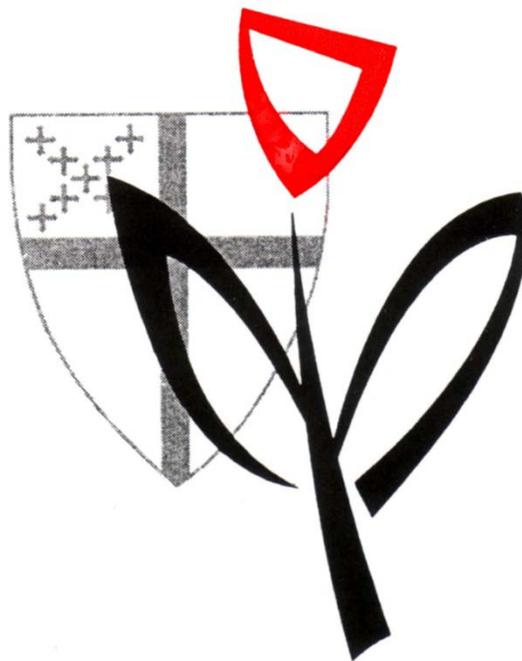


Health Ministry in the Local Congregation

An Introduction and Opportunity



The Rev. Dn. Stephanie L. Ulrich, RN, SD

Congregational Vitality Series #6

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PREFACE

While sensitive to the Anglican tradition, this material is not exclusively Anglican. Many of our brothers and sisters from different faith traditions have contributed to the material as we all share the vision and mission of health ministries. Health ministry does not belong to any one faith community. It is a response to and manifestation of God's action and presence in a broken world.

The National Episcopal Health Ministries are grateful to many individuals and faith communities who have been pioneers in the health ministry movement over the past 30 years.

Collaborative efforts come from congregational health ministries serving a variety of faith communities. United Methodist Church, Presbyterian Ministries, Lutherans, Mennonite Community, Church of the Brethren, United Church of Christ, Baptists and Catholics have all shared their stories, ideas, and visions. National organizations such as the National Health Ministries Association, Interfaith Health Program, Carter Center of Emory University and The Lutheran Brotherhood Foundation have also contributed to education and program ideas for health ministry over the years.

We are grateful to **all** who have come before us. We give special thanks to many clergy, nurses, health educators, teachers, wellness specialists, and hospital chaplains, who comprise the National Episcopal Health Ministry board. They are truly an inspiration to those who are committed to seek and serve Christ and the Church in this particular ministry. Thank you...Good and faithful servants!

A special tribute needs to be paid to The Rev. Jean Denton R.N. and The Rev. Allen Brown D. Min. These two individuals were instrumental in bringing into being not only the initial publication of this work but also the National Episcopal Health Ministries. Their enthusiasm and leadership continues in the hearts and minds of all of us who strive to be "a living witness to the healing activity of God" in space and time. Thank you...Good and faithful servants!

A special thanks to the dedication and perseverance of those persons working currently with NEHM who have gently urged and supported me in the revision of this work. With gratitude, I thank Matthew Ellis, Diane Beyer, Tom Black, James Strickland and all others for their support and hours spent retyping, researching, and updating information for this second publication. Thank you...Good and faithful servants!

The Rev. Dn. Stephanie Lyn Ulrich RN, SD.

Chapter One

INTRODUCTION TO HEALTH MINISTRY

One of the many challenges the Episcopal Church faces moving into the twenty first century is to rethink its notions about health and health care. Initial work by The Standing Commission on Health, during the 1991-1994 triennium, began the dialogue. Five principles, or “elemental objectives,” for an approach to health care were defined to assist the Episcopal Church in coping with the complexity of our current system of care.

- That universal access of quality, cost effective, health care services should be considered necessary for everyone in the population, including those requiring long term care.¹
- That “quality health care” should be defined to include programs in preventive medicine, where wellness is the first priority.
- That “quality health care” should include interdisciplinary and inter-professional components to insure the care of the whole person—physiological, spiritual, psychological, social—in the community in which that person lives.
- That “quality health care” should include the balanced distribution of human resources and not merely of financial resources, so that health care professionals, including primary care providers and nurses, under-serve no region of the country.
- That “quality health care” should include the treatment of incurably ill persons such that pain and distress are relieved even if doing so shortens life. Followers of the crucified and risen Christ do not place highest value on mere biological existence.

Continuous change in the health care system has America struggling. Competition is fierce among health care providers, health insurance industries, state, local, and national governments over the prioritization of health needs and health care delivery. High cost technologies, increased demand for services and health care system fragmentation all contribute to the complexity of health care resulting in consumer bewilderment.

In both the public and private sectors of this country, dialogue continues on health care and reform. We cannot avoid everyday conversations about the myriad concerns surrounding health or health issues. Faith communities are not exempt from this change or the impact it has on its members. Now, congregations have an opportunity to reclaim their historic status as the OHO, or “Original Health Organization.”

Leland Kaiser, author, psychologist, and health care authority, who lectured years ago on the future of health care clearly described the task set before us all. Dr. Kaiser said, “We now have the responsibility of humankind to make things work. Nowhere is this process of change more evident than in our shift in focus from medical care to health care.” He goes on to say, “We know there is very little relationship between medical care and health. Most of what makes

people sick has very little to do with our medical care system.”

Although some of the major causes of sickness and early death are due to sanitation, nutrition, and lifestyle, many of the societal variables we face today—violence, drugs, racism, poverty, youth gangs, divorce, single parenting—lie outside the medical care system. As the Rev. Dr. Thomas A Droege² says, “These are spiritual problems calling for changes in behavior, not medical problems calling for scientific breakthroughs.” Faith communities are charged to respond to these issues whether they like to or not because of the very nature of their existence. Healing and health are part of the church’s mission. To reclaim the full ministry of teaching, preaching, and healing, we need to be intentional and committed to that mission. John’s Gospel speaks to us: “*I came that they may have life, and have it abundantly.*” (John 10:10.)

Developing a congregationally based health ministry changes the paradigm of health. The future in health will be to focus on working together in integrated ways, sharing resources, and meeting one another in community. Schools, hospitals, health agencies, and churches must come together with a common mission empowered by the community itself. Continuing changes within the current health care system and recent denominational recommendations have challenged all faith communities to strengthen their roles in health and healing. This has prompted a significant movement in this country towards health ministry in the local congregation.

We know that church communities who are faithful to their missions promote solidarity, give meaning and purpose to life, and inspire hope. Considerable research and experience support the idea that one’s faith and outlook are integral to the healing and health of the body. Clearly, the parables of Jesus’ healing ministry reveal this relationship.

Health ministry in a faith community is an approach to wholeness and health that builds on strengths of the congregation/community. It stresses wellness, health promotion, and disease prevention, by encompassing congregational/community resources and partnerships. It focuses on body, mind, and spirit for the health and healing of the community.

Intentional efforts by the church to reclaim their roots and concern for health and health care continue. The Episcopal Church recognizes that health ministries play a unique and critical role in facilitating the overall health of clergy, staff, congregations and the communities in which they serve. It makes sense therefore, to be intentional in our efforts to explore health ministry in every local congregation.

During the 2009-2012 triennium, Health Ministries Resolution A077, proposed by the Standing Commission on Health- passed.

The Resolution is as follows:

Resolved, the House of Deputies concurring, That the 76th General Convention urges the congregations of The Episcopal Church, which have not already done so, to explore and implement health ministry as an organizing concept or vital component of outreach and pastoral care of the congregations by 2012; and be it further

Resolved, That the General Convention encourages congregations to raise awareness of health ministries and promote the understanding that health includes body, mind and spirit.

Chapter Two

WHY THE CONGREGATION?

The Rev. Dr. Martin E. Marty, editor of *Second Opinion* and *Context*, speaking before the Seventh Annual Health Ministries Association Conference stated, “The major agency to support health and healing is the local congregation. It takes a long time for the obvious to be spotted.”

Thomas Droege, Associate Director of the Interfaith Health Program at Emory University has said, “When congregations are faithful to the example and mandate of Christ, they are by definition, communities of health and healing. In the current revolution in health care, congregations are in a unique position to improve the health of the communities in which they worship and serve.”

As Christians, we are to see health, among all other things, as a God-given gift. Churches naturally promote health by encouraging prayer, music, fellowship, and assisting individuals in need. Churches are still considered one of the more stable institutions in our society. In a changing world, they offer support, forgiveness, education, and outreach. Many have become centers where health fairs, healing services, support groups, and other volunteer care-giving activities take place. Stephen’s Ministries and BeFriender groups, which are deeply imbedded in the Christian tradition, are increasingly important in church ministry.

Anglican traditions, according to David H. Smith in his book *Health and Medicine in the Anglican Tradition*, have accented “sharing,” a term profoundly rooted in theology and the calls for justice. The central Anglican rite is the Eucharist, or communion, a sacrament of sharing, whose effect is “to make clear the sacredness of society.” An important extension of this view is sharing power. “One of the hardest questions in modern medicine,” Smith writes, “is who should make the difficult decisions...[But] the suggestion that decisions are rightly made by physicians, economists, or geneticists fits poorly the Anglican notion of community, which shares power.”³

Anglicanism also supports sharing resources. Historically, churches have worked closely with the public order. According to Smith, “We have to make some judgments about the relative importance of some ‘medical care’ needs....Thus some form of rationing, [of] ‘painful prescription’..., is not only inevitable but appropriate for a community whose medical goal is a healthy life in which finitude is acknowledged.”⁴

There is much concern today about the health and well being of individuals and their communities. This concern creates the need for community resources to begin to work effectively with one another. Despite the proliferation of health services, we know that some people do not get health care and those who do are not necessarily healthy. Health and health care are not synonymous terms. Faith communities’ roles are changing. They are being called to respond to more complex and multiple needs of individuals and families.

Many people are “falling through the cracks” because they do not fit into a “system.” When human and economic resources from the greater community are exhausted, people turn to the church. Needs and demands are increasing. They are reflected specifically in the increased number of poor, elderly, and children seeking help. In many faith communities, discretionary funds and pantry supplies are exhausted well before the month is out.

Of particular concern and challenge is how best to serve an aging population. Once family and work responsibilities are over, individuals may still have a third of their lives to live. What will be the quality of those years?

Health ministries exist for the purpose of preventive health care and wellness. While emphasis may be on the poor, elderly, and children, health ministries are meant to serve the needs of the whole congregation and greater community. Health ministries are **not** created to replace traditional health systems methods that offer sickness care and cure. Our goal is to work in concert, to co-exist in such a way that promotes optimal whole person health, healing, and general well-being.

Difficult choices need to be made about good stewardship and allocation of resources. The value of the human being from the Christian standpoint calls us all to build a society where every individual is cared for according to his or her needs and not according to his or her assets.

Droege reminds us, “Health leaders are recognizing that improvements in health will come about only as people assume a greater responsibility for their own health and the health of their communities.” They also recognize that congregations are social institutions with great potential to affect lifestyle changes for health promotion. In the *Journal of the American Medical Association*, a recent article revealed that lifestyle factors (tobacco, substance abuse, diet, sedentary lifestyle, toxic agents, sexual behavior, motor vehicles, firearms, and illicit drug use) contributed to half of the deaths in this country.

Individual congregations, by reclaiming and strengthening their healing roles, are in pivotal positions to promote health through community building, enhancing the meaning of life, nurturing spiritual values, and sponsoring health-related programs.

Christian health ministry arises from the gospel itself and our Lord’s command to love and care for one another (John 13:34-35; Matthew 25:31-46). It is thus an extension of the ministry of Jesus in space and time—*now provisional until such time as all things are made in him.*⁵ One aspect of reclaiming the full ministry of Christ is to include health ministry in the congregational setting.

Why the congregation? It is at the local level that we bring into reality our promises made at baptism—the covenant that we each have with our Lord. Question: *Will you proclaim by word and **example** the Good News of God in Christ?* Question: *Will you seek and serve Christ in all persons, loving your neighbor as yourself?* Each carries the response: “I will with God’s help.”⁶

Who else can rightfully claim this ministry except the local Christian community—the church gathered in that place—the congregation.

Chapter Three

HISTORICAL OVERVIEW

The Church and the communities in which she serves have had a long history of concern for personal well-being, community health, and providing for the poor, the sick, and the needy. For centuries, the Church has been the conscience of society calling Christian men and women to bear witness against all forms of social evil, injustice, and discrimination.

Many civilizations developed health codes or rules. The Hebrews, for instance, developed the Mosaic Code. Rules for disease prevention and control, communal sanitation, dietary restrictions, sexual conduct, circumcision and personal cleanliness were all part of a fundamentally holistic attitude Hebrews have towards health. There were even codes of law that included a sliding scale fee for payment for medical services rendered.

In the early Christian era, sojourners traveling unfamiliar lands would often receive medical and nursing care at a local village inn. Monastic monks and nuns cared for the sick in their own communities, as well as the aged, the orphaned, and the indigent. In early civilizations, the priest was also the physician and public health inspector.

During the time of the Crusades in the 11th century, hospitals and hospices were established along the routes Crusaders traveled to the Holy Land. By the end of the 13th century there were approximately 19,000 hospitals scattered throughout Europe. Religious orders were established to care for the sick and to defend the Holy Land. The Benedictines and the Knights of Hospitallers of St. John are two of the orders that still exist.

During the sixteenth century Reformation, many of the monastic hospitals closed and the number of monastic nursing orders declined. Secular hospitals began caring for the sick, the poor, and the handicapped, giving rise to the secularization of health care well known to us today. Donations from the monarch, nobility, and taxes paid by citizens supported the hospitals.

In the 1800's, The Age of Enlightenment, the Church once again began looking at health and illness in terms of man's relationship or lack of relationship to God. Mistrust mounted between medical science and religious doctrine. During this period of transition, many of the poor and sick suffered from the lack of medical facilities. In the United States, large hospitals of religious or charitable foundations were virtually unknown.

One of the most prominent 19th century figures in the Anglican history was The Rev. Dr. William Augustus Muhlenberg. A pioneer of Christian action in the 1800's, Muhlenberg had the vision and courage to see the multiplicity of social, medical, and welfare problems in the modern city. He was instrumental in initiating programs of Christian action in these areas. In the 1840's, there were reportedly 1000 cots in all the public hospitals combined, most of which were occupied by dying paupers and homeless sailors. One of the many achievements brought about by Dr. Muhlenberg's dedication and work was an infirmary on church premises run by sisters. It became the foundation or the first Episcopal Church hospital. St. Luke's Hospital in New York

was established in 1858 with Sister Anne Ayers and other sisters serving as nurses. St. Luke's, now located at a site adjacent to New York's Cathedral of St. John the Divine, became a leading medical institution. It remains an inspiration to many church hospitals in other cities.

Charged with Christ's solemn word, Muhlenberg took literally the Gospel words of Matthew 25: 35-40: *For I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me...In as much as you did it to one of the least of these my brethren, you did it to me.*

In the early 1900's, significant movements towards health and welfare services became one of the chief activities of the Episcopal Church's Department of Christian Social Relations. At the 1952 General Convention, the Church was charged with the call "to take their part in the life of the world and, through the power of God's grace, to transform it."

The Episcopal Church's hospitals range from the large, St. Luke's in New York City, to the small, Hudson Stuck Memorial Hospital at Fort Yukon, Alaska, due to the work of the sisters of the Society of St. Margaret in the Diocese of Haiti.

Once over two hundred institutions and welfare agencies were operating in the name and under the sponsorship of the Episcopal Church. There were hospitals, convalescent homes, rest houses and institutions for child and maternity care as well as community and settlement houses. Many of these, over the years, have been consumed or have merged with other health care entities. One that continues to be a leader in today's health care climate is St. Luke's Episcopal Hospital at the Texas Medical Center in Houston, Texas. St. Luke's opened its doors in 1954 and today its Department of Pastoral Care and Education has a successful and active Clinical Pastoral Education (CPE) residency program, The Center for Pastoral Nursing and Outreach and the Community of Hope -- the lay ministry training program.

There continue to be counseling agencies, chaplaincies in penal institutions, and mental hospitals. A large number of these are diocesan foundations supported by the church in a particular diocese. A few are parochial. Most of the remainder are ventures of private philanthropy associated with the diocese in which they are located, and partially supported by endowments, gifts, and annual offerings. Operating costs of all hospitals, homes, and other agencies total nearly 50 million dollars each year.

Supplementing the church's concern for caring institutions was the advent of the International Order of St. Luke the Physician. Local parish chapters came into being throughout the Episcopal Church as part of an international fellowship of faith, prayer, and service. Lay and clergy members believe healing to be an essential part of our Lord's own ministry and that this ministry of Christ belongs in the church today.⁷

Intentional efforts and interest in reclaiming Christ's full ministry of healing and health, resurged in the later part of the 20th century. The health ministry movement in this country is credited to the instrumental efforts by a Lutheran pastor, The Rev. Dr. Granger Westberg. As a significant presence, advocate and pioneer in the work of religion and medicine, he taught at various seminaries and medical schools including the University of Illinois College of Medicine and the

University of Chicago. Dr. Westberg said, “We are part of a movement in history much greater than ourselves...a movement of the Spirit renewing human life.” In the 1960’s and 1970’s, he founded several whole-person health clinics in churches, staffed by physicians, nurses, and pastors. In 1984, Westberg collaborated with Lutheran General Hospital⁸ in Park Ridge, Illinois to found the first parish nurse program. Ann Marie Djupe had the honor of being the first “parish nurse.” The International Parish Nurse Resource Center had its beginnings during this time.

Early in 1983, the Rev. David Carlson explored ways in which a hospital and congregation could foster better health care for the congregation and the local community using resources available to both. The Minister of Health Education Program was formed in 1986 at Iowa Lutheran Hospital in Des Moines and graduated its first seven Registered Nurse as ministers of health. Registered nurses were prepared to minister in a congregation, emphasizing the pastoral role of the nurse in contrast to the traditional medical model. This particular program has now expanded its role to include a pastoral care ministry.

Interest in the development of congregational-based health ministries continued to grow. In September 1989, the Health Ministries Association (HMA) was incorporated as an educational and networking membership organization for anyone interested in health ministry. By 1996, this interfaith, global Association had grown to a membership of over 1000, representing 46 states in the U.S., the District of Columbia, and international representation from Australia, Canada, Great Britain, Kenya, Korea, and Zaire. Currently many denominations and faith communities are participants in HMA activities with 30 regional chapters in the United States. Australia and Canada were in the planning stages of chapter development.

In June of 1996, the National Episcopal Health Ministries met for the first time at Loyola University in Chicago. This group included nurses, clergy, a health educator and other educators who committed themselves to this mission: To scatter seeds of health ministry throughout the provinces and dioceses of the Episcopal Church thereby assisting local congregations in reclaiming the Gospel mission of health and wholeness. Their operating definition of health ministry is two-fold, addressing both health and healing: “Health ministry encourages whole-person health through increasing self-knowledge, personal responsibility, and interdependence among God’s people. Health ministry is a living witness to the healing activity of God emphasizing the integration of body, mind, and spirit.”

Traditionally, the emphasis of the church has been on curing rather than prevention of disease and suffering. Today calls for a new paradigm. As we re-evaluate what constitutes health, we are asking different questions.

National Episcopal Health Ministries (NEHM) continues to respond to ongoing efforts and denominational mandates to strengthen their roles in healing and health. NEHM educates leaders for Episcopal health ministry and parish nursing, supports those engaged in health ministry in Episcopal congregations, and provides resources to local congregations, dioceses and provinces. Collaborating with other faith communities, institutions and health organizations NEHM seeks to be a valuable resource for those seeking assistance in the development of an intentional faith response that supports a Ministry of Health Care.

Chapter Four

BIBLICAL ROOTS OF HEALTH MINISTRY

For I will restore you to health, and I will heal your wounds, says the Lord. (Jer. 30:17)

All health and wholeness is rooted in God. The Holy Scriptures provide us with an understanding of God's love and healing activity as well as a paradigm for health and wholeness of the community. The scriptures abound with narrative accounts that disclose the essence of what it means to be part of the people of God or the body of Christ.

The concern for one's health and healthiness, as well as for the health of others, is seen throughout the Scripture: from the simple inquiries about "how are you" (Gen. 43:28; 2 Sam. 20:0) to a concern about the "balm in Gilead" (Jer. 8:22) to John's wish that "you are as well physically as you are spiritually" (2 Jn. 2).

Likewise, from the time of the Exodus onward when Yahweh speaks, it is 'I am the Lord that heals you' (Ex. 15:26). This thought of healing is so powerful that we observe the psalmist crying out, "O Lord, heal me: (6:2)—a cry that is repeated in various forms through the remainder of the Old Testament (Is. 6:10, 53:5, Jer. 17:14; Hos 6:1). The same theme is intensified in the New Testament with the manifold healings of Jesus in the Gospel accounts. Jesus is the healer; Jesus is the Son of God; Jesus is the savior. Luke the Physician notes the same theme in the Acts of the Apostles (i.e., 5:16). Luke stresses, as do others, that one of the requirements for God's healing is faith (Acts 14:9).

In the Hebrew Scriptures, health is portrayed as one of God's great gifts, and the responsibility is placed on people to lead lives that cherish and protect this treasure. Yahweh gives both sickness and healing. Typically, illness is viewed as being a result of divine intervention in response to disobedience or sin. Since God is the physician, healing is usually associated with divine forgiveness. God alone forgives sins and heals disease.

While the cure of disease is left to the Divine Physician, the prevention of disease is very much the province of the community. The primary emphasis of the Torah is on prophylaxis. Leviticus 11-15 provides a summary of the purity code relating to diet and cleanliness. In Deuteronomy, sanitation measures were instituted to control air-borne and fly-borne plagues (Deut. 23:12-13). Degrees of consanguinity in marriage are prescribed carefully (Lev. 18:6-18). In addition to this, the Sabbath is declared a day of physical rest for humans and domestic animals (Ex. 23-12, 31:13-17).

Words play an important part in theology and it is through them that we come to the real meaning of concepts and theories. In Hebrew, the verb used time and again meaning "to heal" is *rapha* while in the New Testament, we find three different words being used: ... Θεραπεωωμαι σωξω ... each reflecting the verb "to heal." There is, however, a subtle difference. The word *therapeuo*, from which we get our word therapeutic, implies that someone attends to the healing. In other words, healing does not take place in a vacuum nor is it a solo experience. God

is always present and God is always active.

For the ancient Greeks, *sodso* and *soteria*, mean first “to save” and “salvation” in the sense of an acutely dynamic act in which gods or men snatch each other by force from serious peril. During the Hellenistic period, the sense to save from an illness or to cure, occurs in a collection of stories of healings by Aesculapius, the healer of ailments, and it is used in relation to both a physician and a medicine. The same word is also the root of the word that means not only “to be cured” but also “to be or stay in good health.”⁹ Philo often uses the same word in his works to denote the work of the physician or the effect of means of healing. These are the words of healing in the Synoptics as one is “made healthy.” The Theological Wordbook of the New Testament notes that “in the healings of Jesus, *sodzo* never refers to a single member of the body but always to the whole person, and it is especially significant in view of the important phrase ‘your faith has saved you’.”¹⁰

The root word *sodzo* is the basis “to make sound or whole.” This is the word used for the majority of our Lord’s healing miracles. It is also the basis of the word *soteria*. In the Septuagint version of the Old Testament the most common meaning of the word implies not only “deliverance from enemies” but also “bodily health and safety” and is consistently connected with and attributed to God who directly relates to the crises of the world and the crises of the individual. The New Testament refines what has been in the context of what is and what will be and *soteria* evolved into many nuances as it came to express Christian salvation. One author notes that *soteria* involves repentance, faith, endurance, fear, and grace among several other elements.¹¹ The verb form implies the saving of an individual in the eternal sense. Salvation in the New Testament is wholistic: it saves a person, body and soul. Bultman notes, “The Church’s legitimation to forgive sins is its power of miraculous healing.”¹² The prayer that transforms the sinner and heals the sick is a prayer of absolute faith that all things are possible with God.

The final word with which we need to concern ourselves is *hiaomai*. In the third millennium the ancient Egyptians developed the practice of medicine, however, the Greeks first established the art of healing on an empirical and rational foundation. Many miracles of healing are recorded in ancient literature with the gods dispensing healing. Albrecht Oepke notes that in the Old Testament and in Judaism, “...the true and only doctor is Yahweh. To define the relationship between His creative power and human skill is more difficult than in the non-biblical world. Yet the tendency is towards a both-and rather than an either-or, with the accent on the ultimately omnicausal power of Yahweh.”¹³ Rules of hygiene are given in the Wisdom literature and in their culture high value is placed on ways to cure human ills.¹⁴ To a large extent, sickness is still believed to be the result of sin and therefore prayer to Yahweh becomes the chief means of healing.

It is important to note that this cultural theme carries over into the New Testament; however, Jesus breaks through the rigid dogma of retribution thus removing the cultic from the physical problem.

Jesus shared his power of healing with the disciples as he sent them into the world equipping them to witness to the kingdom of God by word and act. The gift of healing is not given to build up one’s self, but to enable a right relationship to occur between the individual, the healing presence, and God the Father. Healings were an operation of the ascended Lord through the Spirit and were not restricted to the local leadership. For example, one of St. Paul’s spiritual

gifts is that of healing (1 Cor. 12:9, 28, 30), a gift that may be given to any member of a congregation. Within the early Christian communities, healings never occurred alone, but were bound up with the community in prayer.

Jesus rejects the notion that sickness is punishment for sin but maintains his power over disease as evidence of his power to forgive sin, demonstrated in the story of the healing of the paralytic in Mark 2:9-12. [*Which is easier, to say to the paralytic, “Your sins are forgiven,” or to say, “Rise, take up your pallet and walk?” But that you might know that the Son of man has authority on earth to forgive sins—he said to the paralytic—“I say to you, rise, take up your pallet and go home.”*]

Examples of this connection between Jesus’ healing ministry and his redemptive mission are evident in Mark 2:17 [*Those who are well have no need of a physician, but those who are sick; I came not to call the righteous, but sinners*] and in Mark 5:34 [*Daughter, your faith has made you well; go in peace and be healed of your disease*].

We cannot overemphasize that one aspect in reclaiming the full ministry of Christ is to include health ministry in the congregational setting. Christians have a unique role in participating as agents of health and healing for it is God who heals; as vessels of God, our Lord Jesus Christ commands and empowers us to do so.

Health, healing, and wholeness are relational. Being healthy means being in relationship with all aspects of the self, others, God and creation. The baptismal covenant calls us to seek and to serve Christ in all persons, loving our neighbors as ourselves, and to proclaim by word and example the Good News of God in Christ.

A strong, theological emphasis in the Anglican Communion has been the Incarnation. The Incarnation undergirds the relational as Christ continually relates to us as the *Word made flesh*. The Rev. Marlin L. Whitmer, a long-time hospital chaplain, likes the John Knox translation of 2 Corinthians 1:3-5, 7. Here the relational is stressed by the use of the word “befriend.”¹⁵

Dr. Barbara Pursey, in her article “Healing for the Whole Person,” wrote: “No one knows the intricate complexities of any person but God Himself who made that person. To accept the holistic biblical model of the body-mind-spirit does not mean we have explained everything, or that we can invent yet one more simple... foolproof method of healing. There is much mystery beyond our ability to comprehend in this whole area of sickness and health. What we are doing is admitting the complexity of human nature, broadening and deepening our understanding of healing and wholeness, and hopefully gaining a more humble and total dependence on the Lord, our Healer...who alone has it all figured out.”

Chapter Five

HOLISTIC HEALTH

The basic philosophy underlying holistic or whole person health is that we are integrated wholes: spiritual, physical, intellectual, emotional, and social beings. It is an approach to health rooted in the Judeo-Christian tradition that is both personal and communal. It is a creative approach to wholeness based on sound philosophical assumptions about the nature of man and his relationship to himself, to God, to others and the creation...and it is supported by the very foundations of our faith belief...the cornerstones being tradition, scripture and reason. The key to understanding the meaning of whole person health or holistic health is to acknowledge the relationship or interconnectedness of all aspects of ourselves. We are created to be in relationship with ourselves, God, others, and creation. We are not created to be divided either within ourselves or in relationship to God or the community in which we live. We are spiritual beings, created in the image of God, with unique gifts to be used for individual growth and contribution to community. This philosophy is the background of health ministries based on what we know about the nature of persons, health, society, and the church.

For too long now, our culture has narrowly defined and understood “health” as being the “absence of disease.” That working operative continues to support a disease and illness oriented mentality. Health is a broader concept. We all have a sense of what health is, what illness is about, and what death looks like. Each culture has its own attitude towards health and illness, life and death. Health is both personal and communal.

HEALTH IS RELATIONAL

If we accept this philosophy of health, it would seem to follow that any change in any aspect of one’s self affects the whole person... directly or indirectly. Conceivably then, one might define “dis-ease” or illness...as being out of relationship with one or more dimensions of the whole person. Our sense of well-being depends on being in proper relationship with ourselves, God, community, and creation. In the circle of life, human beings move through a continuous process of growth and adaptation...physically, emotionally, intellectually, socially and spiritually. It is important to appreciate that everything we do, everything we feel, believe, think, or choose has an impact on our relationship to our own and others’ wholeness, spirituality, and general well-being. One aspect of Christian responsibility calls us to choose health as a way of life, becoming what God calls us all out to be...our highest potential... which includes good stewardship of our bodies, minds and souls. Faith and health are parallel journeys that share a basic philosophy that affirms life and relationships. Indeed, there are many people who are not ready or willing to acknowledge these interconnections. One of the major challenges in presenting health ministries to clergy or congregations is this mindset that separates or divides spirit from body and religion from health.

HEALTH IS PROCESS

There is a direct relationship between the wholeness and health of a society and that of an

individual. You can not have well individuals for very long in an unhealthy society. You can not have a whole society with numerous sick or unhealthy individuals. There is a reciprocal relationship. True healing and health do not occur in isolation. It is only in the context of community that they become possible. Giving and receiving are mutual in a community where health is viewed as both communal and personal. A human being can be truly human only within a community in which each member is valued as a part of the whole.

Whether we accept it or not, we are open and living human systems constantly in process of growth and adaptation. We are continually moving towards wholeness or completion. We are always in the process of falling apart and putting ourselves together again, dying and living. We are never wholly well or wholly ill. Our society unfortunately focuses on the duality of the either/or. Our language is very inadequate in transcending that duality. Transcending duality means to embrace the validity of both existences. It is the heart of the Gestalt theory of wholeness. A person is not only greater than any one individual part; he is greater than the sum of his parts. That is the reality. Essentially, it is impossible to understand an isolated element of a person without considering the whole person. Further, Gestalt philosophy extends itself beyond the individual to that of being “one with the environment.” The ultimate gestalt is a beginning awareness of the immensity of the extent of our inter-action with everything else and experiencing this to the depths of our being. As we increase our ability to be aware of and in touch with our SELF- emotions, thoughts, and sense of being, we will experience living in a manner that is creative, self-actualizing, responsible, flexible and open to change. Our Creator places us in relationship to the creation in such a way that challenges us to be all we can be. God calls us to our highest potential.

HEALTH IS CHANGE

Change is inevitable. Change is predictable. Change requires us to adapt. We are not the same persons we were a minute ago, an hour ago, a week ago. We will not be the same persons a week from now, a year from now, or ten years from now. When we speak of change we must also speak of loss. They are inseparable. We have an accident, lose a loved one, become seriously ill or disabled, dreams shatter and doors close for all of us. This is part of the human condition, none of which is new. It is how we respond to the external and internal changes and losses in our life that constitutes whether or not we experience ourselves as whole and well or sick and diseased. We are not alone in this mysterious thing called life. In one of the suggested New Testament readings in the Episcopal Burial Office, Paul proclaims, “We will all not die, but we will all be changed.”¹⁶

HEALTH IS CHOICE

When we speak of change, we have two choices. We can respond to change as threatening and develop a crisis orientation to life, never risking nor doing anything that might cause struggle, discomfort or pain; or we can respond to change as an opportunity to grow and be transformed. We can choose to be happy, healthy and whole because it reflects an attitude or outlook on life at the moment. We fantasize about the future: someday having more money, being able to retire, becoming successful, writing a book, spending more time with the family, or taking a well deserved vacation. Sometimes we romanticize the past, longing for the “good old days.” What we conveniently forget or choose to forget however is that the “good old days” had their share of

pain and struggle also. When we seek to live in the false security of another time, whether the idealized past or future, we deprive ourselves of embracing fully the present. We have only today. Once we accept the notion of change and loss as part of life, we are much healthier and better-equipped to move forward. We can participate in life regardless of age or the changes and challenges we face throughout all stages of our lives.

HEALTH IS ETHIC

Charles Dougherty, director of the Health Care Policy and Ethics Committee at Creighton University, notes that “health is an ethical activity.” The connection between religious faith and health is that of the “ethos”— character, disposition, a set of behaviors and attitudes, a way of life. It is being alive while we are living. It is saying yes to the contradictions and dualities of our existence.

Charles Fahey, writing in *Affirmative Aging*¹⁷, states that ethics is the science and art of doing the right thing in the light of human reason, while holiness is doing the right thing in the light of Christ’s message. Former WWII General Omar Bradley was quoted as having said, “We have grasped the mystery of the atom and rejected the Sermon on the Mount...The world has achieved brilliance without wisdom and power without conscience...Ours is a world of nuclear giants and ethical infants...We know more about war than we know about peace...More about killing than we do about living.” Ethics and spirituality are inseparable.

In *Education for Ministry, Year One*¹⁸, the authors suggest that human beings are created to live in communion with God. By God we are saved, made whole, in a state of grace that is health. Ethical thinking maybe conceptualized as learning how to act in accordance with our dignity as God’s good creation. Ethical living is the life of joyful response to God our creator. As part of Christian witness and responsibility, choosing health can be a part of the way of life that embraces the blessing of wholeness for which we were created.

HEALTH IS POLITIC

Exploitation, abuse, fraud, burglary, and senseless killings seem to be the order of the day. Human cruelty, prejudice, injustice and envy continue to break both hearts and spirits. Wars and ethnic conflicts ravage whole populations stripping young and old of their futures. Poverty, hunger and homelessness confront us daily in the news. Cancer, heart disease, mental illness and AIDS stand up to mock the progress of modern medicine. Accidents, floods, hurricanes, and earthquakes complete the feeling of helplessness that pervades our society. If that is not enough, I do not need to point out the current economic, leadership and political challenges we are facing right now in the country and the world.

Robert Bellah wrote in his book *The Good Society*¹⁹, that the major problems facing our world today require a great deal of caring, “indeed a politics of care.” He states, “The most obvious problem is the neglect of children in our society, levels of infant mortality, child poverty, and inadequate educational opportunities.” Bellah continues, “We fight the war on drugs but do not fight what causes despair leading to drug abuse. More police, prisons, or military interventions are not the answer.” Bellah, ends with the statement, “threats to our environment and the future of our planet are obvious.

HEALTH IS SPIRITUAL

Life is a struggle! One of the most important tasks and challenges in one's life is to be able to live in a state of wholeness where we are willing to be transformed and in turn...become transforming agents to others...growing into the full stature of Christ in service to God, others, creation and the world. There are times in our lives when we are not sure where God is in seemingly chaotic world we live in. This too is part of the human condition...our humanity or lack there of...We start questioning why we exist, why things are happening to us or in many ways to others and our world. During difficult times in our lives we all tend to become more self-focused, self-involved, and self-conscious rather than God conscious. We do not see with the eyes of God. It is important to acknowledge, in order for any of us to be whole, we need to step outside of ourselves and ask for help from others. We all need healing in our lives. True healing does not take place in a vacuum. Whether we accept that claim or not...is a choice.

Life is both messy and sacred at the same time. But God who is faithful does give us what we need to grow. Life's difficulties are never ruled out. The challenge is finding the sacred in the struggle. One thing is certain, if a portion of our true nature is denied we suffer. We must not overlook the importance of carrying pain correctly as part of a process of becoming whole. Wholeness does not equate with happiness, peace of mind, or security. In fact, greatness seems to be born out of conflict, pain and struggle, and not peace, unless it is the "peace of God which passes all understanding," which is that sense of oneness that comes as a gift of God to the struggling soul. St. Gregory of Nyssa declares, "The soul who is troubled is near to God." St. John of the Cross writes in the *Dark Night of the Soul* that it is not peace of mind that brings wholeness but struggle and conflict. Spiritual enlightenment occurs only when a person has been through dark and disturbing trials of the soul.

Becoming whole does not mean being perfect, but being complete. Health does not mean perfect health but optimal health. It is often painful, but never boring. If we are to become whole, our life must have a story which means we encounter or come up against something that forces us to stop, reflect and possibly change direction, otherwise a story can not take place. Some people are destined to be whole. Fighting outer forces, encountering inner forces of the unconscious...some involve both. If we stand on the outside of life it is clear that wholeness can not emerge. John Sanford writes, "If we are to become whole, we will have led a life in which darkness has been faced and an encounter with evil has been risked." What he is saying here is that good and evil are inherent in any meaningful life process. It is being able to perceive the meaning and patterns of events that form and inform our lives. It is not getting out of life what we think we want but rather, it is the development and purification of the soul.

The mission for health ministry adopted by the National Episcopal Health Ministries is appropriately written as being an active response or living witness to the healing activity of God. It emphasizes the integration of body, mind, and spirit. Its philosophy (holistic health) is based on sound philosophical assumptions about the nature of people and their relationships with themselves, God, others, and the environment. Health ministry's goal is to empower and encourage whole person health through increased self-knowledge, personal responsibility, and inter-dependence among God's people.

This approach to health invites and challenges us to participate responsibly with the process. It helps us to appreciate balance and humor in our lives. God wishes all of us to be healthy and whole.

Chapter Six

REFLECTION: HELPING A CONGREGATION DISCOVER ITS HEALTH MINISTRY²⁰

Health ministry is an innovation. It is a call to change, to be changed and a call to transform, to be transformed. Yet at the same time, it is about reaching into our religious roots and reclaiming the Church's historical role in health. This reclaiming involves renaming, to define anew and to bring into the present. A new health paradigm is in the making that embraces our history and the value of modern science and medical care, but creates something greater than the two. This kind of social and cultural renaming does not happen overnight. It requires time for relearning, for discovery. Therefore, the adoption of a health ministry must grow from a process of reflection and new learning. This section offers a set of educational principles and suggestions for implementation which supports this kind of new growth.

Reflection means taking the time to see and understand who we are now. As individuals and groups, we are still making decisions about health and health care resources based on a western medical model which emphasizes access to health care services. We are spending 99% of our health care dollars on treatment and 1% on preventive measures, all the while knowing that 70% of early deaths and disease are preventable.²¹ This creates an opportunity for a congregation to reflect and to come to a new understanding that impacts how individuals and society make decisions regarding health. This new understanding then becomes an imperative role for the Church.

Learning that transforms does not happen solely from lectures or reading new information. Paulo Freire, a Brazilian educator, based his work in education and development on the principle that people will learn and act on issues on which they have strong feelings and they learn best what they discover for themselves. There is an underlying assumption of equality, that participants are the experts at identifying their own learning needs and finding their own solution to those needs. The role of the facilitator is to listen for themes; provide opportunities for creative thinking around these issues; raise questions such as why, how, and who; provide input of knowledge when it is asked for; and allow participants to describe, analyze, decide, and plan based on their learning together. The key is to learn to listen so people will begin to speak. This becomes a learning experience which transforms.²²

In this country during the two or three decades, public health educators have been using Freire's principles to empower community members who are working to create healthier communities. In the faith community, a physician named Dr. David Hilton from Ecumenical Health Ministries in Atlanta, Georgia, has been using this approach to facilitate a new understanding of the role of the church in health. The learning approach described in this section is based on the work he has been doing in this country and overseas.

EDUCATION FORMAT AND PROCESS

Facilitation and participatory education is initially much more difficult and it would be quite

impossible to convey this kind of information and skill within a few pages. What follows is a list of “training for transformation” techniques that are useful for health ministry education in church settings.

- For classes, a circle of chairs is preferred over rows so that a climate of community is created.
- Do not use tables which present physical barriers to community.
- Rather than standing at the front, the facilitator should sit in the circle with participants in order to be part of the community, not above it.
- The process is participatory, meaning each hour of class time should have a least one small group activity (3 or 4 people maximum) with open-ended questions used as discussion starters.
- If appropriate, use nametags with first names printed largely so that they can be seen across the so the participants can feel affirmed by being addressed by name.
- Input or lecture from the facilitator should always follow small group discussion and participant inquiry rather than precede it.
- Record participant responses on a flip chart and post the sheets around the room.
- Save recordings of participant responses to posts at subsequent classes or meetings for continuity and affirmation.
- Listening is a crucial role for the facilitator and the person(s) designing health ministry learning. So often education is designed around what the instructor thinks the student should know. Always “hear” as our Lord was fond of saying.
- Select topics and assign roles based on an ongoing process of listening for generative themes (issues on which participants have strong feelings).
- Pose questions that ask why, how, what can be done, and who can do it? so the root causes are identified and a new understanding of what can be done is discovered.
- A case study, story, or biblical passage that represents a generative theme and poses a problem but does not give an answer is useful for learning in small groups followed by large group discussion.
- This is about asking the right questions rather than giving the answers. Paul Tillich notes that “the worst error in pedagogy is throwing information, like stones, at people who are not asking the questions!”

A reflection and learning process can take as long as a year in a church setting. Give it the time

it needs. Being a healthy congregation means taking the time to understand its role in health and healing. Our culture supports a “hurry, let’s do something” approach. Listening and learning together assures a health Ministry that can discern and respond to the health and healing needs of its people.

SUGGESTED CLASS TOPICS

A priority when designing health ministry education is identifying the generative themes or issues of concern of the health committee members and the congregation as a whole. What follows is a list of five possible topics to use as the congregation begins its learning journey using the techniques listed above. The “passion points,” or generative themes, of congregation members should take precedence even over these suggested topics.

Topic I: Health Is

A first step is to give participants an opportunity to share their own perspectives on health and build from that.

Small Group Activity:

Have participants break up into small groups and to create together a response to “Health is ...” (a usually written up on a flip chart for focus). Ask for one group of volunteer to share their definition. Record this on the flip chart. Then ask for suggestions from other groups to add to or modify the recorded definition to the satisfaction of a larger group. Save for future reference.

Input and Discussion:

Following the small group exercise, use handouts or transparencies to give the larger group information about health and the breadth of determinants and underlying causes of disease and early death. One input could be the World Health Organization’s definition of health written in 1948.

“Health is not simply the absence of disease, but a state of complete well-being-physical, mental, and social.”

How is this different or the same as their definition? If this is similar to their definition (minus spirituality of course), ask what organization they think might be the true World Health Organization. Hopefully, they will say, the Church. Do not define health for them, but give information and stimulate them with questions such as what, why, how, and who to support creative thinking and new learning.

Resource Materials for Background and Input:

1. A chart depicting in the actual causes of death, tobacco, diet/inactivity patterns, alcohol, etc. as contrasted with the 10 leading causes of death, heart disease, cancer, etc.²³

2. Pie charts or graphs depicting medical care expenditures and preventive measures expenditures as compared to the percentages of early death and disease preventable through each of these. Find something that reveals how little medical care is associated with reduction of early death and disease. Both of the above can be found in Prevention Report. The local public health agency, public library, the National Health Information Center may be able to provide you with this information.²⁴

3. An article written by Theodore Pincus, “What Explains the Association Between Socioeconomic Status and Health: Primarily Access to Medical Care or Mind-Body Variables?” is useful for discussion and input related to the underlying behavioral, psychological, and cognitive mind-body constructs of health status.²⁵

Topic II: The Role of the Church and Health

The content of this class builds on the first one. Through small group process, input, and question posing, this session should delve deeper into a new understanding of the role the church and health. There is enough content to expand this topic into more than one session. As facilitator, be prepared to provide input related to the information included in the Resource Materials.

Small Group Activity: (select one for each hour long session)

1. Using Mark 2:4-14 and the following story is told us by Dr. David Hilton as handouts for discussion, ask them in small groups and to identify ways that the healings in each scenario are similar and ways that they are different.
2. A patient, let us call her Jane, was brought to my office in a wheelchair when I was in the practice of family medicine. Though only in her thirties, her hands and legs were twisted with arthritis. In spite of intensive treatment by specialists with the most powerful medicines available, she was forced to quit her job as a laboratory technician and come to live with her sister in the town where I was practicing. Over the course of several visits, encouraged by empathetic listening, Jane related the story of how, as an adolescent, in a moment of passion, she became involved in a sexual encounter that had left her with great guilt, shame, and fear. She had no one in her life with which to share these feelings, so she had lived alone with them for 15 years. Gradually her hands had become twisted and her body immobile.
3. Using James 5:14-16 as a handout, direct each person to underline every word or phrase that has anything to do with healing. Next, ask them to share this in small groups, allowing 5 to 10 minutes.

Input and Discussion:

Follow both of these small group discussions by a plenary discussion of their ideas and input from the facilitator verbally and with handouts or transparencies. Instead of scripture handouts, participants may wish to use their own Bibles and/or various translations.

Resource Materials for Background and Input:

1. Articles by David Hilton (see Appendix F).
2. Kelsey, Morton. Psychology, Medicine, and Healing (see Appendix F).
3. Identify local professionals or written resources that address issues of psychoneuroimmunology and can link that knowledge to the attributes and responsibilities of the faith community.

Topic III: Is Health a Right?

The objective of this class is to maintain a broad understanding of health and to raise the difficult but important issues of responsibility. When engaged in efforts to promote healthy behaviors, it is tempting to get caught in a blaming the victim posture. This is to be avoided by the church at all costs. To do so requires an intentional, focused, and continuous examination of the church as obligations for the “health” of its members and others in society. The case study recommended for use in this session was designed to fit a particular socio-economic and cultural environment. If necessary, alter the case study to be meaningful for the audience. A case study should be straightforward and pose a problem rather than present a solution.

Small Group Activity:

In small groups have the participants read the following case study and discuss the suggested questions:

For a year or more, John and Jane Smith had been having difficulties in their marriage. In addition to this strain, John had been under stress at work. The company where he worked was anticipating going through a downsizing. John was unable to share his worries with Jane and was drinking heavily. The company did downsize and John lost his job 3 months ago. Nothing opened up in his job search and his drinking became more of a problem. Last week he was in a car accident and is now in the hospital in critical condition.

Jane has been working part-time in a preschool. She and their 2 teenage children attend church sporadically. Jane has not shared with others in church what she and her family have been experiencing. They have not been able to pay for health insurance. John is in the local city hospital and has been in the intensive care unit since his accident. When he was admitted, his blood alcohol level was very high.

Questions:

1. What is Jane and John’s responsibility for their “health” and what is society’s responsibility?
2. Does the Church have obligations in this situation? If so, what would we base them on as Christians and as U.S. citizens?

Another option for use of the case study is to assemble a panel of persons from the congregation to represent the different stakeholders in this case. Use several persons to represent the

perspectives of the church, the employer, the hospital, the insurance company, and the legal community. After each panelist shares views related to their responsibilities in this situation, open it up to the larger group for Q and A and discussion.

Input and Discussion:

In either option described above, the leader should facilitate discussion that identifies two significant dimensions of this case study. One being the broad picture of health and the other being the many players involved in the “system” of responsibility. Jane and John’s health status is initially impacted early on by their marital relationship. In addition to John and Jane’s own responsibility for their health, this case study shows many ways the church and the others are responsible for the outcomes and had a potential role in preventing this sequence of events. Analysis of this case study would be enhanced by the availability of a medical ethicist or someone familiar with ethical issues related to rights and responsibilities. Their role would be to present an objective perspective on this, accentuating both the complexity of the social and environmental circumstances and the danger of blaming the victims.

Topic IV: Models of Health Ministry

Once a broad scriptural, ethical, and social-environmental approach to understanding health has been explored it is time to look at the variety of applications. This can be done with handouts, a presentation, or a panel, depending on the program resources in your local community. Again, the intention should be to keep the focus broad as the journey continues to be opened and undefined. The content in the following section of this guide on stories and models of health ministry can be used along with information from the following resources.

Resource Materials for Background and Input:

1. Health Ministries Association (see Appendix E).
2. What If Every Congregation? A compilation of community and congregation-based health promotion program descriptions (see Appendix E).

Topic V. The Congregation as a Place of Healing

A concluding session or two should give the parishioners an opportunity to share thoughts on the health and healing role they desire for their congregation. One way to begin this is to look first at the existing capacity of the congregation to be in health ministry. In what ways do current ministries promote health, healing and wholeness? From this picture, then explore ways that they hope to be promoting health and healing in the future. What is our parish called to be and what actions should it take?

Small Group Activity:

A suggested framework to use for this topic is one developed by Kent Miller of Health Education for an Abundant Life (HEAL) for the Presbyterian Church USA. He describes four potential styles or roles of healing for the congregation and four levels or environments for actualization of these roles (see below). As facilitator, first provide an overview of the different styles. Give

them an opportunity to read the descriptions and then have small groups complete the following chart (see Figure 1) with their perceptions of the congregation's current style of healing in each of the different domains listed. Remind them to have one person in each group record their ideas on the chart. Reading the descriptions of each style and discussing congregation activities in small groups could take as long as 25 minutes. The ideal is to have a large group sharing process that gets recorded in a composite document. In order that everyone gets an opportunity to contribute, go around the room and have each group share one thing. Repeat the process until all the ideas have been shared. If possible, during the sharing process, have a second person record the responses on a large replication of the chart posted in the front of the room. This same small group process can be used to identify the future, ideal healing styles and activities of the church. Before beginning the future, ideal discernment process, it is important that the facilitator and class participants review the content of the previous sessions. Post in the room any collection of responses from earlier sessions, particularly the one when health was defined.

RESOURCE MATERIAL FOR INPUT AND DISCUSSION:

[The following is reprinted with permission from Kent Miller of H.E.A.L. (Health Education for Abundant Life) Institute.]

CONGREGATION AS ADVOCATE.

The role of advocate is an ancient and familiar role in each of our faith traditions. Each tradition places strong importance on the religious person and the community of faith as standing for justice, engaging in making peace, working for shalom, standing bedside with those in need, speaking for those with no voice. This style is that taken by the prophet in each tradition. The only real question is about the health issues or groups of persons for which we should advocate. As your congregation studies and develops its priorities, there should emerge a range of advocacy issues and persons or groups for whom you can speak. Personal advocacy on behalf of individuals is a common form that most of us do regularly. The congregation taking on the task of advocacy is less common, but more powerful.

The role of advocate is easily discovered as the congregation talks with and works with members and urban resident. The committee will learn who is not well served by current arrangements, and who has no voice. After hearing them it can develop strategy to advocate with those persons and institutions that have the power to make changes. The role of advocacy may be friendly and enabling. It may begin with simpler issues of keeping a clinic open in the evenings. It may be to get commitments for funding low cost services, such as immunizations, or more responsive emergency services. As your group becomes more experienced your issues may become more difficult. Strategy and tactics for advocacy should vary with the situation.

CONGREGATION AS HEALING PLACE.

Another ancient and traditional action style that is a natural for the congregation is to become a healing place, both to members of the congregation and within the community. Each tradition has its symbols for the place of healing: The Temple, The Holy Mountain of Zion, the foot of the cross. This style recalls the heart of what each religious faith proclaims: showing kindness, acting in charity, being compassionate, offering healing to the broken. Each tradition also

provides forms for healing services and rituals which include prayers for healing and wholeness.

All worship should be healing. Try asking the question: “Do people leave our worship more whole than before? Do they experience healing from the brokenness in their life?” Beyond that, can persons ask this question generally after being in the midst of the congregation: Is this a place where wholeness is experienced?

The language of brokenness and wholeness may need to replace traditional language of sin and salvation as the congregation talks about faith with people not accustomed to the religious language. The mission and outreach to the residents of the community may need to become more “holistic” in conception and presentation so that the community begins to identify the congregation as concerned with the whole person, and not just with their “salvation,” or righteousness.

Educational classes and evening programs can teach about health and healing in the context of faith, and can present the meaning of our faith in ways that restore the meaning of wholeness to our faith in concrete ways. This can be as general as study of scripture or study of issues, or as particular as offering classes to help people quit smoking or loose weight or cope with stress.

CONGREGATION AS HEALTH PROVIDER.

The congregation as provider of health care is another role that is natural. Each religious community has deep roots in its tradition of its clergy being trained in medicine, or members of its staff or religious orders being trained to provide different types of health care. Often the buildings associated with the congregation were places of medical and associated with health services. Many congregations or denominations established health care and medical facilities.

This tradition is easily continued when clergy offer counseling. Less often, but no longer infrequent, are those places where the congregation provides medical clinics, dental clinics, and other forms of health services directly to the community. Volunteers often perform the professional services, and the clients are usually poor. Our system of religiously based hospitals grew out of this tradition.

CONGREGATION AS HEALING AGENT.

The final style of healing for the congregation is that of a healing agent among members within the community. Being a healing agent requires that the congregation itself become a means of healing. Where there is brokenness, the congregation will offer itself as a means of healing. This style is rich in tradition and symbolism. This is the role of Israel, the People of God, as a “light to the nations.” It is “The Suffering Servant” found in the prophet Isaiah. It is the role of John the Baptist as a forerunner, the one who breaks open the message, who prepares the way for God’s activity. It is the role of the “Man for Others.” It is the role of the Mediator, who establishes a common ground, a bridge, a connection, between parts and parties that are split, broken and disconnected, uniting the alienated.

Common formats for the congregation using this style can be those of offering “good office” or neutral context and persons for disputes, discussion, and mediation between persons or groups.

It can use its symbolic power to offer legitimacy to outsiders, or less popular viewpoints. It can sponsor forums, educational seminars and workshops for topics (such as health) that are often only discussed by groups with vested interests. It can foster dialogue between groups.

	Advocate	Healing Place	Provider	Healing Agent
Personal/Family				
Congregation				
Community				
State/Nation				

Figure 1. Congregation Current Style of Healing Chart

Chapter Seven

STORIES OF HEALTH MINISTRY

As we explore the various aspects of congregational health ministries as well as the communities in which they are located, we recognize that we share a common mission and vision. Manifestations of congregational-based health ministries are diverse and unique to each congregation. Influencing the nature of a health ministry will be the economic, political, social, cultural, and environmental aspects of the people it serves. There is no absolute formula for building a health ministry.

All health ministries are in the process of becoming. They are living, moving systems continually evolving as they respond to the changing needs of individuals, community, and the environment. Eventually they will take on a life and character of their own as they identify the changing needs of their members and the community they serve.

Every congregation involved in health ministry has its own story. Here are several.

St. Michael's Church – Bristol, RI

Health ministry began in the fall of 2001 with the parish nurse initiating and developing programs supported by the Rector. After initially funding the position, the church moved on to secure grant monies for the succeeding seven years.

Two annual health fairs came about through networking and collaborating with the senior center in town. Soup kitchen attendees in the Parish House across the street availed themselves of the parish nurse's time for referrals, listening, and advocacy. Eventually a pattern evolved in the church with our older women seeking out the parish nurse's input regarding health, safety (bathrooms/lifelines) resources, and referrals. The nurse visited the homebound with communion and served on the Pastoral Care team.

Health education articles and Care Notes (Abbey Press) are available on a narthex table for easy reference. The church's monthly newsletter includes articles stressing spirit care and a timely monthly health issues calendar.

Annual blood drives were held and church members attended community flu clinics advertised in the church bulletin or newsletter.

Grace Church – Providence, RI

Two years ago, the seed was planted for health ministry at this inner city church that is the hub of activity for coffee hour daily except weekends. The church also serves a lunch meal every Wednesday. The parish nurse speaks to the attendees, who are a mix of those without a job hence no home, traumatic stress, substance abuse and mental illness. It has taken time for the men to acknowledge the parish nurse presence but recently when yarn, knitting needles and

crochets were offered to the women – a good number responded with enthusiasm.

In the fall, we hope that we can develop an afternoon for knitting/crocheting to build up trust.

Networking has had a positive outcome –

- Shape Up Rhode Island – a walk/weight 8-week program developed by a Brown University medical student
- Faith Walk for Charity – an annual walk benefitting a local charity

The parish nurse entered name of the Rhode Island Free Clinic at the Faith Walk for Charity meeting. The outcome of a vote was to name the Free Clinic as a beneficiary of walk monies.

The American Baptist Church, the Roman Catholic Diocese leaders have embraced the parish nurse in wanting to participate with her in envisioned projects.

1. Colloquia at Providence College (Dominican) on whole health and healing;
2. Health fairs with Baptist and Congregational churches.

The Health and Wellness started the new year, with a leader, who felt called to this ministry. Our first project is “Safety in the Church.” A safety kit/blanket will be stored under a church pew in the event of need. Inserts in our bulletins on a quarterly basis will advise parishioners on what to do “... in the event” Ushers will collaborate with medical/nursing professionals in the congregation to affect response rather than reaction to any situation that develops.

The parish nurse at present has been the only witness in Rhode Island for the past nine years. As Diocesan liaison from National Episcopal Health Ministries, the work will extend to bring the message of vision and mission (NEHM) to other Episcopal churches in the diocese of Rhode Island. This fall, the parish nurse will introduce Rhode Island Episcopal clergy to Health Ministry.

Komo Kulshan Cluster of Churches - Skagit Valley, WA

The Komo Kulshan Cluster (<http://www.skagitcluster.org>) is a collaborative effort among Episcopal and Lutheran churches in the Skagit Valley. There are five congregations in the Cluster, namely, Celebration Lutheran in Anacortes, Christ Episcopal in Anacortes, La Iglesia Episcopal de la Resurrección in Mt. Vernon, St. James Episcopal in Sedro-Woolley, and Saint Paul’s Episcopal in Mt. Vernon.

The health ministry for the cluster involves five very different congregations. They share staffing but each has its own identify. There are four Episcopal congregations, one of which is primarily indigenous Mexican many of whom speak neither Spanish nor English. The annual meeting is in five languages, three of which have no written form. The fifth congregation is a Lutheran

congregation that does not have a building and meets in a rented public space. In their ministries, each has its own focus but at the same time, they share resources and energy. The Episcopal and Lutheran congregations (Christ Episcopal Church and Celebration Lutheran Church) in Anacortes, WA came together to set up a system for checking on each other in case of emergency. The first step was to map out where they all lived and to break the area down into smaller sectors with a facilitator named for each. Sector meetings resulted in the creation of notebooks and plans for contacting people during times of infrastructure failure. The plan got a test during one of Puget Sounds once a decade two-foot snow dumps and it worked well.

Saint James and Saint Paul's work together in supporting Friendship House, the only men's shelter in the county. Friendship House also supports a three meal a day feeding program.

All of the congregations work with Resurrección to understand that culture and assist as needed.

There are two powerful health ministry stories.

The first has to do with that good old routine blood pressure check, how much starts around that seeming mundane piece of information. One of Saint Paul's members had a sudden increase in his blood pressure and so tracked it a little time. Due to financial issues, we had to work to get him seen when the pressure did not come down. As we got him onto Medicaid and worked for the evaluation that discovered he had adhesions from a previous surgery wrapped around his right kidney. This affected his renal arteries and that was causing his blood pressure to rise. As a result of a second surgery, his blood pressure was lowered significantly and he continues to do well.

The second has to do with the farm workers supported by Resurrección. In response to a request, I went out to one of the "migrant" camps that we support and to see a woman. She is the mother and grandmother to a large family, the keeper of the home and matriarch. She was crippled and the condition was growing worse. When I saw her, she was having back pain and her right leg was, basically, a stick that she swung under her to help stand. The migrant clinics prescribed medications and sent her home. A translator, she speaks only Mixteca, discovered that she was becoming progressively debilitated. She had severe curvature of her spine that she said was getting worse. Working with the clinic was unsatisfactory but fortunately, we were able to connect her with an orthopedic surgeon from one of the congregations. He evaluated her and then things moved quickly, as she became very ill. At Harborview Hospital in Seattle, doctors determined that she had developed osteomyelitis, a bone infection, in her spine. She responded very well to treatment and has now returned to her family to manage the household once again.

From these, and a myriad of other stories, the following conclusions have evolved:

- *Minister of Health/Parish Nurse*
 - a. A professional health care giver on church staff (paid or volunteer) is part of the pastoral team. Health ministers have professional training in health-related care

fields and minister to the health needs, individually or collectively, within the church community.

- b. Parish nurses or ministers of health do not give “hands on care.” Parish nurses/ministers of health primarily function in the areas of disease prevention, early detection and assessment, wellness promotion, and education. For the congregation they are resource and referral agents, health counselors and educators, advocates, facilitators, and catalysts. They coordinate existing health care services within the community to augment the holistic philosophy of health and caring. Parrish nurses/ministers of health also participate in healing services, prayer groups and retreats, and follow a Christian rule of life.
- c. Parish nurses/ministers of health may be paid or volunteer, working within the context of one or more congregations.

- *The Congregation*

- a. A non-medical trained laity is a vital resource for this ministry. They may provide health education, promotion, caring and/or support to an already existing helping network. They may facilitate the connection between the parish and community agencies by, as an example, coordinating health screenings.
- b. One of the great strengths of health ministries is the diverse and unique nature in which each congregation gives expression to the service of health and wholeness of individuals and the community.

- *Parish Leadership*

- a. Clergy/Vestry serve as the gatekeepers. Without their support, there will be no health ministry. Normally the rector should not be the individual who assumes primary responsibility for the development of this ministry.
- b. The health minister is not the health ministry. The goal of health ministry is to enhance lay participation and empower individuals in this ministry. The importance of integrating the health ministry into the life of the church, so that the congregation owns this ministry, cannot be over emphasized. This ministry must not exist in isolation.

Chapter Eight

GETTING STARTED

Below are some thoughts to consider when beginning a health ministry in a local congregation:

- Pray....Pray.... Pray.
- Become knowledgeable. Study the concepts in various materials now available. (See Appendix E and F)
- Share your knowledge and enthusiasm with other people in your congregation. Locate interested individuals in formal and informal leadership positions.
- Use resource people from programs and congregations currently active in health ministry. Contact them for more information on support, and begin the network process.
- Convene discussion or adult forums in your congregation. This enables people to explore the concept and envision the potentials of this ministry.
- Identify strategies that have previously been successful in implementing new ministry in your congregation.
- Be patient. This is about developing relationships, about re-learning our understanding of health and reconsidering the church's role in health and healing.
- When the mission is understood, the money will follow. The key is to approach this ministry as part of the gospel mission to preach, teach and heal.
- Be on the lookout for people who might be part of the team for shepherding health ministry.
- Explore the health and healing ministry already in place within your congregation.
- Listen...Listen...Listen
- Pray...Pray...Pray always!

APPENDIX A

SAMPLE: HEALTH MINISTRY COMMITTEE

A congregational advisory committee, task force, health cabinet, or health commission is vital to the success of health ministry. It works in partnership with the health minister to assess needs, to plan, and to implement health activities that meet the needs of the people in their congregation and/or the community. Below is one example of what an advisory committee might look like and what its responsibilities at large might be.

I. Membership

- This committee is intended to function as a regular standing committee of the congregation, meeting monthly to fulfill its responsibilities and functions.
- The primary membership qualification should be based on interest in holistic health matters for the individual, congregation, and community.
- Include people representing medicine, nursing, social work, education, social ministry, church board, youth, elderly, outreach ministries, etc.
- Size should vary depending on the needs of the congregation with the focus placed on good working numbers (i.e., 4 – 8 members). Rector and minister of health are ex officio members.

II. Roles and Responsibilities

- Plan and participate in an installation service. [i.e., “Celebration of a New Ministry” (BCP).]
- Assist in assessment of needs of groups of individuals as well as the congregation as a whole.
- With the minister of health and pastoral team, develop strategies and programs to introduce the ministry of health to the congregation.
- Conduct studies, surveys or other information gathering functions, in order to help design appropriate programs and activities which meet demonstrated needs.
- Monitor the development and activities of the minister of health and the health ministry program.
- Submit regular reports to rector, vestry, and minister of health director.
- Facilitate and generate support and communication for the minister of health program.

- Evaluate total minister of health program and make necessary recommendations regarding changes, additions, modifications, etc. to strengthen and enhance the congregation's ministry.

APPENDIX B

SAMPLE: A HEALTH MINISTER JOB DESCRIPTION

When a congregation makes a conscious decision to engage in health ministry, each member of the congregation becomes a health minister. All the baptized are sent to minister. A congregation may choose to identify a person or several people to lead the health ministries of the congregation. The following is one example of a job description for such a coordinator.

I. Basic Function

The health minister works with the pastor and health committee to:

1. Identify congregational health needs and promote whole person health.
2. Provide and coordinate educational classes to enable wellness and prevent illness.
3. Provide personal health counseling, spiritual support, health screening, and referrals for members of the congregation as needed.

II. Duties and Responsibilities of the Congregation

The health minister assumes a critical role as a pastoral team leader and staff member. Activities may include, but not be limited to:

1. Act as personal health counselor, home health visitor, and spiritual support provider.
2. Work with the health commission to develop and plan the congregational-based health ministry.
3. Plan and teach classes, schedule speakers, and coordinate support groups.
4. Promote health education through the congregation's newsletter, bulletin, and services.
5. Provide regular health screening and monitoring.
6. Recruit and train volunteers to help with health ministry activities.
7. Provide health referral information.
8. Serve as a liaison between the congregation and community resources.
9. Maintain appropriate health ministry records.
10. Other responsibilities as assigned by the rector.

III. Job Qualifications

1. Articulate a call and commitment to service.

2. Some experience working with health and wellness.
3. Mature, sensitive, caring and spiritually developed person.
4. Able to articulate and communicate effectively the interrelationship between body, mind, and spirit to health and wellness.
5. Good communication, interpersonal and caring skills.
6. Leadership skills and the ability to work with others.
7. Writing and speaking skills.
8. Other requirements as directed by the rector or congregation.

APPENDIX C

SOME THOUGHTS ON MALPRACTICE INSURANCE

Sometimes malpractice is a concern of vestries when they are considering health ministries. Each congregation is responsible for exploring issues surrounding insurance based on their unique situation and scope of their ministry. A few thoughts to keep in mind:

- Liability insurance is very likely available through a rider on the insurance policy the congregation already has in place. Although some church liability policies contain a standard exclusion of professional services other than the clergy's counseling activities, health ministry can usually be added when the scope of the ministry is explained. Unless the ministry specifically requires medical interventions (meaning medical treatment or action taken by a licensed professional that may only be performed under the direction of a licensed physician), insurance companies usually have no problem adding health ministry to the insurance policy.
- If the congregation decides to specify a coordinator of health ministry who is a parish nurse, and if the insurance company is unwilling to cover the health ministry program, the congregation may purchase professional malpractice insurance from a company that specializes in liability for health professionals. (See Appendix E.) As of this writing, there has been no litigation brought against a parish nurse.
- Health professionals need always to carry their own personal professional malpractice insurance, no matter what policy the congregation carries. This applies whether the health minister is compensated or not.
- Some professional liability policies encourage the health professional to carry the congregation as an "additional insured".
- Liability varies from state to state, depending on the Good Samaritan Act and liability limitations of the state. Each congregation must explore this given the unique circumstances of their health ministry.
- Health ministries sponsored by hospitals sometimes have arrangements with local congregations that cover malpractice issues.

APPENDIX D

HEALTH MINISTRY ACTIVITIES

- A Listing of Possible Activities -

I. Health Educator

Dental Health	Death, Grief and Loss
Wellness Weekend – Health Fair	Baby-sitting Training Class
Update Your First Aid Kit	Good Nutrition Class
Wellness for Youth	Homeless and The Church
Sexuality/Sex Education Classes	Mental Health and Depression Class
Healthy and Bible Study	Lifestyle Wellness Class
Sabbath Keeping Seminar	Free To Be Thin Class
Lifestyle Change Class	Conflict Management Sessions
Health Refreshments for Meetings	Cancer Treatment Class
Time Management Workshop	The Caring Question Class
Chemical Health Series	Living with PMS
Good Touch – Bad Touch Class	Violence in the Home Class
Prayer, Stress, and Healing Class	Gifts of the Spirit Workshop
Meditation Relaxation Education	Healthy Heart Class
Prayer and Medication	Corporate Wellness
Women’s Wholeness Health & Spirituality	A Spiritual Christmas Workshop
Stress Management Classes	Yoga Classes
Parenting Classes	Men’s Wholeness, Health & Spirituality
Chemical Dependency Series	Bioethics Seminar
Retirement Planning Seminar	Eating Disorders Class
How to Ask Your Doctor	Seminar on Aging
CPR Class	Living Will/Durable Power of Attorney
Planning Your Own Funeral	Child/Sexual Abuse Education
Health and Safety	Living With Alzheimer’s Class
Drugs Intervention Class	

II. Coordinator of Volunteers

Cards/Calls of Concern	Teen Support Group
Widow’s Support Group	Training for Greeters
Care Givers Support Group	Adopt-a-Grandparent
Phone Ministry Follow-up	Arthritis Support Group
Stop Smoking Clinic	Spiritual Support Group
Parents Anonymous Group	Unemployed Support Group
Respite Care Training	Mothers-Day-Out
Stephen Ministry Training	Weight Loss Support Group
Hospital/Nursing Home/Visitation Training	Parents of Teens Support Group
Prayer Chain Training	Caring Community Training
AIDS Support Group	Children’s Ministry to/with Elderly

BeFrienders Training
Senior Fellowship Meal/Day
Member Referral Network
Coordinate Transportation Pool
Divorce Support Group

Single Parent Support Group
Retreat for Elderly
Mental Health Support Group

III. Personal Health Counselor and Home Health Minister

Home Visits
Pre and Post Hospital Visits
Nursing Home Visits
Expectant & New Mother Visits
Dysfunctional Family Visits
Teenage Mother Visits
Ministry to Pastors & Staff
Volunteer Network for Home Care
Advocate for Nursing Home Patients
Case Conferences with Pastoral Staff

Personal Prayer Requests
Building Accessibility
Sermon, Mediation, Homily
Expand Prayers of the Church
Services of Prayer and Healing
Worship/Devotions in Nursing Homes
Staff Education: Consultation & Listening
Church as Non-Smoking Facility
Fire/Smoke Alarm Check – Church & Homes

IV. Health Monitoring and Screening

Blood and Organ Donation
Personal Health Assessments
Health Standards for Day Care
Blood Pressure Screening
Diabetes Screening
Glaucoma Screening

Confronting Child and Family Abuse
Low-Impact Aerobics
Cholesterol Screening
Well-Adult Screening Clinic
Living with Chronic Illness Group

V. Health Resource and Referral Agent

Life-Line Emergency Phone Systems
Medical Service for Uninsured
Transitions from Home to Care Facility
Community Health Educator & Liaison

Personal/Family Crisis Intervention
Ministry to the Homeless
Resource for People of Special Need
Case Management

APPENDIX E

RESOURCES

ORGANIZATIONS

- The Center for Theology and Land 563-589-0273
333 Wartburg Place
Dubuque, Iowa 52003
www.ruralministry.com
- The Episcopal Church Center 1-800-334-7626
Congregational Ministries Cluster
815 Second Avenue
New York, New York 10017
www.episcopalchurch.org
- The Health Ministries Association 1-800-280-9919
P.O. Box 529
Queen Creek, AZ 85242
www.hmassoc.org
- Park Ridge Center 837-384-3507
205 Touhy Ave. Suite 203
Park Ridge, IL 60068-4202
www.parkridgecenter.org
- National Episcopal Health Ministries 317-253-1277 X34
6050 N. Meridian Street
Indianapolis, Indiana 46208
www.episcopalhealthministries.org
- The International Parish Nurse Resource Center 314-918-2559
475 East Lockwood Avenue
Saint Louis, MO 63119
www.iprnc.org
- The Wheat Ridge Foundation (800) 762-6748
One Pierce Place - Suite 250E
Itasca, IL 60143
www.wheatridge.org

EDUCATIONAL OPPORTUNITIES

Marquette University College of Nursing 414-288-3802
Faith Community Nurse Preparation Institute 414-550-8519
P.O. Box 1881
Milwaukee, WI 53201-1881
www.marquette.edu/nursing
Email: patrice.olin@marquette.edu

VIDEOS –Websites that may or may not be applicable for your congregational needs

<http://ipnrc.parishnurses.org/Home.aspx?ContentID=202>
<http://www.wheatridge.org/site/c.khLSKZPDLof/b.2394399/k.C62E/Videos.htm>

PUBLICATIONS

Seasons for Wholeness: Monthly Programming for Parish Nurse Health Ministry
Order from the International Parish Nurse Resource Center, \$15.00 includes shipping and handling. These two books have health theme articles for 24 months that are suitable for church newsletters or bulletins. Save lots of time writing and planning.
<http://ipnrc.parishnurses.org/Home.aspx?ContentID=202>

Second Opinion

Order from the Park Ridge Center, \$45.00 annually. This quarterly journal highlights themes of health, ethics and spirituality. One issue to consider purchasing by itself is: “Second Opinion: The Churches Challenge in Healthcare”.

Available online at: <http://www.parkridgecenter.org/Page676.html>

MANUALS

Steps to a Health Ministry in Your Local Congregation. This manual provides users with an in depth, step-by-step process for starting, running, and sustaining a health ministry.
National Episcopal Health Ministries
6050 N. Meridian Street
Indianapolis, IN 46074
www.episcopalhealthministries.org

“Parish Nurse Coordinator Manual”

1-800-280-9919

Health Ministries Association
P.O. Box 529
Queen Creek, AZ 85242
<http://www.hmassoc.org/index.asp?mid=64&mid2=157>

INSURANCE INFORMATION

The Church Insurance Company

1-800-223-6602

445 Fifth Avenue

New York, NY 10016

<http://www.cpg.org/aboutus/churchinsurance.cfm>

Marsh Affinity Group Service of

Seabury & Smith

1-800-503-9230

12421 Meredith Drive

Urbandale, IA 50398

www.proliability.com

APPENDIX F

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APPENDIX G

ENDNOTES

Chapter One:

- ¹ These “five elemental objectives” are from the Standing Commission’s report to the General Convention and are found in The Blue Book, p. 293. These were presented to the Convention in resolution as the position of the Episcopal Church regarding health care.
- ² The Rev. Dr. Thomas Droege is the Associate Director of the Interfaith Health Program at the Carter Center of Emory University.

Chapter Two:

- ³ David H. Smith. Health and Medicine In The Anglican Tradition. New York: Crossroad Publishing Co., 1986. pp. 21ff.
- ⁴ *Ibid.*, p. 34.
- ⁵ Revelation 21:1-5.
- ⁶ Book of Common Prayer, p. 305

Chapter Three:

- ⁷ For more information about the Order of St. Luke contact their office at: North American OSL Office, Box 13701, San Antonio, TX 78213, (219/492-5222)
- ⁸ Now “Advocate Health Care”.

Chapter Four:

- ⁹ G. Kittle and G. Friedrich, ed. Theological Dictionary of the New Testament. Grand Rapids, MI: Eerdmans, 1965. Vol. VII, pp. 966ff.
- ¹⁰ *Ibid.*, p. 990.
- ¹¹ William Barclay, A New Testament Wordbook. New York: Harper and Brothers. pp. 117f.
- ¹² Rudolf Bultman, Theology of the New Testament. London: SCM Press, 1965. Vol. 1, p. 61.
- ¹³ Gerhard Kittle, ed. Theological Dictionary of the New Testament. Grand Rapids, MI: Eerdmans, 1965. Vol. III, p. 201.
- ¹⁴ Sirach 19:f; 30:14ff, 23f; 37:27ff.
- ¹⁵ “Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and the God of *all befriending*, who *befriends* us in all our affliction, so that we may be able to *befriend* those who are in any affliction with the *befriending* with which we ourselves are *befriended* by God. For just as the sufferings of Christ are abundant for us, so also our *befriending* is abundant through Christ....Our hope for you is unshaken; for we know that as you share in our sufferings, so also you share in our *befriending*.”

Chapter Five:

- 16 I Corinthians 15:51
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Chapter Six:

- 20 Special thanks to the work of Mini Kiser, Interfaith Health Program at The Carter Center,
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