Stories Parish Nurses Tell about their Role in Wholistic Healing through their Work with Parishioners

By

Michael Tutton

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Certificate of Ethical Acceptability for Research Involving Humans

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Dr. Alyda Faber

Chair, Research Ethics Board

Atlantic School of Theology

660 Francklyn Street

Halifax, Nova Scotia B3H 3B5

Stories parish nurses tell about their role in wholistic healing through their work with parishioners

Michael Tutton

Abstract: The author conducted extensive interviews with three Canadian parish nurses in diverse settings about their experiences in this ministry over the past decade, with the goal of hearing narratives about how they influenced wholistic healing in their work with parishioners. The guiding theology heard in many of the stories was the healing power of Christ, where the nurses restored relationship between patient and God through their largely unconscious living out of the Gospel's healing stories, both physical and spiritual. The nurses often address the deepest needs of their parishioners in the stories. These include the parishioners' spiritual struggle, their lack of helpful relationships, their changing physical needs, their isolation and/or their need for advocacy. While parish nursing numbers have been falling in Canada, there is evidence that the wholistic healing they practice remains a valuable sign of the Church's mission, particularly as the health care system shifts towards placing patients in community settings for their continuing care.

Contents

Introduction

The research question for this project is: "What stories do parish nurses tell about their role in wholistic healing through their work with parishioners?" Even experienced medical professionals in Canada can be unclear on the definition of the nursing ministry referred to here,[1] and so I begin my paper with clarifications to guide readers. While parish nurses may lead clinics to test blood pressure or blood sugar levels, in general they do not administer injections or prepare dressings for their parish patients, according to the parish nurses interviewed and their national association. Rather, parish nurses are hands-off practitioners of wholistic health care, meaning they recognize "the interconnectedness of body, mind, spirit and environment"[2] in the health of their parishioners, and give special attention to the spiritual dimension of human health. The ministry's North American founder, the Rev'd Granger Westberg, has described registered nurses as the members of the parish health team who offered parishioners (1.) health education; (2) pastoral counselling/spiritual care; (3) advocacy and referrals for care by the public health system and (4) the training and empowering of others to help in the care of parishioners.[3]

In a Canadian context, the question arises over the necessity for and efficacy of parish nursing, given the availability of a universal health care system supported at its inception by most Canadian Christian denominations. These denominations generally accepted the division between a secular health care system that trains, hires and oversees health professionals, and faith communities which provide chaplains and pastoral care workers who may interact with some of the sick and dying.[4] The existence of this public system has evident benefits, as the Canadian Medical Association Journal notes that Canada has the 10th longest life expectancy in the world, at an average of 82 years age, with World Bank data indicating it slightly improved

between 2011 and 2015.[5] However, my research as a national journalist in Atlantic Canada has over the years raised personal questions for me about gaps in this system, including instances of improper care and ensuing disintegration of hope.[6] Meanwhile, by the middle of this decade, deaths involving spiritual struggle and despair began increasing as Canadians turned to opiates and substance abuse in larger numbers.[7] I wondered if parish nurses and the stories of healing they bring might play a hopeful role – one of bringing Christ's peace into the world's struggles – amidst evidence of deep human spiritual storms and areas of the public system that fail to address this need?

Literature review

Granger Westberg began making his case for a renewed vision of nursing as having a strong pastoral/spiritual component at its core beginning in the 1950s, suggesting it had become too focused on purely physical care. This view was outlined in small works like *Nurse, Pastor and Patient.* By 1990, he'd published *The Parish Nurse*: *Providing a Minister of Health for your Congregation*[8] and was arguing physical illness could be "prevented or ameliorated in the early stages through easing the spiritual suffering and anxiety caused by psychological outlooks on life."[9] The general claim of the parish nursing ministry made in Westberg's texts, and among his adherents, is that this wholistic healing is related to having an inward religiosity, which parish nurses participate in and encourage through counselling, prayer, Scriptural advice and spiritual encouragement towards integrating health and faith. A question arises here of whether there is quantitative evidence, in a Canadian context, that inward religiosity does contribute to better health? A 1994 publication in the *Journal for the Scientific Study of Religion* work by B. Gail Frankel and W.E. Hewitt has argued there is. It compared university students who actively participated in campus Christian groups with those who did not. The study with 299 participants

concluded students' religious affiliation and involvement "appears to be important to health outcomes," based on measurements of stress, physical health, use of health services and psychological well being, while suggesting the students' involvement in the campus faith groups as indicators of "inward religiosity," and arguing their findings suggested "the presumptions of sociological theory generally (and much empirical research) linking religious commitment to health outcomes is certainly on the right track."[10] This perspective was repeated in 2001 by nursing professor Phyllis Ann Solari-Twadell, the former director of the International Parish Nurse Resource Center, in her article *Parish Nursing: Clarifying the Relationships among Faith, Health and Values*. She uses the Ontario data to similarly argue that parish nursing can take healthy, intrinsic religiosity further by actively encouraging the participant to understand the relationship between their discipleship to Christ and their physical, emotional and mental health. She is among those who argue Christian knowledge/belief, including the view that suffering "exists even in a God-ruled world" and is both beyond our grasp or understanding while being countered by God's evident self-giving love for humanity, is a comfort that assists in avoiding emotional distress.[11] Parish nursing advocate Sara M. Schreiner was among the authors in a 1988 special edition of the *Chicago Theological Seminary Register* who documented Westberg's pilot projects in wholistic health centers in Chicago in the 1970s, noting he had surveyed patients, with 58 per cent of respondents "acknowledging beneficial changes in their lives attributable to the wholistic centres," and "these changes categories were given as health habits, acceptance of self, relationships with others, family interactions, work productivity, personal health understanding and sense of individual wholeness."[12] More recently, in 2004, a large survey study led by Ana Maria Catanzaro in the United States interviewed 349 pastors about the congregational health ministers, nearly all led by parish nurses, in 80 different denominations. It

concluded that with limited resources, congregational health ministers provide significant health promotion, disease prevention, and support services.[13] Researchers also sought to describe the common elements of spiritual care provided by parish nurses in the United States. This included a grounded research, qualitative study that interviewed 10 parish nurses between 1998 and 2001. It resulted in a general analysis of the social process nurses went through, where stages were described as, "trusting God, forming relationships with the patient/ family, opening to God, activating/nurturing faith and recognizing a spiritual renewal or growth," and the "essence is bringing God near to people as they face health challenges."[14]

Literature describing how Canadian parish nurses fare in positively effecting determinants of health is much less extensive than in the United States. However, one of the qualitative studies of how wholistic healing functions was completed by Margaret Elizabeth Myers' in *The Integrative Parish Nursing* Model, using grounded theory and a methodology that included interviews with 51 nurses from both Canada and the United States. She saw a common theoretical framework for the deeply "integrative" nature of parish nursing in either national setting. Her emphasis is on the "dual nature" of parish nursing, where the role of pastor and spiritual adviser is as central as that of the professional nurse. Her framework describes the constant interaction and interplay of the human body with the human spirit. In her subsequent work *Parish Nursing Speaks*, Myers followed up with stories from parish nurses about their practice. This is a resource that gave voice to how Canadian parish nurses experienced their vocation up until about 2001.

In terms of theological study, Christological work has played a key role in considerations of parish nursing. Wesleyan theologian Thomas Droege took this approach to parish nursing ministries in several chapters of a small book published in 1979. He noted that shortly after Jesus

proclaims that the kingdom of God is at hand in Mark's Gospel, the second person of the Trinity called upon Israel's people to reconcile themselves to God (Mark 1:14-15). "Following this statement, Mark records one healing act after another, more healings than in all of the Old Testament."[15] Droege added, "this close relationship between word and act is characteristic of the entire ministry of Jesus. Rarely do you find one in isolation of another."[16] In addition, Droege, who would go on to become the chairman of the interfaith health program at the Rollins School of Public Health at Emory University, argued Jesus' healing process discerns our deepest struggles and engages "the person at the point of … particular need,"[17] whether they be physical or otherwise.

> In some cases that was a physical malady, such as leprosy, blindness, deafness, or paralysis. In others, the disorder was mental or emotional, persons possessed by demons. In still other cases the disorder was spiritual, the woman taken in adultery or the man who could not give up his possessions. In each case, Jesus met the person at the point of the particular need with the intent of bringing wholeness where there was brokenness, integration where there was disorder, peace where there was dis-ease.[18]

This assertion is a recurrent focus of parish nursing theology: Jesus's active life of faith involves caring for human health in a wholistic sense, with a unique ability to focus on their deepest needs, whether physical, spiritual or psychological. The Gospels have 72 accounts of exorcisms or healings (about one fifth of total content).[19] This healing is continued in the Book of Acts, where the parables contain a common thread of intense knowledge by the healer of the one receiving help. The scenes feature the verb *atenizo*, translated from Luke's gospel as "fastened eyes upon" in healing scenes, one in the Jerusalem temple as Peter and John care for a person who cannot walk (Acts 3.1-16), and again in Lystra, where Paul restores mobility (Acts 14.8-18). The root source of healing in the early church is explicitly ascribed to Jesus in these instances, and the apostles take note of this source of their power in both parables, as did the

founders of the early church of Europe. St. Jerome would comment in the 4th Century, that failure to offer healing is a grave sin, saying woe would befall the "proud mind of the rich man for not having helped Lazarus,"[20] lying wounded at the side of the road (Luke 16.19-24). St. Fabiola, a 4th Century Roman Christian who came under St. Jerome's tutelage, became a caregiver in this lineage, which has carried on in various forms in the centuries that followed.

> She was the first person to found a hospital, into which she might gather sufferers out of the streets, and where she might nurse the unfortunate victims of sickness and want. … She gave food to her patients with her own hand and moistened the scarce breathing lips of the dying with sips of liquid. [21]

Alan Kreider has argued that in the pagan world, the Christ-centred approach to illness by the early Church was a form of spiritual discipline, a *habitus*, that helped give it a sense of unique identity and potency. For example, faced with the plague in the 3rd Century, early Christians had already formed a practice of nursing one another that was impressive to the pagan world. "The Christians had the charitable institutions (the community's financial chest [*arca*], attentive and active women, and deacons) as well as the *habitus* that equipped them to assist each other in time of need. People with this tradition, this *habitus* of mutual aid, will not leave their suffering fellow believers to die…"[22] However, in recent centuries, the unique role of the church in terms of physically nursing those who are ill and dying has faded alongside the rise of empirical thought and secular medical systems, and the Church has retreated to limited roles in chaplaincy and clinical pastoral care in the secular system. "Apart from various expressions of healing prayer and pastoral care, health ministry in general has not been a significant strand in Western church life over the last sixty years,"[23] argues historian Helen Wordsworth in her historic review of the church's role in health care.」

The goal of my research is to add some more recent narratives from Canadian parish nurses, who are operating alongside a publicly funded health care system. I was seeking the details of the nurses' experiences, in diverse settings, in describing how they bring Christ-centred healing into the lives of patients. I hoped to take the theory described in the scholarly literature and textbooks for parish nurses and explain through stories how Christ-centred healing emerges in their daily live and ministry. I've also been particularly interested in how nurses enable the communities of faith from which they operate to care for one another, thus bringing the Christian idea of the Holy Spirit to full fruition.

Method and data collection

In some respects, the parish nursing movement has been a reaction to the distancing of the church from its historic healing mission, and an attempt to renew the above-described earlier identification of healing as a central part of mission. My study is picking up on the lives and experiences of nurses over the past decade and a half caught up in that renewal, looking for the stories they tell about how they influenced wholistic healing in their work with parishioners. My primary goal was, through repeated interviews and questions, to hear about the processes of the healing experiences in a Canadian context in diverse settings. Using narrative research methodology, I looked for how stories of healing began and what kinds of turning points and endings and outcomes the stories had. In some ways the nurses are similar. They are all female, have pensions, are now over 60 and had decades of notable experience in nursing before beginning their training as parish nurses and starting out for a sustained and deeply engaged ministry. In other ways, their unique gifts and identities emerged during multiple interviews that usually lasted over two hours in duration, and which were continued on the telephone for follow-up discussions. I also interviewed two ministers who worked extensively with two of the

participants in the study, seeking context and ideas and prompts on stories the parish nurses might have partial or incomplete memories of. The interviews were transcribed, and themes were highlighted and noted; they were then re-arranged and coded more chronologically, and, in the final stage, I made single page, visual summaries that captured three main stories each for the nurses. I attempted to choose stories that differed from one another. The stories chosen represented other stories, such as various tales of how nurses advocate for patients who receive misdiagnosis.

Data analysis

Nurse 1 – inner city nurse

LB is a parish nurse with a diverse Christian background who grew up in a rural area. She said if people came in to the doctor's office in her hometown and "they were agitated or depressed, he (the doctor) already knew why, because he knew their stories." She worked in very diverse fields of nursing in her over three-decade career, including in hospitals, in palliative care and in a doctor's office in the same neighbourhood. She had dry spells in her relationship with God in the years after marrying into her husband's faith community, but generally her Christian faith grow amidst her life struggles, including some personal injuries and the chronic illness of her partner. Amidst this she undertook pastoral care training, and a nun became her spiritual director. A patient LB was in dialogue with at her doctor's office, a woman whose daughter was ill, told her about the ministry. She was interested and within days found herself at the church putting in an application. By the spring of that year, her ministry had started. At last, she could bring her faith, "not only to the bedside, but to the people," she recalls thinking.

Story A: reconnecting a family to a struggling, elderly couple, where the husband has Alzheimer's

Within a week or two of her ministry, LB was finding stories that redefined for her what nursing might be. This initial insight came during a visit with an elderly couple who the priest was having trouble fully understanding. They had been active in the parish for years but now seldom came to church. It did not take LB long to discern upon arriving at the home that the husband was suffering from illness and his wife wasn't able to cope with the status quo. "Immediately it spoke to me that this was a woman who was scrambling to cover for the fact that her husband had Alzheimer's disease." She contacted a doctor, she contacted a daughter who lived outside the city, and she set up some volunteer support through the church community, where the couple had connections. "I brought them together," she said of her tying together of the mother and the daughter. As she worked, she prayed for guidance. Was she meant to talk to the daughter? Will she be receptive to me? In a short nurse-patient meeting, the decision and process might have been to swiftly shift the husband to a nursing home. Instead, there were supports brought in, connections re-established, family awareness was heightened, as was church community involvement.

This story of an early experiences of connections with the congregation was told amidst the story of the creation of a women's bible study group, which was important to the nurse as a source of support and connection with the parish. Some of the women shared their problems; they talked about "difficulties with families, difficulties at home, the usual stuff that people experience. … Sometimes the tears would be because they were feeling financially pressed, and not sure how to deal with it." There were connections made that would last throughout her ministry. However, in general, "the congregation seemed not that receptive," and in the second

year the health ministry team encouraged her to expand her scope to "go into the community and to decide what you could do in the community."

Story B: "A truck driver, alcoholic … He couldn't believe he was worthy of prayer."

LB she set up a blood pressure clinic at a food bank. She also helped with checks on blood sugar levels. "It wasn't about being accurate and getting accurate blood sugars or blood pressures. I knew it was about talking to people and making them aware there was a parish nurse up the street." One man started to see her regularly and came to her for seven years. He was an alcoholic and a diabetic. He struggled with his addiction and there were family issues as he was separated from his wife. "But the turning point, I think, for us, when he had really fallen off the wagon and the drinking (was heavy), and I said, 'Would like us to pray about that?' And he said, 'you would pray with me?' And I said, 'Of course. Why don't we pray about this because this is a difficult thing to do on your own!'" She noticed he cried after she prayed with him. "This is a truck driver alcoholic, a big guy," she recalled. "He couldn't believe that … he was worthy of prayer." The outcomes over time of the story were that he remained an alcoholic, but his periods of abstinence increased; he learned prayers of his own, particularly a meditation on the Lord's prayer; she helped and encouraged him to find housing in a safer environment where he would be less lonely, "in a clean and safe environment." She heard back from others, "He tells me that you've given him a meditation on the Lord's prayer to help him sleep at night and it's working."

Story C: Making apple crisp

LB met a man at one of the outreach breakfasts, and he started coming to her office where she'd take his blood pressure; she noticed he had issues with breathing and his heart. One day she realized she hadn't seen him for six weeks. She had her brother make inquiries, and when he

found him, the brother said, “LB is worried about you. Do you think you could pop in and say you’re okay?” When she saw him eventually, he said he could have been away from his family six months and they would never have sought him, “But you, you came looking for me. You cared that I was okay.” Later, she listened to his chest after an out-patients clinic had sent him home, telling him he was fine. She heard a problem, “something very wrong.” She went together with him to a clinic, he received a diagnosis of a serious illness and he was operated upon and hospitalized. “I don’t know if you understand that happens so many times they go into the out patients and … people just see what they want to see. They do not listen and they don’t read between the lines.” On another occasion, the man came to an outreach breakfast and he had a big bag of apples and “(he) didn’t know what to with them.” The nurse brought them home, “and I made him a pile of apple crisp in all those little containers so that he could freeze them.” When she went to his funeral, many people didn’t know who she was, but as the priest was giving a eulogy he mentioned the incident as being deeply touching to the man’s spirit. “He (the priest) said, ‘All I’m going to say to end the day, go home and make apple crisp for somebody.’”

Parish nurse 2 – LS rural parish nurse in small congregation

In 1994, two decades before she became a parish nurse, LS would occasionally preach at her church. When I arrived for our second meeting, she had retrieved one of these sermons. It began with the question: “What is your life built on?” LS answered her own question with reference to Matthew 7.24-27, where a parable by Jesus makes it clear that to survive a storm, people must build upon a structure with a foundation. “The differences in the houses was only detected when the storm struck,” the nurse said. “When storms come into our lives, that structure we’ve built for ourselves may be torn down and scattered; so how do we find this foundation?” Drawing upon Isaiah 4’s imagery, she recalled how God provides a *chuppah /* canopy as “shade from the

heat of the day, and a refuge and hiding place from the storm and rain," (Isaiah 4.6). To find our point of peace in a storm, God has sent Jesus alongside us – in our boat, in a metaphorical sense – in times of adversity, distress or sorrow, she explained. "The Bible says that Jesus arose and rebuked the wind and said unto the sea, peace, be still and the wind ceased, and there was a great calm," the nurse recalled. (Mark 4.35-41)

This nurse saw herself as participating with God rebuilding as best she could, stone by stone, a foundation for peoples' troubled lives amidst storms. She felt she was called to bring Christ's peace into the situation, offering his calm and stillness. This desire to build on foundations is partly because of a deep attachment to the people and place where she's from. The nurse had grown up in the community. She knew many residents. When asked for influences in her life, she recalled an elderly couple who she brought the mail each day. They were attentive to her, and she learned about the power of an ongoing relationship. "It was just a case of, somebody took an interest," she recalled.

Story A: "You get me her favourite soap"

In the early years of her ministry, after some of those connections were made in the church, LS was helping a family where a parent had dementia. They called to draw upon her as a resource person for this illness, knowing she had background from her decades of working with the elderly. She went to the home with information and talked to "quite a few family members." In that same family group, the mother was diagnosed with the cancer and LS started visiting her as well, praying with her, "but her health failed quite quickly." "So, one Sunday I went to take the bulletin in to her and the VON we're visiting at this point and she wasn't doing very well at all and so she actually passed in my presence." The family gathered. She had them come around

the bed in a circle. “It was very, very sad and very hard.” She prayed with the family around the death bed, and then as more family came, there were additional prayers. The family wanted to wash the body before it went to the undertakers, and “they asked me if I would do that. I said ‘I would’… I said, ‘You get me her favourite soap,’ and we did the cleansing and they were there with me. … It was very meaningful to me.” To that family, that was a moment of comfort, and afterwards she felt a sense of “Wow!”

Story B: The ladies on the farm: “let’s just go for a walk.”

There were four women who lived on a farm on a hill who’d known LS from childhood. She and the minister would visit them as “the ladies” grew older and frailer. Then their health failed. One died at home. Another one went to a nursing home and eventually died. And another one was in hospital and eventually died. “We’d talk about living up on the farm and looking out over the fields and remembering when they would be cutting hay and other such stories,” she recalled of the visits. The minister described it as “right out of Anne of Green Gables.” But one of the things that jumps out in this story was the differences in approaches between a nurse and a minister. The minister remembered sitting and talking, but the parish nurse took the women for walks, including the woman who lived at the nursing home as her memory diminished. “It wasn’t more than 10 metres, but it was enough so that she could sense the world around her and I really sense that for her … that was important,” said the minister, who took notice of this more physical approach. When I asked LS about this, she seemed surprised. It was simply a natural thing for a person with a sense of the human body to do, she said. “It was very hard to talk with her (the woman being visited). She was deaf, so I would try to go (and visit) when she's not in bed, so she'd be up.” Rather than sitting with her in her room, she’d say, “Let’s just go for a

walk." And then they walked through all the corridors. If they saw a plant, they'd stop and look at that, or if we saw a painting, they'd stop and look at that. "That's our time together. … and then we'd find a quiet corner and then we'd have a prayer and then I'd take a church bulletin and go to her room."

Parish Nurse 3: suburban parish nurse

JJ's career had been as a public health nurse, including a time in management. Her ministry started about eight years ago and is an ongoing one. She came into the world of parish nursing after a late-life move and while attending a new congregation where the minister encouraged her to consider this ministry as it fell in line with her deep faith and her professional background. Among her early steps was to create a group where more than a dozen people in the suburban congregation joined and started to form bonds with her and with each other. There was information at the gathering about nutrition, about active living and about sleeping. She notes there is a strong pastoral care team for visiting at her suburban church, so she tends to limit her involvement on that level to those cases where there is "nursing intervention," and "everybody knows now that … I visit (for) nursing intervention, I'm really careful to keep the pastoral visiting to keep that nursing component to keep that combination together."

Story A: The role of support to couple in grief and in a "rough, rough time."

The group was a "safe place to come," and it included a couple whose adult son – who had young children of his own – was dying of cancer. She recalls, "they went out and stayed with him for quite a while and then would come back and … it was like they were getting their tires pumped up so they would come to the group and, you know … it was a safe place to be able to

just come and, and say, 'I don't know whether I can do this. ... you know, it's so hard watching my son.'" The group could provide the couple with emotional support, as it was "a safe place to shed a tear." Amidst this process, JJ learned that she come to embrace the role of praying with and for others. "We prayed in the group … and we'd pray people pray individually, kept them in their prayers." The young man died. It was very difficult for the couple, but the nurse has been with them, and the group has stayed close to them, throughout. She recalled a time when the father came and sat with her. "I always think for a man to cry in front of someone takes a lot of courage and strength to do that. And, so I listened. I listened. …You know, there's no answers here. … It's just listening."

Story B: the story of the team that helped the woman with Alzheimer's

As a public health nurse, JJ had a strong consciousness of the value of training and teaching others, and she employed this in what she called a "creative" way. When a husband admitted to the pastor he was starting to sag beneath the weight of caring largely on his own for a spouse with Alzheimer's, JJ identified a wider need in the parish, trained about 15 people, and from that group, a team emerged that could assist in the care of the woman so that she could attend a support group in the city and then be dropped off back at home in the middle of the afternoon, and a team of "friends" were there to greet her and ensure she got back in the house. In doing this, they provided wholistic care as a team (including JJ as one of the volunteers) for the husband and for the woman. "I find that I can be very creative in what I do and also very practical in parish nursing," she said of this wholistic healing team.

Story C: Becoming aware of your situation and choices…a hospital help scene

"A (man from the congregation) was hospitalized and they were recommending him go to long-term care. And so, and, and that was the outcome of this, this meeting," she recalled. She held close conversations with them, attended meetings with health care providers, and she helped them to *think* about their situation. Her questions would be: "What does this mean for you?" or "How is this for you?" People face huge changes in their lives, and they need guidance and referrals and advocacy in their care. It may be helpful to ask them how their lives were guided by God in the past. "Then, where does God fit, where, you know, where is your faith in this," is something she would ask. She would ask how faith had helped them before and whether it might be applicable now, and how. Meanwhile, she is "answering practical nursing questions as well." In the end, there is a reality to face, "You're going to be living apart," and once faced, the process of some "peace" with the situation, even amidst acknowledging frustration, may begin, as, "it's okay to be angry about this. This isn't what you were planning in your life." Healing has a physical component, but there is also an emotional and spiritual element, and "if you can come to terms with what's happening in your body … and find some peace," that to JJ is a major step forward.

Theological insights

In these stories, the nurses often help the parishioners come closer to God, finding creative ways of stimulating their remembrance of the divine. LS helps bring the remembrance of God into the lives of the old women on the hill by a short, 10-metre walk that leads to prayers. They see the fields, the barn, or – once in the old age home – a painting or a flower. They take notice of these things, and then they go and sit and pray. In her story about attending a death, LS

demonstrates her intrinsic theological sense of the precious nature of each human before God, and in doing so she demonstrates to those present that God's loving kindness exists for all of us in a unique way. She doesn't simply agree to wash the body, she suggests the family wash this blessed human body with the soap the woman loved the best. God's grace and provenance is front and centre in the mere existence of the relationships the nurses are participating in, and their acknowledging of the dignity of the human body. "I honestly believe that all those things that happened in my life, God placed me in all those areas and prepared me for this final journey," LB said of the parish nursing vocation.

The Hebrew concept of *chesed* is helpful here in understanding the healing unity that has unfolded through these encounters. The term is present in the Psalms about 120 times as a noun to describe a quality of God's relationship to us, and the way we need to be in right relationship to be whole. As Strong's points out "in general, one may identify three basic meanings … which always interact: 'strength,' 'steadfastness,' and 'love.'[24] *Chesed* is important in the parish nursing stories in their descriptions of how God is intimately involved with God's people, even if they are struggling with a sense of absence from God. Psalm 6 describes this inner longing, "Return O Lord, deliver my soul; Oh save me for *sake of your chesed.*" (Ps. 6. 4). The parish nurses act in diverse ways to form a pathway to this reunification. Augustine's language in the *Confessions* reveals the power of this reconciliation into God's loving kindness[25] when he writes, "there is something of man that not even our own spirit knows."[26] It's not physical beauty, nor is it glory during our lives. Rather it is an "embrace of my innerness where the soul is floodlit by light which space cannot contain, where there is sound that time cannot seize, where there is a perfume that no breeze disperses … and where there is a bond of union that no satiety can part. That is what I love when I love my God."

The nurses also act as Christ's resurrected presence to assist in spiritual struggles to restore broken bonds of union with God. The story LB tells of the big trucker who cried when she prayed for him is a good example of the parish nurses' role in spiritual struggle. The nurses acknowledge and are aware of forces other than God that draw us, even torment us. To LB the man's alcoholism seemed to include feelings of being worthless and being tormented by his personal demons. The nurse's desire to pray with him helped him experience forgiveness, self worth, and a sense of growth and accountability into God, and this bore some fruit in reduced alcoholism and better housing. Some of the theology here was provided by LS, the faith builder, who had worked out some of her relationship to Christ decades before her ministry began. Life is full of storms, and those include illness, alcoholism, addictions, mental health crises and grieving. And each of those storms require the person to be guided back to their foundation, where God's basic steadfast love is present. The way back is through Jesus (Mark 4.35) as he cried out "calm, be still," to the raging seas. As the heavyset trucker departs, he feels this calm, this peace, in the nurse's prayers for him. She has given him a way to meditate on the Lord's prayer, to maintain this peace. At night, as he bows his head, he hears the words Jesus instructed us to pray. "Give us today our daily bread," and "lead us not into temptation, but deliver us from evil." In the spiritual struggle, the parish nurse helps the person pray with Jesus for reconciliation and a stepping away from those things that torment them. "He cried after I prayed with him," she remembers him saying. In the story of the apple crisp, our mind is cast to the image of Jesus seeking a single lost sheep, as LB sends her brother out to ask about the man who used to come to the food bank-based blood pressure clinic and who is coming no more. And when this man comes with his bag of apples, she turns it into small packages of apple crisp. This man's spiritual

internal struggles were notable, but one wonders whether the taste in each sweet and sour bite of apple crisp pierced through the sense he was alone in his struggle.

There is an element of time being sanctified in many of these stories. By this I mean that the attention given is focused and fully aware of the other's needs, giving it an element of what theologian Rowan Williams has called the "dying to the neighbour,"[27] where we release ourselves fully to focus on the needs of others, paradoxically healing ourselves in the process. As BL puts it, "wholistic medicine takes a lot longer because trust comes into it, big time." Many of these stories exist within the timeframe of the parish community, where relationships unfold over years, rather than in brief, intermittent visits to a clinic or doctors office. As Solari-Twadell has put it, the congregation is a community well suited as a setting to sanctifying time, for it "fosters development of values that people live by through the life span, from birth until death."[28] What we often see occurring in the stories is what she describes as the extending, assisting and even enhancing of existing health care resources through this provision of time.[29] However, to enhance, extend and assist requires ongoing knowledge and attention to the person in an ongoing health story, sometimes for long periods of time. This is what happens when JJ spends time over many months with the middle-aged man who is having to go into long-term care, and the need for he and his family to acknowledge their choices, discuss them and consider "how does this feel," and then have the nurse present as a resource to listen, to guide, to explain what is likely coming, and to help them ask questions of their journey and even of God, this is an important thing. The nurse is aware that a first step must occur wherein the patient(s) and caregivers let go and begin adjusting to their new realities.

Evaluation and implications for pastoral theology and ministry

The context of parishes in Canada is that for some years to come there will be rising numbers of parishioners who are destined to require health care. In 2010, as the parish nurses in this study commenced their ministries, western societies were already experiencing growth in the population aged 75 and older. As the *Canadian Journal on Aging* noted at that time, the numbers of the population who would become chronically ill was to increase notably in the decades to follow. "The overall prevalence rates for almost all conditions associated mostly with old age would rise by more than 25 per cent, and health care requirements would grow more rapidly than the population – more than twice as rapidly in the case of hospital stays – if the rates for each age group remained constant," noted Frank Denton and Byron Spencer.[30] Meanwhile, Canadian health systems have gone through a shift away for hospitalizing ill patients to moving them swiftly back into the community in a trend that accelerated in the 1990s[31], with an emphasis on extra-mural and community-based supports for patients. This begs the question of what kind of communities are in place to support this shift? Dr. Rob Rutledge[32], an experienced radiation oncologist who advocates for integrative, wholistic care, and who treats Atlantic Canadian men with prostate cancer, raises the issue of large gaps when he cites the example of a recent study of what men are telling researchers about their lives between brief visits to the cancer centre. Key findings showed that there were high rates of difficulties in intimacy and sexuality, poor attendance at support groups, perceived lack of good educational resources at health centres, and increased mental health and psychological disorders.[33] As Rutledge puts it in this example, it's clear the actual physical treatment, "addresses such a tiny aspect of … what they're suffering"[34] amidst disease. His reaction to hearing of the existence of parish nursing is to embrace the possibilities of communities of support. "When you say, 'parish nurse,' I hear 'community.' I

hear, 'How do you connect people?'" said the oncologist. A study led by Krista Wilkins, a nurse and teacher at the University of New Brunswick's school of nursing, is addressing the value of faith-based nursing for cancer patients and is discerning the presence of community in faith-based nursing. As she noted in a power point presentation provided to me "it's not over when it's over. When treatment ends, just don't assume someone is well again. Side effects can be long lasting, physically, emotionally and spiritually."[35] As Wilkins puts it in her power point presentation, there are times when a person moves away from their acute care medical team due to a cure or their shift into palliative care, "but the parish nurse will always be there. And so, the parish nurse can step in to give support."[36]

Here we gain a glimpse of the argument of the need for faith-based nursing in a system that appears to be crying out for a response from communities of faith. Yet, in the Canadian context, the parish nursing movement has been declining numerically, with the membership of the Canadian Association for Parish Nursing Ministry declining from 97 members in 2017 to 74 this year, and with an increasing number of these nurses becoming part-time volunteers rather than paid staff.[37] However, it is premature to suggest this means parish nursing as a mission is fading. These stories of wholistic healing suggest a movement in its preliminary stages, where the way forward is still being explored with considerable creativity, while funding is scarce. The stories that parish nurses tell about their provision of wholistic health care appear, even from this small sampling, to depict a process that addresses many deep needs of parishioners in ways that dissolve the traditional barriers between spiritual and physical care. The man ignored by a hospital ward gains attention; a daily trip to an Alzheimer's support group is facilitated by a group of trained volunteers; an alcoholic is more abstinent because he's prayed for. Still, the Church should be cautious of seeing the results of healing in terms of a series of purely physical,

clinical, measurable indicators. The Christian God may act in the world, but God may not give the response (or non-response) we initially ask for. The nature of Christian healing is not the secular world's notion of healing. The problem of considering the efficacy of parish nursing may be a little like that of considering the efficacy of petitionary prayer itself. As C.S. Lewis notes "They (prayers) have not advised or changed God's mind – that is, His overall purpose. But that purpose will be realized in diverse ways according to the actions, including the prayers, of His creatures."[38] The peace / *eirene* disciples are promised before Jesus' death and resurrection is not just what they think they desire, but what occurs in the sharing of God's love with others. This is what parish nurses do in these stories. "Peace be with you. As the Father has sent me, so I send you," Jesus said, breathing upon them. (John 20.23) As we hear in these stories, this peace has the power to transform lives, and to act as a defender amidst the world's transgressions of human dignity. This study has relayed "lived and told"[39] tales of wholistic healing to be passed to a future generation of parish nurses, drawing out some theological themes that can be passed along and discussed as they move forward and attempt to renew and restore this field in response to apparent need, with a particular focus perhaps on advocacy within the Canadian healthcare system. These stories also need to be told in the church and told publicly. They need to be told in a context that understands that faith communities and health ministries like parish nursing have a role to play in this bringing of Christ's peace into health care, with each nurse having the potential to bring long-term engagement, advocacy and support in the health journeys of parishioners, and to form communities of support around them as they engage with the secular system.

End Notes

[1]"Personal conversation with Dr. Phillip Cooper, lead palliative care physician, St. Martha's Regional Hospital, Postulant in Community of Associate Parish Priests Community, Nova Scotia" interview by author, November 17, 2018, during fall retreat.

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[3] Barbara J. Dilly, "The Parish Nurse: A Critical Component in Local Congregational Health Care Ministries," ed. Alexander Rodlach, *Journal of Religion and Society* Supplement 7 (2011): 11. "The nurse listens, counsels, and prays with people at the spiritual level but she also places them in small support groups, educates them and connects them with public and private health services … They are often the best link between individuals and their families, communities, and the health care network."
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[12] Sara Schreiner, "The Parish Nurse/Minister of Health Program: A Promising Wholistic Health Concept: 28.
[13] Ana Maria Catanzaro et al., "Congregational Health Ministries: A National Study of Pastors' Views," *Public Health Nursing* 24, no. 1 (2007): 6, doi:10.1111/j.1525-1446.2006.00602.x.
[14] Leslie Van Dover and Jane Bacon Pfeiffer, "Spiritual Care in Christian Parish Nursing," *Journal of Advanced Nursing* 57, no. 2 (2007): 213, doi:10.1111/j.1365-2648.2006.04081.x.
[15] Thomas A. Droege, "Religious Roots of Wholistic Health Care," in *Theological Roots of Wholistic Health Care: A Response to the Religious Questions Which Have Been Raised*, by Granger E. Westberg and Thomas A. Droege (Hinsdale, Il.: Wholistic Health Ctrs., 1979), 16.
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[17] Granger E. Westberg and Thomas A. Droege, *Theological Roots of Wholistic Health Care: A Response to the Religious Questions Which Have Been Raised* (Hinsdale, Il.: Wholistic Health Ctrs., 1979), 9.
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Appendix A: Invitation to Participate

(Date)

Dear (Name)

My name is Rev. Michael Tutton and I am in my final courses of the Master of Divinity degree at the Atlantic School of Divinity at the Atlantic School of Theology. I am a transitional deacon in the Anglican Church of Canada, and it is expected I will be ordained as a non-stipendiary Associate Priest within a year. My intention, which has been sanctioned by Archbishop Ron Cutler, is to become a stipendiary priest after my degree is completed, and upon my retirement after a 30-year career as a journalist, currently as a reporter/editor with The Canadian Press, Canada's national news service, in the Halifax bureau. Your name was provided to me by (contact person) as a potential participant in the research project; and I would like to invite you to participate in this study as one of the core participants.

Study Description

This is a narrative method study where the researcher collects the detailed stories of one or two parish nurses about the role they play in holistic healing for their congregants/parishioners. The researcher would seek to meet on at least three occasions over August and September to hear the stories and, with the participant's and patient's permission, observe during a visit that's relevant to the stories. The interview questions would focus on your life as a parish nurse and your recollections of how healing occurs in a wholistic way. It would seek to understand the changes this has brought about in your own life, and the lives of others, focusing on points of transition, recurrent themes and the changes transformations over time.

You would be asked to sign a consent form prior to the interview process, and you could end your participation at any time, in which case all materials would be destroyed that had been collected to date.

The results of this study would be presented at the Atlantic School of Theology in a public presentation on Dec. 6, 2018, as well as being written up and made available at the school's library.

Benefits of the study

The researcher expects you will benefit from the recalling of your stories and reflections based on some years of experience as a parish nurse, and that in collaboration with the researcher, discover theological meanings and themes can emerge that describe parish nursing. Your reflections, and the researcher's reflections, on the key themes of your story may also be useful as the parish nursing vocation considers a way forward in Canada at a

time of numerical decline. Stories restore possibilities and hope, even as they describe challenges. These reflections may be helpful to your colleagues in ministry.

Risks of study

Both your identity and those of your parishioners will need to be protected in the story. This can be addressed through the steps described below for preserving anonymity of the participant and of people in their healing story.

Confidentiality

Your participation in this study is fully confidential. In both the public presentation and the written summary of this research, your name and any other personal identifiers will be changed. The audio recording of the interviews as well as the transcripts of the interview will be destroyed on completion of the research. If you have any further questions related to the study, or if you would like to participate, I invite you to contact me at Michael.Tutton@thecanadianpress.com or 902-221-7011. I very much look forward to hearing from you.

Sincerely,

Michael Tutton.

Appendix B: Informed Consent

I acknowledge I have been given a description of the research project, "Stories told by parish nurses of their role in wholistic healing of parishioners." I am aware that my participation is strictly voluntary, and that I can end my participation in the project at any point in the process.

I am aware that my participation is confidential. An audio recording of the interview will be made and field notes may be taken. This recording along with the transcript of the interview and field notes will be destroyed following the completion of the research project. My name and any other personal identifiers will be changed in order to maintain confidentiality. This consent form will be stored separately from the research data in order to maintain confidentiality.

This project has been approved by the Research Ethics Board of the Atlantic School of Theology. Any ethical concerns about this project may be taken to this Research Ethics Board.

By signing below, I am consenting to participate in this research study.

Name: Date: