SHORT COMMUNICATION

Why are MedSend grant recipients leaving the mission field? An internal review

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Introduction

Attrition of healthcare missionaries is a significant issue. The Global Health Workers Needs Assessment survey (GHWNA) of current and former MedSend[1] grant recipients found that the average length of service was 4.77 years.[2] Ending service after five years of experience has been described as particularly disappointing, because at this stage missionaries tend to be perceived as culturally competent and are able to pursue tasks more in line with their skills and interests.[3] In the last few years, MedSend has noted that the rate of departures from the field has been increasing.

Some have estimated that the cost of supporting an American missionary family of five for five years is $395,000 USD.[3] A large portion of that cost is incurred in preparation and set-up. The personal cost to the missionaries, their families, their teams, their supporters, their patients and their hosts in an earlier-than-anticipated departure is impossible to estimate but is substantial.

The experience of healthcare missionaries is different from that of other types of missionaries, such as church planters or bible translators. Healthcare missionaries tend to be exposed to much more death, suffering, and life-and-death ethical dilemmas, which are compounded in a cross-cultural setting. The reasons for healthcare missionaries' departure from the mission field can be expected to have some differences from other types of missionaries. Previous studies have sought to understand the reasons for departure specifically for healthcare missionaries, usually using survey instruments.[4,2] Those studies have proven to be very useful in guiding retention and support efforts.

MedSend has a relatively unique window into this issue because we work with missionaries from many different sending agencies, serving in many different geographic and professional fields. MedSend has initiated a Longevity Project, which is committed to support healthcare missionaries in thriving on the mission field and prevent avoidable attrition. When a MedSend grant recipient leaves the field, we conduct an exit interview and, therefore, have a corpus of potentially useful information to help guide efforts to lessen healthcare missionary attrition. This internal review of those exit interviews was conducted to guide the efforts of the Longevity Project and to assess whether previously-reported issues remained problematic and whether additional issues deserved attention.

Though the information from our exit interviews is relatively unstructured and, therefore, its interpretation is subject to significant limitations, we chose to use this available information while preparing for a more structured prospective study. Further, many of our interviews have been conducted within the last two years, and so, we had opportunity to consider the contribution of COVID-19-related issues. We believe that the information in aggregate has the potential to be helpful in guiding efforts toward healthcare missionary longevity.

Methods

MedSend conducted an internal review of the exit interviews of all MedSend Grant Recipients who

left the mission field between January 2018 and October 2021. The reviewers used notes from exit interviews and recollections of personal conversations with these missionaries. All available pertinent issues regarding the reason for departure from the field were identified and categorized. The authors worked together in identifying issues and categorizing them. No attempt was made to verify the missionaries' reports with any other source, and reports were accepted as they were presented.

When themes were tallied, we noted a clear grouping of major themes. Three themes were reported by 9–12 individuals, and no other theme was reported by more than five individuals. Therefore, themes were categorized as "major" if they were reported by 9–12 grant recipients, and "minor" if they were reported by 2–5 grant recipients. Themes that were reported only once were considered to be "isolated."

Results

Records of 53 missionary "units" were reviewed. "Units" may be defined as a single missionary, a married healthcare missionary and his or her family, or two married healthcare missionaries and their family. Ten records did not include data regarding reasons for departure and were not considered further. Forty-three records described at least one reason for departure.

Because of the limitations of this data, it would be inappropriate to report percentages or overall importance of contribution to the reason for departure from the field. But there was a preponderance in reporting of certain themes. Major themes (9–12 responses) included:

- Overwork associated with burnout
- Inability to obtain licensure or visas, or inability to work in one's field
- Change in personal situation (such as new marriage, marital problems, children's educational needs)
- Change in role (such as change in vocation, transition to headquarters leadership)

Minor themes (2–5 responses) included:

- Isolation and lack of support
- Issues with leadership or management
- Personal safety
- COVID-associated issues
- Team issues / interpersonal conflict
- Medical problem or need for ongoing counseling
- Cultural adjustment problem

Isolated themes (1 response each) included:

- Called by God to return
- Financial hardship
- Frustrations working with national staff

In this report, we choose not to expound on themes such as change in personal situation or change in role, as they may be unavoidable. Surely, some of those changes were associated with other issues. For instance, marital problems may be associated with overwork or isolation, but we did not have enough information to confidently make such connections.

Comments by category

Major Themes

Overwork associated with burnout: This category was the most commonly reported avoidable issue. Several missionaries reported that overwork was well known as a problem at their station, but it was accepted by leadership as part of medical mission work. Some reported that attempts to establish boundaries to prevent burnout were not appreciated by others on the team and led to team conflict. Some reported that they had no idea there could be ethical boundaries to limit work. In contrast, some missionaries who had left the field for other reasons reported strong support from their team toward personal and team boundaries which allowed a healthy and balanced work schedule.

Inability to obtain visas or licensure or inability to work in one's field: Some felt that their host countries were deliberately seeking to deport missionaries and were using visas and licensure as means to remove them without direct confrontation.

However, a significant number of missionaries reported that they went to their station without adequate administrative preparation. For instance, some reported that their country of service required that they have work permits prior to arrival, and when they arrived without work permits, this prevented them from ever being approved for work permits. Some reported that they were not able to work for years due to an administrative oversight.

Minor Themes

Isolation and lack of support: Several reported that they served as the only missionary or only Westerner or only medical person at their station, and the lack of community or acceptance or support was intolerable. Some reported that they were not accepted by their host community or team, which rendered their service fruitless in some ways.

Issues with leadership or management: This category included issues with both expatriate and national leadership, and the themes were similar in both groups. Some missionaries reported that they felt powerless in an authoritarian structure. Some noted that work was overprioritized above personal needs.

Personal safety: Significant safety issues were reported with varying ability to cope by different members of families. A few missionaries reported that they had received no significant preparation to function in their high-threat place of service.

COVID-associated: The problems associated with COVID-19 were diverse, including difficulty in travel, lockdowns preventing their work, team conflicts, family conflicts, hostility among hospital staff and among people in the community, and concern about a family member's ability to be treated after acquiring COVID.

Team issues / interpersonal conflict: Issues with teammates did contribute to the decision to depart in a significant number of our missionaries. However, we did not find this to be a major contributor unless it was paired with leadership issues.

Medical problem or need for ongoing counseling: From information available in these interviews, it seemed that most of the individuals who needed more extensive counseling were receiving counseling due to experiences on the field which led to moral injury or trauma. Most of the medical problems (such as cancer or diabetes) did not seem to have been specifically related to the location of service, though this was impossible to ascertain with certainty.

Cultural adjustment problem: A few missionaries or their spouses or children were not able to adequately adjust to the new culture. Specific issues included being seen as only providers of money, a perception of disregard for the truth among colleagues, untrustworthy behavior in patient care among colleagues, and inability to have personal boundaries.

Discussion

Previous studies have reported on healthcare missionary attrition statistics.[5,2] These studies usually are structured as written surveys using pre-determined Likert scales. Our report instead used information from relatively unstructured exit interviews. Though the unstructured nature of these interviews led to significant limitations in interpretation, this unstructured nature also provided an opportunity for the participant to introduce issues which might not have been included in a Likert-scale survey. For instance, in the PRISM study, the issue of overwork with burnout was not provided as an option in the survey, and we found that this issue was our single most commonly-reported reason leading to departure.

Our two major preventable issues, burnout associated with overwork and inability to obtain licensure or permits or inability to work in one's field, deserve further comment.

Overwork with concomitant burnout was our most commonly-reported serious issue. Burnout and overwork are not identical, but for the purposes of our coding, the two concepts were consistently related. The PRISM study did not assess overwork as a cause of attrition in its survey.[4] The GHWNA study did note burnout as a cause of attrition, but it

was reported as a "contributing" factor, rather than a "top" factor, and the category of overwork was not reported.[2] We believe this issue to be far more important currently than has been previously recognized. This opinion is shared by Gail Gambill, director of the Post-Residency Program at Samaritan's Purse/World Medical Mission (personal communication, Mar 2022). She states confidently that overwork is the most common reason for departure from their program.

Difficulty in obtaining licensure or work permits and inability to work in one's field have been recognized as significant problems before.[2,4,6] Nonetheless, several of our grant recipients reported that they arrived at their mission stations without adequate preparation for licensure or permits or without ensuring that they would be able to work in their fields. Some said they were advised that such preparations were not critical and that they could manage the arrangements after arrival. However, in some cases, arrangements were impossible after arrival. Some governments will not consider license or work applications after the individual has arrived in the country. This issue must be recognized by missionaries and sending organizations as a vital pre-field preparation.

Comments regarding some "minor themes"

We were impressed by the need of support for healthcare missionaries who serve alone. Some missionaries who seemed particularly well-suited and otherwise well-prepared for healthcare missions service described isolation and lack of support as the primary reason for their departure. The emotionally and spiritually challenging nature of healthcare missions may cause a greater need for supportive community.

COVID-related issues were identified as factors contributing to departure in four of our 43 interviews. We were surprised that this issue was so rarely reported. We are aware of some missionaries who were required to depart their stations of service and have been waiting in the US for an opportunity to return. Such missionaries were not included in this analysis.

Recommendations

From this body of information, some recommendations are warranted to combat attrition of healthcare missionaries.

- Agencies, and especially stations, should embrace and actively develop team-supported boundaries to prevent overwork and burnout.
- Agencies should ensure that all requirements for licensure and immigration status are known and reasonably satisfied prior to sending missionaries to the field, especially if it may impact their ability to commence work upon their arrival.
- Agencies should avoid sending missionaries to isolated duty unless they have been carefully vetted and found able to set and maintain personal boundaries, are especially able to integrate into a supportive community, and have an intentional group of supporters to maintain regular contact.
- Stations should prioritize strong community and mentorship to support all on the team, to include dealing with trauma and moral injury as well as building team relationships.

The information in this brief report is subject to several important limitations. The information was provided by the missionaries themselves to representatives of our organization and no effort was made to verify the information's accuracy or completeness. Such efforts may not have added to accuracy. According to previous reports of reasons for missionary attrition, correlation between the missionaries and their sending organizations tends to be low.[2,6] The information in our report was not obtained in a structured, prospective fashion but was instead gleaned from unstructured notes. However, the information in this report is consistent with our experience obtained in other venues. We hope that this information may be used to help healthcare missionaries thrive in their vital and strategic service and strengthen the overall impact and successful utilization of healthcare missions in the sharing of the gospel.

References

1. MedSend assists healthcare missionaries with grants to cover their monthly educational debt payments. These missionaries, or "grant recipients," all serve with mission agencies which have relationships with MedSend.
2. Strand MA, Wood A. That healthcare missionaries might flourish: Global Healthcare Workers Needs Assessment Report. MedSend; 2015.
3. Strand MA, Chen, AI, Pinkston LM. Developing cross-cultural healthcare workers: content, process and mentoring. Christ J Global Health. 2016;3(1):57–72. https://doi.org/10.15566/cjgh.v3i1.102
4. Strand MA. Medical missions in transition: taking to heart the results of the PRISM survey. Christian Medical and Dental Association. 2011.
5. Missio Nexus. Field Attrition Study Research Report. 2019. Available from: https://missionexus.org/2019-attrition-study-research-report/
6. Strand MA, Paulson E, Myrick T. Characterizing the global context for cross-cultural healthcare work by regions of the world. Christ J Global Health. 2015;2(2):23–38. https://doi.org/10.15566/cjgh.v2i2.78

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