patients. We simply must learn a more realistic assessment of our capabilities and duties.

Happily, there are effective ways to address these expectations, which we will describe shortly.

BALANCE BETWEEN MISSION AND PERSONNEL

Effective leaders understand that they must continually balance the needs of the mission with the needs of the personnel. An organization usually exists to accomplish a particular mission, and that mission is carried out by people who have their own needs. The mission and the needs of personnel are not necessarily opposed

[2]https://www.fmcsa.dot.gov/regulations/hours-service/summary-hours-service-regulations

[3]Occup Environ Med. 2000 Oct; 57(10): 649–655. doi: 10.1136/oem.57.10.649 PMCID: PMC1739867 PMID: 10984335. Moderate sleep deprivation produces impairments in cognitive and motor performance equivalent to legally prescribed levels of alcohol intoxication. A Williamson and A. Feyer

to each other, but often they are in conflict. For instance, an army platoon may be given a mission to charge a hill and take an objective, understanding that casualties are expected. In that situation, the mission is important enough to sacrifice the needs of the personnel. But that mission can only come after the personnel have been prioritized over time. Before the order came to charge the hill, the personnel were fed, housed, rested, clothed, trained, equipped, motivated, and led. If the personnel are given one challenging mission after another without opportunity to rest and resupply, they will quickly lose their effectiveness and the mission will fail.

However, the needs of personnel can be overprioritized. If leave is granted to everyone who has a family event or is somewhat uncomfortable, no one will be available to carry out the mission.

The same is true in healthcare missions. The mission, caring for patients in Jesus's name, is important, and is worth our dedicated effort. But if we don't attend to the needs of the personnel carrying out the mission, the mission will eventually fail due to attrition. **We must balance the mission with the needs of the personnel, including ourselves.**

POTENCY OF MEDICAL MINISTRY

God has allowed us to provide potent, effective treatment in our medical ministry. We do make a difference in our patients' lives. However, we can easily tend to overemphasize the importance of our own potency in our patient's outcomes and therefore overstretch our limitations. Moses was potent in the law, and he began to burn out, until Jethro taught him how to delegate. Jesus was potent with healing and teaching, and clearly prioritized time with the Father, and followed the Father's direction to move on to different locations and different people.

FAMILY CONSEQUENCES

This next observation is **uncomfortable**, but it needs to be said. Too often, in order to avoid discomfort, this observation is ignored. But let us enter into it with a spirit of grace and without judgementalism, and with hopes for a better outcome.

There **are family consequences for overprioritization of work.** Those consequences often are especially manifested in the children of the overworkers in the teen years or young adult years. When those children were small, they may not have been able to articulate their needs well. It is very easy to develop unhealthy work habits when the kids are young. But after years of seeing patients prioritized ahead of themselves, some of these older children will show emotional or behavioral problems, and when the kids are older, we cannot go back and change their years of feeling inferior. We tend not to talk about this phenomenon, but it is exceptionally common. Such emotional or behavioral problems aren't universal, of course, but they are predictably more common in families of parents who overprioritized work.

Interestingly, some of the **pioneers of healthcare missions** understood the importance of work/life balance. Clive Irvine, the founder of Chogoria Mission Hospital in rural Kenya where we served, learned how to serve sustainably with an emotionally healthy family. In one of Irvine's letters back to his home church in Scotland after nine years on the field, he described his typical workday. At the time of this description, he was the only doctor in the entire region. One nurse and some locally-trained orderlies also saw patients. According to his letter, he worked only five clinical hours a day, attended two or three chapel or prayer services a day, and spent two or three hours doing administrative duties. He took a full hour each for breakfast, lunch and dinner, and stopped work at 5 pm every day to play tennis or go for a long walk. His day was structured according to his priorities. He used boundaries. He served as a healthcare missionary for forty years and his son served as a medical missionary as well, founding another hospital further afield. The Irvines knew how to be effective. They started hospitals, schools, and multiple training programs, built a sawmill and a brick foundry. And their legacy remains, 100 years later. They kept the long view in mind.

Such a work/life balance was far from universal in historical pioneer missionaries. And, sadly, the consequences in family relationships were often substantial. Such family consequences were apparent in the lives of David Livingstone and Francis Schaeffer, for example. We would do well to imitate the example of Clive Irvine and take warning from the example of David Livingstone for the sake of our families and the families of those who follow our example.

YES MEANS NO

Stan Haegert, who served for years in Africa, and describes himself as having burned out on two continents, wisely teaches that **"No also means yes, and yes also means no."** When we say 'yes' to an opportunity, we are saying 'no' to other options that we could have been doing in that time. When we say 'no' to an opportunity, we are allowing ourselves to say 'yes' to opportunities that are more important to us. And it's important to find balance in those decisions. We can say 'yes' to a specific number of hours of patient care, then say 'no' to more hours so we can say 'yes' to our families and friends and 'yes' to God and 'yes' to rest.

THE IRON TRIANGLE

Economists might be able to help us gain a more realistic vision of what we can offer in healthcare, in the form of **the Iron Triangle.** This principle pertains to the possibilities in offering products or services. The Iron Triangle says: "You can have it (the product or service) good, fast, or cheap. Pick any two. If you want it good and fast, it won't be cheap. If you want it good and cheap, it won't be fast. If you want it fast and cheap, it won't be good." In other words, if you want a good plumber to respond right now, it will be expensive. If you want a good, inexpensive meal, you'll probably be waiting behind a long line of people. If you want a cheap car right now, it probably won't be very good.

Often, in healthcare missions, we have an ideal of providing excellent medical care at very little cost, essentially on demand. But this ideal is not realistic. Medical supplies are expensive. Demand is high and supply is low and time is limited. The Iron Triangle remains as a ruling principle, like the principle of gravity. We can try to work around it, but such work-arounds tend to produce much frustration from unrealistic expectations. We would do very well to embrace the principle and establish reasonable expectations for ourselves and our practices. We will need to attenuate overall quality or quickness or affordability, or some proportion of all three.

The Iron Triangle can be used to guide strategic decisions. For instance, if there is a high demand for same-day inexpensive services, it would be prudent to hire several providers who have less training and have lower salaries. If quality surgical services are required, they will be expensive. Some expenses may be covered by donations, but someone will pay for them. We should remind ourselves of this principle if we become frustrated by our inability of providing good, cheap, fast medicine.

IMPORTANCE OF STRUCTURE

The word 'boundaries' implies structure, and intentionality is important in establishing godly boundaries. If we don't structure our days, our priorities become drowned in a sea of other people's urgencies and trivialities. But if we can identify our priorities and structure our days to ensure our top priorities have dedicated time, we can keep the trivialities in perspective.

For our boundaries to be effective, they can't be a "line in the sand," which can be crossed with impunity. They should be substantial, like a hedge with a gate. When the gate is closed, we are working on our main priorities and are not available for other requests. Dr. David Stevens, former CEO of CMDA and former medical missionary at Tenwek Hospital in Kenya, said that when he and his team of missionaries had a day off, they did not allow any work-related requests to come to them, and they supported each other's boundaries on days off. He also said that when he is working on a priority project, he has found it necessary to post a notice saying that he is not to be interrupted except for emergencies. Those are excellent examples of functional boundaries that protect priorities.

EXAMPLES OF GOOD BOUNDARIES

The following paragraphs include examples of boundaries that have proven helpful for healthcare missionaries.

1. **Specific start/stop times.** We mentioned before that we should not start "ox in a ditch services," in which the work never stops. But some medical specialties, such as Emergency Medicine and Hospitalist Medicine, are inherently "ox in a ditch services." In the emergency department, there's always an ox in the ditch. How have emergency physicians learned to manage that situation? They work in shifts and turn over their patients. They know they can't be present for every emergency, because the emergencies never stop. So they have specified start and stop times. They work very hard during their shifts, then leave to attend to their other priorities. As an emergency physician, I can say sometimes it's important to be flexible

and stay a bit longer, and sometimes it's difficult to leave patients in the hands of someone you might not know very well. But those are disciplines we must learn in order to thrive in that "ox in a ditch service." If you find yourself in that sort of situation, you will need to learn how to turn over patients, delegate care to less-highly-trained colleagues, and trust God with the outcomes.

2. **Literal fence.** Sometimes, we need a literal fence with a gate around our houses. There are some cultures in which unannounced visits or solicitations occur at homes many times every day. Such unregulated access to our homes may disrupt our feelings of peace at home and disrupt our ability to truly rest or get away from the pressures and obligations of work. Sometimes, a literal fence and gate may help in providing privacy and peace. This sort of practice may be challenging to certain cultural norms, and may come at some relational cost. And, to be sure, the gate needs to be open at times. But the peace and privacy may be worth the relational cost.

3. **Training and Delegating.** We may be able to train people to take over many of our responsibilities. In residency training programs, delegation is to be expected, and is quite desirable for the growth of the trainees. Every situation of delegation involves some added risk, and we should be judicious. But we should be willing to increase the amount of delegation when necessary if our workload becomes unhealthy. Of course, in delegating, we should be cognizant of the workload of our trainees as well.

4. **Hire help.** Many of our responsibilities, especially our administrative responsibilities, can be carried out competently by other people. Also, commonly in our overseas communities, there are people who would be very grateful to be hired for such jobs at a pay scale which we would consider to be very affordable. We can make our lives easier as we make their lives better by hiring help. The training we provide may also position them for other jobs later.

5. **Agree on a sustainable work schedule.** Rather than allowing the work to dictate the schedule, decide on a sustainable schedule and determine how much work can be done within that schedule. That's typically how a medical work schedule is determined throughout much of the world. A number of mission locations have settled on a schedule of four clinical work days, one administrative work day, one community building or non-medical ministry day, and one Sabbath day per week. The administrative work day is usually easily filled with teaching, preparation for teaching, grant writing, managing projects, researching, communicating with supporters, attending meetings, completing reports for the mission agency, and similar work. Most successful long-term healthcare missionaries tend to be involved in additional non-medical ministries, such as chaplain support, community evangelism and orphan ministry. Providing a day to engage such fruitful work is important, and that day may also be spent in building unity in the medical community.

6. **Manage your queue.** An open-ended queue is the devil's playground. An unending queue of patients tends to be demoralizing for the clinic staff, tends to rush patient care which requires shortcuts and leads to mistakes, and frustrates patients at the end of the line. A new missionary inherited a clinic which was had always been open-ended. Her department had previously been staffed with three doctors, but all of the others had left. She found it impossible to fulfill all of her duties, and realized she would only have a limited time to conduct clinic. She placed a limit on the number of patients who would be seen in clinic. Initially there was 'pushback' from the clinic staff. But then the staff learned how to effectively triage patients, the patients learned the new system quickly, and within a couple of weeks the staff morale was outstanding. They were able to spend appropriate time with the patients, were able to generally predict when the clinic would be completed, and were not wasting time with patients who could be more appropriately seen elsewhere.

7. **Manage your other duties similarly.** Ward rounds need not be open-ended. If there is a limited time available, the ward team may need to strategize ways to reasonably delegate and prioritize attention to new patients and sicker patients. Similarly, meetings should not be open-ended. Limiting meeting duration and

frequency can greatly improve the quality of those meetings. Also, administrative duties should not be open-ended. Those duties can tend to accumulate, especially when staffing is more readily available. It is often very useful to place a limit on the number of committees or other duties for each person, then decide which committees can be shrunk or even deleted. Some hospitals have realized that they didn't really need a transfusion committee or could temporarily halt their pharmacy committee or didn't need two nurses on their needy-patient committee.

8. **Prioritize Sabbath.** We have already touched on the biblical and vital importance of Sabbath. Sabbath can be observed in various forms as a healthcare missionary. Sabbath day can be staggered between different people on different days to allow for more uniform provision of services while still allowing a full day away from the pressures and obligations of healthcare. Some missionaries experience difficulty taking a Sabbath and remaining on the hospital housing compound, either due to their own sense of obligation or because other people call them with issues. When possible, it may be wise for those missionaries to physically depart for Sabbath. I spoke with a missionary who drove away from his station every other week for a two-day Sabbath, because it was not feasible to drive away every week.

   Another missionary who served as the only doctor in his area had a wonderfully spiritually mature approach to the clinical issues of taking Sabbath. Every Saturday night, he would conduct turnover rounds with God. He would gather the ward team and pray something like this: "Lord, thank you for the privilege of caring for these people made in Your image. We are grateful that we have a part to play in Your plan, we know You are a far more powerful and knowledgeable physician than any of us, and the life and death of our patients is in Your hands. In keeping with Your word, I will obediently take Sabbath starting now, and will be back on Monday morning. In the meantime, please guide our excellent nurses in their decisions and care, and I trust them to follow your guidance. If any of our patients pass on, we will know it was Your will. In Bed 1 is Mr. Gitonga, who has heart failure. If he were to decompensate, I would do this….." He would then proceed to turn over every patient to God in the hearing of the nursing staff, and he would go home to a peaceful Sabbath. He told me that the Lord was very kind to him, and that the death rate during his Sabbaths was essentially the same as during the rest of the week.

9. **Get away.** In addition to Sabbath, it is important to remove ourselves for a significant period from the burdens of cross-cultural healthcare. In Matthew 8:18, we see Jesus's example of this. He had just healed many in Peter's hometown, and the crowd was still around Him, wanting more from Him. Matthew tells us:

   > When Jesus saw the crowd around him, he gave orders to cross to the other side of the lake. (NIV).

   Luke tells us something similar.

   > Yet the news about him spread all the more, so that crowds of people came to hear him and to be healed of their sicknesses. But Jesus often withdrew to lonely places and prayed. (Luke 5:15,16 NIV).

   Jesus healed many and taught many. And then, He chose to remove Himself from healing and teaching for a while. We should follow His example.

   Jesus often used boats to remove Himself or distance Himself from the crowds (Luke 5:1-3, Mark 6:31-2, Mark 5:45-6, Mark 4:35-6). And some wonderful ministry occurred when he left the crowd and departed in boats. He calmed the sea, walked on water, and healed the Gadarene demoniac, for example. If He had allowed Himself to be obligated by the unending needs of the crowds, He would not have been available for those miraculous events. Similarly, we can be confident that when we take Sabbath or take time away from the ministry as God leads, we are following the finest example for a Christian.

WATCH OUT FOR TRAPS

As we at MedSend have been listening to healthcare missionaries, we have repeatedly heard stories of unfortunately common scenarios in which the

missionaries find themselves trapped. Watch out for these traps which have the potential to derail your ministry.

THE SOLITARY SERVICE TRAP

Serving as the only medical person in an area is especially perilous to your well-being. This can also be true for those serving as the only person in a high-demand specialty. When the need for medical services is unending and you are the only means of providing this service, burnout is predictable. We have heard many, many stories of godly, well-meaning missionaries who went to places that were very needy, but found that serving there was almost impossibly difficult.

We have all heard stories of pioneer missionaries who went to isolated stations and served heroically for many years. Those stories are popular and inspiring. But we often are not told the stories of the far more common situation – **medical missionaries who served alone for a short time** before they had to leave for their own survival.

Many of those successful historical pioneer missionaries arranged healthy boundaries for themselves. For instance, we previously mentioned the story of Clive Irvine, who had clear boundaries for clinical and administrative work, and was able to serve for 40 years. To be fair, some healthcare missionaries have been able to work for amazingly long hours for many years. It seems that some of them have been given a special dispensation by God to work like that. Most of us seem not to have been given that dispensation. And, as mentioned before, such long work hours do tend to take a heavy toll on family relationships. Some people are truly called to solo service. If you feel strongly called to solo service, it will be imperative that you establish strong boundaries.

THE LEFT-BEHIND TRAP

This is a very common story in healthcare missions. A missionary goes to the field to work with a team or to join in partnership with an experienced missionary, and then the team or the partner depart from the field for some reason. The new missionary is then expected to fill the role of the more experienced missionary or even of the team. Sometimes, the new missionary may feel a pressure to maintain a historical service or greatly needed ministry or high-profile ministry. This trap may be more insidious even than intentionally going to serve alone, because the predecessor usually was experienced and productive, but the newcomer is inexperienced and less productive, and therefore feels a need to work harder to meet expectations. This situation commonly leads to high-level burnout.

If you find yourself in the situation of being unexpectedly left alone, one of the healthiest questions to ask is, “Is the Lord giving this mission station a time without a healthcare missionary, or at least without a missionary with my skill set?” We should never assume that the Lord always wants to continue a ministry, even one as needed as medical ministry. The Lord may want you to depart and join a team elsewhere. If you feel led to remain as a solo missionary, you will need to establish strong boundaries. Those boundaries may need to be more significant or limiting than those of your more experienced predecessor. Especially if that predecessor left due to burnout.

THE DO-MORE-WITH-LESS TRAP

This may be the most common trap of all. In this trap, a mission hospital’s staff increases and so services expand and an expectation for those services becomes established. Then when members of the staff leave, there are fewer members of staff to perform the expected services. For example, a mission hospital had one family physician and one medical ward, then two internists joined the staff. Since more doctors were available, a second large medical ward and an ICU were opened and rapidly became busy. All three of the doctors were working

at capacity to care for all of the patients and shared every-other-third-night call. Other hospitals referred sicker patients to them because of the presence of the ICU. Then the family physician left for a one-year home assignment and one internist departed permanently due to family issues, and there were no replacements. So the remaining internist inherited the full-time jobs of three people.

In such a situation, **three options** are available to address the worker/workload mismatch:

1. **Work harder.** The remaining staff try to continue providing services by working longer hours. In our example, the remaining internist started rounds at 7 a.m. and finished around 9 p.m. and was on call every night, hoping and praying for some help. This scenario reliably leads to burnout of the remaining staff.

2. **Hire more help.** To address the worker/workload mismatch, more workers are brought in. The hospital hires personnel who can most closely meet the expectations of the departed staff. If another internist and family physician are available (and affordable), they are hired. If a specialist doctor is not available, doctors without specialty training are hired, and expectations are adjusted. In our example, the hospital might hire a family physician and a medical officer who has finished her internship. Call could be shared among all three, and expectations would be adjusted when the medical officer is on call. This option is obviously more expensive for the hospital than option 1.

   A related option might be **delegating** some workload and autonomy to already-existing personnel, such as residents or physician extenders. This sort of delegation may be problematic, due to educational program restrictions or qualifications.

3. **Cut some services.** Because the worker/workload ratio is mismatched, the ratio is improved by decreasing the workload. In our example, if no additional staff are hired, one ward may be closed and most of the ICU beds may be closed. This option is often unpalatable when significant investment of time and material have been spent on expansions, and also because patient needs would go unmet.

Usually, some combination of those three options can be used to reach a reasonable plan. Unfortunately, the first option is often over-used. The hospital is unwilling or unable to hire additional helpful staff, and is unwilling to curtail services. So the existing staff are encouraged to do the work of three people. The mission is prioritized above the needs of personnel, and casualties are expected.

Another military metaphor is appropriate here. When a military unit is engaged in a battle and finds that it is outmatched and outmaneuvered, that unit can either try to stand its ground or can retreat. The 'stand our ground' strategies are lauded in popular stories when the 'stand' is successful. But far more often, outmatched units that refuse to retreat are routed, completely defeated. Many people are killed and many are taken prisoner and no effective fighting force remains. Instead, outmatched units usually should carry out a tactical retreat in which they temporarily give ground while still fighting, and live to fight another day.

If a mission hospital finds itself in a situation in which there are not enough workers for the workload, they should call for reinforcements (hire additional help) or give ground temporarily (cut some services) so they are not routed.

THE VISITOR EXPECTATIONS TRAP

We usually are sincerely grateful to those people who come to provide short-term help at our mission stations. Visitors may bring special skills and education or may provide a break from our workload. But visitors' expectations may inadvertently cause guilt, or may bring additional work. Visitors may not embrace boundaries, may choose to "do as much as I can" during their stay, and may perceive of the long-term missionaries with boundaries as lazy or uncompassionate. Even if visitors don't convey such thoughts, long-term missionaries may judge themselves harshly in comparison, if the visitors are working all hours and the long-term missionaries are not.

Some visitors come with expectations of support from the long-term missionaries. Some clinical teams, such as specialty surgery groups, may require additional screening and diagnostic work, additional imaging and laboratory tests, dedicated clinical space, and additional follow-up work from the long-term team. Some educational groups may

expect clinical schedules to be curtailed or special arrangements made for their educational efforts. These expectations may lead to frustration (or worse) in a hard-working missionary team.

Expectations should be discussed with visitors before the visit, to build unity and to avoid conflict. The long-term missionaries may want to teach the visitors about the importance of boundaries. The visitors might learn boundary practices that could serve them well in their daily practices.

BOUNDARIES NEED BOUNDARIES

Although the exercise of godly boundaries is a critical practice in sustaining a career in healthcare missions, boundaries can become problematic if they are overused or contentious.

For instance, a missionary family knew that they needed boundaries, but they established **boundaries which were so numerous and restrictive** that the family didn't bond well with the hospital team. They didn't socialize or engage in mutual support in the work of the station. As such, they never "fit in," and when a significant misunderstanding occurred, they didn't have the support of the hospital.

DISCORDANT BOUNDARIES

At a different hospital, a new missionary knew that he needed boundaries, but the rest of the team of long-term missionaries did not recognize the importance of boundaries, and had established expectations of work that didn't allow for boundaries. When the new missionary tried to live within boundaries, the rest of the team thought he was divisive and selfish. He was called a **"part-time missionary,"** though he actually worked almost 80 hours a week.

Discordant boundaries, or boundaries not shared among the team, can be a disruptive source of shame. The missionary with boundaries can be shamed either directly or inadvertently as someone who is not dedicated or who is lazy. Missionaries without boundaries who have sacrificed much for their patients may be shamed either directly or inadvertently. They may be thought of as people with misplaced priorities or with an inadequate understanding of God's sovereignty.

Boundaries can cause problems for mission teams. That's a major issue, because unity among Believers is a fundamental biblical goal. Unity is praised throughout Scripture.

Eph 4:1-6 Therefore I, the prisoner of the Lord, implore you to walk in a manner worthy of the calling with which you have been called, with all humility and gentleness, with patience, showing tolerance for one another in love, being diligent to preserve the unity of the Spirit in the bond of peace. There is one body and one Spirit, just as also you were called in one hope of your calling; one Lord, one faith, one baptism, one God and Father of all who is over all and through all and in all. —NASU

John 17:20-23, Eph 4:1-6, Eph 4:11-14, Col 3:12-17, and Psalm 133 all extol the importance of unity.

SHARED TEAM BOUNDARIES CAN BE LIFE-GIVING

Discordant boundaries have the potential to disrupt unity. But when used well, boundaries have the potential to powerfully reinforce unity. Boundaries can be mutually supportive, and can be life-giving to everyone on the team.

One missionary team made a covenant to support each other by establishing healthy boundaries for each other. For instance, the team only had one surgeon, and this surgeon had a tendency to accept any work that was requested of him. So his teammates said, **"We protect our surgeon.** We know that he will burn himself out, and we don't want to lose him and his family. So when he has been operating through the night, we don't allow him to

take outside phone calls. When someone wants to refer a patient to him, we make that decision for him, and refuse most of those transfers. We round on his post-op patients for him and see uncomplicated follow-ups in his clinic. We send him and his family away for four-day weekends at least every other month. During that time, we don't have a surgeon, but we know that is far better than losing him long-term."

When all of the members of the team look after each other and establish **mutually-supportive boundaries,** the team is far more likely to thrive long-term.

The establishment of team-wide boundaries may initially be unpalatable to experienced missionaries. Long-term missionaries who have functioned without many boundaries and have sacrificed their own sleep and family time may feel that their sacrifice is disrespected as new team boundaries are considered. When introducing the idea of team boundaries, it would be unkind and unwise to portray the sacrifices of the experienced missionaries as mistaken or unwise. The team should honor the dedicated work of those who have served for so long and with such endurance. At the same time, the establishment of new, mutual God-honoring boundaries can be expected to improve the overall health of families and team members, extend the duration of healthy service for many team members, and provide many more opportunities for care and ministry.

When thought of properly, boundaries are understood as **acts of humility.** We know we are not omnipotent, and we don't have control over life and death. Only God has that power. When we recognize that we are limited, and then act accordingly, we are acting with humility. If we seek boundaries out of arrogance or selfishness, we should confess and repent. But more commonly with healthcare missionaries, we tend toward overestimation of our own role in caring for patients and an avoidance of boundaries.

CHOOSING BETWEEN MORAL INJURY AND BURNOUT – A TEAM BOUNDARY STRATEGY

Several missionaries have told us, "Being a medical missionary means having to choose between moral injury and burnout." In other words, in our setting of great medical need and short medical supply, if we do everything that is asked of us, we will surely burn out. But if we don't do what is asked of us, we are morally injured. We feel that we are guilty of not fulfilling our duty. And almost always, if we have to choose between burnout and moral injury, we will choose burnout. A surgeon said, "If you put a patient with an acute belly in front of me, even if I am totally exhausted, there simply is no way I would walk away. I will operate on that patient and follow them and deal with their complications. To do otherwise is intolerable to me."

And that's a wonderful, self-sacrificial attitude, which I think we all admire. So how do we deal with the dilemma of having to choose between burnout and moral injury? The answer may lie in submitting to a mutually supportive team. If, as a team, we see the big picture and realize that if we are able to serve sustainably we will be able to care for many more patients over our careers, and if we are able to see that sustainability requires boundaries, **we can establish healthy boundaries for each other** that remove us from our own sense of obligation with every situation. If we, like the missionary team mentioned before, take care of each other in the same way they took care of their surgeon, we can bear each other's ethical burdens and make decisions that would be too much for an individual.

A mission hospital had a high census of very sick children and only **one pediatrician.** He was significantly affected by the high numbers of child deaths. So his team, which consisted of internists and surgeons and an obstetrician, wrote his schedule

for him and sent him home when his workday was over. They taught themselves PALS, covered emergencies as best they could, and built a powerful sense of community.

Jesus used boats to distance himself from the crowd when the time was right. We can **"make boats"** to provide each other with some distance, or share the burden from ethical decisions when the time is right. Some ways in which teams have cared for each other in this way:

> Take phone calls for each other and make decisions about whether to accept patients in transfer.
>
> Give permission to each other to delegate duties to less-highly-trained personnel.
>
> Write each other's schedule.
>
> Send each other on long weekends.
>
> When the ward becomes overfull, re-triage patients by more selective criteria and transfer patients or send them home.
>
> Cover ward rounds or clinic or call for each other.
>
> Cut non-vital administrative duties for each other. If a committee or working group can be reasonably done by one person or a fewer number of people, make the change. Limit reports to one page of bullets. Limit duration of meetings to 15 minutes.

CONCLUSION

In the **Resilient Global Worker Study** of almost 900 missionaries, Whiteman et al concluded that global worker resilience was closely associated with three factors: A vibrant relationship with God, mutually supportive relationships with others, and a strong support of self.[4] These factors resonate powerfully with healthy boundaries, especially with boundaries made in community to support each other in serving a loving God.

In our interviews with experienced healthcare missionaries, the issue of overwork and lack of boundaries is one of the most important negative factors in their service. For many healthcare missionaries, their main reason for leaving the field was burnout from overwork. Many of the missionaries who have continued in service have recognized the importance of boundaries and have humbly determined to establish boundaries consistent with a recognition of their own limitations. We pray that you will learn from our experiences and determine to establish God-honoring, mutually supporting boundaries in unity with your team. Because the management of God-honoring boundaries is an essential spiritual discipline in cross-cultural missions. To God alone be the glory. ✝

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[4]Whiteman, G. (2020, December). *Resilient Global Worker Study: Persevering with Joy.* Presented through **ResilientGlobalWorker.org**