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CE 2.3 ANCC contact hours

Potential Pitfalls of Short-Term Medical Missions

ABSTRACT: *Participation in short-term medical mission (STMM) trips has grown dramatically in recent years in response to increased global communication, travel, and awareness of inadequate healthcare services in impoverished countries. Some argue STMMs have the potential to do more harm than good. Common criticisms include unsafe practices, lack of consideration for cultural differences, and lack of coordination with the host country. Improving the outcomes of STMMs requires increased awareness of potential pitfalls. With awareness and planning, the positive impact of STMMs in providing needed services to resource-limited countries can exceed the potential negative impact. Guidelines for medication donations and STMMs are included, along with resources for further study.*

KEYWORDS: *best practices, global health, healthcare disparities, missionary nursing, service-learning, short-term medical missions (STMMs)*

INTRODUCTION

Caring for the sick has long been considered a hallmark of Christianity. Christian healthcare workers cite biblical references of the call to medical missions as an example of God's unconditional love (Matthew 10:8; Luke 10:8–9, 25–34). Although Christians have been involved in medical missions throughout history, participation in short-term medical missions (STMMs) has grown dramatically in the past few years (Grundmann, 2008; Langowski & Iltis, 2011). "The availability of instant and continuous worldwide news and information has increased exposure to global issues" (Hawkins & Campbell, 2012, p. 89), while quick and affordable travel allows individuals to respond to global needs. In response to increased awareness of global issues, international medical volunteerism is on the rise. It was estimated in 1979 that around 22,000 Americans were involved in short-term missions (not all medical); in 2007, there were approximately 1.6 million (Soderling, Butler, & Yorgin, n.d.).

STMM teams travel to impoverished countries to address inadequate healthcare services (DeCamp, 2011). However, some argue that these trips have the potential to do more harm than good. Common criticisms include unsafe practices, lack of consideration for cultural differences, and lack of coordination with the host country. But the positive impact of STMM teams in providing much needed services to resource-limited countries calls for continued efforts to sustain this ministry. Improving the outcomes of short-term mission trips requires thoughtful planning and consideration of issues surrounding the practices of mission teams. Team members need to be aware of the potential pitfalls in order to address or avoid as many problems as possible.

ADDRESSING THE NEED

The limited availability of healthcare services, as well as troubling key health indicators in developing countries compared to developed countries reveals a significant disparity. A striking 40-year gap exists between the average life expectancy in low-income versus high-income countries (Central Intelligence Agency, 2012). The infant mortality rate improves from 36 deaths per 1,000 births in low-income countries to 4 per 1,000 in high-income countries. Over 70% of the worldwide burden of preventable deaths in children is limited to just 15 countries (World Health Organization [WHO], 2012b).

This disproportionate burden of disease supports the need for medical mission trips. According to the WHO, the world's richest countries receive over 70% of essential surgical services, while the world's poorest countries are recipients of just 4% of surgical services (WHO, 2012a). Short-term medical volunteers provide scarce health resources and services to developing countries. Operation Smile has treated over 135,000 children in need of cleft lip and cleft palate repairs (Ott & Olson, 2011). These services are provided across the globe in over 60 countries in some of the most

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resource-limited countries (Operation Smile, 2012). The nonprofit organization, Physicians for Peace, has a similar global presence in over 60 countries (Physicians for Peace, 2012). Universities may partner with nonprofit organizations to add an educational component to the short-term mission while providing much needed in-country services. Old Dominion University, in partnership with Physicians for Peace, deploys an STMM team annually to provide education and training to vulnerable populations.

The needs are great. In developing countries, patients often have to choose between life-saving medications and life-sustaining food (Wall, 2011). In addition to surgical services that impact morbidity and mortality, medical mission teams provide healthcare goods, services, and education to help fill the gap where access to care is extremely limited. Mission teams commonly operate community medical clinics and distribute costly medications free of charge (Hawkins & Vialet, 2012; Seager, Seager, & Tazelaar, 2010).

Table 1: Why Patients Are at a Much Greater Risk of Serious Harm From Drugs in the Short-Term Medical Missions Setting (Gorske, 2009)

• Lack of knowledge of the patient (every patient seen is a *new* patient).
• Lack of adequate medical record, medication list, allergy record, list of diagnoses, and so on, to determine whether a drug may be contraindicated.
• Lack of adequate time for obtaining an accurate and complete history.
• Lack of adequate time/facilities for obtaining an accurate and complete physical examination.
• Lack of availability of reliable laboratory testing.
• Lack of adequate provider training and knowledge of WHO international standards and evidence-based practice guidelines for developing countries.
• Lack of emergency medical systems and intensive care units for timely and appropriate treatment of adverse effects.
• Confusion due to language and cultural differences.
• Lack of patient familiarity with a medication's adverse effects.
• Lack of adequate time for counseling by a physician, pharmacist, or nurse.
• Increased risk of drug interactions and drug overdose.
• Disrupted continuity of care for chronic conditions for which the patient is under the care of a local provider.
• Increased risk of accidental ingestion related to lack of knowledge of child safety requirements, safe storage area in home, or child-safe containers.
• Increased mortality due to lack of poison control centers, emergency medical systems, and intensive care units for timely and appropriate treatment of accidental ingestions or overdoses.
• Lack of availability of follow-up; neither the prescribing provider nor the dispensing pharmacist will be available if there are adverse effects to the treatment.
• Local in-country healthcare providers and pharmacy personnel usually have little knowledge of the medications brought by short-term teams and/or lack the resources to treat drug-related complications.

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ANSWERING THE CALL

Clearly, healthcare workers have a duty to provide care when properly equipped and in a position to address these disparities. Responding to human suffering is a moral and Christian obligation. Medical mission teams, commonly sponsored by faith-based organizations, may support a strong belief in the sanctity of life and universal access to healthcare, as well as the Christian responsibility to provide for underserved populations. A 2008 study by the WHO found that faith-based organizations are significant healthcare providers in developing countries, for example, providing 40% of health services in sub-Saharan Africa (WHO, 2012b).

In addition to fulfilling a moral and Christian obligation, participation in medical missions promotes cultural sensitivity, civic responsibility, and civic engagement as well as enhances academic opportunities for health science students (Amerson, 2010; Beyerlein, Trinitapoli, & Adler, 2011; Crump & Sugarman, 2010; Zaidi, Ahmed, Ud Din Saif, & Khan, 2011).

Sustainable solutions to healthcare disparities start somewhere. The volunteer experience contributes to the sustainability of improving health outcomes through the building of personal relationships. Healthcare missionaries often establish long-term relationships with repeated trips to the same community. Building long-term relationships with the community allows for a continuity of personal support (Bajkiewicz, 2009; Hawkins & Vialet, 2012). This continuity of personal support is consistent with the Apostle Paul's principle of Christian mentorship to the various churches in Asia Minor. Paul built a network of support that was very personal; he often mentioned people by name in his letters and touched multiple lives in the process. STMM sustainability may well hinge on the ability of teams to personally engage in the lives of

those they serve. Engaging in their lives and developing personal relationships clearly improves awareness of the circumstances of those served.

This personal engagement and increased awareness may impact the future practice of healthcare providers and ignite an interest in future ministries. Health educators believe that increasing global health awareness better equips students to practice in their own communities as well as abroad (Hawkins & Campbell, 2012). The students recognize participation in medical mission trips as life changing and influential to future career choices including careers in global health, public health, and primary care specifically of vulnerable populations (Crump & Sugarman, 2010; Hawkins & Vialet, 2012).

POTENTIAL PITFALLS

Unfortunately, STMM teams have the potential to cause harm. Unfamiliarity with the patient population, the language, and common health problems as well as the short-term nature of the trip can lead to inappropriate and unsustainable treatments. There may be an increase in errors that occur during STMM trips. Gorske (2009) identifies several reasons short-term medical clinics have an increased risk for medical errors including unavailability of or inadequate health records, health histories, laboratory testing, emergency services, examination facilities, and referral services for follow-up. Language barriers and limited time with the patient further inhibits the ability to obtain an accurate health history or provide effective patient teaching. Furthermore, the visiting provider is most likely unfamiliar with the practice standards in the host country while host country providers may be unfamiliar with medications and treatments provided by the mission teams (Gorske, 2009). Table 1 delineates specific concerns to consider in STMMs.

Table 2: Guidelines for Medication Use in Short-Term Medical Missions

1. Medicines for distribution should be planned for with the host country health providers with whom you are coordinating the mission trip.
2. If possible, buy medicines in country as directed by local providers.
3. Medicines taken into the country should be approved for use in the country—on the National List of Essential Medicines or equivalent, or on WHO Model Lists of Essential Medicines, unless there is justification for use otherwise.
4. Only take and give away medicines you would take yourself or that would be used in your country.
5. Medicines given to patients should be based on an expressed need of the patient.
6. The presentation, strength, and formulation of medicines should be, as much as possible, similar to medicines commonly used in the country.
7. Medicines must be obtained from quality sources and comply with quality standards.
8. Never use free samples or medicines that were returned to a pharmacy for donations to patients in other countries.
9. All medicines need to have at least one remaining year of shelf-life.
10. All medicines should be labeled in the language of the patient and health providers in the country.
11. All medicines should be labeled with written instructions or symbols in the language of the patient.
12. Medication distribution areas (pharmacies) should be staffed by trained, licensed personnel, preferably a pharmacist.
13. Medication labels should contain the International Nonproprietary Name or generic name, batch number, dosage form, strength, name of manufacturer, country of manufacture, quantity in the container, storage conditions, and expiration date.
14. Medicines should be in containers suitable for the patient and appropriate to the setting.
15. All costs (transportation, clearance and customs, handling, etc.) should be paid for by the mission team/donating agency unless specifically agreed otherwise in advance.
16. Make sure patients can follow up with local providers in some capacity; this is critical for long term use/need for medications.
17. "As a general rule, medicine donations are neither a long-term solution to underfunded health systems nor a solution to the lack of access to medicines in poor countries—especially for diseases that require lifelong treatment or large numbers of treatments. However, donations can be temporary solutions to defined problems" (WHO, 2011, p. 7).
18. Refer to the WHO *Guidelines for Medicine Donations*.

Sources: Bajkiewicz (2009), Center for the Study of Health in Mission (2009), Gorske (2009), Seager et al. (2009), Soderling et al. (n.d.), WHO (2011).

Common practices of short-term mission teams such as consolidating sample medications and dispensing in cost-effective plastic bags rather than appropriately labeled and child-proofed containers contribute to the potential dangers (Seager et al., 2010). Depending on the availability of a pharmacist, these makeshift pharmacies may be staffed by nonpharmacists or even nonhealthcare members of the mission team. In addition, medications distributed in STMM projects can be donated and expired or soon to expire. The WHO offers guidelines for donating medications to developing

countries (WHO, 2011). Table 2 summarizes information from the WHO guidelines with a focus on STMMs. Similar guidelines are provided by WHO for equipment donations.

An overarching principle for Christians to follow is "So in everything, do to others what you would have them do to you" (Matthew 7:12, NIV). If a medication is not something you would want to take because it is expired or is not properly labeled, don't give it to someone else. If someone is performing a procedure they would not be licensed or qualified to do in your country, don't do it in another country. Table 3 outlines basic guidelines for optimal STMMs.

Limited accountability and liability as well as inadequate knowledge, preparation, or resources to meet the needs of the community can lead to the injudicious inclination of providers to practice beyond their scope of training (Langowski & Iltis, 2011). The increased popularity of health science students participating in medical mission trips as part of their educational programs may contribute to this problem. Student volunteers are often at the early stages of their training and may take advantage of the unregulated environment to practice skills and techniques that are beyond their scope and level of training (Wadhwa & Youssef, 2011). All providers, from students to experienced licensed personnel, should attempt to work within the scope of practice of their home country while working in short-term missions. The Center for the Study of Health in Missions (Center for HIM, 2009) advises that best practice, although time consuming, is to obtain appropriate licensing in the host country for each team member. If that is not possible, obtain approval through local authorities and/or proceed with great caution when it is not possible to obtain licensing because of an unstable government or lack of a licensing health ministry.

Another criticism for the deployment of medical mission teams is that the expense of sending a team may not be the most cost-efficient means of providing aid to resource limited-countries. In some cases, mission teams have caused more economic strain on the host country than the benefit they provided. This was observed in the rapid deployment to Haiti in response to the earthquake in 2010 where well-meaning volunteers consumed scarce resources of food, water, and shelter (Langowski & Iltis, 2011).

Deployment of STMM teams provides an opportunity for missionaries to understand firsthand the healthcare realities of resource-limited countries. This may lead to long-term personal relationships and sustainable missions (Hawkins & Vialet, 2012), but teams need to take extra measures to avoid negatively impacting the host country.

Table 3: General Guidelines for Optimal Short-Term Medical Missions

1. Begin with prayer; ask God if he wants you to go, with whom, and how he wants to prepare you?
2. Research mission-sending organizations; go with an established, respected group.
3. Coordinate with host country health providers to identify felt needs and determine common goals for all trips.
4. Study the culture of the country you are going to; learn the language if possible.
5. Go with a willingness to serve in whatever capacity is needed.
6. Attempt to obtain licensure in the country for which you are going to practice; work with your mission-sending organization/team leaders.
7. Practice within the scope of your licensure and preparation; if you can't do it in your country, don't do it in another country.
8. Work closely with host country health providers; follow their lead, learn from them.
9. Arrange for patient follow up with local health providers in some capacity.
10. Work closely with translators for improved communication.
11. Include community health development/health education based on needs identified by local providers.
12. Follow WHO guidelines for obtaining and distributing any medications.
13. Follow standard safety guidelines for care just as you would in your own country.
14. Plan for long-term commitment; the mission-sending organization should work toward long-term relationship with local health providers and/or a local church.

AVOIDING PITFALLS

Although there are no easy solutions to the pitfalls associated with STMMs, it is important to consider drawbacks when planning a mission trip. The mere act of considering the hazards leads to increased awareness for the team members. Awareness is the first step in minimizing negative outcomes that may occur as a result of common practices of short-term

mission teams. Following best practice guidelines of medical missions will improve safety and minimize risks (Crump & Sugarman, 2010, 2011; Seager et al., 2010).

Team leaders should ensure that healthcare providers practice within their scope, follow standard safety guidelines, and work closely with host country providers and translators for improved communication. In essence, all providers including students need to be aware of and follow best practices and the highest standards of healthcare ethics whether practicing at home or abroad (Morrison, 2009).

Mission team leaders should collaborate with host country leaders to determine common goals. This enables the mission teams to establish partnerships and better serve the healthcare needs of host countries. Requiring short-term missionaries to complete cultural sensitivity training may help to facilitate cultural considerations in providing medical care to host country recipients.

Another aspect to consider in medical missions is focusing on community health development, that is, consider health promotion in addition to or even rather than curative medicine. Issues such as clean water, safe disposal of human waste, nutrition, immunizations, sexual abstinence or loyalty, healthy behaviors, and protection from disease-carrying pests can be critical issues in developing countries (Stanley & Stanley, 2008). Resources for community health education abound and can be located on the Internet (see Web Resources), noting that direct patient education is optimally given by local nationals with support and resources from the mission team before, during, and after a mission visit (Bajkiewicz, 2009). An additional area where nurses can make a huge impact is serving as educators in nurse training programs. An overarching principle to follow in STMMs is to build local capacity by working with local providers to support what they are doing . Missionaries should work to meet the stated needs of the community and to establish trust in the process of serving (G. Tazelaar as cited in Stanley & Stanley, 2008).

There are a number of Christian mission organizations promoting excellence in short-term healthcare missions (see Web Resources). The U.S. Standards of Excellence in Short-Term Missions organization (SOE) offers seven standards of excellence as a code of best practice for all short-term mission practitioners (SOE, 2013). The standards begin with focusing on God and the desire to glorify him, and emphasize mutual partnering and collaboration with recipients. SOE offers a free downloadable booklet discussing the seven standards in detail at http://www.soe.org/explore/the-7-standards/. The Center for HIM (2010) seeks to help the global church explore and apply "biblical revelation, scientific evidence, and cumulative experience as they relate to health and wholeness." Center for HIM is a resource to explore biblical thinking about health and the church's role in promoting health.

CONCLUSION

Each Christian has a gift that should be used to serve others (1 Peter 4:10). Healthcare providers often feel called to serve as medical missionaries. Developing countries have limited access to life-sustaining or life-improving medical care. Answering the call to serve on STMM teams provides an opportunity to respond to healthcare disparities. To minimize negative outcomes associated with short-term mission trips, medical mission teams should be aware of some of the common pitfalls and make efforts to address potential problems. Long-term, sustainable impact should be the goal of STMMs. Growing interest in medical volunteerism increases the urgency of these concerns and emphasizes the need to raise awareness in order to improve outcomes of short-term mission trips.

Web Resources

- Best Practices in Global Health Missions—http://csthmbestpractices.org/
- Center for the Study of Health in Mission—http://centerforhim.org/index.php?
- Standards of Excellence in Short-Term Missions—http://www.soe.org/
- Nurses Christian Fellowship—http://ncf-jcn.org/resource/missions
- Medical Missions.com—https://www.medicalmissions.com/
- International Association of Medical Regulatory Authorities (licensing and permissions)—http://www.iamra.com/index.asp
- Global Community Health Education Network—http://www.chenetwork.org/
- Community Health Education—http://www.hepfdc.info/
- Hesperian Foundation—http://www.hesperian.org
- TALC-Teaching Aids at Low Cost—http://www.talcuk.org
- WHO Guidelines for Medicine Donations—http://www.who.int/medicines/publications/med_donationsguide2011/en/index.html

Amerson, R. (2010). The impact of service-learning on cultural competence. *Nursing Education Perspectives, 31*(1), 18–22.

Bajkiewicz, C. (2009). Evaluating short-term missions: How can we improve? *Journal of Christian Nursing, 26*(2), 110–114. doi:10.1097/01.CNJ.0000348272.27924.24

Beyerlein, K., Trinitapoli, J., & Adler, G. (2011). The effect of religious short-term mission trips on youth civic engagement. *Journal for the Scientific Study of Religion, 50*(4), 780–795. doi: 10.1111/j.1468-5906.2011.01607.x

Center for the Study of Health in Mission. (2009). *International standards and practice guidelines for medical missions*. Retrieved from http://csthmbestpractices.org/resources/3+Permission+to+Practice.pdf

Center for the Study of Health in Mission. (2010). *Mission statement*. Retrieved from http://centerforhim.org/index.php?option=com_content&view=article&id=8&Itemid=2&lang=en

Central Intelligence Agency. (2012). *The world factbook*. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html

Crump, J. A., & Sugarman, J. (2010). Ethics and best practice guidelines for training experiences in global health. *The American Journal of Tropical Medicine and Hygiene, 83*(6), 1178–1182. doi:10.4269/ajtmh.2010.10-0527

Crump, J. A., & Sugarman, J. (2011). Guidelines for international service learning programs. *Developing World Bioethics, 11*(3), 170. doi:10.1111/j.1471-8847.2011.00315.x

DeCamp, M. (2011). Ethical review of global short-term medical volunteerism. *HEC Forum, 23*(2), 91–103. doi:10.1007/s10730-011-9152-y

Gorske, A. (2009, January). *Why patients are at much greater risk of serious harm from drugs in short-term missions*. The Center for the Study of Health in Missions. Retrieved from http://csthmbestpractices.org/resources/Harm+from+Drugs+in+the+STM+Setting+Jan09.pdf

Grundmann, C. H. (2008). Mission and healing in historical perspective. *International Bulletin of Missionary Research, 32*(4), 185–188.

Hawkins, J. E., & Campbell, A. (2012). Wikicountries: Enhancing global health awareness without leaving home. *Nurse Educator, 37*(3), 89–91.

Hawkins, J. E., & Vialet, C. L. (2012). Service-learning abroad: A life-changing experience for nursing students. *Journal of Christian Nursing, 29*(3), 173–177. doi:10.1097/CNJ.0b013e31823fabf2

Langowski, M. K., & Iltis, A. S. (2011). Global health needs and the short-term medical volunteer: Ethical considerations. *HEC Forum, 23*(2), 71–78.

Morrison, E. E. (2009). *Health care ethics: Critical issues for the 21st century*. Sudbury, MA: Jones and Bartlett Publishers.

Operation Smile. (2012). *Medical missions and programs*. Retrieved from http://www.operationsmile.org/our_work/medical-missions/mission-schedule.html

Ott, B. B., & Olson, R. M. (2011). Ethical issues of medical missions: The clinicians' view. *HEC Forum, 23*(2), 105–113. doi:10.1007/s10730-011-9154-9

Physicians for Peace. (2012). *What we do*. Retrieved from http://www.physiciansforpeace.org/what

Seager, G., Seager, C., & Tazelaar, G. (2010). The perils and promise of short-term healthcare missions. *Journal of Christian Nursing, 27*(3), 262–266. doi:10.1097/CNJ.0b013e3181e06f33

Soderling, M., Butler, P., & Yorgin, P. (n.d.). *Best practices for short-term healthcare missions: How should we best engage in successful partnerships?* Retrieved from http://csthmbestpractices.org/resources/Partnership.pdf

Standards of Excellence in Short-Term Mission. (2013). *The 7 standards*. Retrieved from http://www.soe.org/explore/the-7-standards/

Stanley, O. L., & Stanley, M. (2008). Healthcare missions: Mobilizing communities for health. *Journal of Christian Nursing, 25*(2), 87–91. doi:10.1097/01.CNJ.0000314585.58911.c2

Wadhwa, D., & Youssef, D. (2011). A four-week adventure to save the world. *British Columbia Medical Journal, 53*(9), 488–489.

Wall, A. (2011). The context of ethical problems in medical volunteer work. *HEC Forum, 23*(2), 79–90. doi:10.1007/s10730-011-9155-8

World Health Organization. (2011). *Guidelines for medicine donations*. Retrieved from http://www.who.int/medicines/publications/med_donationsguide2011/en/index.html

World Health Organization. (2012a). *Emergency and essential surgical care*. Retrieved from http://www.who.int/surgery/en/

World Health Organization. (2012b). *Global Health Observatory (GHO)*. Retrieved from http://www.who.int/gho/child_health/en/index.html

Zaidi, N., Ahmed, M., Ud Din Saif, S., & Khan, W. (2011). Preparing medical students through service learning to provide social justice. *Professional Medical Journal, 18*(2), 280–284.

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