Faith-Health

A Review of the Emerging Field and the Practical Jewish Response

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SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR ORDINATION

HEBREW UNION COLLEGE-JEWISH INSTITUTE OF RELIGION

2015

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Digest:

The faith-health field is an emerging subject of research and applied practice. The area of research and implementation exists at the junction of religion and medicine, and is equally bound by the strictures of both. Although the faith-health relationship has ancient roots, the present incarnation of the discipline dates back only about 20 to 30 years. The religious aspects of the present day field are largely rooted in the Christian faith, although developments in the region of knowledge are equally applicable to the Jewish tradition.

This thesis focuses on three central concerns regarding the faith-health field and Jewish application. First, it presents a broad overview of the current practical discipline, based on personal interviews with leaders of representative organizations. It describes the day-to-day operations and concerns of a spectrum of organizations, including real world experiences and examples. Second, it reviews the findings of the scientific field. It analyzes and summarizes the areas of scientific consensus in the area of faith-health research, in order to promote and support an evidence-based approach to faith-health programming. Third, this thesis explores and analyzes the Jewish textual tradition to track the major faith-health themes that persist throughout the course of Jewish practice. It traces Jewish perspectives on the subject, analyzing Biblical text, with a particular emphasis on Torah, to texts of the Rabbinic era, and the medieval period, up through contemporary thought and practice.

Based on the findings of these three detailed explorations, this thesis includes a comprehensive and systematic guide to creating a synagogue based faith-health program. It clearly and concisely lays out the benefits and requirements of launching a customized program. It provides a method for conscientiously planning out where and how to start, from assessing needs to providing resources for next steps.

Copyright information:

Acknowledgements:

This thesis has only been possible thanks to the help of many individuals. I would like to thank first and foremost my advisors, Rabbis Schwartz and Joseph who helped in the formulation and throughout the process of writing. In particular I wish to thank Rabbi Julie Schwartz, who has demonstrated patience, persistence, thoughtfulness, wisdom, and humor throughout the guidance that she has offered. Several people responded to my requests for interviews in support of the research, and offered their time to answer my questions. They include: Rabbi Richard Address, Marlene Feagan FCN, Gilda Friedman FCN, Rev. Amy Greene, Rabbi Micah Greenstein, Marvin Stockwell, and Rabbi Eric Weiss. I am grateful to each of them for their time and expertise. Rabbi Address, Marlene Feagan, and Gilda Friedman took the time to send me additional materials including copies of their own writing, which were all invaluable in composing this work. Thanks are also due to Ann Hughes, who transcribed many hours of interviews. Those who offered support and encouragement in a variety of ways include Dana Benson, Iah Pillsbury, my family in Denver and in Cincinnati, and in particular Danyul, Rachael, and Adrian Jackson who opened their home to me, fed me, and offered me a place to work. The Klau library staff supported me in locating books and journal articles, and kept the door open late. May you all be blessed with life and joy.

Table of Contents

Part One: Overview of the Faith-Health Field

And Profile of Representative Organizations

Introduction to Part One

The field of faith-health may be regarded as an emerging and rapidly growing discipline. New partnerships are emerging each year in cities all over the world between healthcare institutions and faith community organizations. New types of organizations are being founded, which blur the line between these two areas; faith ministries provide whole populations with direct health care services, and for-profit health care providers are increasingly investing whole-body health, including spiritual well-being.

In another sense however, the link between faith and health can be traced back to their common origin. Religion and health have been linked since the beginning of recorded history, and have remained tied to one another throughout time. The field of faith-health, therefore, is not a newly emerging field at all. Rather, the historical anomaly is the artificial separation of these two areas of human experience. This is well-known within the field of faith-health. Marvin Stockwell of the Church Health center observes, "If you look at the scope of history, …sub-specializing in medicine and divorcing it from a faith view is actually a recent phenomenon. …Hospitals were founded [by religious communities] to serve the poor. It was only later that the rich who could afford to have doctors come to their own house realized that the poor were getting better health outcomes, and they wanted the same level of care."[1]

Only in modern times have these areas begun to evolve and develop separately from one another. This separation has led to incredible progress in the field of physical health, initially in our understanding of the human body, and then in our ability to cure

[1] Marvin Stockwell, interview by Nathan Farb, Phone Interview, October 15, 2014.

and ameliorate physical ailments. The division has arguably also led to a deeper experience and understanding of our internal and communal spiritual lives.

However, we have now reached a point in time that the artificial separation of faith from health may be detrimental to both. There is tremendous evidence stemming from scientific research, anecdotal evidence, theoretical frameworks, and practical application that recommends the reintegration of these two areas. That process has already begun. Numerous organizations across the country and around the world are actively operating in the field of faith-health.

A clear understanding of this discipline as it exists today is worthy of close examination. Such an examination will first require a more detailed, conceptual description of the faith-health field as a whole. Secondly, it will require an overview of the types of organizations that already exist, what populations they serve, and in what ways. Finally, a practical understanding of the field will rely on an examination of the past struggles and successes of real world organizations, as well as their partnerships with one another.

What is Faith-Health?

Faith-health is an entire field which exists at the intersection of the fields of religion and medicine. Faith-health is mutually inclusive to both fields. This means that there is no part of the faith-health field that is external to either medicine, or to faith/religion/spirituality. The entire field is answerable to the standards and expectations of both. The boundaries of this field are still somewhat porous and evolving.

It is called by different names depending on the perspective of the person or entity addressing it. In the religious world, it is sometimes described as health ministry, caring community, church health, wellness, personal welfare, congregational care, caring ministry, etc. In the medical world it is sometimes described or included in terms such as complementary care, complementary medicine, holistic medicine, homeopathy, or alternative medicine. In the organizational world, all of these terms may be used, in addition to healing, wholistic medicine, mind-body healing, whole body healing, recovery, spiritual healing, sacred healing, spiritual wellness, well-being, and a whole slew of other terms. Nearly all of the above terms are imprecise and/or jargon that makes the field confusing. The water is further muddied by the fact that such terms are used inconsistently even within their own field, and may refer to a broader or narrower range of topics.

For these reasons, faith-health may be a better way of describing this field because it is simple, descriptive, and exhaustive. There are areas of the medical field that are sometimes grouped under the same umbrella as faith-health practices despite being separate, such as therapeutic massage. Likewise, there are practices in the faith community that are sometimes spuriously associated with faith-health, such as miracle healing. Faith-health practices are those that are subject to both religious inspiration and scientific rigor (massage is not religious, while miracle healing is not scientific).

There are many practices at the edges of this field whose inclusion may be somewhat unclear. For example, a clinical procedure such as acupuncture or Healing Touch may or may not be considered a faith practice depending on the context and the practitioner. In some medical institutions, these types of procedures might be performed

by clergy as part of their religious mission. Likewise, a religious activity such as a prayer circle may or may not be considered a medical intervention. Such an activity may be exclusively a faith activity, or may be conducted as group therapy by a licensed psychiatrist.

Who Does Faith-Health Work?

The work done in this field is not limited to any one single type of organization. While there are some organizations that deal exclusively in this field of work, there also organizations that are primarily medical or primarily religious, which provide faith-health services. Although there may be some exceptions, the major types of organizations that conduct this type of work may be divided into four categories: hospitals and traditional health care providers; direct health providers such as clinics or healing centers; trade organizations that provide resources, training, and coordination; and faith organizations such as synagogues, churches, and religious federations.

Each of these organizations plays a unique role, brings a different approach, and a different perspective. Some organizations may fall into multiple categories, and some may not exactly fit into any of these. These categories provide an understandable way to conceptualize the field of work as it is currently being conducted. In order to illustrate the field of practice as a whole, a few representative organizations have been selected. These include examples from all four categories, which are exceptional or representative of the field. Personal interviews were conducted with key representatives to find out how these organizations operate in detail.

Hospitals

Hospitals and traditional health care providers tend to be large and well-funded institutions. Some of them are for-profit service providers, and some are nonprofit. Many hospitals have historical ties to religious communities or religious organizations. Some are connected with institutions of higher learning. Despite their funding, all of them have significant financial concerns that impact their operational decision-making. Any of these different types of hospitals may conduct important work in the field of faith-health, whether religious values are considered a core component of their mission or not.

Hospitals have multiple mechanisms that may be employed to support faith-health work. They tend to each have a dedicated department, usually called spiritual services or spiritual care, which provides for the spiritual needs of patients in the care of the organization. They may also offer faith based therapeutic services provided through their own staff, or through partner organizations.

Nearly all hospitals and major health networks in North America have chaplains on staff. Chaplaincy departments, also called spiritual care departments, can take on a variety of different forms. In some cases, they may be comprised of volunteers and/or employees of the religious community. They may be employed by the hospital as a matter of historical continuity. In such cases, the expectation is generally that the chaplains provide on-demand spiritual care, and are available to perform expected religious functions, which may include conducting religious services and performing rituals surrounding death.

In other cases, chaplains may be employed by the hospital to provide an improved patient experience (also called client satisfaction, customer experience, etc.). A growing

number of studies and trends within the world of health care support the attitude that a proactive and well-trained staff of chaplains can improve the overall patient experience and satisfaction. The Director of Spiritual Care at Cleveland Clinic described some of the research that she favors:

> The person I've been working with a lot is named Lynn Underwood, PhD. She has written something called the Daily Spiritual Experience Scale, and she has done a lot of research using this scale. I think she's probably the most effective of all because her scale isn't about one particular religious view per se. It's about the spiritual component of living, and what people experience, and how their experience effects their daily life.[2]

There is also a growing number of institutions supporting the idea that chaplains can play an important role in health outcomes. There are also many hospitals that employ chaplains who can provide complementary therapies, such as Reiki, Healing Touch, etc. directly to patients.

In some cases, they may have one department which includes both of these. The Director of Spiritual Care at The Cleveland Clinic notes, "We have six full-time daily chaplains. …We've got a night chaplain. We've got two part-time weekend chaplains, and we've got four resident chaplains on CPE rounds. …and then, we have four holistic nurses."[3] Hospitals may also provide services which are coordinated through the faith community. Finally, they may make funds available through grants or foundations to support the work of the faith-health community. One Faith Community Nurse summarized her program's funding:

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[2] Amy Greene, interview by Nathan Farb, Phone Interview, October 28, 2014.
[3] Ibid.

> The money [for the citywide Faith Community Nursing program] came from foundations, endowments like Duke University Endowment, [which] gave money each year to sustain it. The Wesley Long Foundation gave money too to sustain it. There were other grants and endowments and now Cone [Health] itself, which has included Wesley Long into its conglomerate of medical facilities, has a Cone Health Foundation and they fund many, many, many programs in Greensboro.[4]

Aside from the spiritual care departments, many hospitals have a system for providing complementary medicine or integrative health care. In some cases this is provided by an in-house department or an adjunct clinical center, while in other cases it may consist of referrals to third party medical providers. Hospitals tend to offer these services because they have been shown to be cost effective in managing certain types of cases, such as pain management. Depending on the particular institution, the services may or may not be offered in the spiritual context.

Some hospitals may dedicate resources to coordinating health care with the geographic area's faith communities. This can take the form of a community health liaison employed by the hospital. Such a position is dedicated (or partially dedicated) to providing health care services at or through faith community centers such as churches, temples, synagogues, and mosques. These services generate income for the hospitals through paid partnership programs in which faith communities pay a membership fee in exchange for hospital consultant, practical, and educational services, as well as through paid direct services that faith and community organizations receive on a fee for service basis, such as health screenings or blood donation vans. An example is St. Elizabeth Healthcare:

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[4] Gilda Friedman, interview by Nathan Farb, Phone Interview, October 30, 2014.

> When you partner with Saint Elizabeth, my services as your consultant are free. …We have different things that Saint Elizabeth provides. …We have the mammogram van that can come to your parking lot of your church if you're partnered. Or if you're not partnered. …We have the vascular van now – which is for all those vascular carotid screenings: Doppler screenings.[5]

In regions where the faith community has sufficient resources, the faith community itself may be able to provide direct care. In such communities, the regional hospitals and traditional health care providers still play a significant role. Through financial means such as grants or endowments, health care organizations tend to fund these efforts directly, or through donating staff, space, equipment, etc., or by offering incentives for their own staff and partners to volunteer their time.

These resources are well spent by hospitals, since faith-health organizations of this type often serve the needs of populations that are unprofitable to the hospitals. For example, the uninsured working class might be served by these organizations. Many such individuals do not have regular general practice physicians, and so receive their primary care through hospital emergency rooms.

> For years Methodist Healthcare backed our work [at the Church Health Center because] it was really… just the right thing to do. …There's a lot that's been written about Emergency Room abuse. People who don't have access to a doctor use the Emergency Room as their doctor's office, and the sad thing about that is that they wait for themselves to get so bad that by the time they come they're far worse than if they just had access to a doctor. …They need hospitalization. Then a few years ago [Methodist Healthcare] got very scientific about it and they said, "You know, we know that we've backed the Church Health Center for year, and we know that the fact that we give them free access to our hospital up to a certain amount… helps abate our write-off cost. But would supporting them at a larger level - providing them X-amount more

[5] Marlene Feagan, interview by Nathan Farb, Personal Interview, October 22, 2014.

> hospital stays and access to surgery centers - …additionally reduce our write-off cost?" They did a study and found that yes it would. So overnight they doubled their support for us in terms of donated services.[6]

Because this group of individuals are uninsured, they often cannot pay, or cannot pay as much, for emergency room services as somebody who is insured. By supporting health care services offered by the faith community in their area, hospitals can effectively reduce these emergency room losses. Direct health care services and clinics are supported by hospitals as well as the faith community.

Clinics and direct health providers

Clinics that provide direct care as part of a religious ministry may appear at first to be primarily health care organizations. They employ doctors, provide facilities for medical care, serve and track patients, make and receive referrals, and do all of the things that one would expect a health care provider to do. They do not necessarily preach any particular religious doctrine to members or recipients of their care, they may not perform any religious ritual functions, and they tend to be composed of people from all different faith backgrounds. However, a clinic or direct care provider may potentially be the perfect example of a faith-health organization.

One such organization is the Church Health Center, located in Memphis Tennessee. They have a number of physical facilities including a main central location that house every variety of medical professionals and equipment, ranging from pediatrics to optical and dental services. There are several distinctive characteristics that make the Church Health Center a faith-health organization. The founder and CEO of the Center,

[6] Marvin Stockwell, interview by Nathan Farb, Phone Interview, October 20, 2014.

Dr. Scott Morris, is both a trained and certified medical doctor, as well as an ordained United Methodist minister, with a Master of Divinity degree from Yale University.

He founded the center on the religious basis that Christians have an obligation to provide for the health and welfare of the poor, as well as for the people in their community. He is not simply a medical doctor with a strong religious background. He's a minister who expresses the mission of his faith through providing medical care to those who need it. "He likes to say, 'I'm a pastor who practices medicine. Not a doctor who preaches.'… This is what God has called him to do."[7]

Over the years the Church Health Center has grown, until they now serve thousands of patients each year. Nevertheless, the religious underpinnings of the work remain intact. It continues to be a nonprofit organization that is primarily supported by donations from the community – primarily the faith community, but also by the medical community. The care that it provides is not necessarily free to the patient, but is offered at an extremely affordable cost, which is not ultimately the major source of income for the organization. As the Communications Director characterized it, "We are donor supported. …We are an easy to back charity because health care access is such a basic need."[8]

Although there are a few employed professionals in the organization, the vast majority of the healthcare workers (doctors, and nurses, and technicians) operate on a purely volunteer basis. Many of the volunteers are also significant financial supporters of the Center. They volunteer their time and skills (and sometimes money) for the same motivations that Dr. Morris founded the Center in the first place. Although they come

[7] Ibid.
[8] Ibid.

from many faiths, they all believe that they have a fundamental religious, moral obligation to give their healing care to all people. They are not employees hard at work, they are congregants engaged in devout prayer.

Trade and training organizations

Recently, the Church Health Center has also come to house the International Parish Nurse Resource Center (IPNRC). This began as a separate organization with a somewhat different mission, but it shares the same underpinnings as a faith-health organization. This falls into a different category, because it is not a clinic which provides direct care, but rather a trade organization that provides training and resources to people who work in the field. Specifically, it provides coordination for Faith Community Nursing, also known as parish nursing and congregational nursing.

Faith Community Nurses are nurses who are licensed and registered under the American Nurses Association with a specialization in Faith Community Nursing, governed by the scope and standards of that formal specialization. "All nurses are called to serve, and to look at faith as part of care," notes the president of Health Ministries Association (HMA)[9]. "But in Faith Community Nursing, in every patient interaction, intentional care of the spirit is the focus of care."[10] The American Nurses Association offers the specialization and defines the standards of practice. Organizations such as the IPNRC provide logistical support. Some of the common functions of these types of associations include providing ongoing training and curricula, providing on demand educational resources, creating networking opportunities, publicizing work done in the

[9] The HMA is the national professional organization for Faith Community Nursing
[10] Marlene Feagan, interview by Nathan Farb, Phone Interview, October 6, 2014.

field, organizing seminars and conventions, and providing practical tools to Faith Community Nurses in the field.

There are several such coordinating organizations in North America. Some are more regional, while some are international. Most of them sponsor conventions, such as the Westberg Symposium, sponsored annually by the Church Health Center/IPNRC, the Health Ministries Association (HMA) annual meeting and conference, or the Annual General Meeting (AGM) of the Canadian Association for Parish Nursing Ministry (CAPNM). These conferences generally include presentations on special topics, providing ongoing and up to date education and training. Most of these conferences will focus on one particular issue or set of issues of current relevance in the field of Faith Community Nursing (FCN). These conventions are also networking and recognition events, in which an individual's work may be highlighted. One FCN described her experience:

> They'll have a speaker, perhaps a new program, or a hot topic, or a new resource in our area, one of those things, and they give us numerous updates on what's going on in the area and a little bit of time for some networking with each other. … I was talking to this woman from, somewhere in California. She was a Director and wanted and was getting ready to add a synagogue into the [Faith Community Nursing] network and so we talked …Do you know she flew all the way from California back east to Washington, D.C. or to Baltimore for this conference and she had only been back in California four days after being in Europe for three weeks. I said, "I cannot believe you did this." She said, "I came here just so I could meet you and see you and come to your presentation [on Jewish Congregational Nursing]."[11]

[11] Friedman, interview.

Another important role of these organizations is in recruiting, training, and advocating for nurses in the field. In partnership with nursing schools, these organizations provide and promote the Faith Community Nursing specialization. They also provide training for professionals in the field other than Faith Community Nurses. They may provide training for clergy or doctors who are interested in introducing Faith Community Nursing in their own area, or for program leaders interested in advocating for an emphasis on health and wellness in their own faith communities.

Faith communities

Faith-health services are also supplied directly and indirectly by faith communities, such as churches, synagogues, mosques, and community centers. The type of services provided, their scope, and the way in which they are providing can vary greatly. In some of the most representative examples, faith communities work closely with another type of organization.

For example, the faith-health program at Temple Israel in Memphis, Tennessee is closely linked with the Church Health Center. The two synagogues of Greensboro, North Carolina have faith-health programs that both operate with the coordination of Gilda Friedman, a Faith Community Nurse. "We have two synagogues in town. …Neither one of them could afford it by themselves so it just made sense to put it in Jewish Family Services and then that way I could serve everybody in the community, whether they were affiliated or not affiliated. The service is free."[12]

[12] Ibid.

Faith communities may provide faith-health services in the form of direct health services, education, advocacy, or resources. Faith communities that are involved with faith-health initiatives consider physical well-being to be a part of their religious obligation or mission. Just as faith communities host food drives or house community pantries to care for the physical well-being of people in the community, some expand that mission more broadly.

In some cases the mandate for faith-health initiatives may come directly from the membership within a community. Members identify a social justice cause that is connected with health care, and petition the leaders of the community or the community as a whole to take action. These can include actions that indirectly impact health such as raising money for cancer research, or direct health actions such as blood pressure screenings or changing to healthier food options at the faith community sponsored events. Rabbi Richard Address recalls, "There was an increasing number of congregations who looked at what they served at Oneg Shabbat and each group event and tried …to change some of the food options that are used…. at the Oneg you go to all chocolate cake and cookies, …now there's fruit or a fruit option."[13]

Direct actions impact the health of the members of the community, and indirect actions aspire to improve health care outcomes or availability for people beyond the limits of the faith community. Some actions may serve both purposes, such as organizing a community biking or running event, thereby promoting health within the community, in order to raise money for medical research and thus promote health care beyond the

[13] Richard Address, interview by Nathan Farb, Phone Interview, November 5, 2014.

community. Rabbi Address described the idea, "Every weekend in the nice weather there's always a sponsored run or a sponsored bike for charity or something. …You turn it into a fundraising event and a social event, and people gravitate to that. It's not like going to the synagogue and being there for a program, but it really is a synagogue program, and you're teaching health and wellness."[14]

The religious obligation for health care is rooted deep within many faiths. Some communities look to the explicit references within their tradition, such as the Christian scriptural descriptions of Jesus healing his followers, or the Jewish injunction to visit and care for the sick. Other communities emphasize health care as an element of caring service that is endemic to a faith community. These different interpretations are by no means mutually exclusive. In part because of the various understandings that lead to the inclusion of health care issues in a faith community, faith-health may be included under different groupings.

A community may have a dedicated health ministry or a health and wellness committee within the congregational structure. Faith-health may be included under a caring committee, such as *bikkur cholim* (caring for the sick) committee found within many synagogues, or in connection with broader missions or committees, such as a community action/ *tikkun olam* committee, or outreach to the needy/ *tzedakah* committee. "These are in-reach programs – programs of basically three major rubrics with tremendous variation – *bikkur cholim*, *chevra kadisha*, and educational programs. Those

[14] Ibid.

are the three sort of chapter headings, and under each are very tremendous numbers of variations,"[15] Rabbi Address summarized.

Under different auspices, faith-health work may take different forms and have different emphases. If it is treated as a function of serving the needy, then it may emphasize providing direct care along with food and emergency resources to people inside and outside of the community, while if it is treated as a function of caring for the sick, then it may be more internally focused on providing medical care and support to ill people within the community.

Congregational communities that are committed to faith-health issues integrate thinking about these issues into every stage of the organization. Rabbi Micah Greenstein describes his approach:

> If Judaism is all about self-improvement and the aim of a life of Mitzvah is the refinement of human beings, we all should get in the game, right? So, I think looking for the synagogues that do the best programs is really not a good way to look at it. It's: Where are the spiritual leaders conscious of this and linked with others in this, communally and within the synagogue?...You may find congregations that do great programs, and then they're one-hit wonders. So what do they connect to? The same with our Church Health Center, we have an ongoing pipeline of volunteers, but we also have an exchange when we talk about the newest things in healing or in medicine.[16]

Food choices at community events send a message about commitment to healthy living. Many of the issues dealt with in the context of faith-health will emerge in a community organically.

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[15] Ibid.
[16] Micah Greenstein, interview by Nathan Farb, Phone Interview, November 6, 2014.

Every community will have different challenges and successes. In each case, a level of continuous effort is required to sustain these initiatives over the course of years. In some cases, these efforts may be supported by dedicated the synagogue members with an area professional expertise, such as doctors and nurses. In other cases, the effort may be sustained by strong ties with other faith-health organizations.

In some cases, there may be institutional support for faith-health work provided by some type of centralized religious structure. Whether or not such institutional support exists can vary widely between different regions, and between different faiths. For example, within the Catholic Church these issues may be promoted through an individual church or through the archdiocese. The Lutheran and Methodist Churches each have a dedicated central office to support faith-health efforts. In the Jewish world, these efforts may be supported community-wide through a JCC or federation.

For example, these institutions may financially support a Jewish organization conducting faith-health work, or directly employ community nurses. In the Reform Jewish world, there had been support at a national level provided by the Department of Jewish Family Concerns of the URJ. Within the department, much of the faith-health work happening through different synagogues was supported through a program called "Caring Communities." Many of the programs that were started under this heading have remained active within individual congregations, although there is no longer national logistical support. Some of the logistical support that had previously been provided by the Caring Communities program continues to be provided on a private consultation basis,

particularly through the Jewish Sacred Aging organization. Rabbi Richard Address operates the Sacred Aging Project, "full-time now all over the world."[17]

Those who work in the field describe the clear benefits of having organizational support for faith-health work:

> The United Methodist, the United Church of Christ, the Presbyterians, the Episcopals… all have directors of health ministries at a national level. Those denominations have just run with it – with health ministries. UCC Church have given a directive that they want every United Church of Christ to have a health ministry team. The United Methodist are not quite there, but they're really close. Then, the Episcopals have a director of health ministries. He's located in Indianapolis. Presbyterians have a department and have had for a long time. [Having a department] says, "This is important and we're going to put someone in a role nationally to lead this." So there is someone sitting in an office somewhere, so that – if I'm a United Methodist – I can call up and ask for what I need [and] get questions answered.[18]

Organizational support can have a particularly positive impact on raising awareness of faith-health work, formation of an individual congregational program, determining the scope and vision of a program, and anticipating and solving issues that arise in the course of a program's operation. Organizational support can also send an important symbolic message that the religious commitment to health.

Who Is Served By the Faith-Health Field?

The faith-health field serves a broader population than just the faith or health systems. In part, this is due to the fact that health care organizations serve populations that are not regularly served by religious organizations and vice-versa. This is also due to

[17] Address, interview.
[18] Feagan, interview, October 22, 2014.

the fact that dedicated faith-health organizations have a mission which is somewhat independent of either religious or health care organizations.

Health care organizations such as hospitals can provide for the spiritual needs of their patients, especially through chaplaincy. Nearly everyone, at some point in their lives, will require institutionalized health care whether they are active in a religious organization or not. Spiritual needs are often more acutely felt at times of crisis such as during an illness. One chaplain noted, "We go to people at their absolute most vulnerable moment and we have to pick up our shoes and we have to say, 'We're here to serve you.'"[19] At these times of spiritual vulnerability, most people are more open to new spiritual experiences than they otherwise would be. These new experiences can be guided with a religious framework for a chaplain, doctor, nurse, or other healthcare professional with the appropriate spiritual training. A rabbi in the field described it:

> Spiritual care is its own distinct element, not strictly what you might think of as psychological counseling, not case management, not therapy but that spiritual care is its own particular component of human need that we all live with all the time but that comes to the fore maybe more poignantly or vulnerably or bluntly or, obviously, when people get sick, when people come to die or when people come to fold grief into their lives. …Everybody has their own natural spiritual hunger that they seek to satisfy.[20]

Religious organizations can provide medical services to various types of individuals who might not otherwise receive care. Religious congregations are particular in that they serve a broad range of demographics, including all ages and socioeconomic backgrounds. Religious congregations are among the only organizations that

[19] Amy Greene, interview by Nathan Farb, Phone Interview, October 21, 2014.
[20] Eric Weiss, interview by Nathan Farb, Phone Interview, November 10, 2014.

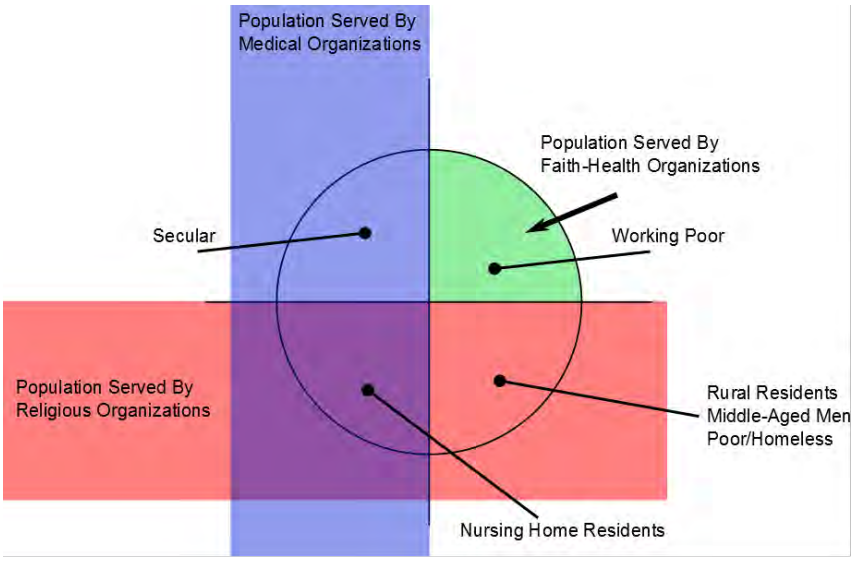
simultaneously serve young children and their grandparents, or the wealthy alongside the indigent. Religious organizations that adopt faith-health initiatives can potentially provide services to all of these groups side by side.

In particular, some of the significant groups that are served in religious organizations that are not served as prominently by medical organizations include the homeless, middle-aged men (especially professionals), remote rural populations, and urban populations. One FCN recalls, "We've done a program a few times called Men's Health. Just to talk. …I've taken it back a couple of times to do it because men are just horrible about feeling weak, having to take a pill or feeling so vulnerable going to the doctor's office."[21]

There are not only important differences in the populations served by different types of organizations, but also how they are served. The medical provider offers spiritual care and non-dogmatic, non-exclusionary way. A chaplain's job is "helping people reconnect to their own spiritual sources of strength or find new ones.… [Chaplains] are not here to be the teachers of authority. That being said, [they] do end up being teachers of authority, because [they] do represent our [their] faith traditions and know about spiritual life.… [They] are not spreading [their] particular religions."[22] Patients need not operate within the framework of a particular creed. Likewise, religious organizations can offer health care in a way that emphasizes dignity, love, and care, and they can have more frequent contact with individuals than a medical professional might.

[21] Feagan, interview, October 6, 2014.
[22] Greene, interview, October 21, 2014.

Dedicated faith-health organizations which are neither primarily health care providers nor primarily religious organizations often serve distinct populations. These organizations meet the medical and spiritual needs of dual populations; both the recipients of the care, and the care providers who tend to be volunteers. These organizations are often oriented more particularly toward populations that tend to be underserved by both religious organizations and health care providers. For example, the Church Health Center in Memphis, Tennessee tends to specialize in serving the working uninsured. These are individuals who may or may not be eligible for government benefits, who often are not active in a religious community, and are priced out of most non-emergency medical services.



The Types of Work

For the purposes of illustrating the type of work that is done by faith-health organizations or by other organizations that are active in this field, most of the services can be divided into five categories: Regular services, which are discrete faith-health services that are offered on a frequent, regular basis (e.g. weekly or monthly); Ongoing

services, which are available on a continuous or on-demand basis; Periodic services, which may be offered annually or semiannually, or only available for a certain period of time; Educational services, which do not provide for an immediate medical need, but rather offer information about a faith-health issue, or increase awareness, and; Advocacy services, in which a faith-health framework is used to give a stronger voice, more options and awareness, etc. to individuals who may be marginalized or disenfranchised.

Regular services

Regular services form the core work of many organizations in the faith-health field. They can serve as the central element of a faith-health practice, as a gateway to other services, or as the services that support the central mission of a faith-health organization. Regular services most often consist of direct health work, but can also take the form of education, advocacy, or awareness.

The most common type of regular service that is offered is a medical checkup. In the case of a Faith Community Nursing program, for example, a trained nurse or team of nurses will regularly attend a place of worship, and set up check-in stations. One FCN described the set-up:

> I'm in the congregation every week for the seniors. Each congregation has a lunch and learn program, and what I do is I set up a table off to the side so we can have some privacy and I do blood pressure screenings. I talk to people about if they have questions about medications, whether it's getting it, paying for it, or side effects or if they need a doctor referral or if they should call. They say, you know, this is going on, should I call the doctor? Whatever questions or concerns they may have, I'm at each synagogue every week doing one thing or another.[23]

[23] Friedman, interview.

These visits are generally timed to coincide with weekly prayer services, preferably at the most well attended service each week. A Faith Community Nurse will try to see as many patients from the community as possible, and perform some basic medical tests, typically blood pressure and possibly simple tests relating to an individual's medical history, such as flexibility or movement.

This visit will also include a verbal check in, which serves a dual function. First, it allows the nurse to gather some important information about medical factors in a patient's life, such as eating habits, past diagnoses, living situation, etc. This type of information allows the nurse to form a more complete picture into practice whole-person health. Just as importantly, it builds a relationship within the community. The formation of strong and open relationships such as these is one of the key outcomes of regular services. The nurses become familiar faces in the community, people build connections with a medical professional that they know and trust, and congregants come to associate the congregation with a positive and open health experience. One faith-health worker described the effect:

> A lot of the people in Covington will walk in off the street because they serve donuts. They do – It's not good, but they serve donuts and coffee. And so, we'll see some of those marginalized people. A lot of people come from the suburbs. Doctors, lawyers, merchant chiefs will sit down and get their blood pressure taken, because people basically have health care illiteracy - and just need help. And so, you give them one little piece of information they didn't know, and then, all of a sudden, they're coming back every month because it's useful to them.[24]

Regular visits like these establish a proactive pattern. They bring care to people in an unintimidating way, that do not require people to make a significant investment of

[24] Feagan, interview, October 6, 2014.

time or money, to set an appointment, or to travel out of their way. Other examples of regular services might include regular pastoral care visits to a nursing home or cancer center, meal deliveries for someone who is homebound, support group meetings, exercise classes etc. A rabbi gave an example, "We did Shabbat yoga in the afternoon, and for staff we have a Pilates class here."[25]

All of these regular services share certain key elements. All of them provide medical and spiritual care simultaneously; they provide for the body and the soul. All of them build important connections and relationships. The relationships that they build enrich people's lives in the present, and they build a network of trusted resources they can be called on in a future crisis. They establish a fixed routine, and offer a deeper and more complete personal understanding of a patient or of one another. They establish an association of that person, place, and/or time as one of healing and safety.

Ongoing services

Ongoing services, on the other hand, tend to be available on an as-needed basis. Often they can be key intervention services. For example, having a chaplain on call on an ongoing basis makes it possible to quickly receive care in the middle of a crisis. A hotline can provide important information and support when it is needed, according to one FCN:

> I have a great many people call me, such as this man from New York. He calls and he says, "I talked to my mom because she lives alone and but she just doesn't sound like herself, and could you check on her."… It makes such a difference to have somebody be able to check in on their mom or dad…. It's helping them with any questions they may have about resources, about if they need free medication or reduced-price medication. It's about teaching the mechanics of helping the person move. It's about making sure that they get some respite care and where

[25] Greenstein, interview.

> they can get that free. …It's being there for them so that they can get the help they need for themselves because so many times the caregiver gets so ill from caregiving that they end up dying before the person they're caring for. I think when you help family to access services and get what they really need, it's very much needed. I think it's essential and it really takes some of the stress and strain off that caregiver so because there are enough challenges as is.[26]

Some faith-health organizations work with volunteer professionals to provide consultation services to a community. For example, a lawyer who is well versed in end-of-life legal issues such as living wills or advance directives may be able to offer important guidance in an area that may be complex and confusing, and often stigmatized. Providing this type of service can help prevent a lot of heartache. A rabbi recalled:

> One [program] we did was on decision-making at the end of life. Again, we traced this whole thing through tradition. I taught my own theory and approach and then talked about all the resolutions dealing with comfort care, hospice care, and usually there's an opportunity to again push the writing of advanced directives, durable power, healthcare proxies, etc. People understood that this was something that they had to do for their own family health and wellness.[27]

The other faith-health organizations employ trained medical advocates, who can assist families and individuals in navigating the medical system. The field of medicine can employ complex technical jargon, labyrinthine bureaucracy, and broad or opaque prognoses. An advocate who is familiar with operating inside the medical system can be a lifeline to people who lack the depth of knowledge necessary to make important decisions about their own care or the care of their loved ones. An advocate can also give

[26] Friedman, interview.
[27] Address, interview.

voice to someone who lacks their own, whether due to illness, frailty, or an inability to communicate.

Offering services that are available on an ongoing basis can be demanding and time consuming. The organizations that provide these types of services find that they are well worth the investment. Gilda Friedman, FCN, described one example:

> There was an elderly woman hospitalized, and the rabbi went to see her and she said to the rabbi, "I'm having a hospice palliative care assessment this afternoon and my family is here and I would like to call Gilda [the Faith Community Nurse] and ask her to come. I want her to be there." So he called me, and I went in and …she said, "I want you at the conference, because you need to hear what the palliative and hospice nurse is going to say, and so you can tell me and I don't want to get it from them. Because you're a nurse, you're going to understand and you can tell me so I can understand."[28]

Periodic and occasional services

Faith-health organizations may also provide periodic or occasional services. These are services that tend to be conducted on a larger scale than the personal or small group setting. They are often public events that involve a large segment of the community. They can take the form of blood drives, health fairs, fundraisers, medical screenings, educational events, guest speakers, etc. These types of services can sustain a broad appeal for specialized topics or services, generate interest and excitement, raise awareness of important issues, and generate community cohesion.

These types of services might consist of one-off events that are part of a larger series, or a regular but infrequent event. They tend to be held annually or a few times a year. Often these types of events focus on areas of interest in the community that have

[28] Friedman, interview.

arisen as the result of other programming. A Faith Community Nurse in Greensboro, NC described the philosophy, "I don't arbitrarily decide what to focus on and nobody really should do that. You base your programs on what the needs of the community are. You can have an absolutely wonderful, blow it out of the ballpark program, but if it's not what the community needs, what good is it?"[29]

Education and awareness

Health education and awareness are an important part of every faith-health organization. There are numerous strategies that are used to provide educational services and raise awareness. They can include printed material, direct word of mouth, public events, and community networking, to name a few. All of this work increases the knowledge of faith-health issues, as well as the work that is being done in this field in a particular community. Ignorance and misconceptions are often some of the most important challenges that confront faith-health work.

Printed material is very prevalent. Pamphlets, booklets, and information sheets can all be used effectively. Displaying pamphlets in a lobby area raises awareness of the faith-health work available in the area. However, nurses, doctors, and patients in a hospital may not be aware of the services offered by spiritual care department. Having some brief information available can help to make the services more integrated with other healing work that is taking place.

This type of material can also be distributed in a more direct way. A hospital may have a policy of providing every patient who is admitted with information about spiritual

[29] Ibid.

care, or making sure that every patient with drug-related problems is given the contact information for faith based recovery programs, such as those sponsored by The Salvation Army. Marlene Feagan, a prominent FCN described her own church's program:

> We developed (which most programs do) a trifold little brochure that explained what it was that we could do. And Father would have them in a back pocket when he went to visit people to say, "The nurses are available to help you if you need help. His vision was …he wanted people to see Mother of God as a health place - a place to come when you have your questions from this kind of global perspective.[30]

Every encounter with a faith-health worker or volunteer is an opportunity to educate. A Faith Community Nurse will use a portion of his/her time with each patient to teach about relevant faith-health issues. This can include how and where to receive medical care, hygiene information, or inspirational prayers. This type of information can often be passed on informally as the patient interacts with others in the community.

Public education events are a great way to raise awareness of important issues that may not directly impact everyone, that occur infrequently, or that are considered taboo or stigmatized. Public presentation can also raise awareness without being a dedicated event. Even a brief mention of faith-health work during a sermon or a staff meeting can spread awareness, and formally provide legitimacy to the important work that is being done.

Because faith-health work is still not well known, and is not centrally organized, community networking can be crucial part of the work that any faith-health organization does. The leader of a faith-health organization might use a gathering of other community

[30] Feagan, interview, October 22, 2014.

leaders in the area as an opportunity to raise awareness of a specific faith-health issue, need, or misconception. Forming and activating a strong network can be very effective way of getting information to many parts of the community at once. Gilda Friedman, a Greensboro, NC Faith Community Nurse described one success:

> The partnership I have with Cone is important. I partnered …two years ago with Cone Behavioral Health and Guilford County Mental Health Association for a mental health awareness day at my synagogue. …When we do something big like this, it's open to the entire community, not just the Jewish community. It was great because Cone Behavioral Health brought all the screening material and Guilford County Mental Health folks brought all the education materials. I provided the synagogue, I provided publicity within all of our venues within the Jewish community. Cone provided the community-wide like the newspaper, radio, TV publicity, and I provided people to do the screenings. Plus I had an MSW with counseling there just in case we screened somebody that we felt we needed …immediate help or more than the screening could tell them. So it turned out to be a really good program without too much work on any one person's part.[31]

Advocacy and referrals

Faith-health organizations often serve as social connective agencies. Faith-health organizations are uniquely positioned in many cases to connect people in need with appropriate service providers. One of the major functions of a robust and well supported faith-health network in a city is to act as an agent between individuals, the health care system, and faith organizations.

Faith Community Nurses are trained to make necessary referrals and to identify unmet medical needs. Because of their specialized knowledge, a nurse can refer a patient to a dentist, eye doctor, physician, or hospital. They can also make appropriate referrals

[31] Friedman, interview.

to social service organizations, such as discount prescription programs. Feagan gave as example, "We have a faith community pharmacy for Northern Kentucky. We have the potential to pay four dollars for scripts if the doctors will write to the ones at Kroger."[32]

On the other end, a faith-health practitioner can use their credibility and their established relationship with the patient to advocate on their behalf. A medical institution such as a nursing home can trust the special expertise and knowledge of a Faith Community Nurse, allowing the nurse to speak on behalf of the patient who might be unable to understand and communicate their own needs, or lack credibility.

All of these functions – regular, ongoing, and periodic services, as well as education and advocacy – make up the body of faith-health work. The distinct organizations may each employ a different blend of services in order to fulfill their vision and serve the particular needs that they encounter. It is the combination of all these different services, distributed across multiple organizations in each city that makes up the faith-health field. Faith-health is the combined and interwoven efforts of an entire network devoted to enhancing the well-being of the community.

Profiles of Faith-Health Organizations

Of the organizations profiled, there is no direct and singular path that has led to their inception. As a field that is in some ways in its infancy, it is unsurprising that faith-health organizations are often innovative and uniquely structured to meet a set of needs that are particular to one community. Some develop organically over time, while others were the product of a single passionate visionary working with a carefully assembled

[32] Feagan, interview, October 22, 2014.

team of partners. Some started on a shoestring, while others branched off of well-established organizations.

Each one of these faith-health organizations faced challenges on the way. The way that they confronted these obstacles and capitalized on the opportunities that they encountered shaped the way that they changed and developed over time. All of these organizations are led by passionate and dedicated individuals who are committed to the cause of faith-health work and the positive impact that it has in the world. The stories of these organizations, in many cases, are the stories of the people who have formed and sustained them.

Mother of God Catholic Church

The Mother of God Catholic Church in Covington, Kentucky has had an active faith-health program for 17 years. The program began when Marlene Feagan, a professional nurse and a congregant at Mother of God, approached the pastor, Father Raymond Hartman. "We're looking for two churches to sign on. We need one Catholic church and one Protestant church. And, how do you feel about faith and health as part of who Mother of God is?" She had written up a proposal for a faith-health program, which came to include many facets of work. She found that Father Hartman was indeed interested, and set about forming in meeting of community leaders who had a special expertise in the health arena, including "some nurses… an alcohol and drug counselor, and a pharmacist."[33]

[33] Ibid.

As the group of people set out to formulate what a health ministry might look like in their community; they considered what type of work such a ministry would do, and how it would be organized. That initial group ended up becoming the Health Cabinet of the church. The Health Cabinet took charge of instituting the Faith Community Nursing program which still exists to this day. They determined what basic equipment they needed, such as a portable, locking cabinet to store medical records.

Although other programs of this type begin with an initial assessment of needs, in this case the cabinet of 15 or 16 people arrived at a general consensus based on their knowledge of the culture of the church. There were a lot of older members in the community, so they decided that they would be doing periodic blood pressure screenings after the Sunday mass. "Mass is at 9:30 and 11:30. So, there are nurses there from 9:30 to 1:30… on one Sunday morning a month."[34] Each month, the pastor makes a simple announcement during services to let people know that the nurses are there, and then he goes to have his blood pressure taken.

Other issues that affected people in the community began to eventually come to the attention of the cabinet. As nurses met with congregants/patients and learned more about them, they noticed certain patterns that would arise. For example, if they look through the records of the six month period and notice that there is a rise in new cases of diabetes, they will ask the question of how the cabinet should respond. At one point they noticed that there were a number of falls in the sanctuary. They brought in a balance expert who is able to draw their attention to issues in the layout of the chapel. "It's really

[34] Ibid.

hard for some people with Parkinson's to walk through the pews sideways. We didn't even know that until we worked with a balance expert."[35]

Marlene has been a part organizing numerous Faith Community Nursing programs. She is currently the president of the Health Ministries Association, which provides support and resources to Faith Community Nursing programs such as the one in her own church. At present, the Mother of God Health Ministry offers monthly blood pressure screenings, sponsors educational programs and lectures, and has changed the culture of the church to be more health conscious. "That's basically how every one of our programs have started. It's about a nurse, or somebody interested in faith and health, saying, 'I heard about this. The church down the street's doing it. Can we look at it?'"

Cleveland Clinic

The Cleveland Clinic Spiritual Care Department was reinvented, beginning in 2006, as part of a large scale restructuring of a rapidly adapting medical institution. Dr. Toby Cosgrove became the president and CEO of the Cleveland Clinic in 2004, and has spent the past decade transforming the Cleveland Clinic into an internationally known center for excellence. Nearly every aspect of the Cleveland clinic has been reimagined, from the staff to the organizational structure to the physical campus. At the heart of every change that has been made is an unflagging commitment to patient experience.

Rev. Amy Greene began at Cleveland Clinic in 2006, as a supervisor of Clinical Pastoral Education. Around that time, the CEO underwent something of a "conversion experience." This was not a religious conversion. "He was a very self-described old

[35] Ibid.

school heart surgeon, Vietnam vet.… He'll make jokes about, 'Back in my day, people were just glad to be alive.'… But he realized that the clinic was not doing as good of a job as we could in terms of the things that make people feel more cared for."[36] When his outlook shifted from prioritizing the quality of clinical care alone to prioritizing the patient experience, the spiritual care department began to play it a more significant role.

"The *kairos* moment came and we were able to start building a Spiritual Care Department that moved way beyond just simply responding to crisis and deaths, to really starting to penetrate the institution with holistic care of the person."[37] The permanent staff was increased, and the department was restructured to work in close cooperation with other disciplines. In what has been described as a "Rubik's Cube" of moving parts, the spiritual care department now includes four holistic nurses trained in Reiki, massage, and guided imagery.

The role of the chaplains was transformed from one primarily concerned with crisis and comfort, to being an important component of the medical care team. "We're part of helping to figure out what's really wrong…. Our job is to look for the spiritual wholeness of the person."[38] In an acutely scientific-minded institution, the Spiritual Care Department is no exception. "Chaplaincy has to be relevant if it's going to survive. It can't be just nice people visiting. It just can't. We have to have outcomes. We have to have measurable outcomes…. there's research that shows that when people's spiritual needs are met, they tend to do better."[39]

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[36] Greene, interview, October 28, 2014.
[37] Greene, interview, October 21, 2014.
[38] Ibid.
[39] Ibid.

Church Health Center

The Church Health Center in Memphis, Tennessee began as the vision of one man. Dr. Scott Morris is a trained and board certified physician, as well as an ordained Methodist minister. Dr. Morris arrived in Memphis at the age of 33 without any base of professional contacts, or a financial structure to support his work. He wrote a letter to fellow Methodist minister, Frank McRae at St. John's United Methodist Church. "One of the early wins for the Church Health Center was that [Dr. Morris] met Frank McCrea at Saint John's United Methodist Church. Frank McCrea had $70,000 in his pastor's discretionary fund. He liked the idea so much he gave Scott all $70,000."[40]

That initial seed money and support of the church was enough to purchase a run-down house that would become the first home of the Church Health Center. Dr. Morris continue to reach out to other organizations for funding. The Plough Foundation, formed by a Jewish philanthropist who founded a pharmaceutical company, offered a sizable commitment. They were joined by support from the evangelical Central Church, and Methodist Hospital. With this diverse support, Dr. Morris was able to renovate the building and open the doors.

Dr. Morris and a single nurse treated 12 patients on September 1, 1987 on the first day that the clinic was open. Today, the Church Health Center treats over 46,000 patients every year, and has an annual budget of over $18 million. It is rated as a four, out of four, star charity by Charity Navigator. "We are a collaborating organization, as part of our foundation…. We enjoy today really robust, multifaceted, collaborative relationships

[40] Stockwell, interview, October 20, 2014.

with, virtually all medical partners in the city…. collaboration is just the lifeblood of what we do."[41]

Temple Israel, Memphis

One important collaborator in the Memphis faith community is Temple Israel, a large Reform synagogue with a long history in the city. The senior rabbi, Micah Greenstein, is a close personal friend of Dr. Scott Morris, and an outspoken supporter of the Church Health Center. With many congregants who work as medical professionals, the synagogue has a community commitment to providing healthcare as part of their religious obligation. "I always say the Church Health Center, if you look behind the name, it's the most Jewish place I know, because it's faith in action, and Scott [Morris, MD] points out that if you look at our Hebrew Bible, …a third of all scripture is about healing."[42]

A big part of Temple Israel's faith-health mission is tied to the church health center. "Our mission is not just to be a sanctuary for prayer and inspiration, and a vibrant center for Jewish learning, and a congregational hub. It's also to be a force for good for the world…. We probably have over 100 people [volunteering at the Church Health Center]."[43] Volunteering time and money is not seen only as an act of charity, but as an act of *tikkun olam*, social justice.

In addition to ensuring that the medical needs of everyone in the community are met, Temple Israel also places a strong emphasis on maintaining individual health. "We

[41] Ibid.
[42] Greenstein, interview.
[43] Ibid.

are called by God, put in this body – this soul that's housed in this body – to take care of it."[44] Over the years, Temple Israel has hosted yoga classes, healthcare learning sessions, and an annual 5k run. A part of how this focus can be seen in the synagogue is through the intentional relationships that are built. "It's not institutional. It's all relational, so when you ask about Scott's input here, he is a frequent temple face and we have some really deep Torah sessions with him."[45]

By building relationships and promoting health awareness, Temple Israel has made faith-health a part of their culture. An important part of the synagogue's mission is to practice *tikkun olam* by healing the sick. They have done this by creating a culture of health, volunteerism, and self-care that begins with early childhood learning, all the way through end-of-life care.

The Union for Reform Judaism

The Department of Jewish Family Concerns was formed in 1997 as a part of the Union for Reform Judaism (URJ), led by Rabbi Richard Address. This department became the central pillar of faith-health work in the Reform movement. Prior to the formation of this department, there was some work already being done in this area within the URJ, such as healing liturgy developed in the education department.

One of the major programs that was piloted by the Department of Jewish Family Concerns was called the Caring Community Program. The Caring Community Program was a broad vision that encapsulated a number of different programming models, which were instituted in hundreds of Reform synagogues. The Caring Community Program was

[44] Ibid.
[45] Ibid.

implemented in synagogues to create three main types of programs; "direct service, major congregational programming, and conversational forums."[46]

Direct service might include a *bikur holim* committee to visit the sick within the community, and provide them with needed resources and services. Major congregational programming might be the center of a health-related educational campaign, such as a series of lectures related to end of life issues. Conversational forums are a way to build community and coalesce a shared vision. In one such forum conducted by Rabbi Address, "One of the things that emerged really at the top of the list was, 'We want to provide, on a programmatic basis, direct service and support for the people and families dealing with cancer.' So that led to… transportation programs for people who needed rides for chemotherapy. It led to… what they call *Caring Caps & Blankets*. They knitted hats and blankets that were distributed to people in the congregation undergoing chemotherapy… and [also] donated a couple dozen of these to the Oncology Ward at the hospital for people who were undergoing chemotherapy."[47]

The Department of Jewish Family Concerns was eliminated in 2009 amid major organizational restructuring. The URJ presently employs a single faculty member to field questions related to this and other areas. There is also an archive of resources developed by the department, which are still made available by the URJ. Rabbi Address continues his work by offering private consultations to synagogues, and through his Jewish Sacred Aging program that provides key resources for the aging Baby Boom generation.

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[46] Address, interview.
[47] Ibid.

Bay Area Jewish Healing Center

The Bay Area Jewish Healing Center in San Francisco begin in the early 1990s as something of a passion among several recently ordained Reform rabbis. Rabbi Nancy Flam, Rabbi Rachel Cowan and Rabbi Susan Friedman "had gotten together to talk about service, and the notion of *bikur cholim,* and helping people when they get sick, and bringing ancient wisdom in to serve the modern era…. and they brought forward this notion of Jewish healing, focused on illness, dying, and grief."[48]

It was Rabbi Flam who later went to San Francisco and formally founded the Bay Area Jewish Healing Center in 1991. She partnered with Rabbi Amy Eilberg, a conservative rabbi, and an administrator to build the logistical foundation of the Center. They were soon joined by other rabbis who also played an important role in those early years of establishing the trans-denominational center for spiritual healing that would broadly serve the entire Jewish community.

The Bay Area Jewish Healing Center fills an important niche in the city's Jewish community.

> Up to 75 percent of the Jewish community itself, actually does not belong to a synagogue.… In that context, people when they get sick, or come to die, or come to live with grief, and want rabbinic support, they don't have a natural phone number to call [as in the case of someone who] belongs to a synagogue…. So we are sort of the rabbinic agency available for the entire community. About 50 percent of our work is with people who are unaffiliated and about 50 percent of people who are affiliated.[49]

The Bay Area Jewish Healing Center arose out of a time and a place that people were rethinking health, illness, faith, and grief. They came to be supported by the San

[48] Weiss, interview.
[49] Ibid.

Francisco Jewish community, including some of the area's synagogues, as well as the Jewish Community Federation, and private donors and endowments. Part of the success and longevity of the Center may be attributed to its robust financial independence. It is currently led by Rabbi Eric Weiss, who serves as the president and CEO, and has been connected with the center from the very beginning.

Greensboro, NC

Greensboro, North Carolina has taken another approach to faith-health work. The Jewish community there is served by one Reform and one Conservative synagogue, neither large enough to independently support a fully developed faith-health program. In fact, the Jewish community was not looking to start a faith-health program in the first place. Gilda Friedman, RN, BSN, FCN, was already a practicing nurse when she learned about the congregational nurse training program, coordinated through Cone Health, the local hospital and health network.

Cone Health offered a program that would pay for the first year's salary of a Faith Community Nurse, then would taper off by 25% each year for four years. Gilda Friedman determined to take advantage of this program, and so began her training. As the Faith Community Nurse for Greensboro's Jewish community, her office is housed under the Jewish Family Services department of the Greensboro Jewish Federation, which provides the facilities and resources necessary to carry out the work.

The funding for the congregational nurse salary was established through a long-term grant from the BJH Foundation for Senior Services, a foundation that is dedicated to improving the lives of seniors living in North Carolina. As a result, the work is primarily focused on care for the elderly in the Jewish community. It includes mostly one-on one

care, medical screening, advocacy work, and home visitation. The Faith Community Nurse visits each of the synagogues on alternating weeks.

Conclusions

Challenges

Organizations operating in the field each face very different types of challenges in establishing and maintaining the work that they do. Some organizations grapple with internal cultural resistance. The Health Cabinet at Mother of God Church lobbied for many years to have the ashtrays at the front of the building removed before they were successful. The Cleveland Clinic Spiritual Services Department has worked strategically and intentionally to successfully communicate the importance and clinical legitimacy of the care they provide within a rigorously scientific institution.

Other organizations are confronted with external forces that can prove challenging. The Union for Reform Judaism eliminated a significant portion of its footprint in response to financial pressures. The Bay Area Jewish Healing Center has had to react strategically and politically to other organizations in the area attempting to replicate or replace the services that they provide. Similar healing centers in other cities have often been subsumed into larger community organizations.

Faith-health programs that are being created often find themselves without an existing model for success. Gilda Friedman of Greensboro has authored a practical guide to Jewish congregational nursing, in order to share that knowledge that she is gained over more than a decade of experience, trial, and error. When Dr. Scott Morris set out to form a ministry centered on bodily healing, he found that no such resources existed within the

Methodist Church. In cases like these, vision, dedication, and opportunity have made it possible to create new types of faith-health programs.

Successes

The successes of each of these organizations can be measured in lives changed and lives saved. Gilda Friedman notes that:

> In the surveys that I have done at these senior luncheons, one of the questions is, "Have you ever asked the congregational nurse for assistance?" …Well, some people will say, "No; however, it gives me great comfort to know that she is there when I need her."[50]

As for the Bay Area Jewish Healing center, Rabbi Weiss has said:

> I think our greatest success is that we actually have presented a new paradigm of Jewish organizational life and service to the community… We actually are a successful model for what I think of an 'artisan agency' …that has created in its particularity a certain kind of depth of reflection that has a much broader appeal to people as an example of what nourishment of Jewish life can be in its specialization."[51]

He continued with a personal encounter:

> We now have over 500 individuals who have come through our Grief & Growing program. We're coming into our 19th year. …I just was at a local business event… and suddenly there are 3 people that I knew from the Jewish community there, and all 3 of them had had very significant interaction with the Jewish Healing Center. One of them had come for the weekend many, many years ago, and they were telling other people just how it shifted their entire life focus, …and brought them through that particular part of their lives …to a place of the kind of healing integration for moving through life.[52]

Rabbi Greenstein spoke about how this work has changed Temple Israel:

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[50] Friedman, interview.
[51] Weiss, interview.
[52] Ibid.

> We just won the gold medal – this is Pekuach Nefesh – in giving blood. For all the churches in Memphis, it's the synagogue got the award from Life Blood…. We started it because of a member of our congregation; there wasn't the right blood for him for a surgery. He died because of that. This was years ago. … They all know what Pikuach Nefesh means now.[53]

Marlene Feagan, the president of Health Ministries Association has seen more than one life saved:

> In [a] church I was working at, a guy came in and [when I took his blood pressure I said,] "You've got to go to the emergency room now." It was on a Saturday night and he said, "No, I'm going to go be a referee at a basketball game." I said, "No. You're not. You're going to go to the emergency room. Something's horribly wrong with your blood pressure, but I also feel you have to go to the emergency room." Between leaving church and [arriving at] the emergency room, he started having chest pains. …I'm sure it was a "God thing" because I mean it could have been a different [week] and we wouldn't have been there. Or, it could have been a different nurse who didn't care so much, or who would drop it, or say, "Just go on." …When people start to feel that caring, that connection is what makes the difference. It's authentic.[54]

Links between organizations

"I'm telling you: partnership, partnership, partnership, collaboration, collaboration, collaboration!" That is how Gilda Friedman put it clearly and simply. It seems that every faith-health program in existence has achieved success through the collaboration of multiple organizations. Most faith-health organizations fall under the rubric of either a faith community, a direct health care provider, or a trade and training organization. All three of these types of organizations play important collaborative roles in the success of any single faith-health initiative, regardless of where it may be housed.

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[53] Greenstein, interview.
[54] Feagan, interview, October 22, 2014.

These are not, however, the only types of partnerships necessary. These organizations each work closely with community funds and philanthropic organizations. They work with universities and research institutions to advance their understanding of the faith-health field, and to promote their work. Professional associations of doctors, nurses, and clergy are integral to coordinating faith-health efforts, whether local associations or national.

An important part of the job for anyone who has dedicated themselves to the faith-health field is building bridges and coordinating between these many pieces. Almost no successful faith-health efforts have been produced by a single person, department, or organization operating in isolation. This paradigm is common throughout the nonprofit organizational world, certainly. However, it no area is it more true than the faith-health field.

This may be a consequence of the fact that the field as it exists today is still quite young. Although faith-health work has ancient roots, there are almost no dedicated faith-health organizations in existence today that are more than 25 years old. The exceptional need for collaboration might also be attributed to the inherent complexity of this work, which exists at a nexus of multiple disciplines. Whatever the reason, an examination of the field reveals one that is highly networked, collaborative, and cooperative. This field changes lives and spirits, but it is only through partnership that it is possible. The power and responsibility for this work does not lie with any single individual or organization, but rather with all of them collectively.

Part Two: Empirical Studies

The Relationship Between Faith, Religious Practice, and Health

Introduction to Part Two

Why Empirical Evidence Matters

An evidence-based model is based on more than just an examination of best-practices. At the core of a such a model, unsurprisingly, is empirical evidence. The strength of using evidence-based programming models lies in their ability to incorporate tested, scientific conclusions that have been measured and verified. Many programs that exist in synagogues and Jewish organizations are based around anecdotal evidence. We see that a particular program is successful at one congregation in helping to meet goals of enthusiasm, attendance, fund raising, etc., and the idea of the program spreads to other communities.

Some programs are easily replicated and instituted in a wide number of communities successfully. Other programs may be instituted according to the same guiding principles and details that were successful in one community, but they do not yield the same results in another congregation. There are many theories regarding which programs work, and why, but frequently the theories are untestable. In many cases, the goals of Jewish organizations are particularly difficult to quantify, define, and measure. Jewish leaders want to know things like how to increase organizational engagement over time, or what factors in youth programming lead people to become active adults and Jewish communities. These types of questions can often defy scientific study.

Medical outcomes are different. While the complexities of a longitudinal study for religious involvement are almost unfathomable, physical and mental health can be quantified measured. There are several important reasons for this. Foremost is the scientific context. Medicine has been centered around an evidence-based system for long

enough that it is deeply entrenched in its culture. Hospitals and medical centers are fundamentally equipped with controlled environments, and very often with trained researchers capable of conducting scientifically rigorous studies for publishing results in peer reviewed journals.

Medical practices are based around outcomes that are quantifiable, often on a completely empirical and objective scale. Religious outcomes are often subjective goals; inspiration is one such example. To be clear, evidence-based programming cannot and should not replace existing programming models. Evidence-based models are most appropriate when certain conditions are met. A successful evidence-based model is dependent upon quantifiable, clearly and discretely defined variables, which are used as inputs. There must likewise be quantifiable, clearly and discretely defined outcomes. These variables and outcomes must be consistent and reproducible. The conditions and the variables must be common enough that a large sample size can be studied in order to find a reliable relationship between the input variables and the outcomes being examined.

When dealing with medicine, these types of conditions are important because it allows doctors to make critical and often lifesaving decisions. When decisions are based on good research and evidence, outcomes can be more easily and accurately predicted before taking an action, even in a system as complex as the human body. Under the right conditions, synagogues can reap the same benefits despite internal complexity.

How reliable is the data?

For at least 15-25 years, medical researchers have studied the effects of faith, religion, and spirituality on physical and mental health in a rigorous and disciplined way.

In fact, the study of this relationship goes back much further.[55] Earlier studies in this field were criticized for being unscientific, and were often conducted by people or institutions who lacked the training and qualification to perform a careful study and analysis. Studies were printed in niche journals that focus on parapsychology or holistic medicine (sometimes called complementary medicine). However, there has been a shift in recent years in the quality and quantity of research. Studies performed by professional researchers began appearing more and more in major reputable journals, such as the *Journal of Advanced Nursing*, *American Psychologist*, and *Annual Review of Public Health*.[56]

They are still many people who are skeptical about the relationship between faith and health. One of the strengths of an evidence-based approach is that it does not rely on anecdotes or beliefs. At the core of this model is scientifically supported evidence, based on empirical research and facts. Because of the increase in recent years in both the quantity and quality of research in this field, it is safe to conclude the scientific consensus has been reached. As Neil deGrasse Tyson says, "The good thing about science is that it's true whether or not you believe in it." In this sense, the conclusions of this field of research have withstood the rigor of scientific skepticism over time, and can be relied on for planning purposes. The strength of the scientific consensus puts aside any skeptical objections.

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[55] See Koenig, King, and Carson, *Handbook of Religion and Health*, 7-9 for a brief summary of the modern history of the field, or 15-34 for a more complete and detailed timeline of religion medicine and health care.

[56] Ellison and Levin, "The Religion-Health Connection," 701.

Understanding and interpreting the data

It is crucial to understand exactly what has been proven, what evidence exists, and what matters are still up for debate. This chapter carefully examines the evidence and conclusions from the field that should form the framework of an evidence-based model. It will present a representative selection of the research and writings in the field from some of the top researchers. Some of the description that follows is written in plain English and should be understandable to a general audience. Some of the more technical aspects of the research will be summarized and interpreted. Whenever possible, exact figures and regression results will be given.

Definitions

The necessity of defining terms

Scientific study is based on what is measurable. Researchers in this field have derived precise definitions of key terms in order to quantify precisely what it is that is being measured. Clear definitions are necessary prior to conducting any research, or interpreting the results. Before making sense of what scientific study has revealed about faith, spirituality, religious involvement, etc., it is necessary to understand exactly what these terms mean to the researchers who are examining them.[57]

Faith

The term faith, as used in this paper, is intended as a broad and inclusive term. It includes a number of more specifically defined terms such as spirituality, religion, religious membership, religious attitudes, attendance at religious services, prayer, religious giving, religious beliefs, meditation, reading scripture, and other concepts that

[57] Koenig, King, and Carson, *Handbook of Religion and Health*, 36.

are discussed more specifically herein. These terms may be used by scholars and researchers in the field in very specific ways, and are clearly defined. There is some variation from one study to the next regarding the scope of these terms, and what metric or metrics are used to measure them. In general, there are some standards in the field which are discussed below.

Religion

The term "religion" includes "beliefs, practices, and rituals related to the sacred. Religion may also involve beliefs about spirits.… [R]eligion originates in an established tradition that arises out of a community with common beliefs and practices."[58] In this sense, religion is defined appropriately and narrowly such that it includes a very broad variety of religious practices and traditions, while excluding beliefs practices and rituals that do not arise out of a common community.

Religion may be identified and measured in terms of religious affiliation such as Jewish, Christian, Buddhist, etc., in terms of a binary like religious vs. not religious or according to various metrics that researchers have developed, centered on the practices of a particular religious affiliation. For example, studies have been performed in Israel examining specifically Jewish issues, such as kashrut[59] or applying a Jewish religious index[60]. "Religiosity" or "religiousness" are terms that represent the intensity of religion or religious practice. Although religiosity or religiousness may be binary, they are often measured on various incremental scales.

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[58] Ibid., 37.
[59] Friedlander, Kark, and Stein, "Religious Observance and Plasma Lipids and Lipoproteins among 17-Year-Old Jewish Residents of Jerusalem."
[60] Rokach, "Coping with Loneliness among the Terminally Ill."

Spirituality

The definition of "spirituality" in the context of contemporary medical research is much more complex, and there is no broadly accepted definition throughout the field. Harold G. Koenig, a leading researcher in the field, discusses one of the primary difficulties with the word "spirituality," which is its changing definition. He diagrams the expanding definition of spirituality from a traditional historical understanding to a modern tautological understanding[61]. In a traditional understanding, spirituality is a subset of religion, which could impact a person's mental state. There was not an understanding of spirituality outside of religion. In the modern understanding, there is a category of "spiritual but not religious," making religion a subset of spirituality, which can impact a person's mental state. The modern tautological understanding of spirituality includes elements of mental state, such as a sense of peace, purpose, meaning, or connectedness.

Koenig therefore recommends against the use of the terms "spiritual," or "spirituality," since it is impossible to measure the relationship between any two phenomena that are not mutually exclusive. Scientific research is interested in the mental and physical health outcomes stemming from religion and spirituality, yet if spirituality includes mental state, then one cannot test the relationship between spirituality and mental state.[62]

Other researchers continue to widely use the Spiritual Well Being scale (SWB) in research. It is an instrument that consists of 20 items that are divided into two subscales,

[61] Koenig, *Spirituality and Health Research*, 197ff.
[62] Ibid., 201ff.

Religious Well Being (RWB) and Existential Well Being (EWB).[63] Researchers have attempted to clarify the term "spirituality" for use in medical research. One analysis found that "spirituality is an inherent component of being human, and is subjective, intangible, and multidimensional…. Spirituality involves humans' search for meaning in life, while religion involves an organized entity with rituals and practices about a higher power or God."[64] This distinction allows researchers to selectively measure the effects of religion and spirituality independently from one another. The benefit of measuring spirituality as an innate human characteristic is that it can be measured consistently across religious backgrounds, nationalities, and other social divisions. Religion (or religiosity), by definition, can only be reliably measured within a homogenous religious group.

Religious Involvement

"Religious involvement" is also used as a term within the field of research. Religious involvement is measured according to a variety of scales. It is especially relevant in studies that aggregate the outcomes of existing research. "Religion" may be used in studies that either compare different religious traditions (e.g. the variation in morbidity rates between different religious denominations), or as a factor among adherents of a single religion (e.g. an instrument may ask members of a certain religion whether or not they follow a given set of practices). Religious involvement covers a wider set of criteria.

[63] Paloutzian and Ellison, "Loneliness, Spiritual Well-Being, and Quality of Life."
[64] Tanyi, "Towards Clarification of the Meaning of Spirituality," 500.

The term "religious involvement" may apply to the frequency of attendance at religious services, the frequency of prayer, adherence to a particular ritual, participation in a religious community, self-reported religiosity, etc. Religious involvement is useful as a broad term to identify trends in the research. For example, a researcher may want to know the answer the question, "is there a relationship between religious involvement and overall health?" The broad definition of "religious involvement" (as well as the term "overall health") allows the researcher to examine a broad range of studies, and compare and aggregate their results in a meaningful way.[65]

What Is "Healthy Religion"?

Researchers have identified across the field that there is a relationship between faith and wellness. The precise nature of the relationship may depend on the specifics of a person's religion. Researchers have arrived at a general consensus that there exist healthy and unhealthy religious beliefs and practices. In particular, much research has been done examining the relationship between religious beliefs for and coping mechanisms. Research in various fields has indicated that coping activities are broadly related to health outcomes.

The areas of religious coping that researchers have identified as being key to predicting positive or negative outcomes include belief in a just and benevolent God, belief in a caring and supportive God, involvement in religious rituals, and an active search for spiritual support.[66] On the other hand, religious beliefs that may be detrimental to patients include belief in a punitive God, belief in an uncaring or unjust God, a sense

[65] See for example: Ellison and Levin, "The Religion-Health Connection."
[66] Kenneth I. Pargament, "God Help Me."

of distance from God or the religious community, or in some cases, the belief in the absolute intercessory power of God.

Religion is most clearly detrimental to physical health when faith is used to supplant medical intervention. The belief in the absolute intercessory power of God may lead some people of intense faith to decline lifesaving medical treatment, believing that prayer alone will heal them. In some cases, people may actually believe that their faith is being tested by an illness and that turning to medical intervention will constitute a failure of belief in God. Such a belief is often accompanied by either the concept of an unjust God who gives and takes life with impunity, or the concept of a punitive God who punishes nonbelievers. The former case, individuals believe that illness or health is a form of God's will which may be arbitrary, and that it cannot be altered. In the latter case, individuals believe that God will reward true believers with healing and punish nonbelievers with death.

In extreme cases, this leads to death. For example, in 2009 a Wisconsin couple were convicted for the negligent death of their 11 year old daughter who suffered from undiagnosed diabetes because they believed that only prayer would heal her.[67] Some believe that this type of behavior is fueled by records of faith-healing, which can take many forms, but may involve a ritual, a pilgrimage, a blessing from a particular person, the use of a specially blessed amulet, holy water, etc. The healing in such cases involves a recovery from a serious, usually chronic illness or disability, independent of any medical intervention that cannot be accounted for by any medical understanding.

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[67] Koenig, King, and Carson, *Handbook of Religion and Health*, 63.

Although there are numerous cases every year of miraculous healings, some of which are closely documented in detail, the general consensus of the scientific community is that such cases hold no validity. In general, these cases are not well documented and are anecdotal. Those that are documented are generally tracked by religious organizations with a vested interest rather than an unbiased scientific examination. When independent investigators look into faith healers, they are almost universally debunked.[68] Nevertheless, some researchers in the field believe that further examination of the phenomenon is warranted.[69]

Research has indicated that religious beliefs tend to be very fundamental to the structure and organization of an individual's system of meaning and values, psyche, sense of self, and sense of place in the world. Because of this, deep rooted unhealthy religious attitudes can have a tremendous impact on an individual's psychological well-being, life choices, and overall health. Unhealthy religious views may be subtle. The religious exultation of a person object or symbol and described variously as "immature religion," or "idolatry." For example, an individual who values service to a particular church above all else may appear to be very devout and acting and healthy way, but in reality can experience very unhealthy outcomes (for example if the church experiences financial difficulties, etc.). [70]

Religious views that are rigid and uncritical may also be unhealthy. In the event of an experience which challenges rigid religious beliefs, a crisis of faith may occur. Individuals may respond by feeling an all-out rejection of their former faith, or by

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[68] Singleton, "Your Faith Has Made You Well."
[69] Koenig, King, and Carson, *Handbook of Religion and Health*, 64.
[70] Oates, *When Religion Gets Sick*. Ch. 2

experiencing religious denial of the challenging event. These are two different types of psychological bifurcation, which are each harmful. On the other hand, self-critical, flexible religion allows for greater resilience and are connected with better coping skills.[71]

Religious beliefs that emphasize a lack of personal responsibility, choice, and self-determination are also unhealthy. Patients who believe that their lives are controlled entirely by external forces, such as fate, demonic possession hold this type of pernicious faith. This can then lead to unhealthy behaviors, unhealthy mental states, and even incorrect or missed diagnoses. These religious beliefs are often associated with the harmful belief in superstitions and sympathetic magic, discussed above. They enable obsessive-compulsive, neurotic, manipulations rather than offering a healthy outlook for coping.[72]

Healthy religion provides a context for life changes and transitions such as life cycle events or times of crisis. This happens in such a way that "the individual grows from one stage of life to another without becoming isolated, estranged, and alienated."[73] This is done through meaningful rites that acknowledge and contextualize transitions like the celebration of becoming Bar/Bat Mitzvah in Jewish tradition. This may include durable peer-groups that offer support and pastoral visitation.

An additional function of healthy religion is in providing appropriate guidelines for behavior. By providing clear guidelines and emphasizing social pressures to conform

[71] Ibid. Ch. 2
[72] Ibid. Ch. 3
[73] Ibid. Ch. 4

to them, organized religions tend to encourage behaviors with healthful outcomes. Examples include positive behaviors such as a healthy work ethic, regular rest, and prosocial behavior. Examples also include abstaining from harmful behaviors such as consuming alcohol, tobacco, and other drugs, engaging in risky sexual behavior, violent confrontation, and excessive consumption.[74]

Speaking broadly, researchers have found healthy religious beliefs and practices tend to correspond to positive medical outcomes. Religion that provides meaning, inspiration, supported social connections, individual significance, self-examination, personal autonomy and responsibility, and positive behavior moderation is considered to be healthy. Religion that emphasizes guilt, shame, denial, punishment, lack of individual will, powerlessness, magical ritual, or a mistrust of traditional medicine is regarded as unhealthy. In addition, the durability of the religious belief system in times of transition and crisis has an impact outcome of a crisis.

Most Effective Faith Practices

Understanding that there are fairly well-established standards for healthy and unhealthy religion, what are the effects of religious practices on health? Medical researchers have examined a range of specific practices to isolate what, if any, effect each one has on measurable health outcomes.

Prayer and Meditation

Examining "Judeo-Christian" religious practice, researchers have concluded that religiosity/spirituality is associated with lower blood pressure, healthier lipid profiles, and

[74] Koenig, King, and Carson, *Handbook of Religion and Health*, 70–73.

with better immune function.[75] This conclusion has been reached through the examination of numerous studies ranging from religious involvement to personal religious practice. Researchers have also concluded that meditation or mindfulness is responsible for a large number of positive medical effects. This area has been somewhat more broadly studied and so researchers have been able to identify a greater number of effects. Namely, meditation is associated with lower blood pressure, lower cholesterol, lower stress hormone levels, less oxidative stress, less blood pressure reactivity under challenge, less stress hormone reactivity under challenge, differential patterns of brain activity, and better outcomes in clinical patient populations.[76]

Distant Healing

Researchers in different subfields have systematized the faith-health relation in various ways. Some include a broader range of medical interventions, collectively termed complimentary alternative medicine (CAM) also referred to as integrative medicine. CAM includes any type of intervention that is intended to complement traditional medical therapies, but which has not been developed according to the western model of medicine. Examples of this include acupuncture, therapeutic massage, homeopathy, aromatherapy, or herbal medicine.

Another somewhat less broad category is "distant healing." Distant healing is a subgroup of CAM that includes interventions that rely on manipulating something immaterial (such as supra-physical energy, chi, divine intercession, etc.) to achieve a medical outcome. These are performed from a distance. Such therapies may include

[75] Seeman, Dubin, and Seeman, "Religiosity/spirituality and Health," 54.
[76] Ibid., 55.

physical contact, but do not purport to rely on any physical effects on the body. Examples include intercessory prayer[77], Therapeutic Touch, Reiki, and external qigong. This area is one of the most controversial in the field,[78] since there is by definition no medical explanation of the mechanism by which these methods can have clinical efficacy.

Many studies have sought to quantify the efficacy of these therapies. A review of the previous research in the field was conducted in 2000 by Astin et al.[79] The study examined the field broadly, considering hundreds of studies that have been done in these areas. This systematic review of the literature eliminated all studies that were not peer reviewed, human, clinical (as opposed to experimental) trials, utilizing random assignment, and placebo control. After applying this reasonably rigorous standard, the investigators identified 23 trials involving 2774 patients for the study that met the inclusion criteria.

The general standard of the field is a 95% confidence level, meaning that a measured effect in a trial is considered significant only if the study can conclude with 95% certainty that the effect is not due to random chance. That is to say for example, if there is a positive beneficial correlation in a particular trial (the distance healing group experiences better outcomes than the control group), the correlation is considered statistically significant if the outcome of the trial could happen no more than 5% of the time if the correlation is due only to coincidence. About 1 out of 20 studies with a 95%

Seeman, Dubin, and Seeman, "Religiosity/spirituality and Health."

[77] Specifically, prayer on behalf of someone else as opposed to praying for oneself. The trials discussed below are examples of such prayer, in which the recipients did not know that they were prayed for.
[78] Consider the differing conclusions of the following: Targ, "Evaluating Distant Healing"; Sloan, Bagiella, and Powell, "Religion, Spirituality, and Medicine"; Rosa et al., "A Close Look at Therapeutic Touch."
[79] Astin, "The Efficacy of 'Distant Healing.'"

confidence level might be expected to show a statistically significant correlation if there were no "true" relation between a treatment and outcome.

Hence, if there is no "true" relationship between distance healing and improved health, one would expect that this study, which identified 23 independent trials would show only 1 or 2 trials with a positive effect and 1 or 2 trials with a negative effect (the control group actually fared better than the treated group), with 20 or so trials not finding a statistically significant result.[80] In reality, the researchers found that of the 23 trials, 13 showed a positive treatment effect, 1 showed a negative treatment effect, and only 9 showed no statistically significant result.

Regardless of the controversy surrounding distant healing, the relatively broad, although not decisive, outcomes of this study reveal that there is strong and well-established support for the belief in the efficacy of distant healing. The study examines each of the trials in more detail, noting that a "meta-analytic approach was considered but was abandoned when the heterogeneity of the trials became apparent."[81] Some of the trials were more critically constructed, but in general the researchers found that the inclusion criteria resulted in a sample of high-quality trials. The disproportionately large number of trials which found a positive effect should give one pause before dismissing the efficacy of distant healing techniques outright. Likewise, the number of trials that found no effect, the selection methods of publishers, and individual anomalies that these researchers found in some of the trials could be enough to suggest that there is no

[80] This assumes that there is no selection bias of the studies. Other researchers have commented that there is a bias in journals to publish trials and studies with statistically significant results. See for instance: Song et al., "Dissemination and Publication of Research Findings."
[81] Astin, "The Efficacy of 'Distant Healing,'" 904.

scientific consensus on the matter. Of the treatment methods studied, intercessory prayer had the least effect on outcomes, while Therapeutic Touch had the greatest effect.

Religious Community

Another study found a strong, long-term negative association between mortality and religious attendance.[82] That is to say – broadly speaking – as religious attendance increases, mortality decreases. The study, published in the American Journal of Public Health, followed nearly 7000 individuals over the course of 28 years. The study controlled for a broad range of variables such as religious affiliation (since some religious groups tend to have higher levels of attendance than others), age, gender, ethnicity, and education. The effects of these variables are mathematically eliminated from the model, meaning that a mutual relationship between any one of these variables and the outcome of the study has been accounted for. For example, women may be more likely to attend religious services than men, and also live linger; thus such conditions are accounted for in the study, separately from the relationship between religious attendance and mortality.

The study also separately examined the effect of health practices like physical exercise, smoking, drinking, etc., social connections such as marriage, number of close relationships, group memberships, etc., and initial health conditions including perceived health, mobility impairment, depression, and recent medical history. These variables were examined in separate models to reflect multiple possible arguments. For example, one person may argue that people who attend religious services are less likely to drink as a result of their religious experience, and so alcohol use should be included in the effects of religious attendance on mortality. Another person might argue the opposite; people who

[82] Strawbridge et al., "Frequent Attendance at Religious Services and Mortality over 28 Years."

attend services may be the same type of people who are already less inclined to drink, so the religious service had no effect.

The same argument may be made for social connections and initial health. Religious attendance may help people form more social connections; on the other hand sociable people may decide to also attend religious services. For example, can a completely secular person achieve the same effect of religious attendance by joining a bowling league? Because of the uncertainty in the theoretical relationship between these factors, this study examines the data in multiple models. One model seeks to rule out only demographic data, still allowing health and social choices to be attributed to religious attendance, while other models include or exclude other variables.

The findings are reported as relative hazard (RH). This measurement compares the mortality over a given time, as compared between two possible behaviors. In this case, it is comparing the relative hazard of frequently attending religious services as opposed to *not* frequently attending religious services. If the RH value is exactly 1, then there is no measured difference between the two behaviors; attending or not attending has no impact on mortality. An RH value above 1 indicates that the behavior is more dangerous than abstaining, while an RH value between 0 and 1 indicates that a behavior is saver than abstaining. The specific value represents the intensity of the difference. For example, say that 20 people die in a year out of a group of 100 people taking a particular drug, while only 10 people die in the same year out of a similar group of 100 people not taking the drug. The RH value is 20/10 = 2. Someone on the drug is twice as likely to die as someone not on the drug in a given period. If the number of deaths were reversed, the

RH value would be .5, and someone on the drug would be half as likely to die in a given time as someone not on it.

The results of the study demonstrate a clear negative relationship between religious attendance and mortality in nearly every model. When only demographic data is controlled for, the researchers found the RH value of 0.64[83]. This means that for two people of similar age, gender, ethnicity, education, and affiliation, the one who frequently attends religious services is only 64% as likely to die in a given time as the one who doesn't attend. Conversely this means that the one who doesn't attend is about 1.6 times more likely to die in a given time frame.

When the same data is used to model the impact while also controlling for health conditions and social connections, similar outcomes result, implying that neither initial health nor more social tendencies can account for the improvement in health associated with frequent religious attendance. The RH values for those models were 0.67[84] and 0.69[85], respectively. When health choices are included, the results are a bit more muddied. A large portion of the lower mortality effect can be explained by differences in health habits. The RH value when health practices and body mass index are controlled for is 0.77[86]. This means that even when all reasonable variables are controlled for, there is still a significantly lower mortality rate among people who frequently attend religious services as opposed to those who do not. This difference cannot be accounted for by improved social connections formed through attending, actual health conditions that may

[83] 95% confidence interval [CI] = 0.53, 0.77
[84] 95% CI = 0.56, 0.80
[85] 95% CI = 0.57, 0.83
[86] 95% CI = 0.64, 0.93

cause someone to attend or prevent them from attending, difference in age, gender, ethnicity, etc.

A portion – but not all – of this difference can be attributed to differences in health decisions between frequent and non-frequent attenders. The difficulty of this relationship is that the causality is unclear and could be argued in opposing directions. On the one hand, the argument could be made that attending religious services may lead an individual to make healthier decisions based on their faith. On the other hand, the argument could be made that people who are more active and healthful in general practice might also be more likely to frequently attend religious services. This difficulty is further compounded by the fact that when males are examined separately from females, there is no statistically significant difference in mortality between attenders and non-attenders in this model.[87] Females, on the other hand, experience more of a significant difference, comparable to models that controlled for fewer variables (RH = 0.66[88]).

In order to attempt to answer this question, the authors of the study took a closer look at the individuals who changed their health habits partway through the study. They also examines some key indicators of healthy social practices. They found that among individuals who were already smokers, those who frequently attended religious services were more likely to quit.[89] Among individuals who did not frequently exercise, frequent attenders or more likely to increase.[90] They were also more likely than their counterparts

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[87] RH = 0.90; CI = 0.70, 1.15
[88] 95% CI = 0.51, 0.86
[89] Odds Ration [OR] = 1.9; 95% CI =1.27, 2.85
[90] OR = 1.38; 95% CI = 1.08, 1.77

to stay married to the same person,[91] increased non-church community group membership,[92] and increased the number of visits with close friends and relations[93]. These are key indicators of social health and stability.[94] Such factors seem to strongly indicate that frequent attendance at religious services leads to improved long-term health outcomes. Many earlier studies already came to similar conclusions,[95] but no other study had been so complete, accounted for different models, or used the same type of longitudinal data.

Church-Based Health Initiatives

Other researchers have focused on the implementation of health initiatives in places of worship. There are several compelling reasons that churches (in the language of one study) are an ideal place for the implementation of health initiatives.[96] Places of worship have deep communal ties, may allow institutional access to underserved populations, serve entire families (rather than a limited age/gender demographic), contain established social networks, and tend to have a history of volunteerism. These factors

[91] OR = 1.79; 95% CI = 1.36, 2.35
[92] OR = 1.58; 95% CI = 1.21, 2.06
[93] OR = 1.50; 95% CI = 1.02, 2.21
[94] The study did not find a statistically significant difference in reducing heavy alcohol consumption, or in reducing obesity.
[95] SEE: House, Robbins, and Metzner, "The Association of Social Relationships and Activities with Mortality"; Zuckerman, Kasl, and Ostfeld, "Psychosocial Predictors of Mortality Among the Elderly Poor the Role of Religion, Well-Being, and Social Contacts"; Ellison, "Race, Religious Involvement and Depressive Symptomatology in a Southeastern U.S. Community"; Graham et al., "Frequency of Church Attendance and Blood Pressure Elevation"; Ellison, "Religious Involvement and Subjective Well-Being"; Levin, Chatters, and Taylor, "Religious Effects on Health Status and Life Satisfaction among Black Americans"; Ellison, Gay, and Glass, "Does Religious Commitment Contribute to Individual Life Satisfaction?"
[96] Yeary, Klos, and Linnan, "The Examination of Process Evaluation Use in Church-Based Health Interventions A Systematic Review," 524.

make places of worship ideal for both implementing health initiatives and also for conducting research in the area of faith and health.[97]

A recent study[98] made a systematic overview of the existing research. The researchers found 67 previous health intervention studies that examined various health outcomes in relation to "church-based health initiatives" over nearly two decades. The selected interventions involved a variety of factors, some event focusing on specific demographic populations, and most focusing on specific health conditions. A majority of the interventions focused on African American populations (58.2%), and adults (77.6%). Most of the interventions (61.2%) were not specific to one gender, although more interventions involved women (35.8%) than men (3.0%). The most common health conditions studied were (in order) cancer, cardiovascular health, and nutrition or weight.

This particular study was focused on evaluating the consistency of the research process across all of the interventions that were studied. While this study makes recommendations for improving the process evaluation of these types of studies, the investigators note that "the efficacy of church-based health programs have been established."[99] This study reports that improving process of valuation will increase our understanding of precisely which factors most contribute to the efficacy of faith community based healthcare interventions.

It is clear, based on a broad range of research over a number of decades, that medical interventions introduced and implemented through faith community

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[97] Ibid.
[98] Yeary, Klos, and Linnan, "The Examination of Process Evaluation Use in Church-Based Health Interventions A Systematic Review."
[99] Ibid., 524.

organizations are effective and efficient in improving the general health and well-being of communities. If the policy implications of such a conclusion are clear, then in order to improve overall health, faith community based interventions should be fostered, supported, and encouraged. Many conclusions and outcomes in the field of faith and wellness remain controversial. The precise mechanisms are debated and not well understood. However, this is one conclusion that is clearly and broadly supported by consensus of the scientific community. When faith communities are active in health care, the health of individuals in the community improves.

Mechanisms

Various theoretical models have been proposed to examine the mechanism by which faith and wellness are related to one another. By far the most common models are centered on psychological and/or sociological effects associated with faith and religious participation. These are thoroughly examined in a paper by Ellison and Levin, who identify and examine seven explanatory mechanisms:

> They include (1) regulation of individual lifestyles and health behaviors, (2) provision of social resources (e.g., social ties, formal and informal support), (3) promotion of positive self-perceptions (e.g., self-esteem, feelings of personal mastery), (4) provision of specific coping resources (i.e., particular cognitive or behavioral responses to stress), (5) generation of other positive emotions (e.g., love, forgiveness), (6) promotion of healthy beliefs, and (7) additional hypothesized mechanisms, such as the existence of a healing bio- energy.100

They argue that religious involvement might both discourage behaviors associated with greater health risks, and also encourage "positive, low-stress lifestyle choices."[101]

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[100] Ellison and Levin, "The Religion-Health Connection," 703.
[101] Ibid., 704.

Beyond religious traditions that specifically forbid or discourage risky behaviors such as drinking, smoking, or substance abuse, "a wide range of religious groups tend to encourage moderation"[102] and offer guidance toward more balanced lifestyles.

The social support offered through religious involvement, particularly through involvement with a religious community, may be formal or informal. The formal social support offered by involvement in a religious community takes the form of pastoral services offered by clergy, organized clubs, groups, committees, as well as initiatives such as education or direct services that address a particular issue our population. The informal support which has been identified and studied in religious communities takes the form of connections and friendships formed with other individuals through the community, as well as benefiting from associating with individuals who tend to have a broader network of social connections, and may be able to provide "tangible aid". The type of social support and stability provided by such a community has been discussed in greater detail elsewhere.[103]

Self-esteem and personal efficacy are two factors that have been linked with faith practice, particularly with religious attendance and personal religiosity. Self-esteem is the broad category that incorporates a sense of moral and intrinsic self-worth, and personal efficacy is the belief in one's own ability to act in a meaningful way, exercise self-determination, and a sense of mastery over one's own being. As previously discussed, there exist both healthy and unhealthy religious views that can positively or negatively impact these two factors. The perception of having a relationship with a divine being

[102] Ibid.
[103] Ibid., 705.

through devotional activities may help individuals develop a sense of self-worth and potency. A self-evaluation in religious context may help individuals perceive inherent spiritual worth in their being, such as wisdom or righteousness. Religious perspectives may also offer nonmaterial valuation and a sense of greater meaning. The bulk of the evidence available seems to indicate that a tendency toward positive impact in these factors correlates with a positive effect on overall health.[104]

A wide range of research has been done exploring religion as a coping mechanism. This is one of the best studied and most agreed upon theory of the mechanism linking faith and health. Coping is the ability to tolerate and manage the effects of environmental stressors, such as life changes, continuous demands, physical or emotional pain, etc. Coping ability has long been known to exert an impact on overall health, as well as outcomes related to specific health conditions. Religious coping has only been studied in depth more recently. Researchers have found that patients who use religion as a part of their coping mechanism experience better outcomes than those who do not. Additionally, studies indicate that individuals with a higher degree of religiosity tend to have better overall coping skills. Researchers have begun to examine the underlying mechanism behind this relationship. Prayer and other devotional activities may provide perspective and alter the perceived severity of difficult circumstances by enabling individuals to develop a more universal context, or as part of a divine plan. Some studies indicate that religious beliefs can help individuals separate their sense of personal identity from their physical conditions, thus offering greater fidelity of personal

[104] Ibid., 706–7.

identity. These theories have been promoted by researchers to explain the observable connection between faith and coping.

Healthy beliefs such as hope or optimism may be fostered by religious faith. Religious activity has also been linked to both positive and negative emotions. Positive emotions include contentment, happiness, and forgiveness, while negative emotions include guilt or fear. There is a theoretical and experimental basis supporting a positive relationship between healthy beliefs, outlooks, or emotions and improved health conditions.

An examination of the various mechanisms that have been postulated to explain the relationship between faith and health reveals that there still remains much work to be done. Researchers cannot yet explain the mechanism behind this observable relationship. Some in the field have argued that the benefits of faith are co-incidental to psychosocial conditions. Although it does not begin to offer an explanation of the mechanism, at least one study discretely measures the effects of Religious Well Being (RWB) as being independent from Existential Well Being (EWB)[105]. We do not yet understand exactly how or why, but we have every indication to believe that faith offers distinct health benefits independent of other factors.

Research Consensus

Overall, what conclusions can be drawn about the field as a whole? Numerous reviews have repeatedly found a positive relationship between religious attendance,

[105] Dreyer and Dreyer, "Religious Involvement, Psychosocial Resourcefulness, and Health."

religiosity and overall health as well as lower morbidity rates.[106] [107] [108] In addition, several reviews of the field have identified specific relationships between faith and medical outcomes. In particular, studies have consistently linked religious attendance and self-reported religiosity with increased cardiovascular health[109] and an improvement in many psychological factors including depression, anxiety, and coping.

Many other claims that have been investigated in the field are somewhat more controversial. Several studies have indicated a relationship between religiosity and an increased rate of recovery from cancer and other acute illnesses. Reviews of the research, however, do not find consistent support of these claims to want a consensus.[110] Some research even indicates that recovery from acute illness may actually be impeded by religiosity.[111] Some earlier reviews of the field identified broader and more dramatic effects. More recent critical examination of earlier research has identified methodological problems with many of the studies, even including some landmark work.[112]

Many claims in the field are highly controversial. Nearly every significant leader in this area of research has called for greater rigor and focus of research. As this field continues to develop, we can expect more answers to some key questions. Opinions are divided on the impact of increased religiosity on overall health. Distant healing continues to be met with skepticism. Clinical implications and application of this research still remains in early development. The mental health care field is somewhat more advanced

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[106] Campbell, Yoon, and Johnstone, "Determining Relationships Between Physical Health and Spiritual Experience, Religious Practices, and Congregational Support in a Heterogeneous Medical Sample."
[107] Miller and Thoresen, "Spirituality, Religion, and Health."
[108] Powell, Shahabi, and Thoresen, "Religion and Spirituality."
[109] Ibid.
[110] Ibid., 39.
[111] Powell, Shahabi, and Thoresen, "Religion and Spirituality."
[112] Thoresen and Harris, "Spirituality and Health," 5.

in this area, although there remains no authoritative and broadly accepted manual for incorporating faith and religion into therapy. Conclusions and implications of research to date are both exciting and compelling. As research in this field increases we will better understand the relationship between how are spiritual lives and our physical health.

Part Three: Faith-Health in the Jewish Textual Tradition

Major Themes from the Bible to Contemporary Writing

Introduction to Part Three

From the very earliest records of our Jewish tradition through modern day practice, our texts have reflected parallel missions of faith and healing. In fact, our tradition reflects a continuous chain of a unified faith-health practice. From the first chapter of the Torah, Judaism has represented a fundamental connection between the spiritual existence of the world and the physical well-being of our human bodies. The early rabbis further detailed the faith-health system of Judaism, medieval scholars and Jewish legalists codified and expanded the system, and modern philosophers, theologians, and lay people have continued to embrace these practices.

From our tradition, we learn three important lessons about the faith-health connection, which are consistent throughout our Jewish memory. First, we each have an individual obligation for our personal health as beings created in the divine image. Second, we have communal obligations to care for the health and welfare of our fellow Jews and our fellow human beings. Finally, faith is a part of healing, and God is a source of healing who provides meaningful support to us. Although these lessons have always been present in Jewish teaching, they have at times fallen to the periphery. Our present age is one of those times. An honest review of Jewish tradition compels us to return this central tenet of Judaism to the core of our religious practice.

Personal Health

Although health is simultaneously a personal, communal, and spiritual endeavor in Jewish tradition, it begins as an individual obligation. Our tradition demands that we care for our physical bodies. There are numerous ways that our tradition has understood this obligation, whether it is out of honor for the divine nature of our physical form or

because of the righteous work that we can do with a healthy body. Throughout our tradition we discover not only the theoretical basis to care for our physical health, but also practical indications, rules, and laws related to maintaining physical health.

Biblical

The Hebrew Bible, or TaNaCH, contains many verses related to the value of personal health. It is the oldest record of Jewish culture, practice, and faith, and is the basis of Jewish tradition even today. One doesn't have to look far to find the first indication in the Torah of personal health as a religious priority. The first chapter of Genesis describes the creation of human beings "in the image of God."[113] This statement has been understood in many ways throughout Jewish memory, and not least of all as an injunction to regard each physical human form as a representation of God. This is supported by a later verse which reads, "Whosoever spills the blood of a human being, by a human being shall his blood be spilled, for humankind was created in the image of God."[114] The phrase "in the image of God" has been connected with other Torah verses regarding the sacredness of the human form and specific injunctions against harming or damaging a person's body.

Some passages in the Torah that address the preservation of the physical form include the injunction against cutting or marking one's body[115], the laws against murder[116] and assault[117], and laws requiring restitution for causing injury[118]. These

[113] Gen 1:26-27, and elsewhere
[114] Gen 9:6
[115] Lev 19:28
[116] Ex 20:13, and elsewhere
[117] Ex 21:19, and elsewhere
[118] Ex 21:22-25, and elsewhere

passages are indications that the physical human form has intrinsic religious worth. There are other indications that the Bible values individual health. The dietary laws[119] [120] and laws of ritual purity seem to carry some indication of health and hygiene. The discussion of the Metzora[121], sometimes erroneously translated as "leper," is a description of physical ailments that result in ritual impurity, and the curative process of purification. These passages are all indications that personal behaviors with impact on one's health are a concern in the Torah.

Throughout the rest of the Bible, there are further indications of the importance of personal health. In particular, this is apparent in the book of Proverbs. Throughout the book, sayings of practical and ethical wisdom are interspersed with warnings of consequences and assurances of benefits of following the advice of the wisdom. The consequences and rewards are often rooted in health and well-being. The words declare that a woman who forgets the covenant with God will drag her household toward death[122], while remembering the Torah (or "teaching") will add years to one's life[123]. There are also more direct health implications listed, such as "It will be healing to your body and strength [or 'marrow'] to your bones,"[124] or "for they are life to those who find them and healing to their bones."[125]

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[119] Lev 11
[120] The Torah does not give a direct indication that eating and health are connected, however there is textual evidence that this connection is apparent. There are several biblical accounts of eating foods that result in illness or death, and dietary laws are linguistically connected to laws of purity, discussed above.
[121] Lev 13-14
[122] Prv 2:18
[123] Prv 3:1-2
[124] Prv 3:8
[125] Prv 4:22

These verses, in context, show a relationship between personal health and individual actions. Moreover, they indicate that physical health is unambiguously part and parcel of religious well-being. They indicate that one of the functions of an individual adherence to a faithful religious life is to bring good health and long life. The book of Proverbs is unique among the books of the Bible in both form and content. There is no other book which is so focused on daily life, along with personal choices and their consequences. Throughout the Prophets and other writings, the topic of health is not framed as an individual, but rather a communal experience. It is not framed as practical living but rather is couched in religious terms.[126]

Rabbinic

The issue is dealt with more thoroughly in post-Biblical writings. Although the personal responsibility for health and its connection to religious life is indicated in many Biblical texts, it is more clearly enumerated in later Jewish works. Philo Judaeus was an important Jewish Hellenistic philosopher who lived near the end of the Second Temple period. In this period between the closing of the Biblical cannon and the beginning of the Mishnah's redaction, there is a continuation of the principles laid out in the Bible.

In a philosophical commentary on the book of Genesis, Philo reflects on the characterization of Cain and Abel, saying, "The body is the soul's house. Shouldn't we therefore take care of our house so that it doesn't fall into ruin?"[127] When a house falls into ruin and disrepair, it no longer serves the function of protecting and keeping anything within it. The philosophical value of the body is in its ability to house the divine

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[126] See later sections of this chapter for more detail.
[127] Philo Judeaus, *The Worse Attacks the Better*, section 10. Quoted from Klagsbrun, *Voices of Wisdom*, 210.

soul. Our obligation to care for our bodies is part of our obligation to protect the living soul, which is the divine essence of our higher being according to Philo.

Rabbi Hillel, according to Midrash Rabbah, took a different approach. He explained to his students that attending a bath house to wash one's body is a sacred act. He compared this to someone who is paid to clean and maintain statues of a king, and is held in noble regard. In the same way that a statue is an image of the king, the human body is in the image of God.[128] Hillel therefore argued that maintaining one's body is a religious obligation. [129] This explanation is distinctly different from Philo's, in terms of understanding the source of the human body's value. According to the reasoning of Philo, the human body is valuable because it is a tool which serves the soul. The sacred value of the human soul is what imparts an obligation to care for our physical bodies. According to the explanation given by Rabbi Hillel, the body itself is intrinsically sacred because it is the image of God. Caring for our bodies is a sacred obligation because our bodies themselves are sacred.

Elsewhere in the midrashic tradition, this idea is upheld and expanded upon. In *Avot D'Rabbi Natan,* each aspect of the world of creation is compared with an aspect of the human body. A person's hair is likened to a forest, a person's breath is likened to the wind, a person's tears are likened to the ocean waters, and so forth.[130] There is a deep and enduring Jewish understanding of the human body as a magnificent and sacred creation.

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[128] Based on Gen 1:26-27
[129] *Leviticus Rabbah*, Ch. 34, section 3
[130] *Avot D'Rabbi Natan,* Ch. 31

The Zohar, the most significant work of mystical midrash, describes the human body as the unification of the heavenly and earthly worlds.[131]

Rabbi Akiva is reported to have discussed personal health in terms of nutrition. He said eating unhealthy foods violates not just one, but three commandments, "in that [one who does so] has despised himself, despised the foods, and recited a blessing improperly."[132] This indicates the great significance that our early rabbis attributed to personal health. Even the fact that it is considered a transgression to despise oneself through unhealthy behaviors reveals that personal health was considered an integral element of religious life.

The Jewish legal tradition likewise discusses the obligation for healthy living. Beginning with the Mishnah, we find indications that the obligation for physical well-being supersedes many other religious obligations. The Mishnah relates that even Yom Kippur, the holiest day of the year, may be, in fact *must* be, violated for the sake of health concerns. A pregnant woman should be given food on Yom Kippur, as should someone who is sick, whether a doctor is present to make the determination or not.[133] Prohibitions against working on Shabbat may be transgressed to give or receive medicine, even for relatively minor ailment, since a minor ailments can grow worse and become life-threatening.[134] The Mishnah indicates by these instructions that protecting individual, physical health is a religious obligation of the same caliber as other religious obligations discussed therein.

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[131] Klagsbrun, *Voices of Wisdom*, 208.
[132] *Avot D'Rabbi Nathan,* Ch. 26, quoted from Ibid., 212.
[133] M. Yoma 8:5
[134] M. Yoma 8:6

The Talmud offers several clear and unambiguous directives to maintain physical health, in addition to expounding on the Mishnah texts above. For one thing, it is telling that several significant rabbis of the Talmud are described as making their livings as physicians, most notably Mar Samuel, a first generation Amora. The Talmud lists ten institutions that should be maintained in any city where a scholar may live; these are a court of law, a charity collection, a synagogue, a public bath, a restroom, a *mohel*[135], a surgeon, a scribe, a butcher, and a schoolteacher.[136] Of these ten, at least two (possibly three or four) are services directly related to the maintenance of personal health. The Jerusalem Talmud carries the injunction a step further by making it absolutely forbidden for anyone to live in a town without a physician.[137] That a scholar may not live in a town without a doctor according to the Talmud demonstrates the longstanding Jewish ethic that one's scholarship depends upon one's physical well-being.

The Talmud gives further instructions related to health that individual Jews should heed. "A person should not speak at meals lest his windpipe act before his gullet and his life become endangered because of it."[138] This Talmudic instruction reflects a Jewish understanding of how day-to-day behaviors and activities can have a significant impact on overall health. "If you're in pain, go to a physician!"[139] Here the Talmud provides a simple instruction that might be considered common sense except for the fact that it is contained within one of the major religious and cultural works of Judaism.

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[135] It is noteworthy that the Talmud uses the word "healer" or "רופא" to describe the *mohel*, while it is Rashi who clarifies the meaning as "to circumcise children."
[136] Sanhedrin 17b
[137] Jerusalem Talmud, *Kiddushin*, Ch. 4, paragraph 12, cited in Klagsbrun, *Voices of Wisdom*, 224.
[138] Ta'anit 5b, quoted from Ibid., 212.
[139] Bava Kama 46b, quoted from Ibid., 223.

Individual health concerns and personal well-being are among the obligations described in the Talmud.

Medieval

Beyond the time of the Talmud, personal health obligations remained a building block of Judaism and are further explicated by medieval Jewish scholars. Several of the most important Jewish scholars of this period were also prominent physicians. Undoubtedly the most famous among them is Moses Maimonides. Maimonides wrote extensively in the areas of Jewish law, philosophy, theology, and the sciences, often combining them. In his seminal work, the *Mishneh Torah*, Maimonides seeks to codify and summarize the entirety of Jewish religious law.

In this work, Maimonides supports the concept of the Jewish obligation to maintain personal health. He favors the Jewish philosophy that the physical body is an instrument that enables sacred work to be carried out.

> Whereas having a healthy and intact body is [among] the ways of God, since it is impossible to understand or have any knowledge of the Creator while one is sick; therefore one must distance oneself from anything that diminishes the body and seek out for oneself that which nourishes and causes recuperation.[140]

This passage states explicitly the reasoning that is hinted at elsewhere in Jewish tradition. It notes that understanding – and therefore service – of God is directly dependent on physical health. Furthermore, care of physical health is a personal obligation of religious importance, as has been seen elsewhere in Jewish textual tradition.

[140] MT, *Hilchot Deot* 4:1

The Mishneh Torah contains detailed descriptions of personal health practices. It encourages healthy nutritional habits such as portion control, eating fresh fruits and vegetables, and avoiding salty foods. It encourages daily exercise each morning and the avoidance of eating late in the evening. It even warns not to swim or bathe immediately after eating, and to wear a warm hat when it is cold outside.[141] In case one might think that Maimonides relates these injunctions as medical advice alone, rather than as religious duties, he specifies the underlying religious intent of these obligations.

> If one habitually follows [the advice of] medicine only with the intention that all of one's body and organs be intact… it is not a good path. Rather one should intend to develop a strong and intact body so that one's soul be upright, and to know God.[142]

Elsewhere, Jewish religious codes are insistent on the primacy of physical health. Authoritative legal codes of our tradition uphold the Talmudic standards set forth by earlier rabbis. They further clarify earlier statements. For example, if a person's well-being is in danger, food that would otherwise be forbidden is considered to be a blessing.[143] There is no time in Jewish memory that the responsibility to care for one's own health has not been a central religious obligation.

Modern day

In contemporary practice, our liturgy contains multiple prayers related to physical well-being. Near the opening of each morning's prayer, we bless God with the words of *Asher Yatzar*, acknowledging our bodies as a network of openings and closures. The prayer acknowledges the miracle of the physical human form. This awareness in our daily

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[141] MT, *Hilchot Deot* Ch. 4
[142] MT, *Hilchot Deot* 3:3
[143] *Sh.A.,* Orach Chayim 196.2

liturgy supports the Ancient Jewish conception of the inherent sacredness of the human body, and every implication that comes with such an acknowledgement.

Obligation to Provide Healthcare

Our tradition is clear and consistent in its insistence upon the individual imperative to care for the health of our physical bodies. We are each obligated to practice good health habits and to do all we can to care for and maintain our health. This is not the only health related commandment that our tradition preserves. We are also obligated to provide for the healthcare of others. It is a *mitzvah* to heal, and our tradition details the practices, policies, and systems which we are individually and communally accountable to uphold. By doing so we ensure the health and well-being of those in and beyond our community.

Judaism has continuously and emphatically upheld three types of obligations relating to serving the health needs of others. First, there is a communal obligation to provide health care. That obligation is detailed throughout the ages, but is always present. Second, we are each personally responsible to help those in poor health and to preserve life. Finally, our tradition expounds in detail the obligations of trained physicians, which are held to a particular religious standard. These three types of obligations are interwoven and share some important ethical and textual roots.

Biblical

The demand upon us to act in support of the welfare of others has its root in the Torah. The most famous verse related to this commandment is “Do not stand idly by the

blood of your neighbor."[144] This single verse is the source of much of what has developed in our tradition regarding providing care to others. This simply stated command is a call to action. It is not enough to avoid harming others. It is not sufficient to make care available. We are each fully and severally responsible to act and intervene when the life or health of another is in danger.

Even Moses cried out to God in the passionate 5-word prayer, "Please, God, pray heal her!"[145] By doing so, he facilitated healing for his sister Miriam. Abraham prayed for the recovery of Avimelech.[146] Our tradition is full of miraculous and natural healing through acts performed by our ancestors and prophets. They are celebrated for their acts of healing, and our tradition has formalized that celebration of healing and offered guidelines for carrying on this holy work. Elsewhere in the Bible, we see the act of healing carried on. Ezekiel chastises the leaders[147] of Israel for failing to heal the sick or mend the injured under their care.[148]

A shared communal responsibility for well-being is made abundantly clear. Disease was certainly not well understood in Biblical times, but interpreted as a form of divine judgment. Although there are a few notable examples in the Bible that individuals are explicitly punished with physical afflictions,[149] disease and health are frequently described in communal terms. It is the entire Israelite community that Moses addresses:

> Now, if you obey the Eternal your God, to observe faithfully all the divine commandments which I enjoin upon you this day… Blessed shall

[144] Lev 19:16
[145] Num 12:13
[146] Ex 21:19
[147] Lit. "shepherds"
[148] Eze 34:4
[149] For example, Miriam's affliction; Num 12:9-14

> be the issue of your womb, your produce from the soil, and your offspring from the cattle…The Eternal will make you the head and not the tail; you will always be at the top and never at the bottom – if only you obey and faithfully observe the commandments of the Eternal your God that I enjoin upon you this day…. But if you do not obey the Eternal your God… Cursed shall be the issue of your womb and your produce from the soil…. The Eternal will strike you with consumption, fever, and inflammation, with scorching heat and drought, with blight and mildew; they shall hound you until you perish.[150]

The entire community is responsible for prosperity or disease. It is not a matter of an individual responsibility for one's own health, but a communal responsibility for the health and well-being of everyone in the community. Although there is extensive Biblical discussion of disease, it is rarely attributed as individual punishment for transgression. This ethic is repeated throughout the prophets and the writings in similar terms. Although most Jews today do not regard disease as punishment from God, the communal responsibility for wellness still resonates.

Rabbinic

However, it is in the works of the Rabbis that our tradition has blossomed. The Midrash interprets numerous Biblical passages through the lens of healing. Abraham, for example, was healed by no less than an angel of God after his circumcision.[151] The aggadic literature is filed with deeds of healing.

> Rabbi Hiyya bar Abba became sick. Rabbi Johanan asked of him, "Are your sufferings dear to you?" He replied, "Neither them, nor their recompense [in the world to come]." Rabbi Johanan said, "Give me your hand." Rabbi Hiyya gave him his hand and Rabbi Johanan restored him to his feet. Rabbi Johanan became sick. Rabbi Hanina asked of him, "Are your sufferings dear to you?" He replied, "Neither them, nor their

[150] Deut 28:1-22, quoted from Plaut and Stein, *The Torah*, 1355–1357.
[151] Bava Mezia, 86b

> recompense [in the world to come].” Rabbi Hanina said, “Give me your hand.” Rabbi Johanan gave him his hand and Rabbi Hanina restored him to his feet. Why didn’t Rabbi Johanan restore himself? Because a prisoner cannot free himself from prison.[152]

The tales of the early rabbis depict them as healers of the sick, as well as compassionate friends who were diligent in visiting one another. They did not necessarily have special medical knowledge, but they used the power of their prayer to bring healing to the sick. Whether they believed that their prayers really possessed curative power, or they merely offered all that they could, it is clear that they actively sought to heal.

> Our rabbis taught: once the son of Rabbi Gamliel fell ill. He sent two scholars to Rabbi Hanina ben Dosa to ask him to pray for him. When he saw them, he went up to an upper chamber and prayed for him. When he came down, he said to them, “Go, the fever has left him.” They said to him, “Are you a prophet?” he replied, “I am neither a prophet nor the son of a prophet.”[153]

Rabbi Joshua ben Levi was so diligent in visiting the sick that he would even sit and study Torah with those who were afflicted by contagious diseases.[154] It is clear that visiting the sick is not a mere courtesy in Jewish tradition.

> There is a tale about one of Rabbi Akiva’s students who became sick, and none of the sages came to visit him. Rabbi Akiva came to visit him, and because he swept and dusted the room, [the student] lived. [The student awoke and] said to him, “Rabbi, you have saved my life!” Rabbi Akiva went forth and taught that whoever neglects to visit the sick, it is as though they have spilled blood.[155]

The act of visiting the sick is upheld throughout Jewish memory as a core principle to which Jews should aspire. This obligation is made explicit in works of

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[152] Brachot, 5b
[153] Brachot, 34b, quoted from Levin et al., *Judaism and Health*, 17.
[154] Ketubot, 77b
[155] Nedarim 40a

halachah, beginning with the Talmud. It is described as one of the six things that benefit us directly, although they are truly performed as holy acts in their essence.[156] It is also related in the Talmud that there is no measure for visiting the sick, which is interpreted in three ways. It means that the divine reward for doing so is unlimited, that a prominent person must visit a lowly person, and that one should visit the sick whenever and as many times as necessary.[157]

Medieval

Jewish legal codes specify the duties of a physician. As a community, we are required to provide a physician. The practice of medicine is codified as a positive commandment – something that we are required to do.[158] This is rooted in the Biblical phrase, "He shall surely heal him."[159] [160] Because it is a positive commandment, every Jew is equally responsible to provide medical care, but because it requires special skill, the act of practicing medicine is delegated to trained doctors alone. It is in fact forbidden to practice medicine if one is not qualified and is considered an offense equivalent to murder.[161]

There are particular stipulations placed on trained doctors by Jewish religious law. A doctor is required to be professionally trained and legally certified before practicing.[162] A physician is legally bound to refer a patient to the best expert available. If a physician

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[156] Shabbat 127a
[157] Nedarim, 39b
[158] *Sh.A*., Yoreh Deah 336:1
[159] Ex 21:19
[160] *Tur, 336:1*
[161] *Sh.A.,* YD 336:1
[162] Jewish legal codes place the responsibility for the certification of doctors on the rabbinic court, but contemporary halachah defers to government certification wherever available. This is in accordance with "dina d'malchuta dina," (the judgment of the civil government is the judgment of the religious law).

does not meet these requirements, they are considered morally and legally liable for any harm that comes to the patient.[163] Furthermore, physicians are required to exercise appropriate care to the best of their ability and are considered accountable for malpractice.[164]

Because the practice of medicine is considered a mitzvah, a Jew is not permitted to accept payment for their knowledge or teaching of medicine. However, they may be compensated for their trouble and effort and for their idleness, meaning the time that they spend practicing medicine rather than laboring to earn a wage. A doctor who withholds lifesaving care is considered guilty of murder, as is anyone who knowingly keeps medical care from someone. This includes charging an unfair price for medicine or medical supplies.[165]

The religious importance of this commandment is such that it can override the laws of Shabbat, dietary laws, and associating with idol worshipers.[166] Anyone in the community who violates the laws of Shabbat to comply with the instructions of a physician is considered meritorious, whether they are themselves ill or if they are assisting in the care of another.[167] Thus it is clear that a physician holds a particular position of authority and responsibility in Jewish law.[168]

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[163] *Sh.A.,* YD 336:1
[164] Ibid.
[165] *Sh.A.,* YD 336:1-3
[166] Yoma 85b; *Sh.A.,* OC 328; *Sh.A.,* OC 618;
[167] *Sh.A.,* OC 328.
[168] There are particular limitations to this authority, but the general principle is apparent. For more detail see for example: Isaacs, *Judaism, Medicine, and Healing*; Levin et al., *Judaism and Health*.

It is also clear that there are communal obligations indicated by a careful reading of these classical Jewish legal codes. It is presumed that the community is involved in the practice of medicine. When the Shulchan Aruch indicates, "It is a mitzvah to violate Shabbat for someone who has a dangerous illness, and rushing to do so is praiseworthy, while stopping to ask questions [of halachah] is equivalent to spilling blood,"[169] the salience of the obligation is clear. Laws regarding visiting the sick also indicate communal involvement. Until modern times, the Jewish community would care for the sick in their own homes, often in community-organized *Chaverim*, societies of individuals who took on the responsibility for the community.[170]

It is difficult to distinguish when and how this communal obligation became formalized because it is not discussed in matters of halachah in the same detail as individual obligations. However, a designated place was set aside in medieval Jewish communities for the poor, for travelers, and the sick. In particular, it seems that the poor who could not afford to pay for a doctor to come to their homes might stay at such a lodging. This building was known as the *Bet Hekdesh ha'Ani-im* (the consecrated home for the poor), or simply the *Hekdesh* (the consecrated place).[171]

Some have speculated that the institution dates to the pre-Christian era, but the earliest certain reference to the *Hekdesh* in the context of a hospital dates to the 11th century.[172] The very name, which means "consecrated" is an indication of the importance of this institution among medieval Jewish communities. These consecrated houses for the

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[169] *Sh.A.,* OC 328.2
[170] Friedenwald, *The Jews and Medicine*, 515.
[171] Ibid., 516–517.
[172] Singer and Adler, *The Jewish Encyclopedia*, 479.

poor and sick are the precursor to the Jewish Hospitals that arose throughout the modern period.

Modern day

Many European and American Jewish communities formally founded hospitals in the 18th and 19th centuries, as well as in Jerusalem.[173] There is a long-standing moral and institutional dedication to providing healthcare by Jewish communities. It has been both a practical and a religious commitment throughout Jewish memory. Every Jewish community is obligated to provide doctors and to attend to matters of public health.

Our contemporary emphasis on the communal religious responsibility for healthcare is best exemplified by our present day liturgy. Prayers for healing are included in both the traditional siddur, and increasingly in progressive prayer. Among the 13 prayers of request in the weekday *Amidah*, one is expressly devoted to healing. It is phrased in the first-person plural, "Heal *us*," making unambiguous the collective intention. This is one of the points in contemporary services when public prayers are said on behalf of the sick in the community.

Another common prayer that has come to serve as an opportunity for public prayers for healing is the *Mi Sheberach Lecholim*, said during the service of the Torah reading either between or after readings. This practice is now so ubiquitous that some of these prayers for healing have come to be colloquially referred to as **the** *Mi Sheberach.* This is in spite of the fact that the term *Mi Sheberach* refers to an entire category of blessings, most of which do not have any liturgical connection to illness or healing.

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[173] Friedenwald, *The Jews and Medicine*, 517–518.

Some synagogues conduct "healing services," entire prayer services dedicated to praying for healing, and in some cases conducted with the intention to have a healing effect upon the participants.[174] There is a proliferating corpus of contemporary healing liturgy, broadly available and published in both print and online.[175] The understanding of our communal religious role in healing cannot be disputed and is as present as ever.

There is potentially some significant potential for growth in this area. A recent study of health and Judaism indicates that "programmatic offerings have both deepened and broadened in the past twenty-five years."[176] This survey of the field found numerous areas of strength and weakness. Some have argued whether this area is in fact a field at all, while others recognized that the field of Judaism and health is in fact past its infancy and possesses great potential for new growth and development.

This area in contemporary Jewish life is deeply reliant on scarce resources. Funding can be unstable and challenging to sustain. Young leaders are not entering this area in the same numbers that current leaders are aging out. There is an acknowledgement of the need for trained clergy that is reflected in the increasing investment in pastoral and practical training in Jewish seminaries. As it exists today, the field is highly collaborative and integrated. Conferences are held that bring together Jewish leaders from different fields and movements of Judaism. Jewish communities have been gradually destigmatizing discussions of aging, illness, and death. This cultural

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[174] Sered, "The Contemporary Jewish Healing Movement."
[175] Consider for example, www.ritualwell.org or the Siddur of Congregation Sha'ar Zahav in San Francisco
[176] Levin et al., *Judaism and Health*, 302.

shift is laying the groundwork for a reconnection to the deep and authentic Jewish roots of communal healing.[177]

God As Healer

One of the strongest themes related to healing throughout Jewish tradition is that of God as the source of healing. Whether it is found in Biblical rite, Rabbinic writing, or modern practice, this message is clear and uninterrupted throughout the history of mainstream Judaism. Although the Western secular ethic places responsibility for healing in the hands of science alone, the Jewish view has always been more nuanced. We understand now that science is a part of healing in a way that our ancestors never could. They understood that faith is a part of healing in a way that we may have forgotten. Judaism has always understood this balance.

Biblical

The Torah is unambiguous about God as the source of healing. Nearly all disease in the Torah is identified as having divine origin of some type, and nearly all healing, recovery, and protection is likewise attributed to God.

When the prophets of the Torah prayed for healing, it is God that performs the healing. God heals Avimelech in the book of Genesis at Abraham's behest.[178] The book of Exodus includes multiple direct descriptions of God as healer, such as "I am ADONAI your healer,"[179] or "Serve ADONAI your God, that God will bless your bread and your water, and remove illness from your midst."[180]

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[177] Ibid., 309–314.
[178] Gen 20:17; see also Num 12:13
[179] Ex 15:26
[180] Ex 23:25

Although the book of Leviticus addresses disease in detail, it does not describe a source of illness or healing among the discussion of Metzora and ritual purity, only how to diagnose the state of the illness and how to respond when it is detected or healed. Deuteronomy, on the other hand, is clear that health and illness are a consequence of God's will. "ADONAI will remove from you all illness,"[181] "They will see the plagues of that land and the illnesses with which ADONAI has infected it,"[182] "I make dead and I make alive, I have cleft and I will heal,"[183] and other passages are clear in this regard.[184]

The Books of the Prophets and the Writings maintain this core ethic and elaborate on the theology of health. Elijah prays to God as the agent of miraculous healing,[185] as does Elisha.[186] God heals Hezekiah after he prays, saying "I have heard your prayer, I have seen your tears. Here I will heal you."[187] The prophets of Jewish tradition make healing a central part of their holy work, through praying to God for healing and instructing others to do so. The specific narratives about miraculous healing may appear to depict prophets as agents of God's healing, but it is nearly always the sick themselves or their families who pray to God through their words and actions.

The prophets make clear that God is the source of healing. Isaiah writes, "God will lead you always and satisfy your life in arid places, invigorate your bones, and you will be like a lush garden; like a flowing spring that is never unreliable."[188] Jeremiah

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[181] Deut 7:15
[182] Deut 29:21
[183] Deut 32:39
[184] See also Deut 28, discussed above, and Deut 30:15-20
[185] 1 Kgs 17
[186] 2 Kgs 4:33
[187] 2 Kgs 20:5
[188] Is 58:11

writes, "Heal me, ADONAI, and I will be healed, save me and I will be saved, for You are my glory,"[189] and, "'I will restore your health, and heal you of your wounds,' speaks ADONAI,"[190] and elsewhere, "Here, I will restore to [this city] health and healing. I will heal it."[191] Likewise Hosea wrote, "Let's go and return to ADONAI! God has torn but will heal us; has struck but will bandage us."[192] These prophets do not mention health or healing outside of the context of God. They understood that there was no divorcing one from the other. The Bible recounts that medicine alone is insufficient without seeking God: "Asa's legs were stricken with illness in the 39th year of his reign. His illness was of the highest order, but [even] in his illness he did not seek ADONAI, but [placed is faith] in physicians. Asa was laid down with his ancestors and he died in the 41st year of his reign."[193]

The role of God in healing is expounded upon nowhere in the Bible more than in the book of Psalms. The refrain of calling on God to heal, praising God's healing power, and thanking God for granting healing permeates the book.

> Have mercy on me, O Lord, for I languish; heal me, O Lord, for my bones shake with terror.[194]
>
> O Lord, my God, I cried out to You, and You healed me.[195]
>
> Though the misfortunes of the righteous be many, the Lord will save him from them all, Keeping all his bones intact, not one of them being broken.[196]

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[189] Jer 17:14
[190] Jer 30:17
[191] Jer 33:17
[192] Hos 6:1
[193] 2 Ch 16:13-14
[194] Ps 6:2, TNK
[195] Ps 30:3 TNK
[196] Ps 34:20-21 TNK

> Bless the Lord, O my soul and do not forget all His bounties. He forgives all your sins, heals all your diseases.[197]
>
> In their adversity they cried to the Lord and He saved them from their troubles. He gave an order and healed them; He delivered them from the pits. Let them praise the Lord for His steadfast love, His wondrous deeds for mankind. Let them offer thanksgiving sacrifices, and tell His deeds in joyful song.[198]
>
> He heals their broken hearts, and binds up their wounds.[199]

The theology of the book of Psalms may be complex and varied, but it makes clear that God is the source of healing through prayer, faithfulness, and God's mercy. The Hebrew Bible does not waver on this point.

Rabbinic

The later Rabbinic literature maintains the integrity of this principle, while still challenging it and presenting nuance within the theology. Beginning with the Mishnah, the Rabbinic writing rejects the idea that healing is somehow separate from God. It contained the unequivocal statement, "The best of physicians belongs in hell!"[200] This statement is not elaborated upon in the Gemara, although it is accompanied by a litany of accusations against those who practice blood-letting, whose livelihood is likened to extortion.[201] The intensity of the Mishnaic statement is somewhat attenuated by Rashi's later commentary:

> This applies only to a physician who does not humble himself to trust in heaven, who sometimes causes the death of his patients, and who can afford to treat the poor without charging a fee but doesn't do so.[202]

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[197] Ps 103:2-3 TNK
[198] Ps 107:19-22 TNK
[199] Ps 147:3 TNK
[200] M. Kiddushin, 4:14, as quoted in Klagsbrun, *Voices of Wisdom*, 224.
[201] Kiddushin, 82a. It is possible to understand "extortion" as relating to the general low character of blood-letters rather than as component of the trade itself.
[202] As quoted in Klagsbrun, *Voices of Wisdom*, 225.

As in the Biblical case of King Asa, the rabbinic tradition makes clear that doctors who operate outside of the assumption of God's role in medicine are blameworthy, and ultimately their healing is unreliable.

Ben Sira explicitly discusses the relationship between medicine, doctors, and God:

> Honor the doctor for his services, for the Lord created him. His skill comes from the Most High, and he is rewarded by kings. The doctor's knowledge gives him high standing and wins him the admiration of the great. The Lord has created medicines from the earth, and a sensible man will not disparage them.… The Lord has imparted knowledge to men, that by their use of His marvels He may win praise; by using them a doctor relieves pain and from them the pharmacist makes up his mixture. There is no end to the works of the Lord, who spreads health over the whole world.[203]

The Midrash contains numerous descriptions of God's role in healing, sometimes dealing with the underlying theology of medicine. One Midrash records the rabbinic understanding of an apparent contradiction in the theology of healing, which come from God yet requires the human intervention of medicine.

> Once, Rabbi Ishmael and Rabbi Akiva were strolling in the streets of Jerusalem along with another man. They met a sick person who said to them, "Masters, tell me how I can be healed." They quickly advised him to take a certain medicine until he felt better.
>
> The man with them turned to them and said, "Who made this man sick?"
>
> "The Holy One, blessed be He," they replied.
>
> "And you presume to interfere in an area that is not yours?" the man exclaimed. "He has afflicted and you heal?"
>
> "What is your occupation?" they asked the man.

[203] Ben Sira 38:1-8, as quoted in Ibid., 224.

> "I'm a tiller of the soil," he answered, "as you can see from the sickle I carry."
>
> "Who created the land and the vineyard?"
>
> "The Holy One, blessed be He."
>
> "And you dare to move into an area that is not yours? He created these and you eat their fruit?"
>
> "Don't you see the sickle in my hand?" the man said. "If I did not go out and plow the field, cover it, fertilize it, weed it, nothing would grow!"
>
> "Fool," the rabbis said, "… Just as a tree does not grow if it is not fertilized, plowed and weeded – and even if it already grew but then is not watered it dies – so the body is like a tree, the medicine is the fertilizer and the doctor is the farmer.[204]

It is understood by the rabbinic tradition that medicine is a part of God's creation. Upon receiving medicine for an internal stomach pain, Rabbi Judah HaNasi is recorded as praying, "Blessed is He who is everywhere, who has delivered His universe into the keeping of those who guard its well-being."[205] At the time of his death, an aggadah illustrates the power that rabbinic tradition attributes to prayer. It explains that as long as the sages prayed for him to remain alive, Rabbi Judah HaNasi did not die, but that as soon as they stopped praying due to a distraction, he was able to die peacefully.[206]

Once again, it is important to note that although the Rabbis certainly professed a belief in miraculous healing, they warned not to rely on it. "Where injury is likely, one should not rely on a miracle."[207] God is the source of healing, but healing directly from God is not guaranteed for anyone.

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[204] *Midrash Samuel*, Ch. 4, section 1, as quoted in Ibid., 223.
[205] Stern, *Book of Legends/Sefer Ha-Aggadah*, 262.
[206] Ketubot, 104a
[207] Stern, *Book of Legends/Sefer Ha-Aggadah*, 599.

Medieval

Later texts maintain the same distinction. Divine intercession found in many of the texts discussed above is explicit. God is responsible for health and healing, although the duty is upon human beings to act in pursuit of a healthy life. Part of the mechanism of God's healing is in human hands even though all healing is understood as originating with God.

> God created food and water; we must use them in staving off hunger and thirst. God created drugs and compounds and gave us the intelligence necessary to discover their medicinal properties; we must use them in warding off illness and disease.[208]

Modern

Other later thinkers likewise identified the theological basis of healing. Rabbi Moshe Chaim Luzzatto wrote, "The rich and the healthy alike are obliged to the One who has blessed them with wealth or with health…. The sick [likewise], because they are strengthened against the weight of their illnesses and their injuries, and God has not allowed them to descend to death."[209]Abraham Joshua Heschel similarly wrote in line with other, earlier Jewish perspectives:

> Religion is medicine in the form of a prayer; medicine is prayer in the form of a deed. From the perspective of the love of God, the work of healing and the work of religion are one.… Medicine is a sacred art. Its work is holy.… It is a grievous mistake to keep a wall of separation between medicine and religion. There is a division of labor but a unity of spirit.[210]

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[208] Moses Maimonides' Commentary on Mishnah Pesachim 4:9, quoted from Union for Reform Judaism, "Jewish Texts - URJ."
[209] Mesilat Yesharim (Paths of the Just), Ch. 8, paragraph 3
[210] Heschel, *The Insecurity of Freedom*, 33.

The inseparability of God and healing is nearly an absolute assumption throughout the history of Jewish thought. This is reflected in modern practice as well. Contemporary religious services nearly all include reference to God as healer and maintainer of health. Each prayer related to health and well-being names God as the source. Be it the *Mi Sheberach* (May the One who has blessed), the *Asher Yatzar* (Who has formed), the *Refa'einu* benediction (heal us [O God, and we shall be healed]), or any of the innumerable contemporary compositions, Jewish liturgy places the power of healing in the hands of God.

Conclusions

The Jewish textual tradition is saturated with detailed descriptions of laws, narratives, and philosophies relating to health, medicine, and well-being. Taken as a single body of tradition, these texts reveal an astonishingly consistent perspective. From Biblical times, healthcare is regarded as a sacred obligation. This religious duty is not tempered or altered in any of the eras of Judaism that followed. In Rabbinic times, Jewish texts deeply emphasize this sacred duty of medicine, caring for one's own body, and the communal obligation that is incumbent upon all Jews to ensure healing for all people, especially the poor.

Medieval scholars expanded on the words of their predecessors to describe in detail the ethical laws relating to doctors, hospitals, and visiting the sick. They elaborated on the importance of preserving human life, placing it above nearly all other Biblical precepts. They expounded on the practical matters of medical training and billing, and recommendations for personal wellness. They carried forward from their predecessors the notion of God's role in healing.

In modern times, we have maintained and refined the teachings of our tradition. Both Jewish thinking and Jewish practice have continued to uphold the religious principles of medicine. However, much of this core Jewish teaching has fallen to the periphery in contemporary Jewish life. Just a few short generations ago, there were scores of Jewish community hospitals across the United States, while now there is only a remnant. Although there are many practicing Jewish physicians in virtually every community, the spiritual, religious, and sacred component has been divorced from the act of healing. It is a disservice to the Jewish tradition to neglect the practice of medicine as a central element of Judaism. The present generation has the opportunity to reintegrate faith and health, thereby realigning present day Jewish practice with the consensus of its history.

Part Four: Creating a Congregational Faith-Health Program

A Concise Practical Guide

Parts one through three of this thesis have established the basis for creating a synagogue based faith-health program. Any program that is implemented in a synagogue, regardless of type, should have both an authentically Jewish foundation, and a basis in reality. Before attempting to introduce a program based in medicine or health, any institution should rely on an examination of scientific evidence. The recommendations that follow are based implicitly or explicitly on the evidence and conclusions of the detailed research conducted and presented above. Faith-health work has been successfully executed by exemplary organizations, including Jewish organizations, for several decades. These organizations offer practical insight into implementation and best-practices. The work of the faith-health field is supported by a consensus of scientific research. Evidence particularly supports the efficacy of faith community based health initiatives for improving the health outcomes of participants. Although many present day faith-health organizations are Christian based, Jewish textual tradition illuminates a long history of Jewish religious involvement in health. Judaism considers the practice of medicine to be a positive mitzvah, which is incumbent upon both individuals and communities, and is possible through the blessing of God. This body of overwhelming evidence recommends the following guide.

Introduction to the Concise Guide

This guide will provide instruction and guidance on creating a new faith-health initiative in a synagogue. In many ways, creating a faith-health program in a synagogue is not different from creating similar programs in other faith communities. However, there are some elements of Jewish cultural norms, synagogue structures, Jewish beliefs, and traditions that make a faith-health initiative in a synagogue potentially different.

In addition, a broad-based and comprehensive guide of this type does not currently exist for faith communities in general. More limited and detailed guides have been created by professional organizations and individuals in the faith-health field to assist in the creation of specific types of faith-health programs, such as Faith Community Nursing or health education / advocacy, just to name two categories. In part, this is because it is impossible to create a single, step-by-step set of instructions that will apply to every congregation in all circumstances. There is such a tremendous variety of approaches, and so many different factors that vary between communities, that such a guide would likely be both impractical to use and impossible to produce.

As such, this guide will not attempt to present a comprehensive exploration, nor a step-by-step guide. Rather, it is intended to offer insight into the scope of the field while offering a systematized manner to approach such an endeavor. It will include relevant information to frame one's thinking about the process. It will clearly and comprehensively outline the factors that should be properly taken into account, as well as outcomes that may be expected. This guide will provide an understandable exposition to the field and the reasons that visionary Jewish leaders should make faith-health content part of the core of their mission.

What does a faith-health program offer a synagogue?

Participating in a faith-health program is not only consistent with the historical continuity of Judaism; it is also an opportunity to expand the core mission of any particular Jewish community. A faith-health program offers opportunities to create new vehicles for member engagement. Participants who can connect with the sacred mission of healing will be drawn to the work even if they are not inspired by study, liturgy, or social activities. Members who view their synagogue as a place of health and healing will feel a stronger connection to the community, and have additional practical and meaningful reasons to attend synagogue events.

A faith-health program also provides opportunities for direct service. Synagogues and other faith communities that participate in active faith-health programming can provide vital, lifesaving care to individuals who desperately need it. As an act of *tikkun olam*, faith-health programs help to literally heal the world, while serving the physical and spiritual needs of individuals across the economic spectrum.

Faith-health programming saves lives. It also contributes to quality of life. Family issues of health, life, and death are fundamental to the mission of any faith community and synagogues are no exception. Faith-health programming can assist members of the community improve their physical and spiritual well-being while providing comfort and resources in times of family crisis.

Faith-health programming is highly scalable. The resources of time, money, and energy can vary greatly from program to program and synagogue to synagogue. Properly invested, these resources can provide considerable benefit regardless of the scale of the

program. Even a small amount of sincerely applied effort in the area of faith-health work can produce life changing and lifesaving results.

In summary, faith-health work is elemental and fundamental to the historical mission of the synagogue. It provides greater member engagement and well-being. It serves the mission of *tikkun olam*. It is resource effective and proven through application. Faith-health programming saves and changes lives.

Assessing the Congregation

Before launching a faith-health program, a synagogue should consider the available resources, needs, and the capacity for long-term commitment. A given synagogue community need not necessarily devote excessive resources to a faith-health program in order for it to be successful. However, it is important to have a good understanding of the resources that may be available in a community before beginning. In particular, a general assessment of the training and availability of medical professionals in the community can create opportunities to make the program successful.

Likewise, examining and understanding the faith-health needs in the community is critical to the success of a program. The program might be appropriately resourced, and well organized, but if it is not serving a real need in the community, then it will not be long lasting. As with any program that does not meet the religious needs of the community, it will not prove to be an effective use of resources, and may even serve as a source of frustration.

Perhaps most important is realistically understanding the necessary capacity for long-term commitment. Faith-health programming in a synagogue generates a cumulative

effect. Although individual pieces and elements of a program might be relatively easy and straightforward to implement, they will not achieve their full effectiveness without the sincere and long-term commitment of the synagogue leadership. The buy-in of the clergy is crucial. The timeline of truly meaningful faith-health work is measured over years and decades, and it is incorporated into the culture and fabric of the community.

Needs

It goes without saying that different communities will experience vastly different faith-health needs. Depending on the size and culture of the synagogue, assessing these needs can be done in a variety of different ways. Some synagogues use regular and formal communication measures, such as a congregational survey, conversational affinity groups, etc. Information about faith-health needs can be included in such an apparatus. Other synagogues may find that it's more appropriate to bring in an organizational specialist with the experience in engaging a community inquiry in this area, for example, Jewish Sacred Aging. Finally, some synagogues will be successful employing informal means such as conversations with active members or tapping potential leaders who have health care knowledge.

It is important to recognize that faith-health needs are not synonymous with medical needs. Although that can be one aspect, there are also spiritual needs relating to family crises, and the spiritual need to provide care to others. Synagogues participating in faith-health work find that it can potentially meet many different types of needs. The details of those needs, and how best to meet them varies from one community to the next.

Is also essential at this point to investigate how the broader community outside the synagogue presently serves faith-health needs. In most communities, there are already

organizations that have begun to intentionally pursue this type of work. In some cases, organizations may even meet some of these needs without categorizing the work that they do as faith-health. Talk to hospitals, community chaplains, charitable organizations, social work organizations, and other faith community organizations about the work that they do. There are likely to be opportunities to cooperate with other organizations in meeting mutual or concurrent goals.

Skills

Finding the right leadership and skills in a community has a big impact on the type and success of the faith-health programming that a synagogue does. People such as doctors, nurses, psychologists, social workers, healthcare administrators, and others who have a direct stake in medicine tend to be the best candidates for forming and executing faith-health initiatives. There are likely to be numerous people in any synagogue who have valuable skills to offer in this area.

For some types of programs, it may be necessary to bring in outside individuals, or to arrange advanced training for members already in the community. For example, most synagogues will have a member who is a nurse, but not every synagogue will have a nurse who is trained in the Faith Community Nursing specialization. Another example might include pastoral or social work training for volunteers to visit sick congregants. Consider what the synagogue's role will be in providing additional training should it prove necessary.

Resources

After assessing the needs within the congregation, the skills needed to appropriately meet those needs, and the skills that will likely be available in the

community, it is important to examine other resources available to a faith-health initiative. In general, most faith-health initiatives will not require extensive investment of time or money. One resource that they will require is leadership. The leadership can be primarily clergy, or clergy supported lay leadership. Over time, some programs may develop a need for professional leadership, but that will depend on the specific details of a particular community.

In most cases, the other resources necessary will be unremarkable. A committee may need space to meet quarterly. If regular medical testing will be a part of the program (as in the case of a Faith Community Nursing program), the synagogue will likely need to provide a secure storage space for medical records, and possibly some basic medical supplies such as gloves or blood pressure cuffs. A nutrition program will require kitchen space, including cold storage for produce. Larger expenses are likely to come up from time to time, such as purchasing an AED, or improving handicapped accessibility in the building.

Organization

Every initiative will require an organizational framework in which to operate. In some cases, this may require the creation of a new synagogue committee with the express responsibility for setting and executing a faith-health agenda. In other cases, it may easily fall under the purview of an already extant committee. Depending on the needs that have been identified, the work may fall under the scope of a *tikkun olam* committee, a Caring Community committee, or even continuing education. The new committee members should be vetted and recruited by the clergy, and given a specific charge to carry out.

Scope

It should be made clear to any organizing group what the scope of their goals will be. This should be based on the needs already determined in the community. In some cases, it may be a part of the health committee's charge to assess the ongoing needs of the community. Will the synagogue be creating a new congregational nursing program? If so, who will be responsible for recruiting nurses? Will the synagogue be implementing new programming? How often? Who will attend? Will the synagogue be inviting specialists to speak and present? Will the synagogue be forming a cooperative effort with other nonprofit organizations already active in the faith-health field?

There are vast differences in the scope of different faith-health projects. Some may be limited and specific: the synagogue wants to host a weekly fitness course; the synagogue wants fresh fruits and vegetables at every oneg. Other projects might be vast and ambitious: the synagogue wants to open a monthly dental clinic for the poor; the synagogue wants to evaluate all current programming to integrate faith-health awareness; the synagogue wants to be a community model of accessibility for all physical and mental abilities.

The scope of the faith-health program should be clearly articulated from the outset and strategically planned accordingly. A plan may need to be ramped up over several years to reach its full potential, or it may need to capitalize on enthusiasm early on. Strategic planning is crucial, even considering that the plan may change and evolve over time. Several programmatic models are discussed below, although they are not mutually exclusive. The most successful faith-health programs incorporate elements of several models simultaneously.

Faith Community Nursing Program

One of the most firmly established models of faith-health work can be found in Faith Community Nursing. The present day model for Faith Community Nursing was established by Granger E. Westberg in the Chicago area in the mid-1980s. Westberg was a Lutheran minister who established what was originally referred to as parish nursing, but has since come to be referred to as Faith Community Nursing after being adopted by numerous types of faith communities.

Faith Community Nursing is a distinct specialization recognized by the American Nurses Association, and governed by the published standards of practice. Faith Community Nurses must be experienced, licensed, registered nurses, and they must complete a training course in order to be officially recognized. There are thousands of registered Faith Community Nurses currently in practice.

Finding a Faith Community Nurse (FCN)

There are several national agencies that actively support Faith Community Nursing, including the American Nurses Association (ANA), Health Ministries Association (HMA), and the International Parish Nursing Resource Center (IPNRC). There are also local and international agencies in many locations. These organizations can help a synagogue to connect with the network of Faith Community Nurses in the area. Because Faith Community Nursing is still so new in the Jewish world, there may not be a Jewish FCN available. There may be one or more Faith Community Nurses who are grounded in other faith traditions who may be open to serve in a synagogue community. It is also possible, perhaps even advisable, to reach out to registered nurses in the Jewish community who may be interested in receiving training in the FCN

specialization. Typical training courses are offered by participating nursing schools once or twice a year, and often take place over two weekends. A typical course might cost anywhere from $200 to $600. A synagogue interested in learning more about training in their own area should contact local nursing organizations or the IPNRC.

What a Faith Community Nurse (FCN) does

Faith Community Nursing is based on the premise that health is a cumulative condition, incorporating physical, mental, emotional, spiritual, and social needs. A FCN has completed and passed a specialized training regimen qualifying them to serve in the unique capacity that a faith community requires. The *Faith Community Nursing Scope and Standards of Practice, 2nd Ed.* describes sixteen standards of competency that each FCN should demonstrate. These standards include descriptions like collecting and maintaining wholistic health information, planning health strategies, consultation, making appropriate referrals, professional leadership, and community education.

A FCN is qualified to provide both medical and spiritual care. A typical practice might consist of either a single nurse, or a team of nurses of managed by a certified FCN. They will visit one or more faith communities, such as synagogues, on a regular basis (such as monthly or weekly). During these visits they are available to meet with congregants to monitor blood pressure, and answer questions about health and medical care. The visits can take place in an open, private, or semiprivate area, depending on the community's needs. The FCN will maintain documentation and assist congregants in addressing their health care needs.

In addition to providing regular medical checkups for congregants, a FCN can perform several important roles. They visit homebound congregants, congregants in long-

term care facilities, as well as Jews in the community who might not be a member of the synagogue. They organize and coordinate educational programs, make broad assessments of community needs, and coordinate mutual efforts with organizations outside the synagogue.

They also play a key supportive role in multiple areas. They advocate for patients, helping them navigate the jargon, bureaucracy, and finances of the medical field. Because of both their trust and expertise, FCNs can be trusted advocates and advisors. They also offer support to families and caregivers. Studies have shown that caregivers often neglect their own health. Finally, a FCN can provide supplemental pastoral care. For example, if a rabbi is already occupied, or is any distant location, the FCN can provide immediate spiritual support in the rabbi's place, or until the rabbi can arrive.

What a Faith Community Nurse needs

A synagogue FCN requires some basic resources. Standards of documentation require a secure location to store medical records. This can be done with a locking file cabinet at the synagogue site, or a mobile cabinet moved between multiple sites. FCNs will need access to basic office functions such as a private phone, desk space, storage for personal materials (such as informational pamphlets etc.), photocopier, fax machine, etc. They will also need some basic medical supplies, which can be decided based on use.

Faith Community Nursing requires a significant time investment. Except in a very small community, it is probably not reasonable for a FCN to be a congregational volunteer. There may be a case of someone who is a recently retired professional nurse who is financially independent and interested in serving a small synagogue for a few hours each week as a volunteer, but otherwise the situation is unlikely. The FCN should

be a half- to full-time employee in most cases in order to perform the work. They might be employed directly by the synagogue, a Jewish organization such as a JCC or JFS, a hospital or other medical organization, or a combination of any of these. The FCN will also require logistical support such as an accountant if any medical billing is involved, legal support, and liability insurance.

Continuing support

Education/Training

It is essential to the success of the program that continuing education and training is made available to the FCN. This includes medical training to stay up to date on current practices, as well as conferences and retreats that serve to specifically support Faith Community Nursing. Conferences and retreats create networking opportunities, present information on specialized topics, and build or refresh skill sets. A Jewish FCN should also receive access to Jewish religious training, such as spiritual retreats, formal religious education, *beit midrash* text study, etc.

Publishing

Any Jewish community supporting a FCN should also consider offering support for publishing. Faith Community Nursing is still a relatively young field and there's a lot of research still being done in best-practices and specialized areas. In particular, not enough has been written about Jewish congregational nursing. Giving support to study, write, and present new research will bring pride to the community, and provide important information and visibility to other Jews in the field.

Educational Programs

Launching a health education program in a synagogue can open up many new opportunities to build community and for congregants to lead better, happier, healthier lives. Educational initiatives are often a cornerstone of faith-health programming, and can serve to raise the profile of faith-health issues in the synagogue. As components within a larger vision, educational programming can generate excitement and involvement.

Introducing a health education program

Health education programming is often planned on an annual basis. Communities who are just starting a health education program will often strategically plan three or four larger tent-pole events over the course of the year. The first event can be in conjunction with an annual meeting, or the high holidays. It can either be an educational event on a topic with broad appeal, or an open forum for gathering input from the community and assessing interests. In either case, one of the essential functions of the first meeting is to generate enthusiasm for subsequent events. It may be worthwhile to consider bringing in a guest presenter who is a healthcare expert or someone who specializes in synagogue health engagement.

Topics

There are broad range of topics that fall under the heading of health education. In many cases, ideas for specific topics will come directly from a perceived need in the community, a current event, or policy issue. For example, congregants may be interested in learning about Jewish views of abortion when a ballot measure is presented, or a congregation may want to learn about mental health issues in the wake of a suicide in the community.

Many of the health-related issues about which people are the most ignorant are also issues that are uncomfortable to discuss in public. End-of-life planning is a significant and complex faith-health issue. However, in many cases it is a topic that people will wish to avoid. The same is true of sexual health and sexual-abuse. Depending on the community, it is almost certain that there will be some faith-health topics that are important to teach about, that are likely to be uncomfortable to people. Open conversations about such topics can be normalized through sermons and other programs, and the education programs should be carefully marketed with both savvy and sensitivity. For example, a program about end-of-life planning should emphasize the positive quality of life goals and outcomes in a heartening and hopeful way.

Of course, not every topic will be uncomfortable or controversial. Learning about heart health, improving memory and attention, using spiritual tools to manage chronic pain, or healthy Jewish cooking, are all examples of topics that are likely to be popular in many synagogues. The rabbi and a planning committee should work together to have the right mix of different topics.

Formats

Most synagogue based health education initiatives include a few large educational events per year. These might be held on weekday afternoons or on weekends, might be open to the community, include guest presenters, or be held in conjunction with other faith-health organizations. A committee or a taskforce is generally formed to carry out the planning and execution of these events. Depending on the individual needs of the community, a synagogue might decide to have one or more of the events repeat on an annual or biennial basis, such as an annual heart health day.

Large, infrequent programming is not the only type of educational programming necessary for a truly effective faith-health program. The impact of faith-health programming is cumulative, as is education, so having more regular programming is essential. There may be certain groups or topic areas that can be served by meeting more regularly, on a monthly or biweekly basis for example. This might include elder-care support for members with parents in nursing homes, or a recovery group.

More often, faith-health programming should be integrated into other synagogue events. A confirmation class can include a session about sexual health and decision-making. Health and fitness activities, such as yoga, running and biking teams, or family cooking programs can be supplemented with an educational component, such as a special guest or cross promotion. A weekly *devar Torah* might include health topics such as drinking and smoking, or using faith based tools to find meaning in grief and illness. Sunday school curricula might include a lesson on nutrition or fitness and taking care of our bodies as part of *betzelem Elohim*. Integrative education of this type helps to keep faith-health issues near the front of people's minds.

Finally, passive education can be an important component as well. Making sure that informational brochures and fliers are available and visible in the lobby ensures that people know where they can get needed information. Listing contact numbers in a congregational directory or newsletter can help synagogue members reach out to faith-health professionals as needed. A successful faith-health education program should take advantage of and incorporate all of these different types of formats.

Volunteering Care

Many faith-health organizations include opportunities for medical professionals and others in the community to volunteer their time for those in need. In Jewish communities, we refer to this work as *tikkun olam, tzedakah, bikkur holim,* or *gemilut hasadim*. It incorporates elements of all four. Medicine is a mitzvah, and volunteering care is an opportunity to enrich the synagogue's Jewish practice.

Benefits of volunteering

Organizing or encouraging a program of volunteering can be beneficial to individual members, and to the synagogue community as a whole. Jewish tradition tells us that providing medical care is a religious obligation. By connecting volunteers with purposeful work, the synagogue is helping to provide the means for its members to fulfill religious obligations. Those who volunteer and provide care are more likely to feel that their lives are happy, fulfilling, and meaningful. When placed in a religious context, those feelings are reinforced.

The synagogue will have members who attach a new sense of meaning and importance to their synagogue activities, feel the support of the community in their work, and experience a renewed sense of fellowship with fellow congregants, especially those who also participate in volunteering activities. Members who donate their time and money with other nonprofit organizations will be more likely to support the synagogue by donating time or money. A culture of volunteerism is a rising tide that raises all ships.

Advocating for volunteer activities

There are many different types of faith-health work that members can perform. Whether a member is qualified to providing clinical medical care or not, there are other

services that they can offer. With appropriate training and supervision, synagogue members can provide pastoral support, logistical support, organize and meals and transportation, participate in fund raising, etc. Any of these activities should be coordinated with the health care community and other faith-health organizations in order to align any synagogue programs with needs in the community. Many of these organizations may already have the capacity to train and supervise volunteers. A synagogue formally partnering with these programs will likely be an efficient and productive means to encourage volunteerism.

There are also likely to be volunteer opportunities for medical professionals. Most cities have charitable clinics that may or may not be faith based, which provide good care to people who are disadvantaged. They are often in need of qualified doctors, nurses, dentists, social workers, etc. In many communities, synagogues have a disproportionately large membership of health care professionals, and it is likely that a successful local charitable faith-health organization already has one or more connections with members of the synagogue. Build or capitalize on these connections in order to actively encourage other synagogue members to participate.

For some synagogues, it may make sense to organize ways to provide direct clinical care. This may take the form of hosting a health fair in partnership with other community organizations. It might take the form of providing free health screenings at the synagogue, in a similar format to FCN visits, but open to the surrounding community at large.

It could be a program that is organized by the synagogue that takes place elsewhere. One example might resemble one of the above programs (such as a health fair

or free screenings), that takes place in another part of town. In many cities this model makes sense because the synagogue maybe distant from the people who are most in need of charitable care. Another example might be a synagogue-organized discount medical care program that allows needy patients to receive discounted care at participating doctors' offices. The discounts can be supported by a combination of dedicated funds raised through grants and donations, as well as private practice doctors donating or discounting their own fees.

Organizing medical professionals

A synagogue that engages a program of supporting volunteerism in the faith-health field will need to have a way of organizing medical professionals. In almost all cases, this task should be undertaken in partnership with another organization or organizations. Medical professionals providing care require resources for documentation, which may be both on paper and digital. They also will require liability and malpractice insurance, and may need additional specialized training depending on the work.

Charitable organizations, nonprofit, and for-profit health care providers who have volunteer programs will already have the knowledge and capacity to manage these issues. A synagogue that is organizing a direct care program should begin by coordinating with local professional organizations for physicians, nurses, etc. who already have the expertise, experience, and resources to organize and supply the necessary services.

Cultural Shift

The long-term goal of any faith-health initiative should be a permanent cultural shift in the synagogue. Whole-person wellness cannot be achieved on an annual programming schedule, through a guest speaker series, through a yoga club, or through

an inspirational sermon. It is a long-term goal with an arc that spans decades, or even generations. The benefits of programming will be lost if the programming is superficial or insincere.

A cultural shift cannot be implemented according to a one size fits all system. However, it can be planned strategically. The true cultural shift is visible at every level of an organization, and becomes imbedded as an underlying factor in everything that an organization does. Some areas of focus in organizational change that are specific to faith-health, or should be particularly emphasized are discussed below. There are numerous books, consultants, and companies that specialize in institutional change. Those tools should be consulted as needed in conjunction with the recommendations here.

Wellness programming

Ongoing wellness programming available at the synagogue or in conjunction with membership can potentially have a lasting impact on the synagogue culture. Programming that is expressly devoted to nutrition and fitness sends an unambiguous message to community members about synagogue priorities. Synagogue activities focused on health and wellness, which meet on a regular basis, are a common component in most faith-health initiatives.

The long-term sustainability of these programs can vary widely. Even though people may be accustomed to running every day, or attending yoga classes weekly, they may not feel the need to do so at the synagogue or with other members. Programs like these often start out strong, capitalizing on the enthusiasm and optimism of the participants. However, when the initial enthusiasm fades, the program can disappear. On the other hand, some synagogue based casual fitness groups can persist for years. Those

with periodic goals and milestones can be regularly rejuvenated, such as a synagogue running group that participates in an annual marathon. In truth, the success usually depends on the dedication and chemistry of the core group. There is no exact formula, but it can be thought of as a numbers game. Some programs will survive a few weeks, some for months, and some for years. Consistently introducing new health and wellness programming creates more opportunities for a successful and long lasting program to emerge.

Wellness programming should be punctuated and supported by educational programs. A program on arthritis should include a presentation from the seniors' swimming club for example. These types of programs should be regularly promoted both formally and informally, and especially by the clergy. Although it may be obvious that a new program should be promoted when it is launched, it's also important to promote programs which are ongoing.

Religious services

There are numerous liturgical options for including faith-health programming. Many synagogues now include healing prayers as a part of every service, such as a *Mi Sheberach Lecholim*. Likewise, many synagogues offer dedicated "healing services" regularly or a few times a year. These types of inclusions as have been seen in synagogues in recent years are a step in the right direction. Healing and recovery are not simply situational needs of small portion of the population. They are fundamental, ongoing realities of the human condition. All people, at all times are in need of renewal and rejuvenation.

Jewish tradition has understood this from the outset, incorporating healing into our daily liturgy. Understanding that health is not the absence of illness and that wellness is not an outcome but rather an ongoing spiritual balancing act is the beginning of creating a more complete approach to healing liturgy. There are many resources now available that contain contemporary healing liturgy, and it is a steadily growing body of work. In a culture of wellness, every service should be healing service. This does not mean to the exclusion of other important themes, but as a thoughtful undercurrent flowing through each service. Just as every service with music is not a "musical service" and every service with poetry is not a "poetry service", every service can and should incorporate healing.

Dedicated healing services do not need to be abandoned either. It is evident that over the course of a human life, there are times when the spiritual need for healing is felt more acutely than others. At times when people are dealing with chronic illness, diminished physical or mental ability, the grief of loss, or traumatic change, exceptional spiritual healing is needed. Healing services can be supplemented by spiritual healing retreats or other, more intentional, activities.

Food

Jews love food! In many Jewish communities, nearly every single program and event includes some type of food. Traditional Jewish foods frequently tend to be high in calories, fatty, sugary, and starchy. We know that healthy eating is a cornerstone of healthy living. America is in the midst of an obesity epidemic, which is expected to become the leading cause of preventable death. Any synagogue undertaking a sincere faith-health culture shift will have to address the question of food.

Synagogues that have actively addressed this issue experience quite a variation in the level of resistance. Some synagogues discover that a large portion of their membership is already pursuing healthier food options. Many Jewish communities are already better educated, more health conscious, and more connected to the health food movement than the general population or other religious communities. Jewish communities are often already engaged in issues of food in the synagogue, taking into account *kashrut*, food allergies, sensitivities, and family choices i.e.: vegan, vegetarian, gluten-free, and the like. In such cases, changing the food culture of the synagogue might be just one more change to a current policy, or involve almost no significant change whatsoever.

In other cases, synagogues that have made this shift have come against significant resistance. Whether it is the annual *Pesach* celebration of overeating, "Mrs. Kakeleivich's famous kugel" that just *has* to be at every potluck, or the Shabbat *oneg* pastries because "calories don't count on Shabbat," some communities have deep seated culinary traditions. These practices can be tough to overturn. Changing this kind of food culture is a gradual, "pick your battles" type of process. In this situation, it's often easier to add than subtract; the kugel stays, but it goes in-between a fruit tray and a salad bowl.

Managing stigma

Creating an imbedded faith-health culture in a synagogue is likely to encounter two types of stigma. The first type of stigma is skepticism about the premise of faith-health work as a unified field. Faith based medicine can seem strange, fringe, or unscientific to educated individuals. "Faith-health" sounds suspiciously close to "faith healing," although they are quite different. The second type of stigma that can arise is the

stigma surrounding public discussion of death and illness. In either case, the same type of head-on approach should be used.

Bimah

The clergy *must* address these issues from the bimah. In synagogue announcements, in community programming, and especially in sermons, a rabbi should not avoid these topics. If volunteer nurses are seeing people after a Shabbat morning service, the rabbi should let the community know what they're doing, and then be first in line for a check-up. If there is an upcoming program on preparing a living will, the rabbi should devote a sermon to discussing the importance of planning ahead as an act of love for your family. Our rabbis cannot single-handedly change the culture of the synagogue, but they can – by addressing topics openly and directly – de-stigmatize important topics.

Printed Material

Printed material such as informational pamphlets can be used to quickly and broadly distribute information about faith-health programming. Any faith-health program that a synagogue participates in should produce an explanatory brochure. Brochures should be made available in a publicly visible area, and also kept on hand by the staff, clergy, and organizers for anybody who might have questions. Pamphlets, booklets, and fliers can pass on information in a less threatening way for someone who is uncomfortable with a subject.

Visibility

Pamphlets also serve to increase the visibility of difficult topics. The more that issues are made visible, the weaker a stigma or taboo becomes. This is another reason to

publicly display pamphlets and fliers. Visibility can also be increased with posters and displays, notices in a newsletter, mentions on a blog or social media, and through frequent mentions of an issue either as promotion or in casual conversation. Addressing difficult topics in the open can de-stigmatize them in a community.

Integrated programming

It is both a goal and a strategy for a cultural shift to have fully integrated programming. The early creation of ongoing opportunities for integrated programming in an intentional way will foster a culture of wellness. As the culture shifts, creating integrated programming will require less effort and coordination, and begin to happen more naturally. For example, if faith-health awareness is integrated into Sunday school teacher training, then teachers will be more likely to include faith-health issues in their classroom. If the synagogue already has an active community of cyclists, sponsoring a bicycle race as a fundraiser will be a natural fit. Over time the goal should be for faith-health to be an underlying consideration in planning throughout the synagogue.

Managing resources and priorities

A synagogue that intends to incorporate faith-health into their organization should intentionally incorporate faith-health concerns into their resource planning process. Every successful endeavor in a synagogue requires time, talent, and money. The values of the synagogue – or any organization – are reflected in the manner that these resources are allocated. Because faith-health programs tend to be highly scalable, it is not necessary to presume that a given synagogue will be committing a large portion of its resources to their faith-health program. It should be expected, however, that dedicating resources to the faith-health program is a priority.

Because the effectiveness of a faith-health program increases over time, there should be a long-term commitment of resources reserved for the program, however large or small that might be. This approach leads to the following questions. How will the faith-health work fit into the congregational budget? Will it be a single line item or will it be spread across many categories? How will calendar planning be impacted by faith-health programs? To what degree will new leadership prospects be encouraged and directed toward faith-health work? How will the synagogue's commitment to faith-health be maintained from year to year? The answers to these questions will be reflective of the long-term success of the cultural shift.

Organizational Partnerships

Importance of partners

It has been stressed throughout this guide that organizational partnership is a key to success in the faith-health field. Because faith-health work straddles and blurs the lines between multiple fields, it requires the partnership of multiple organizations to achieve a fully formed program. Furthermore, partnerships can arise naturally because faith-health work benefits multiple causes. The types of partnerships that emerge will depend on the type of program, the needs of the community, and the resources available.

Other faith organizations

Many faith-health programs flourish as partnerships between a number of faith organizations. An individual synagogue may not be able to support a fulltime FCN, but two or three synagogues working together might form a large enough base. A church or a mosque might want to present an educational program about mental health. By pooling resources and drawing from more than one congregation, a large and successful event can

take place. Consider partnering with other faith organizations when there is a question about scale or resources.

Hospitals

Hospitals stand to benefit greatly when there are successful faith-health programs in their city. Through education, Faith Community Nursing, or direct services, people in the community can live healthier lives and receive treatment for serious conditions sooner than they otherwise would. In particular, services that are available to the poor and uninsured can help hospitals decrease emergency room abuse and lower their write-off costs. Hospitals can offer financial and logistical support, as well as training. A hospital may find it cost effective to grant funds to a faith-health project, to offer a training program, to donate equipment, or to offer incentives for employees to volunteer.

Professional associations

Professional associations provide information and networking. A local medical society can be a great place to recruit volunteers, or to learn about useful resources to assist or supplement faith-health work. Medical professionals will want to demonstrate financial support for a faith-health program that is established and proven effective. Professional associations may also be able to assist in assessing the efficacy of a program.

Jewish community organizations

Jewish community organizations such as a Jewish Federation, Jewish Community Center, or Jewish Family Service can provide resources and logistical support to a faith-health program. Any program that has an impact beyond the walls of a single synagogue will be of interest to the broader Jewish community. Like partnerships with other faith

organizations, community organizations can assist with accommodating scale. In addition, they can provide operational resources such as office space, experience navigating the medical system, case management, grants and donors, etc.

Local nonprofit organizations

Local nonprofit organizations can fill a variety of valuable roles as faith-health partners. In some cases, there may be local nonprofit organizations that already execute high quality faith-health programming. A synagogue can supply such an organization with volunteers, funding, and publicity. By working with an established and successful program, a synagogue can gain many of the benefits of a more independent program with fewer logistical difficulties.

Other local nonprofit organizations may have specialized experience in one aspect of the faith-health program. They may be able to provide a portion of the services. They may also be able to provide specialized training, or networking opportunities. They are also likely to have detailed knowledge of community needs if a synagogue is seeking to establish a direct service program.

National organizations

There are several national organizations that specialize in faith-health work. Jewish Sacred Aging provides educational resources and community development expertise. The Jewish Board of Family and Children's Services in New York maintains the National Center for Jewish Healing, with detailed resources and best-practices for Jewish faith-health work. Faith Community Nursing is supported by organizations that can offer resources and guides to setting up and maintaining a FCN practice. Church Health Center is a large and well established direct care provider that provides replication

seminars to learn the ins and outs of faith-health work. National medical associations such as the AMA, ANA, APA provide informational resources and guidance, research, and may be able to assist in forming a faith-health program.

Advocating for movement-level resources

Several Christian churches have national or regional offices to support faith-health work. If a local Methodist or Lutheran church wishes to set up a new faith-health program, such as Faith Community Nursing, help is only a phone call away. Their national offices offer guidance and expertise, and understand the field-tested methods for setting up the faith-health program that is particular to their own religious circumstances. The Reform Jewish world unfortunately lags far behind. The URJ currently maintains one specialist in a national position who is responsible for issues of Jewish family life, community inclusion, and health and wellness.

Reform congregations who are passionate about faith-health work, who have launched successful programs, or would like additional resources should seek to raise the profile and highlight the importance of faith-health programming. By making the demand for resources known, and lobbying movement leaders, Reform congregations can help make new and better resources available. The Reform Movement is positioned to be a national leader in faith-health work, which is both an emerging frontier, and an ancient obligation closely bound to the core of Judaism.

Resource Guide

Jewish Sacred Aging jewishsacredaging.com rfaddress@aol.com	Provides Jewish texts and resources, books, frequent updates, Consulting and workshops for health education and programming
National Center for Jewish Healing jbfcs.org/NCJH 135 West 50th St | New York, NY 10020 (212) 582-9100 Toll-free: 1-888-523-2769	History and resources supporting Jewish healing centers, best practices, articles, healing center directory, assessment tools, books, printed materials, source sheets
Kalsman Institute of HUC-JIR huc.edu/kalsman	Supports Jewish faith-health research, publications, pastoral education, hosts learning events
Health Ministries Association, Inc. hmassoc.org P.O. Box 60042 | Dayton, OH 45406 800.723.4291	National professional organization for Faith Community Nursing. Provides formal representation of the discipline, publications, hosts national events
International Parish Nursing Resource Center www.churchhealthcenter.org/fcnhome	Coordinates curricula for Faith Community Nursing, training courses in USA, international partnerships, hosts national events
Caring Community, URJ urj.org/life/community emencher@urj.org 212.650.4296.	Coordination and best practices for synagogue in-reach programs including health and wellness, model programs, resources, topic-specific resources
Ritualwell, RRC rutualwell.org 1299 Church Rd. | Wyncote, PA 19095 215-576-0800 ritualwell@rrc.edu	Contemporary prayers, healing liturgy, articles
Church Health Center churchhealthcenter.org 1210 Peabody Ave. | Memphis, TN 38104 (901) 272-7170	Faith clinic replication seminars, articles, publications

Appendix: Interview Transcripts

Listed in alphabetical order

Included in this appendix are transcripts from a series of interviews conducted by the author with various experts and representative practitioners of faith-health work. These are intended to be used as a reference only, particularly as a cross reference to Part One of this thesis, which owes the bulk of its information to this material.

The transcripts represent the author's best interpretation, to the greatest degree of accuracy possible, of conversations conducted over the phone or in person in October and November of 2014. The words, to the best of the author's ability, are the words of those interviewed. This work would not have been possible were it not for the generous and thorough work of Ann Hughes, who produced the original drafts.

The author has made every attempt to accurately and reasonably edit these interview transcripts for content, spelling, and grammar. The author takes full responsibility, with apologies, for any error, misrepresentation, misinterpretation, or inaccuracy that may be found in what follows. Please contact the author if you wish to reference or reproduce any part of this appendix.

Rabbi Richard F. Address, D.Min, 5 NOV 2014

RA: Okay. So, they really… This wave really began with us probably the 80s and 90s when you had this whole healing service movement, was very, very popular in many synagogues, where you actually have congregations instituting regular healing services. I did a bunch… I mean, when I was working in and running my department in from New York, that wave has crested. Very few synagogues do it anymore. Some of will do it and incorporate it into like High Holiday liturgy, or they'll put a little slot in sometimes on Yom Kippur in the in the afternoon. They'll throw in a little healing service. It's institutionalized now in our congregations now in the *Mi Sheberach* - the Debbie Friedman. You know, when I was growing up, we never did that.

NF: Right.

RA: But with the change in Judaism in the 70s and the feminization of Judaism in the 70s and 80s, this came in as a result of a lot of that conversation, and so now every congregation is institutionalized as the *Mi Sheberach* either the Debbie Friedman song or there's 4 or 5 or 6 variations on the *Mi Sheberach, El Na Refa Na La*.

NF: Yeah.

RA: From Exodus. That melody. So that's one of the ways that the majority of reformed congregations in the United States of America and Canada have begun to have institutionalized this part of this issue.

NF: So, are there… Let me pause for a second because I think that I would like to hear more about the liturgy, but I'd like a little bit more maybe of an overview, if you could talk to me about your work with Sacred Aging or… I just read the article you pointed towards about your work at Mekor Shalom.

RA: Right. Alright, so I… And before I get off the phone, you're going to have to send me your address because there's some material I may want to send you.

NF: Oh, absolutely.

RA: You can throw in as an appendix.

NF: Okay.

RA: Most of this stuff was created for the movement out of my department, the Department of Jewish Family Concerns, which I started in 1997, and they have ran until 2009-… until about 5 years ago or 4 years ago when the URJ cut down and destroyed all the regions and department. They got rid of all of them, and they're restructuring.

NF: The big restructuring, yeah.

RA: Yeah.

NF: What existed in this area before 1997?

RA: Very little. There was some work being done out of education out of the worship department with Sue Ann Wasserman.

NF: Okay.

RA: Sue Ann Wasserman really ran some of the healing service programs for reform congregations. She got caught in the first major purge about 6, 7 years ago. They let her go. She's now someplace in New England, somewhere around Boston.

NF: Okay.

RA: I don't know whether she's still in the Rabbinate or not. I think she's doing some part-time work. But she really got clobbered, when the Union started cutting rabbis left and right, and she was in the first major purge.

NF: So, in '97…

RA: [Inaudible 8:29].

NF: … you were the first director, I guess, of the Department of Jewish Family Concerns.

RA: Jewish Family, right. I started the department. I was their only director because they killed it…

NF: Okay.

RA: … along with everybody else.

NF: Oh, okay.

RA: So, those departments don't exist anymore nor do the regions exist anymore.

NF: Right.

RA: It was part of the Union's restructuring.

NF: Well, so what kind of work did you do during that?

RA: Right. So, in our… Some of the programs that gravitated towards some of the liturgical development of healing or health and wellness moved out of the Caring Community Program, which I still do consulting on around the Country, and, then, also a lot, as we evolve the Sacred Aging Project, which I do fulltime now all over the world. I think I sent you the website – jewishsacredaging.com

NF: Yeah. Yeah, I…

RA: I saw it there in the back and in the archives and stuff. You can even find some prayers and stuff. One of the *Mi Sheberach* prayers that we published in the *Mental Health Book* was a specific *Mi Sheberach* prayer for families dealing with mental-health issues, and in that book, called *Refuat HaNefesh* which you can get from the URJ Press. Hurry up. They just killed the press.

NF: Yeah.

RA: That book has 2 healing services specifically that we published that deal only with families dealing with mental-health awareness. They're very unique, and we published them about or whenever we published *Refuat HaNefesh* in the last decade. And you can look at that and say here's an example of how healing health and wellness has been institutionalized dealing with mental-health issues. I was just in San Diego Thursday and Friday consulting with Beth Israel. They're developing a whole mental-health program, and they use some of this material. I spoke about it Friday night. So, the mental-health component is really something that's going to grow with pushing this a lot of the Sacred Aging work because of the expected growth in Alzheimer's and dementia in the next 30 years as the baby boomers age out…

NF: Right.

RA: … and there's a real awareness growing around caregiving, around issues like that, that there really is a need for congregations to respond not only programmatically but liturgically, so in the study guide we did on the Jewish approach into the dementia and Alzheimer's, we actually included [Paul Kipnis inaudible 11:25] in Calabasas, California, did some work on prayers and liturgy dealing with caregivers and who are dealing with that. This is a growing, a growing need around the whole rubric of wellness and heath that is focusing in on a lot of developing rituals and liturgy around caregiving. [Typing]

So that's something that's really emerging, and you'll deal with it smack dab as soon as you walk into your new office in July. So, in fact, if you take some of this… The stuff

that you're doing will have immediate and direct application in your congregation wherever you… Are you tracking into a congregation or not?

NF: Yeah. I'm expecting to, yeah.

RA: Well, this thesis will come in handy within the first week of you being in your new job because you'll immediately sense the great need for this stuff amongst the people. I just got off the phone with a family from my former congregation dealing with a recurrence of cancer, and the need for this type of education and liturgical stuff, every time I go out into a caring community setup or anything on the Sacred Aging Project of caregiving, this alw-… Liturgy always come up, the need for rituals. In fact, the class I'm teaching this semester at HUC in New York on the longevity revolution, we just… we're just going in to on Monday a unit on ritual of prayer. So this is all emerging. So, the health and the wellness stuff is growing. One of the things I'm going to send you is this whole health audit that we created when we were working for the department that is a…

NF: Okay.

RA: … 4-page kind of a glossy, all text based, outlined, that you can steal next year, put your congregation's logo on it, and when you do a program around Jewish approaches to health and wellness, give it out to the people because it has 3 pages of checklists about what people should be doing and institutions to stay healthy, and in the back is a whole checklist of what individuals can do to continue to stay healthy, from testing and blood and exercise. And there's a who slew of text that emerge out of Jewish tradition that speak to health and wellness, a lot of great stuff out Maimonides I use when I go out and teach this stuff. Laypeople just go, they just go crazy. I just did a whole

weekend on this for West Hartford, Connecticut, a week ago, and some of the study guide really that we did for them, I remember… I don't know whether it was Saturday or Fri-… I don't remember. But we used some of the Maimonidean text on the preservation of health. His essay on the preservation of health and the importance of exercise and nutrition and body movement, and 2 doctors walked up to me and immediately said, I need that text because my group needs to know that this stuff exists, and I'm going to use this in some professional work so…

NF: Yeah, any…

RA: [Inaudible 15:07].

NF: I'm just beginning to get into another section of this thesis that is centered around Jewish text and anything you could send me, I would, certainly, appreciate.

RA: There's a ton of material… I have a bunch of articles on this and study guides that I've done when I go out and teach this stuff in congregations. It has some text in it. I'm on the road for the next couple of days…

NF: Okay.

RA: … but I'm going to try to put… As long as you don't say I need this by Monday, I will try and put a packet together for you in the next couple of days and get it to you ASAP, and you can just pick and choose and cut and paste, and if there's a question, pick up the phone and call me and say where'd you get this or... There's a lot of stuff. One of the other websites you probably should check out…

NF: Uh-huh.

RA: … is the Kalsman. Are you familiar with the Kalsman Institute?

NF: Yeah, sure.

RA: Okay. So, there's stuff in the books that we just published, because I'm on their advisory board.

NF: Okay.

RA: The books we published on Judaism and health have just a ton. I mean, all you need is those 2 books, the last one [inaudible 16:27] that article, the one I mentioned, the *Body Politic* or something that I did as a chapter in that book. There's a ton of textual material and resources just from that book alone, and that's the whole frigging thesis right there, just rip it off.

NF: [Laughter] Yeah, great, great [laughter].

RA: You'll be very, very happy. And I think we have the covers of it on my website. I think my web guy put the covers up so people can click on it. And they're all on Amazon. If they're not in the library. But you should have them for your own library, anyway, because you're going to use them.

NF: Great.

RA: [Inaudible 17:06].

NF: So…

RA: There's a lot of good resources in there.

NF: So let me ask… I'm trying to l pin down where… what type of organization, what type of work you'd be able to tell me the most about in terms of nuts and bolts. You mentioned sort of at least 3 different categories of things – the programmatic, the ritual and liturgy, and the education.

RA: Right.

NF: Could you talk a little bit more about maybe what each of those are? What that looks like in a synagogue?

RA: Okay, so let me tell you… I'll take it from what I just did when I was at Mekor.

NF: Okay, sure.

RA: I left the Union. I went into this congregation to help them out because they were having rabbi issues, but I knew the congregation because I was the regional director.

NF: Okay.

RA: I knew them intimately. So they hired me for 3 years to settle things down and to bring some programming and to make sure that they could elevate the young assistant to be the senior rabbi, all of which we did.

NF: Okay.

RA: So I went there and said to them, some of the… a lot of the successful work that we were involved in the department had to do with elements of health and wellness. So I was going to bring this to the congregation. They loved it. So we created this whole health-and-wellness initiative, which we ran for the 3 years that I was there.

NF: Okay.

RA: And…

NF: So what were the element of the initiative?

RA: [Inaudible 18:46]. With what?

NF: I said what were the elements of the initiative that people loved so much?

RA: Okay. So we launched it. I'll take you through and then I explain it. We launched it with a big congregational forum right after the holidays where we build as sort of come and learn about Judaism and health.

NF: Okay.

RA: And we did some text study, and then what we did with the congregation, and we ran this through the Caring Community Program, which is natural home of the congregation-land, we really polled the congregation. We had 75 people who showed up for this forum, which was 9 to like 2. We asked them what where the priorities that they saw within the congregation from their own experience. We butcher papered it in and what did they… how they saw the congregation being most responsive to the areas of health and their own health and wellness.

NF: Okay.

RA: That emerged into a couple of programmatic initiatives. There was a very brief flurry of teaching yoga, and it petered out because the people who were enthusiastic about it wound up not continuing it, which is not unusual. But the major thrust that came out of that was an appeal, and I was surprised by that. I didn't expect it. But in congregation-land you get a lot of surprises.

NF: Sure.

RA: There's so… There was so much cancer in the congregation…

NF: Huh.

RA: … that one of the things that emerged really to the top of the list was we want to you provide on a programmatic basis direct service and support for the people and families dealing with cancer. So that led to, then, some programmatic initiatives out of Caring Community that were transportation programs for people who needed rides for chemotherapy. It led to the development of a couple of small groups of mostly women… [Typing]

RA: … who then… who did not want to do direct service but who were knitters and crocheters, and they developed a program, which I think is still ongoing, on knitting, what they call *Caring Caps & Blankets*.

NF: Okay.

RA: They knitted hats and blankets that were distributed to people in the congregation undergoing chemotherapy, and they actually wound up making a deal with Cooper Hospital in Camden, a huge oncology thing, and donated a couple dozen of these things to the Oncology Ward at the hospital for people who were undergoing chemotherapy.

[Typing]

RA: Which I felt was really just an absolutely wonderful outgrowth of this whole program because it was really… It's real interfaith that it's just good. I don't know what the right word is. … So the health and wellness initiative programmatically started with this forum, emerged out of some direct service program, continued to , and then housed in the Caring Community , which was the institutional framework for them. And then other outgrowth was a series of annual health and wellness forums.

[Typing]

RA: We did 1… We did 3 every year, which I urged congregation [inaudible 22:31]. One was on Judaism and mental health. These were 2-hour forums. We did it on Shabbat afternoon, and they called them Shabbat conversation. [Coughing]. You can do them anyway you want.

NF: Sure.

RA: One was on Judaism and mental health, and we traced the tradition in the text about Jewish approaches that taught me the conversation *Chagigah* mentioned in the

Tanach, and the implications of that on mental health. The second one was on caregiving, and we traced… Basically these are workshops I do. They're all over the Country, but I brought them …[coughing]… to the congregation. The caregiving one was traced… the conversation was based upon the 3 repetitions of honor and respect in the Torah. Talmudic conversation on *Kiddushin*, the implications and, then, the resources and the local… and our local community that dealt with caregiving, hospice people, which every community had legions of. And, then, the third one we did was on decision-making at the end of life. Again, traced this whole thing through tradition. I taught my own theory and approach and then talked about all the resolutions dealing with comfort care, Hospice care, and usually there's an opportunity to again push the writing of ethical… not ethical wills, advanced directives, Durable Power, healthcare proxies, etcetera., so people understood that this was something that they had to do for their own family health and wellness.

NF: Okay.

RA: So that was the educational component that grew out of the forum and was all rubriced under the Health and Wellness Initiative, and we found that the language, this is something else we found, that when we work as a department, how you market something to a congregation really… that's a key, and I'm not good at this, so I've always relied on people who knew how to market things and use the right language. Most of us don't have a class on that at HUC .

NF: Okay.

RA: But the people in the congregation should know how to… Like I said, if you decide next year to run a forum on decision-making at the end of life, because it's very

important, and you advertise it as: come Sunday morning from 9:30 to noon, then we'll have breakfast, and we want to talk about your death.

NF: [Laughter]

RA: It'll be you and the janitor [laughter].

NF: Yeah [laughter].

RA: And… But if you market it as something of dealing with taking care of your own life or caring for your loved ones or, I don't have the right words.

NF: Okay.

RA: When we did it, it was how to make a sacred decision, and that seems to work better than come talk about you dying.

NF: Right. Right. [Laughter]

RA: So that's on one thumnailed, brief how that idea of health and wellness that got translated into the congregational culture on major programs, and the second year, we did another major Sunday morning forum specifically on cancer. And there are other congregations who have done similar things around it. This year, I know Karen Fox who is at Wilshire Boulevard Temple, many, many years ago, we printed this up some, when we had the department, did a whole daylong conference on what she calls the Theology of Cancer … [typing]… and brought in people from Cedar Sinai and [UCA 26:32] all the major people [inaudible 26:35].

But, anyway, so that's how the health and wellness initiative got institutionalized with the core and those 3 areas are direct service, a major congregational programming, then the conversational forums, which were targeted on these 3 specific areas. [Typing] Now, congregations now have taken a lot of this from… They do it a variety of different ways.

So, for example, the congregation I was just at in San Diego, they're going to launch a whole program on mental health. The congregation, I think, is [inaudible Harper 27:44] really is focused on caregiving and a lot of end-of-life stuff because [inaudible 27:59] like here in New Jersey. Connecticut also has a Bill in the legislature, like we do, on the choice of dying well, like the one in Oregon, and the rabbi there, Rabbi Pinkas, I think was focused on that particular issue because it's very important for them now that [inaudible 28:20]. [Typing] Sunday morning with the mob. They had to bring in extra tables and chairs 'cause people do want to look at this, and then I did the Jewish, here's what Judaism and what the texts have to say as we approach this issue. So, there was a run for about 10 years, in the last decade of several congregations that did major community and congregational programming on mental health. There was an increasing number of congregations who looked at what they served at Oneg Shabbat and each group event and tried and have somewhat successfully tried to change some of the food options that are used, what's better. At the Oneg you go to all chocolate cake and cookies…

NF: Yeah.

RA: In those congregations, now there's fruit or a fruit option. Some youth groups have gotten away from the mandatory pizza dinner and try to have some other options, although I don't know, that's tough sometimes. There is not a lot of emphasis curricular-wise.

I mean, if you really want to do something next year that is really needed …[typing]… and that is to develop a whole curriculum on Judaism and health from the text for

religious schools. Hardly anything exists, and there's a really great need for it, by the way.

NF: Okay [typing].

RA: So, the major sort of like manifestations of this in congregation-land have been around areas like end-of life stuff. Some congregations have grown into developing classes in yoga and nutrition where they'll have yoga classes, and in a lot of those congregations that generally happens on the east coast There's a real need for some guidance, some of it in the nutrition stuff. It's hard to fit into congregational programs because people don't realize or look at it. That's why the most used, the most or the most requested or the most… I don't know what the right word is… health and wellness dealing with end-of-life or caring for the caregiver. It's a real up-and-coming thing because of all the literature that's coming out about caregivers who really don't take care of themselves and wind up getting sick.

NF: Okay.

RA: These types of things.

NF: So, let me ask… [throat clearing]… In these congregations that you've gone to where there's been this big push, you're talking able like 3 major programs a year, have you seen that to be sustainable?

RA: No. [Laughter] I mean, I'm going to be honest with you.

NF: Okay.

RA: The 3 years I was at Mekor, we did meet every year.

NF: Yeah.

RA: Now whether my successor continues it, I don't know. Not everybody… It's not a very common thing, you know. The reason why I push it is because people are living it [laughter].

NF: Yeah.

RA: They're living it every single day, and they have no knowledge of what Judaism has to say about it, none. But it's not… And, so, I think it belongs in every congregation, and even if the rabbi isn't into it, and not every rabbi is, I guarantee you that the congregation you go to, there will be nurses, doctors, mental-health professions…

NF: Yeah.

RA: … who are quite capable of teaching that part of it. They're not capable of teaching the Jewish part of it, and that's where the rabbi really comes in, and I've found and I've been doing this a long time, I have found that laypeople will eat this up. They just don't know. They just don't know that Judaism has been talking about this stuff for … [typing].. centuries, and it's part of who we are. So, in many ways, it's enlightening, enlightened adult education if nothing else. But it takes… Anything to be sustained within a congregation, there's always that initial rush and then challenge is how to maintain continuity of this without driving yourself crazy because your time is so compressed. As a congregational rabbi, you're called upon to do so many things.

NF: Yeah.

RA: But you really have to put on your schedule and let the congregation know that we're doing this once a year and it will evolve, that's the sustainability of any program, is a challenge in the congregation because people change, priorities change…

NF: Yeah.

RA: … and there's also people who get all hot and crazy, one group will support it, and then they do it and then they sorta burnout or get caught with other stuff or the next big thing comes along. So that's one of the challenges we all face congregation-land, how to keep these ideas and programs. Of course, the easiest thing to do is when you do it 3 or 4 times, you get a hold of a family who's been touched by this, you will have a relationship with and have them endow it. That's the secret of doing this.

NF: Yeah, so…

RA: It's a really… The subject matter is exciting because every person in your congregation who will have… who will begin to have to be impacted by these issues, every single one.

NF: Yeah. What… So what I'm hearing you say, that in terms of sustaining large-scale, whole-congregation programs, what I'm hearing you say is that that has to come from the rabbi and the rabbi's priorities?

RA: Oh, yeah. Hey, if they haven't told you this at HUC, they should. Anything that happens within a congregation.

NF: Yeah.

RA: The only reason why it happened is because the rabbi wants it to happen.

NF: [Laughter]

RA: If the rabbi doesn't want it to happen, it don't happen. I don't care what anybody tells you or whatever, that's the truth. That is drop-dead, down-home truth. Because in most congregations if ideas emerge up to communities of the board or somebody will walk into your office and say, I think we really should do this. I really would like to do this. And you'll dialogue with them and assume that they'll do it. 'Cause a lot of times

they'll come in and they'll say these things but the expectation is that you'll do it, and you don't have the time to do everything.

NF: Right.

RA: But we've all been there, and somebody will come up with an idea, and either it's not a priority of mine or I just don't have the time or it's not the right time or it's not my thing, but we'll try it anyway and I'll back it, but I'm not going to be able to invest a priority of my time on it, which is in many ways fine. It does send the message that you're supportive, but you're pulled in a million different directions, and most laypeople will understand that.

NF: Sure. Well, now let me ask about something that's a more like regular, systemic-type changes, some of the things you're talking about, like the food. Do you find that that's more sustainable or do you find a similar kind of drop-off?

RA: Yeah, I do, especially now. Especially now because there's so much more awareness of food. First of all, you probably run programs and youth programs or and half the battle is on gluten-free…

NF: [Laughter]

RA: … I'm a veggie; I'm a partial veggie; I'm only a vegetarian on Thur-… Thursday between 2 and 4.

NF: [Laughter]

RA: … I don't eat red meat; I only eat gray meat; I don't eat chicken, but I eat fish, but I…

NF: Yeah.

RA: … only eat fish that's grown it the Atlantic and not farmed.

NF: [Laughter]

RA: I don't eat farm-raised fish. You, know I can't have…

NF: Yeah.

RA: … I can't have, but I love Snickers.

NF: [Laughter]

RA: Shut up and eat this already, you know. So the food thing has become very, very… So, to say, to sort of walk into a synagogue and say, you know, I've looked at the oneg, and maybe we should have fresh fruit or vegetables and dip instead of all the Shirley's Schneken that she cooked…

NF: Yeah.

RA: … and if you take it way, she'll quit the temple, and maybe we won't serve juice as much to the kids, which is 100 percent fructose…

NF: Yeah.

RA: … and do something… There's a lot more awareness of this in congregation-land. A lot of the parents and especially a lot of the baby boomers are really, really much more tuned into what's healthy and what's not healthy.

NF: So are there other things besides the food that you find to be sustainable even after the yoga drops off, after when the…

RA: Well, you know what a lot of… some of congregations are doing?

NF: Yeah.

RA: There's a congregation here, the rabbi is a runner, a lot of… sometimes congregations use it as a fundraiser but sponsored run, bicycling, bicycle because there's a lot of congregations who have gobs of people who bike. They really bike a lot, and

there's always every weekend in the nice weather there's always like a sponsored run or a sponsored bike or a charity or something. [Inaudible 38:44] people will gravitate to that, to runs or sponsored walks or Congregation Anshe Whoopee Annual Bikeathon, and you turn it into a fundraising event and a social event, people gravitate to that. They don't think it… It's not like going to the synagogue and being there for a program, but it really is a synagogue program, and you're teaching health and wellness, though… I mean, you could go out there to your congregation next year and …[typing]… develop a whole health initiative, and not only tie it with food and educational programs but exercise and nutrition and things with the religious school and group and the youth group with biking and running and walking and challenging. It's really… People are lot more aware of that now because a lot more of them are doing it, and it is sort of like a no-brainer, and people gravitate towards it.

NF: Okay, great. So, then I guess, in terms of those 3 categories, we didn't really talk a lot about ritual and liturgy. Apart from the Mi Sheberach and other things that have sort come out that Debbie Friedman being the El N Refa Na La, other things that have sort of entered the regular service. Apart from that and apart from a healing service which happens maybe once a month or every couple of months, what do you see in terms of ritual and liturgy happening in congregations?

RA: Well, this, I think, is the next, one of the next waves to grow.

NF: Yeah.

RA: We've done a lot of this out of the Sacred Aging Project a lot. In fact, it's Monday's class, my longevity class that's in New York, rituals dealing with end-of-life stuff, rituals dealing with remarriage, rituals dealing with cohabitation, rituals dealing

with celebration of wisdom. These are not specifically health and wellness rituals, but they speak to this growing awareness, and the part I personally think is because I work in there, out of the baby boomers who had a growing disaffection with institutionalized religion but, yet, want some sense of connection to something beyond themselves that ritual and prayer, especially ritual. It seems to be a natural thing. So, a lot of these rituals are recovery rituals or thank you rituals, Nina Beth Cardin's book on Tears of Sorrow, Seeds of Hope, which is a brilliant book, you should have it, on infertility, miscarriages, etcetera, etcetera. There's just a little of liturgy on the… The manual that we did for eating disorders, *Litapayach Tikvah* out of the department. The whole back several pages are nothing but prayers and that were written by people walking this walk and in recovery and their journey back to health, and it was, and I didn't expect it, but it was… When we went out and did workshops, people responded to us on this, they thanked us for including the ritual and the prayers more than they did the other stuff, which I was surprised at, but it told me, and this was 16 years ago.

NF: What…

RA: It told me that it does speak to them. So, the Jewish Healing Center in New York… What's his name? *Simkha Y. Weintraub* has published stuff on prayers and liturgy with surgery and recovery of surgery, going into surgery. These are all the types of stuff that are beginning to emerge, and they're Jewish faith. Rabbi Hoffman did some stuff on this. Again, Simkha has done some stuff on this. Debbie Pearlman has written poems and prayers just dealing with all kinds of… A lot of them are healing oriented, not health and wellness but healing oriented, but these are starting to bubble up …[typing]… a lot. So that's where the liturgy and prayer stuff has really begun to emerge. There's a

lot of it on the healing side and recovery side as opposed to celebrating, you know celebrating I just got a clean colonscop-… Pretty much people would just say thank God and move on.

NF: Okay. So, what I'm hearing is in addition to the sort of, maybe the one-touch during the weekly service and some sort of semi-regular healing service that's dedicated to healing, adding specific ritual that corresponds with the lifecycle events that we're experiencing?

RA: Correct.

NF: That's the new frontier?

RA: That's the next stage in this health and wellness …[throat clearing]… league. Whether you're going to see people start to really create some… And, some of it, like I said, it started a variation from the liturgy stuff. We're going to go through a whole day of it on Monday with my clients, and we'll see what happens. We're publishing some of them but nothing on health and Sacred Aging publishing stuff in the To Honor & Respect book that we did, the whole chapter on creating new rituals for growing for longevity, but they're not necessarily health and wellness, they're sort of like based upon the life stages that people go through.

NF: Okay. I, certainly, would agree that there's a connection there, that there's more than just…

RA: Oh, there's a connection…

NF: It's not artificial.

RA: Oh, there's definitely a connection. No question about it.

NF: Okay, well let me ask you a little bit more about Caring Communities. You mentioned a few times how that involvement has played a role. Can you tell me sort of what your experience and your perceptive with Caring Communities is and what that looks right now in the movement?

RA: Right. Okay, for the Caring Community Program for the Reform Movement started in my regional office in about 1982…

NF: Okay.

RA: … when they asked some of the regional directors to take upon themselves responsibilities to create programs for the movement, and one of the things they asked me to take a look at was the development of this care-and-community concept. We had just began to take off as a result of some congregations, one in Maryland and one in Florida. So making a long, long, long, long, long story very short, these are basically… you can't show like the organizing principle of my department, and these are in-reach programs, programs of basically around 3 major rubric with tremendous variation *Bikur Cholim*, *Chevra Kadisha*, and educational programs, but those are the 3 sort of like chapter headings, and under each are very tremendous numbers of variations. On the theme is each congregation that I've worked [inaudible 47:02]. I don't know how that many congregations I've been involved with trying [inaudible 47:07], as late as last week in San Diego, work with these congregations in developing and maintaining their Caring Community programs, all of which evolve and morph into their own uniqueness depending upon the congregational culture and what the needs are. So…

NF: So every congregation is going to have its own flavor? Does that…

RA: Every congregation has its own DNA…

NF: Yeah.

RA: … and depending on their demographics and the needs, their Caring Community program really took upon themselves that representation of those needs from the direct service front. There are a lot of congregational Caring Community programs in addition to doing direct service would also sponsor these educational programs that would take a look at a specific issue with the idea that out of that discussion would then emerge groups of people who would want to come forward and work on that particular issue.

NF: Now, is there still…

RA: A simple way to keep the program growing.

NF: Okay. Now, is there still organization and resources at a movement level in the URJ or?

RA: It's all been- in the US they killed it all when they got rid of my department. It's all housed within my head and files, here in southern New Jersey.

NF: Okay.

RA: And I still get calls. Well that's it, as late as week, to consult with the Caring Community committee and sit with them and sort of like …[throat clearing]… San Diego. This where we are. We want to go in this direction, and how do we get there?

NF: So this is still…

RA: So…

NF: … persisting as something of almost a grassroots-type of…

RA: Yes.

NF: … sustenance?

RA: Yes. Yes.

NF: Okay.

RA: But many… Hundreds and hundreds of generations now have a variation of its Caring Community program. They're called by different names. The Mitzvah committee, the Caring Community, Tzedakah Committee. When you talk to Micah Greenstein…

NF: Yeah.

RA: … in Memphis.

NF: Yeah.

RA: Their program, which was created, I think back in the '70s, by their previous… by Micah's predecessor, because I worked with this committee a couple times in Memphis, a place called God's Unfinished Business. That was the name of the Caring Community program. It was great. This is great. And typical southern. I mean…

NF: Okay.

RA: … you never find that in New York because people would say what the F are you talking about.

NF: [Laughter] And that was…

RA: But he works in Memphis. He works in Memphis, and they have done unbelievably… In fact, I'm interested to know if that program is still in existence.

NF: Okay.

RA: [Inaudible 49:56].

NF: And that would have been Harry Danziger? Is that right?

RA: Harry Dan-… Yeah, Danziger created it.

NF: Yeah. His son is a classmate of mine here.

RA: Oh really?

NF: He's, I think, a year behind me. Yeah. Yeah. Michael.

RA: Oh, yeah. Well, yeah. Harry Danziger was really… He did a great job there, a wonderful job.

NF: Great.

RA: He's a good man, a good man. So, yes, so the Caring Community programs they're still in existence in congregations all over North America, and I still have resources here, and, like I said, I occasionally get called on to do some consulting with them. And we did… We published a lot of stuff under them. We actually did a major program book called *The Coming of Kehilat Hesed*, which actually took the congregation on through how to create a program, what things worked, what didn't work, resources, text to use, stuff like that. I mean, every time the congregation would call, before I went out and talk to them, we will send them the Kehilat Hesed book, sort of like get… starting to get familiar with them… with it.

NF: Alright, well…

RA: So…

NF: I think that covers most of the information that I'm looking for in this phone call. I mean, I could ask you a little bit more about the history and some of the challenges and successes that you've had. I think that you've talked a little bit about a lot of that stuff sort of throughout our conversation, but let me sum up one or two things to make sure I'm not really missing something big here. So, it sounds like through your work with Sacred Aging now and previously with Sacred Aging and also the other parts of the Department

of Jewish Family Concerns that had existed [throat clearing], it sounds like there was a lot of creation of support materials that rabbis or congregations could use and…

RA: Correct.

NF: … trainings in how to implement programs, how to introduce things, and consultation. Does that sum up the…

RA: Yep.

NF: … the work of your department pretty well.

RA: You're absolutely correct. I spent 3 weeks… 3 weekends a month on the road in the congregation … [throat clearing]… working with the congregation on developing all these types of programs.

NF: Um-hum. And now you find that… Do you find that you're doing much of the same work, just outside of the umbrella of…

RA: Well, most of the work now is really focused around the Sacred Aging Project because…

NF: Uh-huh.

RA: … that's really been my rabbinate in the last 10 years, and even when I left the Union… Even when I was in the congregation, I still was going out and doing stuff on the road, and now I'm a free agent as of this summer, this year is pretty well tacked with stuff that really is all focused around the general heading of the Sacred Aging Project, and under which there's a lot of health and wellness discussions because a lot of the workshop and a lot of the conversations eventually morph into that conversation because even the book I did for this, *Seekers of Meaning*, the subtitle is *Baby Boomers, Judaism and the Pursuit of Health Aging*, and the whole thrust of the whole project and really…

plus all the teaching I do are the tradition through and I use a series of Torah texts to show that in the tradition that says no matter age you are, you continue to grow, evolve, to dream, to risk, and health is a part of that. So, it's been… It's kind of exciting, actually. And there's a lot of stuff hap-… There's a lot… In the general… Because the baby boomers are all now in their 60s and every baby boomer is at least 50, and they're starting to really focus in on what does it mean to get older, what does it mean to stay healthy, what does it mean if I lose my health, how can I stay healthy, do I have more Botox, do I go to 7 gyms instead of 1…

NF: [Laughter]

RA: … do I only eat gluten-free this or whatever, and without… With all joking aside, to understand the Jewish component in this. There's text and approaches to all of these various aspects…

NF: Yeah.

RA: … it's kind of exciting to teach it.

NF: Wonderful. Well, I will definitely take a closer look at some of the resources on your website, and I would love anything that you could send me.

Marlene Feagan, MA, BSN, RN, FCN, 6 OCT 2014

MF: … to be involved with this organization, to be president of this organization, because living in northern Kentucky, I have no idea where you're from, but, living in northern Kentucky, I have had a very, narrow lens on exposure to other faiths. It's got…. just kind of what it is. You know, I have a couple of friends who are Muslim. I have a couple of friends who are Jewish. But, in general, my life revolves around a Christian community, so, health ministries has been great for me. But, the caveat here is that we have a very small portion – amount of, Jewish members and, you know, we've always had a very inclusive approach. And, here's the deal, health ministries would fit perfect in, any synagogue. And there are programs, and there is someone who I can connect you to, from a best practices standpoint. She is a member who is Jewish, she just presented at our conference, and she would be great for you to talk to. But, from a general perspective, what is, that health ministries is and does is exactly what you said. It's trying to connect people to understand the correlation and the importance of faith and health. "Are they connected," is a good question for some people. And, if so, then what is your responsibility as far as your faith calling you to take care of your health. And, then it goes beyond. You know, there is the personal health that we have from a whole person perspective. But, you know, faith goes beyond that because there, you know, what is our responsibility to creation, you know, what is our responsibility to taking care of the earth?

NF: Yes.

MF: From a health perspective, we try to call people to go back to early, teaching of the church. Let's say, you know, the church and why we gather in community the church was the price for, for where we went to get answers. And that's kind of the premise of

health ministries. So say for example, in my Catholic church, we have a health ministries program and we've had a team there for eighteen years, I think. And, that group of people provide education. So, they bring in speakers or we have programs two, three times a year on different health care topics. We have monthly blood pressure screenings. We help the priest so that if he knows there is someone getting to end of life, maybe like a terminal illness, we help to introduce that person to hospice and the possibility of that as a continuum of care. Every two years, we do a program on living will advance directives. Now that has become part in our church of marriage preparation. And the priest actually meets with the couple and talks about now is the time; talk about what would happen if there was a horrible accident and you were sitting in the emergency room needing to make a decision for this new mate. We want to talk about these now. And then, his exercise is that the couples sit and talk with him. Then, they take their plans back when they've developed them. They come back the next week with kind of, "We talked about this, and this is who we are. And this is what we would want." They go through their living will advance directive and then they share 'em with both parents or both sets of parents or both families so that everybody's on the same page because part of the end of life issue is just beginning the conversation so that everybody knows what your wishes are, what would be appropriate. And, then a lot of that is the culture of your faith dictates some of those decisions, too, but, it's getting it all out there.

NF: Yes.

MF: What else? Yeah, um…

NF: Well, Marlene, it sounds like you've been very active or very connected with these events or initiatives in your church. Is that fair to say?

MF: Oh yeah.

NF: Would you be willing to talk to me at, more length about, how that process began and continued and arrived at where it's at today?

MF: Sure.

NF: OK.

MF: And, you know, I am employed – I mean, this is my work as a nurse. My nursing specialty is called Faith Community Nursing. It is a specialty under the American Nurses Association. And, all nurses are called to serve, or to look at faith as part of care. But, in Faith Community Nursing, it says that in every patient interaction, intentional care of the spirit is the focus of care. And so, I work for Saint Elizabeth Hospital and do the health ministries program for them. And then, you know, I work in my church. But, I work in the community at large. Yeah, I'd love to talk to you. I'm very passionate about what I do.

NF: I can tell. I get that sense even over the phone. I can feel your energy and passion for this. It's exciting to me.

MF: Yeah. And then, the other thing is, I will get information to connect you with a Faith Community Nurse who is Jewish, and is working with her community, doing the same kinds of things I'm doing here. But, we do not have that happening in any of - as far as I'm concerned, or as far as I know of - any of the synagogues in Cincinnati - yet. Doesn't mean it won't happen. But, we do not have it happening to date.

NF: Yeah. This is one area where, part of the reason this is my, rabbinical thesis, before, ordination, the entire project. And, part of the reason that I'm, doing this is because there is so little proportionally, that exists in the Jewish world.

MF: OK. And, I can't imagine - and this has been something that I've been interested in for a long time in fact, I can't imagine that a rabbi and his health, or the health of rabbis in general, is all that much better than the health of clergies who are Episcopal or clergy who are Baptist, or clergy who are priests in the Catholic Church because health of…

NF: Yes.

MF: …those that, it's just poor. I mean, that's the reason that the divinity school has, what is it a 25 – 20 million dollar grant looking at health of clergy – because it is so poor, because they're so giving that they don't take time for themselves. Because they work crazy schedules and are on call 24/7 that they don't have the best heart health. They don't have, the ability to really take good care of themselves. I can't believe that it would be, highly different. That's just me.

NF: [Coughing] Excuse me. Yeah, I think that you're right. I get a sense that that at least is a topic that is part of the conversation in Jewish communities – certainly in the Reform movement, that I'm a part of. Now that specifically is a little bit beyond the scope of, um…

MF: What you're looking at.

NF: … what I'm looking at. But, it certainly, is, a very, you know, clergy health is certainly a very important issue across faiths.

MF: Well, it's health in general changes your faith. And that's why I say, there are people who I work with in the community - and I do a lot of work with homeless and underserved in northern Kentucky. And, if you say to someone who is labeled "noncompliant," say they have a heart failure diagnosis and they're just not being

compliant. One of the magical pieces of what it is that we do, is that you call people to personal health by their faith. So, you would say to someone, "Do you have a faith which you believe in? How do you believe?" and then, "Do you believe that you have a responsibility in that faith to take care of your health? Do you believe that?" And, for some people, they've never, ever, thought of that before.

NF: Yeah.

MF: And it does make a difference in how they become, involved, invested in their own health. If I heal in them "my body is a temple", I can start to care for it in a different way. You know, in physical, emotional and spiritual care, like, they're all important. And, without each one of those we're not whole or not a real person. And the person who I'm going to connect you with, she'll – I mean I do want to meet with you and talk to you. But, her name is Gilda Friedman…

NF: Yeah, I think actually Michelle had also mentioned her to me. I think that she's going to try to get ahold of her.

MF: OK. Well, I have her information and Gilda would not mind at all you calling her.

NF: OK.

MF: And, I was looking at what she just presented on at our conference in September – "Jewish Congregational Nursing: A Roadmap to Impact Jewish Lives in All Faith Communities." And so, she's taken the element of faith and healing and wholeness in Judaism and, is doing that in her community – building partnership and, strength in her community. And, I have her contact information which is…

NF: OK.

MF: Gilda Friedman. She is a BS and RN. She has her bachelor's in nursing. And she's from Greensboro, North Carolina. …And she has been doing this for a while, so she is going to know, a lot about what kind of implementations that she has made in her community, and, you know, resistance or acceptance, or stories of impact. I mean, stuff like that, she's going to… OK, she works for the DJH Foundation. Do you know who that is?

NF: DJH?

MF: Mm hm. Foundation.

NF: I'm guessing the J stands for Jewish but, I have no idea.

MF: Right. And, then she – they partner just like I have churches partnered with me at Saint Elizabeth. They partner with Cone Health which is part of, you know, in that community, it's their health care system. And, she's been very active and involved. So, she would be someone that would help you, be able to, you know, talk from kind of her Jewish perspective about how she's been able to, you know, implement faith rituals involving, you know the Jewish community. I would love to be able to work with a synagogue, because it would be a wonderful learning curve for me and to share some of the principles, because the principles of health ministry are - were born, you know, universal and, like, my friend who works in, in Chicago, they have synagogues that partner with Aggregate Health System which is a large health care system in the Chicagoland area. But, it just hasn't been that way to date here. But, the principles work. And there's no reason that it wouldn't work or couldn't. And Gilda would just be somebody that's actually doing it. But, I would still like to meet with you and talk because I find the whole thing really a love. Um. I'm getting ready to do, a project in

twenty-fifteen where we're going to be doing some conversations around helping staff here to be more inclusive, of faiths because our, you know, the very Christian environment is changing. And so, we're going to be doing some things and I'm working on that now. So, the whole thing is very, interesting to me that, health ministries, can work, or the principles of health ministries can work. So, do you - you're a student here that lives here in Cincinnati?

NF: Uh, yeah. Yeah, I live in Forest Park and I'm on campus right now in Clifton.

Marlene Feagan, MA, BSN, RN, FCN, 22 OCT 2014

MF: When I was hired here, there was a man who actually just retired from the free food store, John Young, he hired me and he said, "You know there's five people, more education than you, more experience than you. But, we need a change in the environment and chemical dependency." And I was really interested in addictions and…. "We need… it's a bad environment and we need a change. And I'll give you six months." And I said, "That's perfectly fine. I'll take the job and I'll take six months." And we just started working through how you look at, the…the rule was, from day one, the very first meeting, is that anybody walking into treatment here, you need to use where you are in your faith, and see who this person is through that lens. So for me, Christian. And I'm going to see Jesus in the face of that person. Who is it that you're going to see in the face of every patient and family? The second rule is that any, of anybody, who is a patient in chemical dependency, could be your brother, your father, your uncle, your son. Keep in mind that this is a marginalized person with a disease. And thirdly, their family. We will never talk negatively about a patient or a family. Not if they are the most miserable family in the world. Not when you are here on the clock. And if you are going to have those feelings, have them in the car going home because it doesn't do us any good. And the - the truth of the matter… and I could say that to them cause I had already worked in chemical dependency. I never… I loved every child. Because I had worked in adolescent chemical dependency. Many families I could just tolerate, but I did it from a respectful base. I mean the incest, the stuff that was going on was deplorable. But I gave them the respect that they had and the position as that family to that patient. That's it. Those were the three rules. And everything turned around pretty quickly. Because the people…

NF: When was that?

MF: Twenty-five years ago.

NF: OK.

MF: But that was before I had had the real epiphany. Because when I was working in chemical dependency, I kept saying, "What keeps someone sober?" It had nothing to do with the family support group. It didn't have anything to do really with the education, because people really got that on the first day. You know, drugs are bad for you, and this is where you're at. And, it's chemical. You've made bad choices. And if you keep using drugs, you're going to be back here again. I mean people got the gist. Where they got hooked, was if the really got pulled into the Twelve Step Program when they got to the faith. Even the kids. The kids could relate to the fact that there was... There were assets to build on when you went back and looked at your faith. Just do pure asset building. What worked for you in the past, what's working for you today, and how are you going to build on that. And that's when I went back and got my masters in theology. I was like I need to know more. I need to be able to talk to people in a way that I'm understanding better. And so just doing classes like synoptic gospels, really helped me to better understand my own faith and how I could share that with people. But understanding that each person in recovery was only going to recover if they really got the faith piece, because every day is difficult and you're not going to recover.

NF: Yeah. So let me ask I'm sort of, as you're talking, getting a picture of, sort of the different ways that you're connected. I am sort of looking this intersection between faith and healing, from an organizational standpoint, sort of three different lenses. One from the - the point of view of the church or the synagogue, temple, etc.

MF: Right. Faith community.

NF: Faith community. One from a medical standpoint - a hospital or clinic, and one from a, professional organization or training organization. You seem to sort of have a foot in all three of those.

MF: I'm definitely employed by a hospital entity who made the choice to live their mission out in the community through health ministries. So that's kind of where they made the choice to employ me. , the other choice is that 100% of my salary and the program goes to community benefits - which are important to every hospital, more important under the affordable care act.

NF: Right. And you'd mentioned, on the phone that your home church also has a health net… Which church is that?

MF: Mother of God.

NF: Mother of God?

MF: Mother of God. 6th street and Covington.

NF: Which is the - the faith community and then also the, nurse's training that's not uh…

MF: Faith Community Nursing.

NF: Right

MF: I'm going to give you - I'm going to lend you some books because I want you to look at them.

NF: Now, is that based in Dayton? I have a Dayton address.

MF: Health Ministries, which you called yesterday is based in Dayton.

NF: OK.

MF: It's actually… That's it. That's who you called yesterday. Yeah.

NF: OK.

MF: And it's, it's based in Dayton, Ohio.

NF: And…

MF: So, our office is in Dayton.

NF: OK. And, your role here…

MF: I'm president.

NF: Is the president?

MF: Yeah. I'm president. For one more year

NF: OK. Is – is that like, an elected position or…

MF: Right.

NF: …or is it appointed by

MF: Correct.

NF: …a board?

MF: No. Well, there is a board of directors… But it's an elected position. And I served in other leadership...

NF: OK. Is the president a part of the board?

MF: Uh huh.

NF: Or is it…

MF: Uh huh. Part of the board of directors of the organization. Yeah.

NF: OK.

MF: Yeah. And that has allowed me to do a lot of national work. So, that's why when we were talking yesterday, it's like, well, I know some of these people and what's going

on. It's because I'm on the phone daily with people across the nation who have programs like this. A lot of my peers have the same. They're supported through a health system. And some of them have a lot more diversity than we do in northern Kentucky. , and then, Saint Elizabeth has been very good to allow me to do some national work. So, I'm on, like, the White House Let's Move Program. I'm part of that committee. , and we've done some work with childhood obesity. And we've done some work with – some national work - with Faith United, which is an organization that takes on different topics. So, they've done Faith United doing Childhood Obesity. They've done Faith United. They've worked with Brady's on gun legislation. So, there has been a lot of opportunity to work with different entities around the nation - from Health Ministries. And I do some public speaking, so that allows me to get out and do some stuff.

NF: OK. And what is your title here at the hospital?

MF: Yes.

NF: OK, so I have a little bit less than an hour today. Because I actually have, another meeting back in Clifton.

NF: which one of these three areas would you most like to talk about today? And I would love to have the opportunity to talk about all three.

MF: Yeah. You pick.

NF: OK, well, I'm most interested, right now in, the church.

MF: OK. Ah, so what's happening - like what's happening in our church?

NF: So, yeah. I'd like to know about what happens about, the - the starting point that this came. , how that's come about. What kind of partnerships exist inside and outside the church, and what kind of obstacles, what kind of successes. So, I guess my first question

is, you started telling me a little bit on the phone when we talked, what programs currently exist at the church related to health care?

MF: Just at my program?

NF: Just, yeah.

MF: OK. At Mother of God? What we have… we're in our …seventeenth year. We have a health cabinet. The health cabinet are people who just kind of came together. Basically, have kind of stayed together. There's a lot of the same original people. And we meet… we used to meet quarterly. We meet twice a year - to develop strategies for, health and wellness in the church. And, once a month, we have blood pressure screenings. So, after both masses, we have blood pressure screenings. We carry documentation – documentation. So this would be, like, what we have on every client in the church. And it's all kept locked. And it only – it belongs to - you know, the nurses, or the faith community team. And then - it's pretty benign documentation. These cards - we write on them, and staple. So, at some of our sites in the community, where we're seeing people every week, these are getting really thick, but we don't have, like, a paperless documentation system. And then, the other piece of that is we make - so you'd see for your blood pressure, I know what's going on. If I'm the same person and you want to see the same nurse every time - that would be probably the same nurses. Those are, registered nurses. In the state of Ohio and the state of Kentucky, a registered nurse can do personal health counseling. So, that's what we do under our state Nurse's act.

NF: And that varies from state to state…

MF: It does.

NF: … in terms of what a nurse can do?

MF: There's a little of a variant.

NF: I understand.

MF: But a registered nurse is really supposed to have, whether you have a two year degree or a four year degree is supposed to be able to do health counseling. Now … the call is that I am not a pediatric specialist. I worked two years of my whole career, way back, as a pediatric nurse, but I'm not a pediatric specialist. So I would only counsel any areas that I am really clear on. So, most of the – the nurses are doing continuing ed. around Faith Community Nursing issues or issues that are pertinent. Like, I consider myself to be a hypertension specialist because I am constantly doing blood pressures and referring people. So, the next part is, you know, we follow people. , last Sunday, I gave flu shots at my church.

NF: Do you think that is something that you do…

MF: Every year – uh hum.

NF: … every year? OK.

MF: We try to inform people that every one that is reasonable should get a flu shot. All clergy are free.

NF: How do you, get that information out to people?

MF: Oh, I have all kinds of things - like this, right here.

NF: So these are - are flyers that are mailed out to people?

MF: Yeah.

NF: Or, they are posted in the church?

MF: Well, the people who have programs are connected with me. And I would be saying, "Do you want to do flu shots? Give me your days and times." And, then I send

out all kinds of information. We put church bulletin information in every week with something around health and flu starting in August. We run different things because people do read bulletins, if you're still paper. Some of our churches are now paperless. And so they are not – so, they're tweeting or whatever. , but we provide that. That's part of the service. When you partner with Saint Elizabeth, my services as your consultant are free. So, then we follow the patient and then the next thing is if we make referrals to anyone. If we make referrals, we fill in this information. Write down the referral. I give one to the patient and then I put the other one on here. So, we're following them pretty strategically.

NF: OK.

MF: Documenting - that's required under the scope and standards of Faith Community Nursing, - trying to get them better connected. So, I could refer to a pharmacy appointment saying, "I've just worked with someone. I've given them a pill box. Can you make sure they continue to work on compliancy on medications? This is what we've done." If it's to a physician office saying, "I've seen your patient three months in a row and continue to see an elevated blood pressure on Sunday mornings. I've given information. We've been working on some things and I don't see a change. Could you please work, you know, please, use these numbers - write these numbers down and evaluate. I mean you can't say to someone, "Maybe your doctor's not doing a very good job." But you can make suggestions like "Does your – do you have a good relationship – a good rapport with your physician? OK. Then let's talk about how you can strategize what you want to say at your next appointment." We do a lot of planning. "Your appointment's coming up. These are things you've said to me." So a lot of times

people sit down because you have your stethoscope on and a blood pressure cuff - and we have a little blood pressure card. I'll show you that, too - that they just follow the little blood pressures on. But, sometimes they come and sit down, and we always say hello. And, you know, you look at the card and say, "How are you doing?" and then it's just that they need to sit there because they have another issue. And, so then, it's just listening to the story. So maybe it's. "My blood pressure is up because we've just taken in our mother-in-law who has dementia." So, then, it's like, "What kinds of services are you hooked to?" Maybe we give them the Northern Kentucky Senior Service Guide. Maybe make some suggestions about calling. I have a man at my church who just lives alone. So, he'll sit down every month with me and we'll talk about how hard it is to eat appropriately when you are single living alone.

NF: When – when does he see you?

MF: After mass. At my church, mass is at 9:30 and 11:30. And so, there are nurses there from 9:30 to 1:30. So, we're there on one Sunday morning a month, there are nurses there. So, he can come early, before the 11:30 mass or later and sit and talk. And we have a deaf community. We serve the deaf. There, everything is signed. And so, we have one nurse who signs - who is predominantly there at 11:30 every month - so that we can better serve them for flu vaccines, to ask the right questions. Actually, we probably now have about three nurses who sign. A lot of the people in Covington will walk in off the street because they serve donuts. They do – not good. But they serve donuts and coffee. And so, we'll see some of those marginalized people. A lot of people come from the suburbs. And doctors, lawyers, merchant chiefs will sit down and get their blood pressure taken. , because people basically have health care illiteracy - and just need help. And so,

you give ‘em one little piece of information they didn’t know, and then, all of a sudden, they’re like coming back every month because it’s useful to them. You know, we have like pill boxes. We have different things that Saint Elizabeth, provides that we can give out. , we have the mammogram van that can come to your parking lot of your church if you’re partnered. Or if you’re not partnered. But…

NF: And how often do you…

MF: Churches do that? Our church does it once a year. And we have the vascular van now – which is for all those vascular carotid screenings… Doppler screenings. They’re [sounds like “for worried well”]. Because you have to write a check. It’s a retail thing. We have that once a year, too at our church.

NF: OK. What other…

MF: We have blood transfusion. We have Hoxworth come twice a year. We highly encourage people to participate in that.

NF: Donation?

MF: Yeah, they just sit in front of church and we all do that on that - those two Sundays.

NF: Sure.

MF: Our priest is great because he will talk about these things from the pulpit - which really helps because when you stand up there and say, “Today is flu shot Sunday and I’m getting my flu shot from the nurses downstairs. Make sure you get yours.” It’s really good – because people – we all want to be able to give the sign of peace and be healthy. You know - or something like that.

NF: What is – what is the extent that he, talks about that from the pulpit?

MF: Oh, just like that.

NF: OK.

MF: I mean it's not like, you know, he will always mention that "The nurses are here today. Stop and see them – you know - as a service." He stops and gets – gets his blood pressure taken. But it's kind of from that top down kind of thing. He has cardiac issues and so we are worried about him and, he will frequently talk about if he has a hospitalization, we're one of the first people he will call – you know, to come in to help him hear what is being said. So, we do discharge planning with patients if they need that - or with families. We work with some of the families who have older adults, who live out of town.

NF: So how would that come to your attention? Somebody would contact…

MF: Father. Father Hartman would say we have the nurses…

NF: …ask you for a consult?

MF: There's a phone number. The person who is in charge there is Carol Fause. And then she will just send out an email, "I need a patient seen at ten o'clock on the first person - on Tuesday and the first person who responds will get that person. Communication's tough because we don't have an exact line that somebody's listening to. Every church does it a little bit different. Some of our churches do have a direct parish nursing line. But at our church, I think I mentioned end of life referrals? We do have one of our – one of the people on our health care team has done the volunteer program for hospice. So, she's like our hospice contact in the church. So, if you - want to talk about hospice, she's listed in the church bulletin as the hospice expert – you know… the hospice volunteer for our church – so she…

NF: And so then her contact information is in the bulletin…

MF: Yeah…

NF: … each month?

MF: Yeah many of the… it just listed in there every week. Or on the website. , many churches do it in different ways. Hospice is… end of life issues… we do a program once every two years – on living will, advance directive. We have someone who comes – we change it up because it gets boring if you just keep using the same people. We usually have someone who would come and talk about ethics … as it pertains to Catholic end of life issues. We have someone come from hospice and talk about why you should be talking about hospice as your continuum of care and then we'll have living wills, advance directives. And in the state of Kentucky, we have one from the – it's a Catholic one. And people like it if you're Catholic. It talks Catholic language. It's from the four bishops. So we have that and then the other one we use is Five Wishes or whatever – there is two different ones we have available for people. They can sign up there. They can take 'em – start the conversation. It's all about the conversation. So, that's why we have that program once every two years. Because we think people are either, , new or need that - because people sign into the hospital all the time and they say, "Do you have a living will?" and they go, "No." and nobody ever does anything about it. So, just getting people to realize it is your responsibility to think about these matters - and talk about them with your families.

NF: Sure. Now, what other kinds of, either regular or periodic programs do you have there?

MF: We do, anything from… smoking cessation. We've done like, a potpourri of exercises. Like we did Tai Chi, Yoga … and something else. And the other one - we did demonstrations of that. …

NF: Are these one off type things - or is there like a… series?

MF: They're just like one month. We have done yoga at our church because we have enough people who are willing to pay for classes … and when we pay for classes, we can invite people in from the community and we provide mats for them. We've done a lot of cardiac issues, because we're the hub for cardiac issues in this area so, we've had cardiologists come in and talk about know your numbers. What does it mean when you get your cholesterol taken? What does it mean for your triglycerides?

NF: So, what would an event like that look like? Cardiologist comes in during the week or…

MF: On an evening.

NF: … during the service?

MF: We might follow up with that…

NF: It's promoted as here's an educational opportunity…

MF: Yeah, here's an educational opportunity

NF: Come on Wednesday night and…

MF: You have to just market the heck out of these things. You know, we've done it where we've partnered with other churches. Because we think it is a topic like suicide which we wouldn't get a whole lot of people from mental health to come. So, we partnered with three other churches. And there were four churches partnered together to bring in a mental health person to talk about suicide. But, yeah - it's just marketing like

that. But if it's something big, you know, we will make an announcement from the pulpit, because my priest will allow you, but a lot of churches won't. , a lot of the churches now are using social media. The Vineyard, the Crossroads they use a lot of social media to get out information. And, I am not working with Crossroads, but I am working with The Vineyard. So, that would be a way to get information out to the people, too. Some of the churches – not my church, but we don't do a whole lot of stuff during the week, but like - we look at this, like, there's this umbrella – and, and - what in the church falls under health? What does health look like? So, say for example Saint Thomas - which is a Catholic church up in Fort Thomas – fifteen years ago, they decided to put under health: hospital visitation, shut-in visitation Commun – Eucharistic minsters – sending cards to shut-ins and bulletins. So, it all falls under what they consider health and wellness. So, they do a lot of education with this team on spiritual growth. So that the Faith Community Nurses everyone. They have a pretty comprehensive look at what health is. , AA falls under there. They use the church for AA. This is a good way for a church to look at it. If I go into a new church. I'm going to a small church in Bracken County? Pendleton County? Pendleton County.

NF: So, let me ask about this umbrella and, short segue into the history of how this program came to... I feel like I have a good picture of what it's doing today. I'd like to know what it was like seventeen years ago when this was starting off. .

MF: Mother of God was my church seventeen years ago, so if we messed up the - Father Harman wouldn't care. So we started with this team of people getting together and talking about faith and health and was it important. And, did we have responsibility to help those people?

NF: So, how was that first initiated? What's the first thing you can…

MF: When I wrote this program I went to Father Hartman and said we're looking for two churches to sign on. We need one Catholic church and one Protestant church. And, how do you feel about health - faith and health as part of who Mother of God is?

NF: So, this started with you as a congregant coming to the priest and saying here's this program - will you…

MF: Right. …be interested.

NF: Sign off? Be interested.

MF: And that's basically how every one of our programs have started. It's about a nurse, or somebody interested in faith and health, saying I heard about this. The church down the street's doing it. Can we look at it?

NF: So, what was the next step after that conversation? He said, "Yes, this sounds great. Let's do it"?

MF: We – we gathered a meeting of some people he thought might be interested. So, we singled out some nurses. Singled out an alcohol and drug counselor a pharmacist - and invited people to come to say how do you think we would be able to live out this ministry at Mother of God?

NF: And at that initial meeting – how many people do you think were there, roughly?

MF: Maybe fifteen, sixteen.

NF: OK. And so, at that initial meeting, then, that group of people, more or less became the – the commission…

MF: Cabinet.

NF: … or the cabinet. As that cabinet was transitioning from this group of people who were invited to this meeting on health how did that become the cabinet?

MF: I think people just signed on and said, you know we chose somebody to be in charge - which she still is. And, we talked about how we were going to have to buy some equip… – very little equipment. But, we needed a cabinet that would lock. And, how were we going to move that cabinet around. And, it's the same cabinet that we're still using. It was just came out of what we were going to do, initially in that first or second blood pressure screening. And then we developed, which most programs do, a trifold little brochure that explained what it was that we could do. And father would hand - have them in a back pocket when he went to visit people to say the nurses are available to help you if you need help.

NF: OK.

MF: And, we all tried, and he – his vision was - buying into the fact that, , the chur – he wanted people to see Mother of God as a health place - a place to come when you have your questions from this kind of global perspective.

NF: OK. And, how did you decide, as a group, what fell under that umbrella? How did you decide basically what you were going to do? You decided that you were going to create a brochure that could be handed out. You decided you would have…

MF: I think it was just consensus of the people. I mean, I think that if you understand the culture of the church. Like we've never done – lots of churches would have done an assessment up front. We didn't do that. , but, a lot of churches do. They even do them yearly or bi-yearly. But, I think what we did was more the consensus of knowing the culture of the church and knowing that we had a lot of older people. There were issues

that we thought that we could address. And some of ‘em were political in a way, like, you know, fifteen years ago, smoking was still an issue. And, then, when smoking became not so much of an issue, there were still urns where you could put out your cigarettes in the front of the church. And, it took almost a year to lobby to get those moved. We just didn’t want ‘em there because we thought it would send a bad message to children. So some of the things have been like ADA kinds of things, like trying to have access.

NF: OK.

MF: But, they’ve just arisen. You know, like, we’ll have a meeting and someone will say, “What about doing something? I’m seeing trends.” or, you know, like, “Over this six months, we’ve had a lot more diabetic people showing up - newly diagnosed diabetics. What about doing a program on diabetes?” So, some of it has to do with we log our results.

NF: So that would be a doctor or a nurse that’s …

MF: Watching.

NF: …that’s hearing about these things in the church or in their own practice or a combination?

MF: Mainly what‘s going on in the church. “Cause each of these programs are going to be very directed towards that congregation. And, it’s going to be – even if you’re in the same block, it’s going to look very different.

NF: So these are – these are the nurses who are there monthly …

MF: Collecting data.

NF: Sort of, yeah. And deciding, oh well this is a new thing or this is ongoing, or this is moving in a different direction than we expected.

MF: Right. And, things that you know, like doing – I mean after the first year or two, we decided to do a walk through for safety …to see where we were in the church with safety. And then, what kind of signage did we have for people getting out of the church in case of an emergency? AED. We now have an AED. SO, somebody has to be in charge of that. We did – we do CPR training every two years for leadership, for anyone who is doing anything with children and ushers. , we develop the plan for if somebody passes out. You know, not fifteen people need to respond, but how are we going to respond? And, we did some mock drills on stuff like that. I mean, we have an old church. But things would come out where people just say, "Well, you know, I think we could have a better plan for…" during flu season, you know, sign of peace becomes a big problem for some people. And during flu season, we highly – we bought stands and put hand sanitizers all the way through. And, now they're there all the time. But, it came out of the flu season one year when we had…

NF: The sign of peace is like, shaking hands?

MF: Yeah, just shaking hands. And people get, you know, when you get, what was it, H1N1 or something which was a big flu thing. So now we have dispensers – like we have dispensers at the front of the lines for coffee. And, all of that came out of health ministries. We try to look at issues of safety and health within the church as much as for the per - you know, for the people who are attending.

NF: So, it sounds like, , in – in terms of executing these, a lot of these are, , it seems like there's a – a range, in terms of the scale, , by which I mean, putting out had sanitizer is a pretty small cost. It doesn't take really much time or effort, or space. And some of these take a lot more time or effort or space - or money.

MF: Mm hm. AEDs… are expensive.

NF: …putting in ramps or AEDs.

MF: Mm hm.

NF: So, I wonder where those resources have come from.

MF: Some of those we have developed ourselves. We have had donations from members. We've had positive experiences or have had nurses walk through difficult things with them. That AED…

NF: So, do you approach people directly?

MF: No, the AED came from an attorney who donated that. I thi - he donated that, when we - a request was put in. Father thought it was a really good idea. I didn't think it was so necessary because our response time is so quick. But he thought it was a really good idea. , so it's…

NF: So that was something that – that …

MF: Parish council.

NF: …using the wrong – the commission – what is the – health…

MF: The health cabinet.

NF: … cabinet. I keep using the wrong word. So that was something the health cabinet has mentioned to him and then he went out and found somebody to…

MF: Do it. Uh huh.

NF: So essentially he did the – the fundraising?

MF: Mm hm. We've done a couple of fundraising events, too. I mean, we've sold some things to raise some money to buy a few things. I'm not even sure what we've

bought, but I know we've had a Tupperware sale. And, I know all of that went to health ministries. …

NF: OK. Was that something that was organized by the cabinet or by the church as a whole?

MF: We brought in someone.

NF: OK.

MF: And, they sold Tupperware. And, you get 40% back – or 30% back.

NF: Sure. OK.

MF: , we haven't spent a whole lot of internal dollars in a while. In the summer, we did, – for the last three summers – we did a fruit stand for kids. So, we built this cute little thing that looks like an old fashioned fruit stand and the kids have bananas. Well, the adults have 'em, too. But they're made – they're kind of a kid thing – trying to increase… We - our church hosted a tri-state event for obesity. And, so, but, we still do donuts. Father will always do donuts. And, so, I mean, he eats 'em until, you know, until he's no longer there. He said that – that, "Donuts will go away when he goes away." , but we add fruit. We add fruit and we add low fat breads on blood pressure Sundays. The rest of the time, it's just donuts and coffee. On blood pressure Sundays, there are fruits available. We buy about twenty-five dollars' worth of fruit. It's all eaten. But, they eat their donuts, too. It's not like they choose one or the other.

NF: Sounds like that's been a little bit of a challenge.

MF: It has been. Food and churches are terrible.

NF: Yeah.

MF: I think in Protestant church – I mean, Protestant churches, Catholic churches and fish fries. You start talking about food, and it is a rub for people. Food is a big deal. I was at am African American Baptist church on Sunday. I couldn't believe it – piles of fried chicken and that was their blood pressure Sunday. , so, yeah, that's a huge rub for churches in general. Because when you get people together it's easy to get people together over donuts that have been bought the same way for - from the same bakery for forty years. And a cup of coffee. , and, people see that as a treat. Not as maybe a suggestion that the faith community's not doing a better job at leading people in the right ways. I think you have a responsibil… – I mean I believe – I was raised on a Southern Baptist Church, so, I know what food is all about. I just think that you can be a leader in some of these areas and leave brain imprints on children that do not mean you have to have a chocolate donut or use it for leverage. You see people do that, too. "If you are good in church, we'll go downstairs and you can have a donut."

NF: Sure.

MF: It's like an association for the wrong reasons. But, it is what it is. Food's a big problem.

NF: Would you say that that's the biggest obstacle that you've run into as a member of this cabinet…

MF: My church…

NF: … in your church?

MF: Yeah. There's no regard to really trying to do things healthier because people like it. Mm hm...

NF: You know you mentioned like the ashtrays…

MF: Well, we finally got that resolved. But it took – it was a while.

NF: Can you describe that for me?

MF: Yeah. It was like, there were these two things that if you were a smoker… you could just stand there and then put out your cigarettes on the way into church. I don't want to walk by that. Nor do I want to walk by with children. And, nor do I think that is what children should be seeing walking into church. And, I'm not there to– I don't care that somebody puts it out in their car. I mean just not in front of church. It sets a bad situ…

NF: So, I'm guessing that that sentiment was unanimous in the cabinet of the health… professionals.

MF: Pretty much.

NF: … so what happened when you took that – did you take it to the church community as a whole or did you...

MF: The church council….

NF: … the church council….

MF: More than once.

NF: And what happened?

MF: There… was some debate. There was a smoker you know at that time on the church council and there was some debate about serving everyone and it's just not – it's not serving everyone when you're – I mean it took a while. You know, it took a little while for…

NF: Was that surprising at the time?

MF: No. I live in Kentucky. Not surprising at all. I mean we're still working with - right now– with patients leaving the premises to smoke. We'll, in a volatile community, where

there's a lot of drug use, you don't know what someone's doing. And when they come back, how long should they be able to be gone to smoke? I mean, it's an ongoing problem. We- we're – I'm not saying that it's nothing. Because I do feel bad. I – two months or so ago, I had an admission to psych with a young woman. She did not realize she was going to be giving up her cigarettes when we got to the emergency room. She's like, "What do you mean?" I said, "I can get you a patch, but, you can't - a cigarette – we are in a hospital." She was shocked. So, I did feel a little bit bad for her. But, not really. The thing is, it's bad for you. You knew to quit smoking. And, so, maybe this is a great opportunity. But, it's really not seen that way. We live in a smoking state. So, you know, it was an obstacle, but, I think most churches have worked – I don't really see so much of it in the last year or so.

NF: OK. Eh, were there other, obstacles or bumps along the way? Or something that – that you put on that were not successful?

MF: Some of the things – some of the hardest part of doing health ministries is you don't want a nurse to volunteer to be a nurse. I want a vol – I want people to volunteer in health ministries to do health ministries. It's more than taking a blood pressure.

NF: OK.

MF: It is about a comprehensive approach to being with people. And, I think that's one of the hardest things. As you know, people get excited when there is a new ministry that – where they really have time and talent for. But, they might not want to put in the work to do some additional education and, or whatever, to do it from a way that on Sunday night, we're at 5th and Green up in Covington. I'm there almost every Sunday night. Like I'm not going to be there this Sunday night. But, we're there 3:30 to 5:30 and that team of

people get – every nurse on that team, they're volunteers. , that's an outreach from Emanuel United Methodist. They all get it. Because if you don't get it, you wouldn't come back. Because they're all living on the street. They're all homeless. And, it's really hard work. But, the care and compassion is incredible. And, we have been doing it for almost eight years. And, we have people who have come back almost every Sunday for 8 years - to see us. So, so, they kind of get it.

NF: Is that - is that connected with the work you do at the church?

MF: Yeah. That's – Emanuel United Methodist has a program just like I have at their church. And Lynn McIntyre is their coordinator - at their church.

NF: OK. And part of their ministry is this sort of public health outreach?

MF: Yeah. They are up at 5th and Green. UP - now the building's owned by Gateway… School.

NF: Does… something like that exist at Mother of God?

MF: Mm hm.

NF: So, just the way it happened to come out, the health ministry at Mother of God is primarily internal. And, other churches have a combination of internal and external.

MF: Exactly. The United Methodist… the United Church of Christ, the Presbyterians, the Episcopals… all have directors of health ministries at a national level. Those denominations have just ran with it – with health ministries. UCC Church has – have given a directive that they want every United Church of Christ to have a health ministry team. The United Methodist are not quite there. But, they're really close. And, then, the Episcopals have a director of health ministries. He's located in Indianapolis. And Presbyterians have a department and have had for a long time. So, it's, , when you have a

denomination that says this is important and we're going to put someone in a role nationally to lead this – so there is someone sitting in an office somewhere, so that, if I'm a United Methodist, I can call up and ask for what I need – get questions answered. It really mushrooms much quicker than in the Catholic Church where that just doesn't exist.

NF: I see.

MF: So, those denominations have been real leaders. Barbara Baylor, for the United, Church of Christ, is now working on the hill for a year. Kind of doing lobbying around some health issues. So, there are creating denominations who – that have really embraced this.

NF: So having that at a National organizational level makes a huge difference?

MF: Huge. 'Cause, one thing, here's what it says: It says to me that, "My faith believes that faith and health is incredibly important in their mission. Because they – they figured out… a way

NF: Symbolic significance in itself is very important?

MF: Right. Plus, it's a resource. If I'm at church and I want an AED I can call and find out how out the United Methodist Churches have done this. Is there a policy? You know, what does it mean? How has it changed a church? If I am a pastor, I can call and say, "I heard about this. Can you help me? Now what I need to do to get started?" But I think more of it is symbolic because a lot of Catholic churches have faith-health ministries and there's not been a lot of recognition to that. A lot of work goes into the ministry, but, no one is report it.

NF: Are there any of those changes that you have tried to work towards that have not been successful so far - either trying to lobby the church in a sense, the Catholic Church to, …create a position or to – to…

MF: I don't know where you would start with that. I guess with the bishop's council.

NF: OK.

MF: I only know that one time, and it's been forever ago, that thirteen years ago that someone talked – spoke there. I think you had to get a bishop. Health ministries in general has not told its story very well because it is still vague to people What it is that we do from a practice perspective? , and, that's something that we are trying to change in this year. We're trying to do more Christian, Catholic faith based radio stations. We're going to be doing more things like that to get the message out. Because there are a lot of doctors, nurses, PA's and LP's sitting in every faith community that could come forward and provide faith and health services. That would change what's happening there. For example, Affordable Care Act. Many of our churches had connectors come in to the church and sit at tables to get people signed up. That's huge service. Now, you know, I – I think that's – that's amazing. And to have people for resources around health care and how complicated it is. A lot of our churches do have a little ministries under that umbrella, like transportation ministries, where you can call up and say, "I need Coumadin drawn every week and I don't have transportation. So, that takes it all off the church leadership when he - that can be turned over at the church office to that health team.

NF: OK. Is that what happens when…

MF: It does. It does. So, if a call comes in. If Father - something comes to him, he will call the coordinator. And the coordinator will get the word out, "We need some help with

- so and so needs help." And, you know, Father used to, like, hand out money to people for dr – not for drugs – for prescriptions. And then, you know, we talked to him and said, "Don't do that. It's not safe." It's not good. We don't give cash. I don't give cash. But, if somebody comes and wants a bus ticket, we'll give them a bus ticket to get to medical appointments.

NF: Right.

MF: So, it's been like a learning curve when you live urban. Peop - Churches can get into some bad behaviors – not the safest.

NF: OK.

MF: And, so, now, we have a means to say, "So and so's having a problem with meds. How can we help them?" But we don't give them money.

NF: So …in a situation like that, "I need a prescription but I can't afford it…

MF: Mm hm. We would get them connected to somewhere they could get the prescription. We have means to do that. But, we don't just hand out money. That wasn't good.

NF: So, the church would contact a pharmacy and pay it out of the fund in the church or…

MF: No, they would refer to a community agency that could help. So, we have a faith community pharmacy for Northern Kentucky. We have, four dollar – the potential to pay four dollars for scripts if the doctors will write to the ones at Kroger. Then, I mean I've been known to do this for Mother of God, just go to 15th Street Kroger and pay for three scripts out of our money for the church. That's sixteen dollars to get somebody's meds.

NF: Right.

MF: Now we're talking of, you know, getting them connected to the Affordable Care Act because then you're going to get your meds. …

NF: Now along this process of getting the ball rolling and, sustaining this effort, were there any unexpected sources of support, something that you, that has made it successful that you would not have guessed when you were first starting out?

MF: Couple of newspaper articles that they really bolster churches involvement and support. Positive stories. A woman with breast cancer, very young, who had a Faith Community Nurse walk that journey with her. My friend who's at a United Church of Christ in, Durham, North Carolina had four women last year under the age of 40 with breast cancer that she just went and sat and scribed during the first two or three appointments and then would sit down with the couples and say, "Now this is what was said." You know, "How are you going t – how are - what do you want to do?" helping them to think through this. You know lots of creative ways that I can use my talents if I 'm interested. She just happened to be a breast cancer survivor and was knowledgeable as an instructor. But, I thought that was a really cool ministry. One of those women has died this year and left some children. And, they were very involved in helping those children. She was very involved in helping those children and getting them connected to hospice up front and hospice services. And so, a lot of things are created and they just come up as they come up. Like, if Father calls and says you know we have this going on in our life. We had a suicide in our church which is which was unexpected of an adult. And, that's what brought on the suicide program that we decided to do in conjunction with those other churches. So, some of it just comes out of living life and what the church is experiencing, or a loss in the church. We've had several older adults diagnosed with

Parkinson's which is a gait problem. And, so, we did a whole thing about fall - preventing falls in our churches – preventing falls in general but preventing falls in our churches. How to respond as we have older adults with gait issues. And, it's really hard for some people with Parkinson's to walk through the pews sideways. And, we didn't even know that until we worked with a balance expert. He was talking – we had a couple of falls and we couldn't figure it out. So, just trying to do things like that. What's happening in the church? And then respond. Or, if you do have an event going back and going over it. How well did we handle it? You know, what did we do? How well did we handle it to make it smoother?

NF: What would you say has been your biggest success in the church?

MF: I think in every church it's been sustainability – of keeping health and faith… in front of…

NF: I mean… specifically at, Mother of God.

MF: Oh, at Mother of God.

NF: Yeah.

MF: Our big success? You know, I would say it would be something really glorious, but I think the biggest successes along the way is when we sit and talk with someone…

NF: What's one?

MF: Which one? One man came to me and he had had an emergency, He had been in the emergency room. Like the night before. The day before. And he sat down with this outrageous blood pressure. Horrid blood pressure. Like, we can't let you leave here. I mean this is a 9-1-1. And so, he's like, "Well, my blood pressure was up in the emergency room. And, he is like in his late - thirty-five - maybe he was thirty- six years

old. I took him to the emergency room from church because we're not that far away. He was admitted. , and, he had open heart. I mean he really was - he has pervasive coronary artery disease that was undiagnosed. And then, working through that with him. Losing weight – you know, it was a very long process. But, like, coming to grips with it at a very young age. Getting testing for the whole family for coronary artery disease, him getting on a diet, him losing weight, him quitting smoking. That's a success that I remember because it's like a success one person at a time. Like, where you really make a change by helping someone over a year – I'm - a year and a half - to come to grips. It's really hard. What we do this – we've done a program a few times called Men's Health. Just to talk. Like, I read it and gave it over to him a man to do it. And now I've taken it back a couple of times to do it because men are just horrible about feeling weak, having to take a pill or feeling so vulnerable going to the doctor's office. And, that's where he was. He felt so deflated. Happened to me again in another church I was working at - where a guy came in and, it's just like, you know, you've got to go to the emergency room now. It was on a Saturday night. And, he goes, "No, I'm going to go be a referee at a basketball game." I'm like, "No. You're not. You're going to go to the emergency room. Something's horribly wrong with your blood pressure, but I also feel you have to go to the emergency room. But between leaving church and the emergency room, he started having chest pains and, has dealt with… But men are just horrible about that. So, trying to sit and talk to someone about where does this come from? Like, you know, is it a biblical thing? Is it just a male thing? Is it an ego thing? How can we get over this thing? Because you really need to take this pill. You know, and you need to take it the same time every day so that you get a blood level. It's horrible.

NF: So what do you think are the factors if you had to isolate, sort of, how that situation came about, in terms of your church or even you personally being able to be there and do that? What do you think are the factors that made that success possible?

MF: Well, first of all, I'm for sure it was a God thing because I mean it could have been a different Sunday and we wouldn't have been there. Or, it could have been a different nurse who didn't care so much or who could drop it, or say, just go on. But, I – I think it's the commitment of when you're sitting in a church any church. But, if you're – if you're a part of a faith community, and you're volunteering as a Faith Community Nurse, there should be no other place that you want to be at that time that you're sitting with that one person than right there. And, I think it's in that connection. When you connect with someone and you can say to people who you're sitting with in your faith community," I – I'm here because I care about you. I wouldn't say this maybe this directly if I didn't care. But, I do care. And, I really, you know, can I call you tonight? Can I call you tomorrow? Can I call you on Tuesday after I know you are going to go to your doctor, right? You know, like, you said you would go to your doctor. Can I call you on Tuesday to make sure and follow up?" When people start to feel that caring …that connection is what makes the difference. It's authentic. And, it does make a difference when you're sitting with someone. And, these are volunteers in your faith community. They're not in paid positions. But, they're really wanting to be there. That changes things for people. People will come back and they'll say, "Guess what? What you did last week, or last month, I've been walking and I've lost four pounds." "Like, wow! Great." "Do you have any other suggestions? What else can we do?" So, it's those kinds of things that you're helping people to reach goals that are theirs. But, you're doing it from that

relational thing that you care. People know that. You can't fake that. And, they don't - you don't get that out in the world. I mean if you are the next patient in the emergency room, maybe you get a caring person who really sits and listens but, a lot of marginalized people are not listened to very well.

Gilda Friedman, RN, BSN, 30 OCT 2014

NF: I'm just trying to meet or at least talk to as many people as I can, who have some knowledge about doing, not necessarily just parish nursing but sort of starting there and spreading broadly. And I was very excited when Marlene told me that you had spoken here in Ohio, I guess, about parish nursing in the synagogue.

GF: Well, actually, the national presentation was in, was in College Park, Maryland.

NF: Oh, I see.

GF: It was a national convention of HMA so, yeah. It was very good. There's a great deal of interest, and coordinators of these program. In other words, there can be a coordinator of several different programs and, as you can tell, the majority are Christian and there's a great deal of interest among these coordinators to get the Jewish community into their group and help them start a program. However, there's a great deal of fear among them that they're going to say something wrong, do something wrong. They really don't know how to approach the Jewish community. It was a real eye opener for me, that even people with PhDs have such mystery around the Jewish community. It's really astounding but, anyhow, I'm going to be doing a follow-up letter for the national newsletter talking about language. In other words, even though the, let's see, the Ministry is the national professional organization, ministry really does not, that word really does not have a place in most Jewish literature. That's a very Christian word, don't you agree?

NF: The word ministry? Yeah, I suppose generally it's not something that you hear in synagogues, although I've found through my research that even "chaplain" until 50 years ago was sort of an exclusively Christian term.

GF: Mm-hmm. Yeah.

NF: But, yeah, I think the language is interesting…

GF: I just don't see it in Jewish literature very much…

NF: Right.

GF: And they, these people, I think Christianity is so much, it's almost like a nationality in America versus a religion and some people, even though they're very well-educated, have not been exposed to that much diversity in their lives and so, for them, they automatically end the prayer in Jesus Christ we pray…

NF: Yes.

GF: …and they use the word church and they use the word parish if they're Episcopalian or Catholic. It's just very, very, very interesting and…so, anyhow, you need to ask me questions and…

NF: Yeah.

GF: …or do you want me just to tell you generally about my practice or do you want to ask specific questions?

NF: I've got some general questions and some specific questions in mind and is it, is it all right if I record our conversation for my records so that I can go back to it later?

GF: Sure.

NF: Okay. So now, I would like to come back to language because that's something I hadn't thought of that I think is, certainly, very relevant. My end goal of this project is to formulate some sort of a implementation plan or a program overview of how a health and wellness program can be brought into and integrated into a synagogue that, hopefully, very optimistically, I'd like to think I can create something that a synagogue would be

able to take and use as-is, so that's sort of the direction that I'm going towards and, certainly, language will be an important consideration there but…

GF: Well, it will and, of course, that's exactly what I had to do in my practice. I had to take this Christian model, Faith Community Nursing, and adapt it to a Jewish one and that's why I was asked to write the book and I did but it's just, I have faith that we're going to get out there some day. It's a little bit amazing that Jewish tradition and literature and rabbinical teachings *everywhere*, it's so steeped with whole health healing and wellness teachings and mandates that it's a little puzzling as to why we have not more readily adopted this Faith Community Nurse concept. It's a little puzzling and nobody really has the answer for that because, actually, we were the first. Look at Maimonides. He talks about exactly, even how to have sex and how to visit the ill, and how to take, and it's not just the physician's job and it's the community's job and so Jewish teachings in school, the wholistic, I guess, is what I'm trying to say, approach and yet we don't have very many Faith Community Nurses at all, which is an independent wholistic practice, which a, meaning that it encompasses the mind, body, and spirit with an emphasis on prevention, which is new to American healthcare. [Laughs] They wanted it to be management and treatment rather than going at the other end and preventing problems to begin with and so that just, it means I'm intervening early and catching something before it gets to be a big problem so…okay, so ask away.

NF: Yeah. Well, I'd like to start off by finding a little bit about how you became involved in this, basically sort of where you started, what was your first introduction to Faith Community Nursing and how you've built up to the point where you are now, just sort of your path to date. Could you talk about that?

GF: Well, okay, yes. I was working in a behavioral health hospital and I saw a posting for a congregational nurse and so I didn't, I had never heard that term before, it was a job posting for a congregational nurse, and so I asked someone, I said, what is a congregational nurse? Now, let me back up.

NF: Sure.

GF: Cone Health is a healthcare, it's a hospital system here that has every hospital around this county and a few around us. They own most of the doctor's offices now, so this was, this was a behavioral health hospital but part of Cone Health Hospital so as I'm asking for info, oh yeah, you know, so they're telling me about it so I said, god, that sounds *great* because you mean you get to say a prayer with somebody? You get to talk to them about how their spiritual life affects their stomachaches and how affects the, the rate and the speed of their healing post-surgery. Come on? Are you kidding me? I'd love to find out! So that's how I first found out about it and, at that time, my mother got very ill and so I went to part-time to help take care of her and then she died and after that I had to help with my father because I'm an only child so but that really stuck in the back of my mind. In the meantime, there was somebody, the Congregational Nurse Program in Greensboro was coordinated out of Cone Health Hospital, so they had a coordinator that had, along with a lot of other people, had developed this program and with endowments and grants from, Wesley Long Foundation did endowments, some other places, they came up with a four-year plan for faith communities, in which a faith community could apply for this and the first year Cone Health paid nurse's salary for 10 hours a week and bought the box, simple medical stuff like blood pressure cuffs and so just simple stuff and educational but most important they provided networking with all the rest of the

congregational nurses and education on a monthly basis so but and then on the second year Cone reduced their financial commitment by 25% and each year thereafter until the fourth year. The faith community was totally responsible financially for the Faith Community Nurse and everybody starts out at 10 hours a week most of the time. It's a little bit different now than it was when I started because of the great need.

NF: Okay.

GF: So that's how I got started. It's really, it's really sort of a blended program in that the congregational nurses are really employees of whatever faith community hires them but we still get collegial support, peer review, education, resources, all that sort of abundance of support from the office at Cone Health. So I applied and…and got the job and it was a little overwhelming. [Chuckles] Ten hours a week, it was just like nothing, to do the job and I had, the first day of work, I walked in and I had 20 messages from people in the community, wanting services, so it was pretty popular right from the very get-go and it's been extremely popular ever since and it is a program where the needs of this particular community are more one-on-one than it is doing a lot of broad-based educational programs. I would say the majority of my work is more one-on-one than it is doing like huge, like a series of six wellness programs, let's say, or whatever. Even though I would love to do that and if I get more hours to work, I would. I'm, I only work 17 now. Well, I get paid for 17, I work a great deal more than that, and I was employed…the program was taken over by Jewish Family Services. We have two synagogues in town, one reform, one conservative, not big, so neither one of them could afford it by themselves so it just made sense to put it in Jewish Family Services and then that way I could serve everybody in the community, whether they were affiliated or not

affiliated. The service is free and…what…I had another thought and then it went right outta my head.

NF: All right. Well, if it comes to you…

GF: Oh, I was going to say that once the Cone money was gone at the end of the four years, I am, my program is supported by a BJH Foundation grant and that is a Foundation that provides grants to people in North and South Carolina that provide services to the elderly, so once I started with just the grant, I had to limit my services just to seniors. But BJH Foundation has been a huge support and considers this their flagship program that they support. So I, maybe a couple of years ago, they decided that I had such a model practice that they wanted me to write this book on how to start a Jewish Congregational Nurse Program so that Jewish communities in North and South Carolina wouldn't have to start from scratch like I did, okay?

NF: Yeah.

GF: They could have a template in which to follow. Nobody realized how big it was going to be because quickly it gained the attention of the American Nurses Association because there's not that much, as you probably know, there's not that much Jewish literature on community, Faith Community Nursing much or really any type of program like this and they are in the process of certifying Faith Community Nursing as a certification, which means you have extra experience and like a critical care nurse or an ICU nurse, so and then HMA heard about it and they very much were in, because there weren't, there's just not that many Jewish resources so that's where I am today. Now, I'm sure you have questions.

NF: Yeah, absolutely. I wonder…as you were going through this program and you found that…it first was, I guess, it was financed by Cone and then is it, it's currently financed by BJH? Is that?

GF: That's correct.

NF: And there, was there, was there an intervening time?

GF: I get just a little, little, little bit of money from the Stern Foundation but it is, it is mostly from the BJH Foundation.

NF: And was there an intervening time that it was funded through the Jewish community, through the Federation or?

GF: The Federation's contribution that they considered is that they give me an office space, a computer to work on…let's see…a telephone not a cell phone but a phone in the office and so their services are more in-kind. They're not, they really do not contribute any financial dollars.

NF: I see. So, so the, I'm trying to get ahold of the transition as the Cone funding went away and you continued to work in the Jewish community. You mentioned that the synagogues were not big enough to support that individually.

GF: Right.

NF: So it was, it was funded cooperatively or was it totally separate?

GF: The synagogues did not pay anything towards my employment.

NF: Okay.

NF: My program is solely supported by the BJH Foundation. Now, as far as the Federation is concerned, they consider their contribution to be the, the physical things I mentioned plus a supervisor, which is the Director of Jewish Family Services, so it's

those kind of contributions that they make, that might be a little bit difficult to grasp but I don't know what to say to that. That's the way it is. [Laughs]

NF: Okay. No, that makes sense. I was just trying to clarify.

GF: I mean, the BJH, I don't know what we would do without the BJH. I don't think that there would be a program here without the BJH Foundation, quite honestly. I don't think, unfortunately, the Federation loves it. They love it and they brag about this program that I have but I don't know financially that they would support it. I mean, they haven't so far and I've been there 10½ years so but, on the other hand, maybe they're thinking, "Well, why should we?" We have BJH so if they're going to pay for it, why should we pay? I don't know. I mean, that's just a thought. That's…

NF: Okay.

GF: But I get a lot of, a great deal of not financial but otherwise support from the rabbis and the congregation, you know what I'm saying? We have a great working relationship together. I called [at one point]…one of the rabbis, to give him a referral because I was with a congregant and her husband…. She needed a bilateral mastectomy and this was her first visit with the medical oncologist to get the pathology report and treatment options and it was worse, it was not a good report. It was worse than what she thought it was going to be and so I gave a referral to the rabbi …to please visit them because it's a difficult, a difficult time. So I have a great working relationship with them and I'm in the congregation every week because the seniors and each congregation has a lunch and learn program and what I do is I set up a table kind of off to the side so we can have some privacy and I do blood pressure screenings, I taught the people about if they have questions about medications, whether it's getting it, paying for it, or side effects or

if they need a doctor referral or if they should call. They say, you know, this is going on, should I call the doctor? Whatever questions or concerns they may have, so I'm at the, each synagogue every week doing one thing or another.

NF: Okay. And you mentioned that you refer people to the rabbis. Do the rabbis ever give you a call and say I'd like you to look in on…

GF: Yes.

NF: Okay.

GF: They sure do.

NF: What does that conversation sound like?

GF: What does it sound like?

NF: Yeah.

GF: Let's see, let me give an instance.

NF: Sure.

GF: There was an elderly woman hospitalized and the rabbi went to see her and she said to the rabbi, I'm having a hospice palliative care assessment this afternoon and my family is here and I'd, I would like to call Gilda and ask her to come. I want her to be there.

NF: Okay, so you can translate the medical information?

GF: So he called me, he called me and I went in and she said I really have some concerns other than, she said I want you at the conference, she said, because you need to hear what the palliative and hospice nurse is going to say and so you can tell me and I don't want to get it from them because you're a nurse, you're going to understand and you can tell me so I can understand, number one, she said. But, number two, I wanted to

talk about some spiritual concerns I have and I couldn't get the rabbi to stand still while in the hospital to do it. and her concern was she said I'm angry with God because she had been, she had almost died like three or four times and she felt like she was in that place that everybody talks about and she kept telling god take me, take me, don't keep putting me through all this stuff. Please, go ahead and take me and she said and he didn't, he didn't take me, and I have been a good person and I've done everything like my life, why is he doing this to me. So that's a…that's one referral. I've had referrals about mental health concerns about does this sound like somebody really in a bad place, suicidal, whatever, and I say, "Yes, keep them in the office, I'll be right there." I've had referrals where the rabbi might be out somewhere maybe 20, 30 minutes away from a patient's home and he gets a call from a hospice nurse and she says Mr. So-and-so is dying. I'm sure it's going to happen within the hour and the wife would like for you to be here and he'll call and he'll say I can't get there in time, can you go, and I do. So those're the kind of referrals I get.

NF: Okay. So I'm hearing you say that your, the referrals that you would get from the rabbi can really range from sort of medical information or just being able to translate some of the medical terms all the way to really providing pastoral care?

GF: Mm-hmm. Yes.

NF: Okay.

GF: Correct.

NF: And, now let me jump back. You mentioned you had a weekly visit in each of the two synagogues, is that right?

GF: Correct.

NF: And so do you go straight from one to the other? Is this like a Saturday morning or?

GF: No. No. Once, what I do is one week I go to the Conservative synagogue. The next week, I go to the Reform.

NF: Oh, okay. So on alternating weeks they have the…

GF: So like on Tuesday, yeah, so like on the second and fourth Tuesdays, I go to the conservative synagogue and, on first and third Thursdays, I go to the reform synagogue because that's when they're having their lunch and learn meetings.

NF: Okay, yeah. That makes perfect sense. And how many people do you think that you see on a given week?

GF: Oh, man. It really varies because sometimes I can spend a *great* deal of time talking with agencies, trying to access care for somebody that does not have insurance, that does not have a doctor, doesn't have what we call a medical home, so I can spend a great deal of time trying to access services for somebody and maybe only see, well…you mean one-on-one see somebody or like be available to everybody at the luncheon?

NF: Well, I'm just trying to get a general picture of what you do so that's, any, anything is helpful. I just was starting with the number of people you might see but that's…

GF: I would say one-on-one as far as home visits are concerned, office visits, I do go to the hospital occasionally. My priorities are to do one-on-one, to visit people in their homes that do not have anyone to take care of them. That's the first one. Then, secondly, it will be somebody that has a, that lives with somebody, somebody's there kind of watching them and taking care of them. And then, third, it'll be somebody in the facility.

So, in the hospital they have people there that're nurses and they have a whole medical team that's taking care of them. However, I am finding myself in the hospital more, in the facilities more like nursing homes or assisted-living or whatever, more in an advocacy role because there are so many seniors with dispersed family. They live alone and they're frail and they cannot advocate for themselves and, unfortunately, in the fragmented, low nurse to patient population ratio, if you don't have somebody that can advocate for you and you can't do it yourself, unfortunately, you may not get all the care and services that you need and deserve. So I do, the advocacy role is increasing unbelievably so I would say one-on-one, I have about on average, let's see…I would say on the average one-on-one about 15 people a week.

NF: Okay.

GF: And that does, and maybe three or four more by telephone. Short, like short conversations. But then as far as an average number of people each week at the senior luncheon, they average around 20, somewhere between 20 and 25. So I'm available and I may say hello and sometimes that's all it takes to get a whole can of worms opened up. [Chuckles]

NF: Sure.

GF: So, in the surveys that I have done at these senior luncheons, I think this is something you need to know is one of the questions is have you ever asked the congregational nurse for assistance or has she ever provided assistance for you in any way and if so what kind. Well, some people will say no; *however*, it gives me great comfort to know that she is there when I need her. And I think that's very interesting and it's an important thing for them to say. It's just my being there, it gives them great

comfort. It gives them great comfort. As one gentleman said, when I try to call my doctor, you get this recording and it goes so fast. He said it's not like in the old days when you called up and there's one doctor and there's one person answering the phone and he said now there's 15 doctors in the practice and there's a lab and there's a radiology department and there's this-and-that together and he said they're saying push this button, push that button, and I get all confused and I don't get to speak to anybody. So he said and so I finally just give up because I say, well, it's not that important but I know that I can call Gilda and she'll either answer my question or she will call the doctor with me or for me and find out what the answer is. So some people may think that's not a big deal but if you could put yourself in a senior's shoes…

NF: Oh, absolutely.

GF: …that's living by themselves and trying to do the right thing, so it's really, I mean, even for me, I have some chronic conditions and I have degenerative spinal problems and I had surgery two times. Just to know that there's somebody that's available to help me, I mean, not that there's anything I can think of for them to do maybe but just knowing that there's somebody for me to call, it's so reassuring and you need that. If you don't have that reassurance then you spin your wheels and you get your whole body into such an anxiety downward spiral that it negatively impacts your total wellness so…

NF: Yeah, I see. Now, I'm curious about the, what sort of role healthcare has in the synagogues and how that has changed. It sounds to me the narrative I have in mind from what you've said is that you, as a nurse, sort of came across this idea of Faith Community Nursing and became involved that way and then took this to the Jewish community that

you already were a part of and how do you think that that has changed the culture of the synagogues that you're, either you're home synagogue or both of them?

GF: You know, it has really changed them a great deal. I had somebody come to me just yesterday and she said my primary care physician has suggested that I start this medication and she said I just told him that I really just needed to think about it and she said because I really wanted to discuss it with you and he said, well, he said you think about it. He said but now I don't want you to go online and be reading up all the side effects because he said that can just really be, that can put you in a tailspin and she said, no, actually, I want to discuss it with my congregational nurse. He said *that* is an excellent idea. He said I tell you, these congregational nurses are the best things that could happen to healthcare. So, after we discussed the pros and cons of her starting this medication and all that sort of thing, she turns to me and she says, you know, I don't know what in the world we did before you ever came. She said but it was not near as good as it is now and I have so many people tell me that. They say, you know, what did we do before you? I said, well, I think it wasn't quite as complicated. I try to really downplay the whole thing because I want them to feel empowered, not that I'm doing it, and I always try to remind them, they say, oh, thank you for what you did and I said, no, we were a team. I said you did it too. I said I couldn't do any of this if you didn't ask me, if you didn't tell me, whatever. I think it has…one of the questions that I answer on my monthly report is have you seen any improvement in the overall health and wellness of like an individual or people in the group and I have to say, in these senior groups, it has been dramatic. It has been a dramatic improvement. And the fact that there is such increased awareness, I think that's the tool because most of these seniors do not have

computers, some of them have macular degeneration so they can't read that well anymore, and, but they're, but they know what areas to be, I mean, they really know for things to be looking out for now and, most importantly, the meals that were being served at these lunch and learn and even the snacks like for every event in the synagogue from young to old, the whole entire, the whole entire nutrition, I mean the, what am I trying to say, not menu but the food selections are so much healthier than they used to be. I look at a Tot Shabbat right now and what they have for their oneg, it's fish and veggies and dip as opposed to what it was eight years ago and it was just candy and junk and there it is right before dinner because they start like at 5:30 or 6:00 o'clock and they're like for half-an-hour. It's amazing! I mean, it is amazing. So the food that is being served and I take every, single opportunity I can to teach.

NF: Well let me ask about…

GF: Anything just like from, okay, where is the hand sanitizer that should be at the beginning of the buffet line? Until it gets to be a joke and people, I do use a lot of humor in my practice and they just, it's easier to, when you're, when you are older and your parents never taught you when you were growing up that you needed to brush your teeth every day or you needed for a girl, you needed to a self-breast exam every month, it's hard to learn these new things when you're an older adult but they are doing it. They are doing it.

NF: So let me ask, I know that food in any congregation but especially a Jewish congregation is a big deal. Was this change in the menu so-to-speak and the selection, is that something that you specifically talked to people about or is it something that

happened sort of organically once people started thinking about health more in the synagogue?

GF: I think it was a gradual process and it came out of me giving programs on healthy eating, healthy lifestyle, speaking with the people preparing the foods. It came out of educational material I just might go over and put a few little educational pieces of information like index card-sized like did you know that sweet potato is just loaded with and it was and so the change, I think was, some things were pretty drastic which was not less fat, less fat, I think. That was pretty dramatic. They were kind of taking the easy way out with a lot of casseroles and but then you have a lot of creamy stuff and this increases the fat content but I think it's been a gradual change and because it's personal thing of mine because I think food is medicine. I think that's the most important medicine we have is food and I think our food industry today is comparable to what the tobacco industry used to be and they're putting in a lot of added sugars and we have become addicted to sugar and I'm not going to do the whole documentary but I hope you've seen it. [Laughs] So I would say it was gradual. Sometimes I would give out, if you throw out little bits here and there like one minute just as people are sitting down and they usually schmooze while they're having lunch and then they'll have their speaker, I'll say, now, I want you to notice that today there are chickpeas in this dish and does everybody know that chickpeas have so many grams of protein and I happen to have a delicious recipe with chickpeas in addition to the one we're having today if anybody would like it. I mean, that's one method and that's, to me, those little, bitty interventions are the way to do it. But I've asked them for some input and I've had nutritionists and dieticians come in and speak on it too.

NF: Okay. And do the rabbis ever talk about health or health-related issues like from the pulpit?

GF: Uh…yes. I have to think.

NF: Do you think that that's been…

GF: They, it may be a part, it may be a part but not…

NF: Not central to the whole…

GF: …the whole, oh, somebody's at the door and my dog is going crazy. Can you hold on just one second?

…

NF: Thank you so much for talking with me today. I appreciate it and…and, also, I need to track down, you mentioned, now what's the title of your book? I was looking for that before you go and maybe I can find a copy here.

GF: No. We only have it and we sell it but if you would like a copy and I mean it not to make money it is that, I mean, it's copyrighted for the Federation because I was working through them when I wrote it…

NF: Okay.

GF: …I'm the author but it's still, but they're charging $18, because just to try to start a little fund to, so we can print more because it's turning out to be so big.

…

[The interview continued after a break]

…

NF: You'd mentioned a couple times references to sort of other nurses that are doing a similar-type of work in your area. I don't know if it's just Greensboro or if it's broader

than that but what kind of relations or connections do you have with other Faith Community Nurses?

GF: Well, in the Greensboro area, we have about 70 congregational nurses or Faith Community Nurses, whatever you want, ANA, American Nurses Association, has designated Faith Community Nurse as the official name, so I really should say that. It's just in this area we've used the word congregational for so long it comes more natural.

NF: Oh, I see.

GF: So, in our network, which is the network connected with Cone, there are about 70 of us, I shouldn't say faith communities, most of them are faith communities. But in the past three years, I will say we have a nurse at the Salvation Army; we have a nurse at the IRC, which is a daycare center for the homeless; we have a nurse in, that's working with Church World Services, which brings in refugees from all over and this year we've been getting quite a bit from Africa so we do have them in non-faith, a few of them are non-faith essentially but they're working with indigents and homeless folks, so about 70. So, Cone provides two meetings a month for this group of congregational nurses; one daytime, one nighttime so you can go to either one. During that time, they serve a meal, which makes it convenient, so if part of that time you're coming and it's your lunch break then you've got that. But they'll have a speaker, perhaps a new program or a hot topic or a new resource in our area, one of those things, and they give us numerous updates on what's going on in the area and a little bit of time for some networking with each other. Now, are you there?

NF: I'm still here, yeah.

GF: Okay. On a national basis, if I go to national conventions. I guess the first year in 2004, I went to Seattle so met a great many there. I had, I took my Faith Community Nurse course in Arizona because it was the only one at that time and still is, the only one that has a Jewish component to it and it no longer does.

NF: Oh, I see.

GF: I know, it's too bad, huh?

NF: Yeah.

GF: I know, I'm going to have to start maybe consulting next. And just to kind of add that piece, which is what Dr. Schweitzer did, Roberta Schweitzer, who was a nurse educator. She worked with the course that was already in place and she added the Jewish component. They were friends of hers. Now, I've been trying to, I have not talked to Roberta in years. I've been trying to get in contact with her. At the last convention, I got two emails for her that the person thought were current but I have not, I've emailed her several times and have not heard from her. If you want to try to get in touch with her, though, she would be a great resource. Her name is Dr. Roberta …and she's in the Indiana area. I don't know specifically where but she's in Indiana somewhere. So I meet these people and some of them you become really good friends with and you converse about this or this or what kind of program have you done for this. Also, we have a regional association, which includes North and South Carolina, and we have a conference once a year and so I have a close, even closer with them but I have to say, well, others, I have people contact me like from California, the greater metropolitan area of Detroit, New Orleans, many different, and I'm not quite sure how they find out about me. It could be that they just Google "congregational nurse" or Jewish congregational nurse and it

goes to Federation's website, I don't know but, at any rate, I've had a great many people call and this last time I was talking to this woman from, oh, I can't remember, somewhere in California.

NF: Okay.

GF: She was a Director and wanted and was getting ready to add a synagogue into the network and so we talked and talked and then I found out that when I was presenting at the workshop, do you know she flew all the way from California back east to Washington, D.C. or to Baltimore or Bethesda, MD for this conference and she had only been back in California four days after being in Europe for three weeks. I said I cannot believe you did this. She said I came here just so I could, just so I could meet you and see you and come to your presentation. So, I said that I would have to say I, the ones that I keep up with, it's really good when I talk with them, but, actually, I don't have any, well, I really don't have any Jewish nurses that I work with.

NF: Okay. Well, can you tell me, it sounds like there are lots of networking opportunities. It sounds like you really take advantage of those. Can you give me an example of how these types of relationships with other community nurses has affected your work or can you give me rather maybe one example of a specific way that you've seen it impact your work?

GF: Hmm… luckily, I will have to say that about a year ago I was thinking about doing another huge health fair at the synagogue like I had done before and, it was not just for Jewish people, it's for the entire community and it was a very well organized, well-attended, I must've had 350-something people come through. I had osteoporosis screenings, blood sugar screenings, blood pressure screenings. I had several pharmacies

there. Oh, and with the osteoporosis screening then they also got counseling, they got supplements, they also got a referral to their doctor. If they didn't have a doctor, we helped find them a doctor, so that part was pretty intense. And then I had, it's like, I helped fill in, so you walk around table to table. I had one on fall prevention from the rehab, physical therapy. I had, oh my goodness, I cannot think. [Inaudible 11:43] going on…

NF: Now this…

GF: …[inaudible – both speaking 11:46] disease, people so, like a year ago, I was thinking about doing another one and several of the nurses said to me, "Forget it, that people are more stretched with their resources today. They don't have time to donate their time and energy to do it and they said we have tried doing it and it was very poorly attended and it was too hard to get the resources in the community to help." So, that was one thing that saved me a lot of time and energy was that that's not a good thing to do right now.

NF: Okay.

GF: I'm trying to think of…well, other than how the other nurses have impacted me, it's just feedback about my practice and that sort of thing because…

NF: So you can…

GF: …you always want, because in this position, it's independent so it's not like you're working in a staff in a hospital, where you have immediate peer review, so it's really good to have peer review and make sure that what you want to do and the goal you want to reach and the objectives, that they've been met and they've been met to the highest standard, so I would have to say that's how networking because I do, I've done

some presentations at other nurses, their church or whatever, and I get feedback not only from the nurse but from the congregants that have come and it's really good to know that what I'm doing is worthwhile.

NF: Okay. And do you ever have programming that's a partnership between different nurses or do you tend to operate pretty independently?

GF: Oh, yes, yes, yes, yes. You, I'm telling you partnership, partnership, partnership, collaboration, collaboration, collaboration. Partnership is and I think you've already gathered that partnership I have with BJH is important. The partnership I have with Cone is important. I partnered with what's that…two years ago with Cone Behavioral Health and Guilford County Mental Health Association for a mental health awareness day at my synagogue and then, of course, here again, when we do something big like this, it's open to the entire community, not just the Jewish community. So it was great because Cone Behavioral Health brought all the screening material and Guilford County Mental Health folks brought all the education materials. I provided the synagogue, I provided publicity within all of our venues within the Jewish community. Cone provided the community-wide like the newspaper, radio, TV publicity on it and I provided people to do the screenings plus I had an MSW with counseling there just in case we screened somebody that we felt we needed to get immediate, that we didn't want them to leave the building, that they needed immediate help or more than the screening could tell them. So it turned out to be a really good program without too much work on any one person's part. But I just think that relationships is the most important thing and I don't care what kind of work you're doing but you *absolutely* have to partner. I mean, it is just the best. and I have partnered with churches and I'm thinking about a creative project now because I'm

really into creative art. I think they're wonderful for folks. It's a way for them to express themselves when they don't even know they need to express themselves. It's like a safety valve, so I'm thinking about a project now where I would have our seniors do some sort of visual art, I mean, I'm just thinking about this, and then there would be somebody from another, I would like to have a Protestant church and a Catholic church and then we could have like a topic brunch.

NF: Sorry, I didn't catch that. You had what?

GF: I think we would have a topic, which is like maybe how do you really feel about seeing homeless people on our streets and maybe they might paint what their feelings are and then we would have like a traveling art show, where our seniors' art work went to the Protestant church, theirs went to the Catholic, Catholic went to ours, and then the next month go around again. You understand what I'm saying?

NF: Sure, like a round robin? Yeah.

GF: Okay. Yeah, yeah, yeah, yeah. And then the other folks like I partner with a lot of people to do programming. I partner with Alzheimer's because they, we have a guy here that is, has his own personal story that works for the Foundation and I have him come in and do an Alzheimer's program. I partner with the American Cancer Association, for the pink ribbon, and the Heart Association, sorry, heart disease is the number one killer of women but a lot of people think it's breast cancer because that's the one that gets more publicity.

NF: Sure.

GF: So I partnered with them last year and the year, each year I've gotten multiple scholarships for women that I know with heart disease to go to an all-day affair that they

put on at the Koury Convention Center and it's a cooking demonstration on healthy food, it's a keynote speaker, it's classes to work out, break-out sessions for them to, educational sessions for them to go to. It may be with the cardiologist, it may be with the nutritionist, it may be with an exercise person, and it's just so, and a wonderful lunch, and it's just and so if people paid to go it would be $150. and I think I've gotten like, since they've been doing it, I've probably gotten a total of 20 scholarships so and then these women are like ambassadors in the community, so I'm going to be doing a program on women's heart health in February and I'll be partnering with them and Cone has just started a health initiative for women's heart and it's connected to the one in Cleveland. Cleveland has one, so we'll be getting all that together. It's just important with a lot of, I mean there's no need in me trying to, let's say do, I mean I could do a program on Alzheimer's but not when I have this guy who has a great story to tell and knows all the latest research.

NF: Okay.

GF: So partnering is a big deal and with other nurses, as well as other agencies and organizations.

NF: Okay. Let me now sort of zoom out and ask some big-picture questions in terms of what you do. Do you, I guess, first of all, who do you report back to? You mentioned in our earlier conversation sort of gathering information about the impact. Who does that go to?

GF: I send a monthly report to the Director of Jewish Family Services. We in turn together, I, well, together we do a midyear report to BJH and then a year-end report to BJH. I also send monthly reports to the Cone Congregational Nurse Program and this is

very important because this will be used for research for best practice, it will be used for outcomes, it can be used to show the value of your program, which you have to show the value, otherwise why are people going to continue to support it financially? The people at Cone can take and I mean it is intense. It is intense and it is detailed and how many people do you see with heart disease, respiratory disease, musculoskeletal, age groups, gender, very detailed. How did you teach, what method did you teach? It's a very, very detailed report and then these are compiled. They use that material to go to the Cone Foundation, which provides money for their program, and then it goes to a national database as I said for outcome, what're the best practices for nurses. It's invaluable. The Cone Health Program is considered one of the best in the nation, so I feel very fortunate to be a part of that group. I don't think there's another group in the U.S. that has such a detailed recording and assessment tool as we have. So that's where I send the reports to. And they're always stories of impact and there's always, well…that's it, stories of impact. One thing that we haven't talked about and I was assuming that perhaps you had done some research on this but maybe not but the different roles that I play are individual education, group education, referrals such as to a doctor or to an agency or like I said to a rabbi, advocacy we talked about, caregiver support. I have a great many people call me, such as this man from [out of state]. He calls and he says, "I talked to my mom because she lives alone and but she just doesn't sound like herself and, could you check on her?" When you get my book, it, this will all be in there and you'll see. I try to put a story with each thing that I'm talking about, so it gives you a better graphic picture of what is actually going on. So, let's see, what did I miss? Oh, volunteer coordinator. You have to coordinate and train your volunteers. Now, in my agency, we have a volunteer

coordinator. Is that it? I'm trying to think. I'm getting reminded here. I did referral, advocacy…I think that's it.

NF: Okay.

GF: So those're all the different roles. No, I left out the spiritual part, I forgot the spiritual counseling, yeah.

NF: Okay. And we…

GF: We talked about that but I needed to say that again.

NF: Yeah. Yeah, I think of what you mentioned and the only thing we haven't talked about in any kind of depth is the caregiver support.

GF: Well, as I was saying, whether the caregiver is here, locally with hands-on or whether the caregiver lives, is trying to do it from far away. I've been there and done that myself. It's, it makes such a difference to have somebody be able to check in on their mom or dad so, locally, it's letting them know about, well, it's helping them with any questions they may have about resources, about if they need free medication or reduced-price medication, it's about teaching the mechanics of helping the person move, it's about making sure that they get some respite care and where they can get that free, and it's about, it's being there for them so that they can get the help they need for themselves because so many times the caregiver gets so ill from caregiving that they end up dying before the person they're caring for, so I think when you help family to access services and get what they really need, it's just, it's very much needed. I think it's essential and it really takes some of the stress and strain off that caregiver so because there are, there's enough challenges as there is without having that so.

NF: Right. Okay. So let me ask, I think my last couple of questions have to do with sort of some more big-picture planning and organizing type of things. You've mentioned Cone throughout our conversation and I understand that this is an organization with half a dozen medical centers or so. How did they become involved or what is the scope of their involvement as far as you can answer with the community nursing?

GF: You mean how did Cone Health become involved?

NF: If you happen to know the history of how that happened, I would sure love to know.

GF: Oh, how that happened was there happened to be a nurse that was Director of their Outpatient Services.

NF: Okay.

GF: And in the outpatient clinic setting, she was seeing a huge need for some sort of transition to be happening because she was seeing people come to clinic too much and too often and whatever and so she went to the administration and said let's think about putting nurses out into the community and she's the daughter of a minister and there were other people involved with her and I'm not sure who they were but, between all them talking and collaborating and thinking about it, they came up with this program and she is the Director and I guess it is about…oh man, I'm not quite sure how old it is, maybe 17-years-old?

NF: Okay.

GF: So that's how it came to be and, as I said before, the money came from foundations, endowments, like Duke University Endowment gave money each year to sustain it, the Wesley Long Foundation gave money too to sustain it. There were other

grants and endowments and now Cone itself, which has included Wesley Long into its conglomerate of medical facilities, has a Cone Health Foundation and they fund many, many, many programs in Greensboro. Our program being one and probably the largest and, certainly, the one that they are the most proud of. Because what happens is in today's world when people are discharged way too early and a lot of times do not understand the discharge instructions or the doctor orders some medication that the patient cannot afford or whatever, these folks go home and they're not really prepared to be discharged and they may go home and the caregiver doesn't understand it either so as a Faith Community Nurse, if they're part of a community where they have one, they depend on the other congregants because of HIPAA you can't, you don't know who's been in the hospital and who hasn't but you depend on other congregants to let you know, oh, so-and-so fell and is having hip surgery and they're coming out today, whatever, so the Faith Community Nurse makes a visit to make sure they're getting along okay, to make sure they have their medicines, go over the discharge instructions, make sure they have follow-up care, so they provide that bridge, we provide that bridge, and we're keeping these folks from being readmitted to the hospital and/or having to go back to the emergency room and hospitals, as you know, are closing down because of having to provide so much free care that they just can't afford it anymore, so that's why we are so valuable as far as the healthcare system is concerned.

NF: Okay. And, yeah, I've heard this story from other cities as well. So that makes sense. And then you talked a little about what Cone actually does. I think I've got enough on that for this conversation. I wonder, you've mentioned in terms of what you do a pretty broad scope, I'm curious about what the approach is to planning. Is there an overall

strategy in terms of what you're going to do? Do you have, do you sit down with anyone or just sit down with yourself at the beginning of the year and say this year we're going to focus on nutrition or this year we're going to focus on heart health or are there certain annual or quarterly or different periodic events that you do?

GF: Well, I think it certainly comes into play when I'm doing the midyear report to BJH Foundation and the end-of-year report and that's a matter of what're your goals for this year. Midyear, they're going to ask what is the progress toward these goals; end-of-year, did you accomplish these goals. And then when you apply for, you have to apply for the grant each year, and so it'll be what're your goals this year? Now, I don't arbitrarily decide what to focus on and nobody really should do that. You do that, you base your programs on what the needs of the community are. You can have an absolutely wonderful, blow it out of the ballpark program but if it's not what the community needs, what good is it. So, right now, there is a great need to increase awareness for women's heart health and there's a great need for more Alzheimer's research.

NF: Okay. How do you make that assessment?

GF: So and then the other thing I decide is I look and I see what're my deficiencies. Like, for instance one year, I took a computer class at the community college. I said, what is it that I need to be boning up on? Or what is it that would make everything better?

NF: Okay.

GF: I, previously, years ago, started a respite program for caregivers in cooperation with the Adult Center for Enrichment, who had a similar program and it's pretty complicated the way we set it up, so I can't go into that.

NF: Okay.

GF: However, the name of it was Ezra, which stands for and I've forgotten, Ezra, well you'll know, that means what, helping or what does Ezra mean?

NF: Yeah, Ezra was a prophet but the root of the name comes from, yeah, like helping.

GF: Yeah. And so we had an Enriching Seniors, let me see if I can Enriching Seniors, ESR…Enriching Seniors for Respite At Home so what we did is we got, we handpicked very, very experienced volunteers who were healthy people mentally speaking and had healthy boundaries and that sort of thing and we had a fairly intense three-day training for them to provide in-home respite so they may go to someone's house and stay at home with the ill person so the caregiver could get out and go to a function or get their hair done or go to the park and read a book or whatever they wanted to or, if the person was mobile, we could take them out somewhere so, in other words, it was a few hours that the caregiver had to do with whatever they wanted to do and what was my point in telling you that? It was something about, what did you ask me?

NF: So we were talking about how…

GF: Oh, oh, oh, I know what it was – about how to plan…

NF: Yeah.

GF: So, unfortunately, the volunteer coordinator that assisted me with that had to quit her job for family reasons and another one came and that was not what she was interested in continuing and so, by that time, the volunteers that we had were also in a different place. They age-out and then they have to go take care of their own parents and that's what happened in our case and then when the new volunteer coordinator came in, that was not something she was interested in doing, so the program fell by the wayside. We now have a new volunteer coordinator and I'm hoping that once he gets his feet on the

ground that this is something I can talk to him about reinstating because I think it is a very, very valuable program. So it's just that whatever I see as needs out in the community and I also do a survey.

NF: So how do you make that assessment in the community? How do you figure out where the focus needs to be?

GF: By from what people are telling me when I go to the luncheons and what people tell me when I go to services or Chevra Torah, wherever I am. They'll say, you know, I wish we had duh-duh-duh-duh-duh or they're very open about approaching me and saying this is what we want or this is what we want, so I do that and then I also do a written survey a couple of times a year and that's, of course, just and that just depends on if the people take the time to fill it out. I try to make it super simple and, of course, it is just for seniors and adult children of seniors, so that's how I take care of that.

NF: Okay. So it's a combination of sort of that survey that you collect a couple times a year and just anecdotal conversations that you have with people about their needs.

GF: Yes. So it's kind of a formal plus an informal and feedback, remember being in Jewish Family Services, we have the Director who is an MSW. We also have an MSW therapist, a volunteer coordinator, so we have a staff meeting each week in which we discuss, it's almost like a treatment planning, what do we need and this and this and this and they'll give feedback. So they're out there in the community also gathering ideas.

NF: And so they'll tell you about, from their clients, things that you might not have heard from people you've interacted with and you can pool it all together.

GF: Right.

NF: Okay. And then in terms of once you've figured out where're you're going to focus, do you have sort of a set structure that's similar each year? For example, maybe you have, we have two big events, we have four speakers every year and the topic changes, or does that change from year to year as well? Does that make sense what I asked?

GF: No.

NF: Okay. So, when you know what your focus is going to be, the, in terms of the programming that you use, that you create or participate in, is that consistent from year to year? Do you have an annual big event…

GF: No, no.

NF: …or it changes. So how do the different changes, whether it's a speaker…

GF: It will change and I'm, the reason I say it will change and who will I use to partner with, it's because the resources change.

NF: Okay.

GF: So, before, I partnered with just the American Heart Association. This year because Cone has just started a new program for women's heart healthcare initiative, they will be included too and I'm going even to do it more awesome and in a bigger way because I'm, because there are more resources for publicity but there more like from these two. In other words, these two places are going to have more free resources for me to use. I don't have much of a budget to get any resources, so I have to be very, very creative. Because Cone's initiative is connected to Cleveland and who's also connected to, oh my gosh, I forgot the, it's a, they make, they, not, pharmaceuticals but a medical

company so we have one of those free resources and a lot more free publicity, so it'll be different. It'll be bigger and it'll be wider. Are you there?

NF: Yeah, I'm still here. Great.

GF: The reason I ask that, my phone's beeping. I don't know if it's getting ready to go or somebody's phone is beeping like maybe it's getting ready to go dead. [Laughs]

NF: Oh. I'm, I am not hearing beeping right now on this end. I do have you on speaker phone so it might, my voice might be going in and out as it switches on and off. But that's, those're all the questions that I can think of for right now. I would be interested in hearing if there's anything else that you would like to tell me about or if there's another person or organization that you think I should talk to?

GF: Well, I do think do you know Richard, Rabbi Richard Address?

NF: I do not.

GF: He is the, as far as I'm concerned, he's like the foremost authority on and now this just has to do with aging but he's written several publications and books. He has a website and I have to write an article for him. He's asked me to write an article for him. He is retired now and just doing this. He has a radio show, a website, and his website is sacredaging, jewishsacredaging and he's written the congregation is a caring, no, the synagogue is a caring congregation and what you need to have in play. He's very, very good; a very, very sweet and kind and knowledgeable man and he will be happy to share with you. I also have a colleague that we just did a presentation on Yom Kippur. We have breakouts, we, the rabbi at my personal synagogue has programming going all day long so people stay in the synagogue and that way we're not tempted to eat, [Laughs] so he has breakout study sessions in the afternoon and the rabbi asked me and Dr. Weinberg to

do a presentation on what're the trends about, that's happening in healthcare as far as faith-based and Bob, Dr. Weinberg, has been doing this research all of his life. He's *especially* knowledgeable but I don't have that at my fingertips. Now, I can email that to you with their contact information.

NF: Sure. I'm actually, as you're describing and I'm a little bit familiar with the Sacred Aging Program through the URJ, through the reform movement.

GF: Yeah, yeah, yeah. Well, he started it and so even though he doesn't work for them anymore, he is still keeping up this. I'm sure you've read many of his or at least have heard of many of his…what am I trying to say…publications. And the Kals-, how do you pronounce it, K-a-l-s-m-a-n Institute in California.

NF: The Kalsman Institute, mm-hmm, yeah, which is…

GF: Well, they used to do quite a bit but they've not done that much in recent years and, personally, I've been *very* disappointed because I really would like to go to something there but you can always, that huc.edu/kalsman so those are…

NF: There is actually, I believe, a conference planned for next year. I know it's been a while since anything's happened. I don't know how much of that's finalized, but I've seen a little bit of publicity, that they are planning another big conference next year, so…

GF: That's good.

NF: Certainly, be on the lookout but I haven't have a lot of productive contact with them, even though the Kalsman Institute is part of Hebrew Union College where I study. They're physically located on a different campus. I'm in Cincinnati and, of course, they're in L.A.

GF: Yeah, yeah. Okay. Do you, have you ever heard of Rabbi Fred Guttman? I would be surprised if you hadn't, he's such an activist, but at any rate, I just wondered.

NF: I could quite hear the last name, so now I'm getting beeping on my phone. [Laughs]

GF: Uh-huh. Fred Guttman, Rabbi Fred Guttman.

NF: Um…the name sounds familiar. I'm actually looking it up right now.

GF: Well, I was just going to say he's my rabbi and he is very supportive of the congregational nurse program so…have you read *How Faith Heals: A Theoretical Model*? Have you read that? It's just a publication. It's in "Explore". It's not that recent, it's March 2009.

NF: I think that that is one of the…yes, yeah. Actually, I have looked at this one.

GF: Okay. Okay. And then *Bringing Caring to the Synagogue with Jewish Congregational Nursing*? Oh, I don't have the year on that. That's on bjh.org. That's just an article but I think it's pretty old.

NF: I don't know if I came across that one. If you have the link or the title you could…

GF: Well, I'm going to send you, I didn't get to talk to anybody in the office, but I'm just going to send you my book anyhow. You want to email me your address and I'll get in the mail the first of the week?

NF: Yeah, absolutely.

GF: If not tomorrow. Tomorrow's Friday and I keeping thinking today's Friday. I might get it in the mail tomorrow.

NF: Yeah, absolutely. I'll send you an email as soon as we're off the phone.

GF: Sounds good. Sounds good. And I'll look up those, that other contact and send that to you too.

NF: Great. Well, thank you so much. I appreciate all the information you've given me and I look forward to hearing from you. I hope we can stay in contact.

The Rev. Amy Greene, D.Min., 21 OCT 2014

NF: Amy, I'm glad you could talk to me today. As I told you, over email, I'm working on a thesis about the relationship between, faith and wellness.

AG: Uh huh.

NF: And for one part of that thesis, I'm talking to about probably a half a dozen different organizations across the country that I've identified as models or success stories in this area. And one of those is the Cleveland Clinic and the chaplaincy program there. The spiritual care program, that I'd like to talk to you about and really, just basically, learn, what you do, a little bit about the history, and a little about your personal experience as well.

AG: OK.

NF: The kind of stuff that I can't get from books, basically.

AG: Right. I understand. Yeah, well I came here about seven years ago. To join Dennis Kenny who has retired since, but, was another ACPE supervisor. In really trying to, how do I put it - not quite create. I mean, there was a CPE program and a chaplaincy program here. …Dennis Kenny came in oh-six and I came in oh-seven on the heels of what was probably not probably, I mean, he's talked about this very overtly. So, on the heels of what was kind of a conversion experience on the part of the CEO – not a religious conversion. He's not a religious man, but, his conversion was that he felt that the clinic's reputation for clinical excellence was still, was, you know, peaking and was really, we were sort of hitting the world stage all of a sudden with our clinical excellence. And suddenly, everybody kind of knew who we were all at once. And then, or I should say, they were because truthfully, I didn't even know who they were. [both laughing]

In the first call, I got in oh-six I never even heard of the Cleveland Clinic. So, it was right before that huge tsunami of ads that can, you know, and, it just sort of hit the airwaves all at once. In my memory, it kind of happened all at once, right around that time right around oh-seven. But anyway, part of that was the new CEO at the time, who's still CEO, Toby Cosgrove. In the early, well maybe mid two-thousands, early two-thousands, had this conversion experience where he got the feedback that our patients weren't happy with how they were treated as human beings. They - they were happy with the clinical outcomes, but, they were unhappy with their, what came to be called, patient experience. And so, he was sort of an old school - he's a very self-described old school, you know, heart surgeon, Vietnam vet. You know, he'll joke about, he's seventy-four years old although he looks sixty. But he'll make jokes about, you know, "back in my day, people were just glad to be alive." You know, he sort of says he had to switch his own thinking from just doing a great job clinically was all people came here for. And so, he then began to really in…

NF: And that's the conversion you're talking about?

AG: Yeah, so his conversion was around the idea that people, you know, I would state it probably a little more, you know, sarcastically than he would. [both laughing] But that people wanted to be treated like human beings. [laughing]

NF: Right. [both laughing] Right.

AG: But you know, he will even say he realized that the clinic was not doing as good of a job as we could in terms of the things that make people feel more cared for. So, that was part – I think, without that huge conversion from the top which meant he created an Office of Patient Experience. He really started pouring resources and effort into it. And,

he had the power to do it. So, I think, without that sort of lightning bolt from above, so to speak, I don't know that what we were trying to do from the bottom up would have taken hold.

Fortunately, you know that kairos is a great – Greek word for timing, [laugh] the, you know, the kairos moment came and we had we were able to start building a Spiritual Care Department that moved way beyond just simply responding to crisis and deaths and start really starting to penetrate the institution with holistic care of the person. And really so we were still training - running the CPE program. We were expanding the CPE program but we were also trying to get staff, chaplains. We had – this place had never had really never really had staff chaplains. And it was also mushrooming into a fourteen-hundred bed main campus facility. All this time, there's constantly building going on. I mean it's just kind of like just an enormous amount of rapid growth and change in the last, ten, seven to ten years - that, in the seven that I've been here.

So, that's the important thing to realize, is that context that we're in. because, in the context we were in, we went from, you know, a really clinically excellent facility that was sort of beneath everybody's radar to all of a sudden, everybody knowing who we were. And, kind of overnight. I think that Obama came in oh-eight and was a big fan right before he was, elected, or oh-seven, yeah oh-seven. And then they, and then both Obama and Romney were commenting on it in the second go round. So, it was sort of like you would have to have lived on Mars to not have heard of it by then.

And so, all that attention, I think, was helping the cause in the sense that we were being able to say we can bring this added value. That what chaplaincy and spiritual care people can do to help bring this added value. Though by no means, I mean, we were a tiny drop

in the bucket. We, talk about what we were doing as sort of the baking soda in the apple pie. You know, we - we were definitely not the crust or the apples or, laughing] you know, the sugar [laughing] or - but that little tiny pinch of baking soda is really important. And, you can have an apple pie without it, but with it, it's just that it gives it that little extra.

And, I think, so this kind of a bigger picture, like, it's been really an amazing decade that took us from it's just a very different place than it was even ten very short years ago. So, I think what we started doing, early on, was we started trying to do a more – Vince came from California, where he had done a lot of holistic stuff. I come from Atlanta where, in the South, you know, spiritual care, pastoral care is just a given. I mean, I mean people just expect it because it's a more religious part of the country and so we didn't have a lot of convincing to do that people want their beliefs and practices taken seriously. So, I came with that mentality that it's sort of a given that people have a right to have their beliefs and practices honored and taken seriously as part of their overall well-being. And so, you know, I think the two of us coming sort of from the outside in and coming from different perspectives but also really passionate about chaplaincy and good training and but very sort of zealous CPE supervisors. [laughing] And so, we were training and you know, trying to get people very much out beyond the sort of traditional chaplaincy

…

But, I think we were trying really hard to push beyond. We know and we knew then and we know now, that chaplaincy has to be relevant if it's going to survive. It can't be we're just nice people visiting. It just can't. We have to have outcomes. We have to have measurable outcomes– and that's always a mixed blessing because it's, as soon as you

start trying to quantify what we do, that's very risky territory. On the other hand, to not have to make any claims about that we're actually having impact seemed a little self-indulgent. You know, that just saying, "Well it's important because we say so," that isn't good enough in a modern health care setting. Where not just financial concerns, but, people have the right to feel like that what they're being offered has merit, and has real measurable merit.

So part of what we were doing too is we were looking at research that showed, and it's out there, there's research that shows you know, that people that are, connected to, you know, that people's spiritual needs, when their spiritual needs are met, they tend to do better, they tend to not… I would refer you to the Health Care Chaplaincy in New York to theirs. They're really starting to – they're really starting to compile some good research on chaplaincy and on the effect of it and on how we do what we do and some of the effects of what we do.

NF: Now, what are they called again?

AG: Health Care Chaplaincy. Health Care Chaplaincy and, if you Google them I think you'll just – you'll get their address right away.

NF: There's one chaplaincy organization in New York that I've been told that they do some research. I wonder if it's the same one. But, I haven't been able to make contact.

AG: Yeah, that's who it is. It's Health Care Chaplaincy, so if you Google it, you - it used to be – the reason I am hesitating is they changed their name. But…

NF: I think we are thinking of the same one. Yeah, I've had some difficulty making contact there. But, I can talk to maybe I'll circle back around to that one because I've heard it from a couple of people…

AG: Yeah. Yeah, I think you - there's a lot of stuff online. But, getting – getting someone to talk to you may be hard because they're all over the place. But I think getting online with what they're printing and what they're, you know, their magazine and their conference. There's some good stuff. I mean, again, I'm a little now this is funny. I work in two worlds as a clergy person who's part of a very secular, very medical institution because I don't… I've always wanted to be cautious about this living in two worlds. I think they overlap very much, but are not synonymous. And so, I'm always cautious about anything that – I don't want us trying to prove our value. That's not – that feels a little morally suspect. [laughing]

On the other hand, like I said, to not feel like we have any need to say we can show our worth. We can show the value of what we do because of the results. , that – it seems a little indulgent not to have to do any of that. So it's a little bit foggy way of saying it, but…

NF: Yeah. I've heard this tension from other people connected with chaplaincy. I mean, I know that you know Julie Schwartz, my, thesis advisor…

AG: Yeah.

NF: She and other people have talked to me about this kind of tension which really is at the very heart of the project that I'm doing. One, significant portion of the thesis is about the scientific research and that's balanced by the real world experience that I'm getting from, these interviews.

AG: Right.

NF: So I certainly appreciate… that tension…

AG: It's a very …lively tension. I think it's a good one to have to live in. Because I think, we don't want to be – it's very interesting, when you feel, if you're a clergy person who's real calling – in the sort of classic sense of that - is not necessarily to choose a congregational setting where everybody pretty much by definition and by self-selection is going to believe, not exactly the same, but a lot the same. I mean, that's part of the comfort of it, that's part of what we're drawn to is to feel like we belong.

In the clinical setting, it could not be more different. We're not pulled here primarily to belong. We're pulled here to go out. And, not even to go out with what we have, but, to go out with – to be sort of helping others to connect to what they already have and what they need and what might fit them in a way that maybe they didn't even know. You know, it's almost like… so, that's really a different task. Like, helping people reconnect to their own spiritual sources of strength or find new ones. You know, that's a really different task than sort of setting your tent, so to speak, and letting people come to you. I think that the congregation, of any tradition, the congregational work is so different because you stake your tent, and then, people come to you. Here, we go to people at their absolute most vulnerable moment and we have to pick up our shoes and we have to say, "We're here to serve you. We're not here to be the teachers of authority.

That being said we do end up being teachers of authority. Because we do represent our own faith traditions and we say, you know, here's some things we know about the spiritual life. You know, not, maybe not the specifics of we're not spreading our particular religions, but we're saying, "Here's what we know about being people today". And sometimes, it's just walking around, especially in a very secular hospital, with a chaplain pin on. It's just this interesting juxtaposition because people are often very

surprised that a place like this even has chaplains. You know, because it seems like just such a clinical scientific place. And so, I'm kind of rambling a little bit.

I think what's really important about how we try to do what we do in terms of spiritual care, is… I believe personally, and I would say Dennis believes this and the people that we have trained here either believe this or go work somewhere else. [laughing] Because it's just too miserable to work here if you don't believe this on our staff. And that is, that people's spiritual condition is so pivotal as to how the rest of their lives will go, including, obviously including, their health because that has to do with how they treat their bodies, how they feed their bodies, how they care for their bodies, how they comply with medical instruction if they get it. You know, all that is so tied up in how people spiritually are, you know, with themselves and with their creator, if that's how they think of the world.

So, so we believe – I believe this. And, I'll say this. I'll try to get something simpler to come out of my mouth. I'm so sorry for you having to weed this down. I will say to new chaplain students that - I'll say to them that "If you believe that a chaplain's job is to sit and be nice and comfort people while the doctors figure out what's really wrong, then this is probably not the CPE program for you, or the chaplaincy department for you because I don't believe that.

I believe that we are part of helping figure out what's really [laughing] wrong. That we're part of that. We're part of helping to figure out what's really wrong". And I take that seriously because I think when people are in despair, in grief, in unresolved, you know, anger, unresolved, all kinds of things that are our spiritual condition. If those things aren't resolved, I don't particularly think that the best medical care in the world

can save you. I mean, we see it all the time when people have horrible things and they don't comply with their own care. And that still, to me, that's rooted spiritually.

So that's kind of my philosophy of spiritual care; that our job is to look for the spiritual wholeness of the person. How are they doing? You know, how there's a great push in that method of travelling – the current method of preachers would always ask each other if they - if they came across one that they would say, "How is it with your soul?" And I think that's probably the best question a chaplain can ask. How is it with your soul? I usually ask, "How is your spirit?" because that's a really different question than "How are your spirits?" which is more of a I'm having a good day; I'm having a bad day – that's a little bit different. And that's important conversation, too, but, "How is your spirit", you know most people will answer that.

It's shocking how few people will say, "I don't know what you mean" or just sort of not want to engage that question. They – they know instinctively that you're talking about the part of them that makes them unique, the part of them that makes them who they are and not the part that can be poked or stuck, or, you know, stitched or measured or whatever else we have to do to them to help them get better. So, our role is to find out how is your spirit. And, if it's not as well as it can be, what's up with that and how could we help with that. And what would you need for that to improve, if you want it to improve. Or, if you don't want it to improve, what's that about. You know, do you want to talk about that. If not, we go away. I mean, we go away quickly. We've got more than enough to do.

So, since we started doing these visits – we started doing these holistic visits jointly back in well, really, as soon as I got here

NF: OK. Jointly with who?

AG: Oh with OK, so I'll scroll back. So, right around the time Dennis Kane got here, oh six, I think shortly, around that same time, the first director of the Office of Patient Experience was hired. Her name is Doctor Bridgette Duffy. And she has also come from out west and she had come from Hawaii which is where we got the term Code Lavender which you've probably heard about by now. I mean, that's where that title came from, from a physician in Hawaii, which is his word for just a holistic rapid response. Everybody's really loved that and I like it fine, but, I actually prefer Holistic Rapid Response because it's more descriptive of what we do. But the Code Lavender idea was that we would join forces with – we had a holistic nurse on site and a person from Social Work who was a counselor and practiced Reiki.

It was sort of self-selected. A few self-selected people decided let's experiment with making these visits together. And so, that's another really long story. But, that has grown over the years. We have four holistic nurses now who report up through me through the spiritual care department and we work together in the healing services sort of approach, where all of our chaplains are cross-trained in Reiki and Guided Imagery and other forms of relaxation and looking for the… Say – our collective duty is looking for the, core of the distress, you know, what's the distress really about.

And so sometimes that comes up in a conversation with – sometimes people will use more theological or religious language for that. Sometimes people will use other kinds of language for that. But, joint approach has been really because we did a lot of team – started just going out as team to – to make visits together. So, you'd have a holistic nurse and the chaplain going together to see someone. And, you would hear different things. They would hear different parts of the story. So, I'm rambling all over the place because,

again, I guess it's been a huge see, really, you could probably do about two weeks' worth of interviews here to get – with a whole bunch of people – to really get – to really get a clear picture of how much and how fast things have changed here at the clinic.

And, like I said, if it wasn't for this top down sort of conversion experience and edict from the top which gave attention and resources too in the culture of the Cleveland Clinic. I don't think any of our – I think most of our efforts would've probably dried in the sun.

NF: You know what it may make sense for my purposes. I'm glad that you suggested that. I didn't think of that. But, it may make sense to talk to some other people there. Maybe, before we get off the line, I could, get some other names or contact information from you.

AG: Yeah. Yeah, we could do that. We could do that. I think things are in such – this place is also like a giant Rubik's Cube. I mean, you come in and you think all the orange pieces are on one side of the square and the next day they're not again. You know, [laughing] so, they're on the other side and you don't know how they got there. Things change a lot here. But, what has been consistent is – I would give you – I would give you Barb Johnson to talk to. She's the lead of the holistic nurses. And, she is sort of the ground troops commander for any of the human services referrals. And we get lots. And we get routinely get doctors – it's just sort of become a part of the culture. I think that's what so interesting is one of the times – one of the things I wanted to do when I got here was to have a better screening question at the admissions interview. I didn't want admissions asking people, "Do you want to see a chaplain". I didn't want that question on there because I thought - because I would say, "No.". [laughing] Like even I would say,

"No.". [both laughing] If I was in - you know, if I was somewhere, unless if I was travelling somewhere where I knew, you know, I happened to know the people there or, you know, they have a decent program. But, I don't think I would just automatically say yes on one of these agendas

Well as it turned out, we haven't needed to have that – we haven't needed to have a screening question because it's just sort of become people become aware of what we do and a lot of people put in healing services referral. Like, if someone's just got anxiety that, you know, they can't seem to manage or pain that's, you know, they're doing everything they can or just general, they've just got somebody that they can't seem to make 'em feel better. They'll often put in a human services referral. Well just, like, here go try this.

You know, and what happens is that you have people who – we have a massage therapist on the team. One of the holistic nurses is also a massage therapist. And she's trained others in what she called – she did a modified course called Manual Therapies for the Hospitalized Patient because most hospitalized patients can't do full massage. They're too fragile. They've got other – you know, they may have sutures. They've just got reasons why you can't be, you know whomping and stomping on 'em. So, they do something, a much lighter form of massage that – it's a super relaxing and helpful. And, we - like I said, Reiki and other things that are combined with what I would then say is a more traditional, you know, just conversation with the chaplain.

But, the team assesses together who needs what. Like, a – like a holistic nurse might go in and start the conversation and realize they really need a conversation with the chaplain. But, the chaplain might go in and start the conversation and realize what they really need

is, you know, a longer session with the holistic nurse and some guided imagery, or some relaxation. And so, we work very much together and we listen for the different needs. And we use a variety of tools. And then, we do aroma therapy, which I have been just amazed at how useful and helpful that's been. And, Barb can tell you more about that, too. But, anyway, I know I'm rambling…

NF: No. No, not at all. , this is a lot of information here. I wonder, what makes -I'm going to ask the same question two different ways. So, the first is, what makes these fit well together? And the second is, what makes this all fall under, the category of spiritual care?

AG: That's a great question. I think what makes them fit together – they didn't always – I think what makes them fit together is the actual particular human beings – and that's what I think is so neat about how this has grown. It has grown really, truly one relationship at a time. And so, when people sort of have called from outside saying I think they've imagined a much larger team of people. We have a small – I mean in a place with fourteen-hundred beds, we have really the - most chaplaincies centers are very small, much smaller than that. We have a very small staff. We have, you know, six full-time daytime chaplains. We have a night-time chaplain. We have a weekend chaplain and then we have students. And then we have two supervisors. That's a really small program for that many beds.

And then, we have… so, what I would – the point of that is, what makes it work is that the – the relationships with each other are really important. And, the common vision – the relationships with each other and the sense of a common mission and a common purpose

so that the holistic nurses used to be – well part of that's that Rubik's Cube I was talking about, about how we ended up reporting through the maze.

The holistic nurses used to be completely under there used to be only a couple and they were over under the Office of Patient Experience. And I'm not even really sure how they got there. , we started working together across these lines. We were in a different reporting structure. In twenty-ten, the Spiritual Care Department became, well we changed from Pastoral Care to Spiritual Care in order to be more inclusive of sort of the non-Abrahamic traditions. And so we just changed it to Spiritual Care. But, we also became housed under the Center for Ethics and they became the Center for Ethics, Humanity and Spiritual Care. They expanded and incorporated us because they wanted us, which was great because we got adopted out from under a place that didn't make any sense to be. Then…

NF: So, what - and that was the Office of Patient Experience?

AG: No. We were reporting up through another whole branch which was sort of the etcetera of hospitals, the – Patient Administration and Support Services which made no sense for us to be under that. I mean, they were nice people, but it made no sense. Anyway, that's another whole story. I don't want to – I'm a terrible brain-scatterer this morning. I apologize. But so we began reporting up through the Center for Ethics, which is a really good thing. And, then, eventually that became a part of the Office of Patient Experience as well. It may not matter because that can change again.

But the point is this place is so big that it's begun to operate in, you know, operate in big silos which is everybody's word for it. You know, it just – everybody sot of just stays in their lane so to speak. And, we had already started crossing lanes way back then. Just

because there were so few, we – there were few of us and hardly any of them and we just felt we could do more if we worked together. So, it made sense. We - once it became clear that we were already working that closely it made sense for them to combine with us and report through us. And then, we became, eventually, part of the whole bigger family anyway, as part of that Patient Experience umbrella. So anything that was sort of non-medical that had to do with patient's care, has sort of ended up over on this other little continent.

NF: OK. So, now the Cleveland Clinic also has the Center for, Integrative Medicine and the Wellness Institute…

AG: Right. Those are really separate which is kind of funny. The Center for Integrative Medicine got moved off the main campus which is kind of funny. It got dis- integrated [both laughing] from the main campus. , which, you know, but, it does exist and it's good and the Center for Wellness, you know, they have a very different approach. Not different in a bad way. I mean, it's just there's a lot to choose from is all I'm saying. Like, we don't have the staffing to keep chaplains involved over there because they're so far off-site. And they have another whole - they have their other whole approach. And that's great. And they have, you know, therapists and all kinds of different practitioners and offerings of different approaches to the whole self, you know, so that everything isn't treated necessarily as it's not seen as - not seen as, not instead of medicine by any means. It's in addition to.

So and how… yeah, I think in all those cases it's about how medicine is part of your total wellness. So it's… how you're eating, how you're exercising – everything. And I think that's spiritual. I think that I've really tried to teach our chaplains to not separate those

out. So someone who's is taking terrible care of their body, one way or the other, it's, you know, that's a spiritual issue. The, you know, to help them look at the spiritual roots of that, of how – of how they're not taking care of it. Maybe they're taking great care of it and it's still sick and so how are they coping spiritually with that.

Where, you know, with the – with the spiritual realities of, you know, being human, and having, you know, illness, being somewhat random at times and those kinds of things. And what spiritual resources do they have, what spiritual understanding do they have. And if they don't have resources, then do they want some.

You know, that's kind of what we're here for too. If you want to be introduced to new resources we help people find that, if they want to reconnect to a religion of their youth or they want to find out about a new one, or they want to learn. You know, we're here to help to educate them as well about what might be out there that might end up being helpful.

NF: OK. Well, can you talk a little about how you do that exactly, what you provide and how you provide it, basically?

AG: Well I think – I mean, there are volumes on spiritual care…

NF: Is that too broad of a question?

AG: I think it might be because it's just so … interesting. I will say this. I will say this. Every single person in health care ministry is grappling with that. Like, how do we answer the question? How do we tell people what we even do? Because it is an art form more than it is a science. It's an art form of knowing how to ask the right questions so that people have their own insights about their lives and their care and how they're caring for themselves and maybe what's impacting them.

NF: OK. Let me ask a different question that may or may not hit some of the same answers and I know that this is also a very broad question, maybe doesn't have an answer. But, what is your typical day look like for you?

AG: Mine's going to be really different because I'm – I'm so far removed from the bedside now. I actually work hard, I didn't want to be – I didn't add supervision and directing and all that to get away from the bedside. I really love bedside care and… my day is filled with meetings and lecture stuff.

The Rev. Amy Greene, D.Min., 28 OCT 2014

NF: You had mentioned the last time we talked that there had been, maybe unsurprisingly, tension between the clinical perspective and the chaplain's in terms of how to integrate that. Does that make sense?

AG: Yeah, I can't remember…

NF: Am I representing fairly?

AG: I can't remember exactly what I said. Do you mean between the holistic nursing and the chaplain?

NF: Or rather in the system as a whole.

AG: I think one of the things when I first got here… I think that this was such a clinical place and such a secular place and they really didn't have a sense of how chaplaincy should be used. They had a long history of a program here that, I think said all students responding to deaths – that's the pager, and there was really not much more than that going on. So, people didn't… I don't even think they chart it. Maybe they did. They kept a log, but I don't think they charted it in the patient chart. So the notion of the chaplain as an integral part of the healthcare team, keep charts and makes notes and pays attention with diagnoses and has commentary on what's actually affecting the patient, that's very new here, and that's in the last 7-8 years since Dennis [Kenney came and then I came. So, between the two of us, we've put that kind of spiritual care on the map. What's been funny is that even though, but I would say we haven't gotten so much resistance as we have just pure, really fairly pure, I don't want to say ignorance, but unawareness, almost a complete lack of awareness of what chaplains really are what we're supposed to do, and so when I first came I thought to myself oh my God, this is

such a huge task. This is a gigantic place, and they don't really know who we are or what we do how do we ever make a dent, and then somewhere along the way…

Well, it occurred to me that we actually were at a great advantage because we were not coming into a place with a staid, traditional view of pastoral care, which we could not get out of. So, the way I thought of sort thinking it about it was that, like my husband and I love old houses, so sometimes you buy an old house, and you think wow, this is great. You get a great deal and it's a fixer-upper. It's great fun, didn't realize it's in an historic district and there's a limit to what you can do [laughter], but can't tear it down. and you can't do just anything you'd like to it, you have to stick within certain codes, and that's how certain hospitals - a hospital with a more established pastoral care department, it's more like a tear down. In an historic district, you can't do everything you'd like to do. Here it's like an empty lot, which on the surface of it seems like, oh dear, that's going to be harder, there's nothing here to start with, we have a blank slate in that empty lot, and so we could do whatever it is we want. So, we had a whole lot less pushback. In reality, there was less push back than there was just simple lack of awareness and the need for education. So, that ended up really energizing us because we both had been at this long enough in various locations to be used to institutional either apathy or pushback is way more deadly than simply a lack of awareness because we both had a kind of forward minded vision that said we don't mind telling you that we're telling you what you're here for [laughter]. We don't mind if we have to keep reminding you what we do and why we're here and it doesn't bother us a bit. So we got to define it, and we got to really make it plain what we were doing here and create it the way we wanted it.

NF: So, starting from that point, we're already, maybe not ahead but, at least, not behind of where you would like to get going. How did you increase the awareness? How did you go from people not knowing what spiritual care was in terms of doctors and nurses or technicians, I'm guessing you're talking about, from not knowing what spiritual care was to knowing how to effectively use spiritual care and when to call you in and what kind of cooperation to have with you, how did that shift happen?

AG: I think we mainly did it by having really high quality. We set the bar real high for the kind of student we would take. A lot of CPE programs accept anyone who wants to wander in there because they need the credit [laughter and some had done that here to for a while, but I just said we got to set the bar really high with people who really have obsession for this work, who already have an innate sense of what a chaplain should be and not wandering in here going I don't know, maybe so. You know, really felt a calling for it, and that was not true across the board, but I'm just saying we looked for certain things and we looked for… and then we hired… Little by little we started hiring the cream of the crop. Like we'd get to the end of the senior year and if we had somebody we really wanted to keep, we'd bust our chops and try to get a position for them. And, fortunately, things were shifting enough that we had, it happened at a good time.

We were able to… Dennis Kenny is a big salesman, so he was out running around outside hiring them. Nobody intimidates him. Really nobody intimidates me. I think a lot of the problems the spiritual care departments face is that they feel… they're not exactly that they can defend their value. You know, they're not actually positive themselves that they can defend their value, so they don't… they just sort of lay low and hope nobody looks, and then Dennis Kenny and I both couldn't be more different. We very much

believe in the value of it, and we're very willing to have it tested again, and we just go knocking on doors until we get it. The JCHA requires it in hospitals. We also appeal to the clinic's national reputation [laughter] because the clinic wants to be number 1 at everything, and so we both walked around saying we're not number 1 at this; we're not very good at it at all. We would come and say Mayo has 30 something chaplains for a lot fewer beds, and we've got two [laughing], so we didn't… neither one of us minded sort of taunting from the inside.

NF: So you had… I didn't quite hear. You… They had 30, and you said we only have?

AG: Two at the time. We had one when I got here. Staff Chaplin. And Mayo is a lot smaller. I mean, I don't even think it's a thousand beds on their main campus and we have 1,400 on our main campus alone, so we were saying… We weren't trying to be stupid about it and get ourselves kicked out of the building, but we were saying if you want to be the best at this, we're not. We're not the best, and this is what it would take: A) It is going to take a lot more staffing and, truthfully, we didn't and I didn't want 30 chaplains. I still don't. That's too many, but we wanted more, and then needed more. I could use more. But we just started… We started telling the institution because that's the part about being able to educate, helping to educate the institution with that being in our favor, that was more of a blank slate.

…

It was more just a matter of people not knowing who we… What is a chaplain, what do they do. And people if they had experiences at all, they often had experiences where one old dude somewhere who maybe had lost his pulpit a long time ago and was just kind of showed up if you needed it [inaudible 15:08] but not really focused on outcomes, patient

outcomes, not focused on half the things that Dennis Kenny and I feel strongly about… so…

NF: So it sounds like what I'm hearing you describe is that you advocated for better resources as a department in terms of more chaplains and a higher quality of chaplain.

AG: Absolutely.

NF: You made sure that the orientation was on outcomes, which was in line with every other part of the hospital…

AG: Right.

NF: …and once you've created this…

AG: I mean, we pull up research that showed the effectiveness of spiritual care in certain settings, and we'd say here's some studies that show the effectiveness, and then we'd, then I think we just got really visible with the healing services group approach which we name Code Lavender, which I think I described the last time, and if not you can ask Barb and Karen more about that too. But when would we do a Code Lavender, see, you would educate a whole unit in one fell swoop. You'd have the whole unit educated about the team that was the chaplains and the healing services nurses, and we came up here to take care of you this afternoon and people would be like what? You do what? And they would be so amazed that we worked for them too, like that was part of the education because educating the system that we were there to care for them as well, and then we were available 24/7, and people didn't know that. The word just sort of leaked out. We also would do a lot of Grand Rounds. We would offer Grand Rounds pretty regularly, just be - do educational Grand Rounds, and I also would bring in a bit of money, and I would bring in some big speakers from… I brought in Harold Koenig, a big

guy out of Duke. He's done a lot of spiritually and health research. It turns out he didn't speak overall here because his research isn't clinic quality, so that kind of bothered me a little bit because he wasn't quite up to snuff on his research methodology even though he's published tons and tons of stuff. But…

NF: I didn't quite catch the name. Who was that?

AG: Koenig, K-O-E-N-I-G, or Koenig.

NF: Okay.

AG: He's worth looking up because he's done a lot of work in terms of determining the efficacy of spirituality in health.

NF: Yeah, I've actually read in a lot of the scientific research out there, he's one of the big names that I've come across.

AG: Yeah, you'll come across it a lot but, like I said, I was too new at the research game to realize that he was going to - here research is at a platinum level. It can't be silver or bronze and His research is silver or bronze, which is good, and I have appreciated a lot of his research, but that's… it's their middle name. So once people started poking at it, really they just tore it apart. That actually was kind of a disaster, but it was okay. The point was I was trying to bring in people who were big names, had put some stuff… You know, had had a few things on the map, and it started a trend of us bringing in people who do presentations and of us learning to speak better research language.

I mean, it helped me realize what credible research looks like and how to use it effectively and so forth. So, but mainly, more even than the research because I'm skeptical about it myself in the sense of I don't ever feel like I want to get backed into the corner of having to prove spiritual care. What I don't mind proving is that people want it

and need it. That's pretty easy to prove, that most people still want it. Most hospitals don't have - it's very easy to prove they have a right to it because JCHA said so – the joint committee on hospital accreditation, which is what every hospital agrees to abide by. It doesn't require, it's a very loose description of what's required, but if they want to do it world class, if they want to do it to the minimum and meet the Federal standards, they do it one way. If they want to do it right, the Cleveland Clinic way, they have to bump it up a notch, and so that's what Dennis and I were sort of calling for.

If you want, you can do the minimum or you can do it the Cleveland Clinic way and here if we wanted to do it. If we wanted to be the best, here's what we'd have to do, and, thankfully, were in a place to wanted to be the best. A place that respects its experts. If you're the expert in the field, they respect that.

NF: So, let me… I want to focus in on that for just a few minutes here in terms of experts in the field and in terms of how researchers and like Harold Koening how that… the research and the researchers have been received. So who are the leaders in the field? What do you think is the standard and what names would you put in that?

AG: Well, it's interesting, I would check out Christina Puchalski, who's at George Washington Institute for Spirituality and Health. She done… She's probably done more than anybody. She's a physician. So it has to be physician driven. So is Harold Koenig. I mean, it needs to be physician driven. I would say, actually, first and foremost, I would say Tracy Balboni out of Harvard.

NF: Say that again. I'm getting a lot breaking up on the line, so I'm not catching all the names.

AG: Tracy B-A-L-B-O-N-I at Harvard. If you Google her, you will get some interesting stuff. I would start with her. Christina Puchalski has been doing it a very long time. She's P-C-H-A-L-S-K-I. She's at George Washington Institute for Spirituality and Health. It's called GWISH. The acronym is GWISH. If you Google GWISH, you'll get tons of stuff. Google Tracy Balboni, and you'll get – anyway you just type in her name. But, anyway, there's some good stuff coming out of - I really like Bonnie. Hers is the most sort of ironclad research methodology, and she's… Her stuff is amazing.

NF: Okay.

AG: So she's studying spiritual support and advanced cancer, and she's also… I think she's married to a theologian, so that helps. They've done some stuff together. I will say… You know a lot of the studies that have been done, though, are sort of what I call low-hanging fruit, which is spirituality and end of life, and that's fine, but it's a little easier. Like people will be a little more friendly toward the importance of it around the end of life, but there's not a ton of good stuff out there yet. About the role of spirituality in sort of regular sickness, like people are… for more than just coping. It's not a wide open field. It's something I'd love to get...

NF: So…

AG: Yes, look up Tracy.

NF: How were you able, or how did you hope to use this medical research to create more support? Or what was the goal there and how did it work out?

AG: We haven't been able to do much. I mean, that's still a goal, is to get funded. The person I've been working with a lot is named Lynn Underwood, PhD. She has written something called the Daily Spiritual Experience Scale, and she has done a lot of research

using this scale, and I think she's probably the most effective of all because she's… her scale isn't about one particular religious view per se. It's about the spiritual component of experience and the effect and what people experience and how their experience effects their daily life. Not what one believes - it doesn't get into dogma and all that. It's much more generalized to any population, including [inaudible 23:41] population because the question can be modified to suit any philosophical viewpoint. So the question might be do I experience God daily? How many times a day or whatever, but you can substitute God. You can substitute the divine or you can substitute the power or you can substitute the transcendent. You can put another word in there that other people would be comfortable with. So it's been translated into like forty languages - a lot of different things. If you Google Lynn Underwood, you'll also get some very interesting stuff. So Lynn is somebody who lives in the Cleveland area, and I've brought her in a couple times doing presentations. I've brought her in to have conversations with people at the table that I'm trying to talk to about the spiritual care and some of the research. We haven't been able to do it yet because we don't have any money to pay her, but I'm sowing seeds all the time of research-based patients, so I keep sowing seeds of if you guys have a study on this or that and can we piggyback on your study with some questions about spirituality, please let me know. So I'm just kind of door-to-dooring to see if I can get kind of [inaudible 24:51] like a free-load. If I can freeload off of some of the existing studies. If you already have a study adding a few questions doesn't cost anything more, and they like that. They like doubling up on things. So that's still really new. That's not happening yet now.

NF: Okay. So what I'm hearing you say is over the past seven years or so the increasing acceptance or understanding or cooperation with spiritual care by other departments and workers at the hospital has been first creating a topnotch team?

AG: Yeah.

NF: Second of all, creating awareness through… connecting directly with the staff through rounds and through the Code Violet just to increase awareness?

AG: Yep. It's Code Lavender, but that's fine.

NF: Oh…

AG: Code Violet is fine [laughter].

NF: What did I…

AG: Code Lavender. Yeah. You said violet, which is the same color…

NF: Yes. Yes, Code Lavender. And, number three, by integrating services through the holistic nursing and so forth that also increased visibility among other staff where they can see what you're doing and what the outcome is and how that's helpful to the outcome everybody wants.

AG: Yep, exactly. That's it exactly. And I was saying…

NF: And at the same time, it sounds like bringing in speakers and bringing in research or researchers has been hit or miss in terms of advocacy, and the next step with that is to bring researchers to do research at Cleveland Clinic?

AG: Right, or use in-house people that are already doing it…

NF: Okay.

AG: … in-house. Hang on one second.

NF: Yes.

[Background conversation]

AG: Yeah, that's it exactly, and… Let's say all of that happened one relationship at a time, and I think forming that forming the crackerjack team is really key because there were people along the way that were, what I would have to say, sort of weakening the chain sort of like a cult, but [laughter].

NF: [Laughter]

AG: There were people that just couldn't get fully on board with the philosophies, and that just made it too hard. It just made it too hard to move that cohesive team, and it's not like we're… I don't mean that we all are alike or we all practice the same way, but there's very wide-ranging approaches to spiritual care. There's not one way we do it, but I think the philosophy of the body, mind, spirit as a unity, as a unified whole - like the people that don't get on board with that don't tend to be very happy here and don't tend to last because it's just too - not the environment. It's not the air their breathing. So, you summed it up great. That's exactly right. And so the research is, you know, a big bubble of mine down the road, and I feel hopeful about that, but I also think that the speakers and researchers a little bit has been a lot less important. In the long run, it's been less important than their relationships and their visibility and just their sort of - it was sometimes like a campaign. Now that I think of it, it has been sort of like a political campaign.

NF: [Laughter]

AG: Where you get a few young, really eager people [laughter] that just work their asses off 24/7. Excuse my language.

NF: Yeah [laughter].

AG: But they just do. They're passionate about it or they want to change the world, and that's what it actually… that's probably more what it's been like for the last two years.

NF: So now how many people are on the spiritual care team as a whole and how many chaplains?

AG: We have five… We have six fulltime daily chaplains.

NF: Okay.

AG: I have myself, and I will soon have a second CPE supervisor, but I've had - it's only been me for the last few years full time as a supervisor and partly we've had to reduce the training program because of that, because I've been carrying both loads at my old job and my new job, so in December I'll have a second supervisor, and we'll start to add interns back in. We've got a night chaplain. We've got two part-time weekend chaplains, and we've got four resident chaplains on CPE rounds. I mean we've had… In the summer, we had interns, but we haven't had fall or spring interns. That's a part-time, you know, supplemental staff. And, then, we have four holistic nurses, and, then, in my department, I also have what we call family liaisons reporting up to me, but they're not part of the spiritual care. They're not part of the spiritual care program, but they're the ones who show up at the point of death and help people with body donation, autopsy, funeral home, everything that requires a million phone numbers. They show up and do that.

NF: Okay.

AG: They're not part of our department, and they are considered part of the spiritual care team, but they don't go… they don't round with us to patient care visits, they only show up at the point of death. So. So it's not a huge team. For a place this size, it's not,

and we cover 24/7. With that number of people, we are on-call 24/7. Someone is in-house, not just on call but someone is here in the building, and that's every single death. There's about between 1,500 and 1,700 deaths a year on the main campus alone, so a given week, whatever that adds up to, 30 to 40 deaths in a week.

NF: Okay.

AG: Which is a good bit.

NF: That's a lot.

AG: Yeah. We're at every single one. So I think just we're really pushing our visibility, and making sure people know who we are, what we do, why we're here has been a big part of that.

NF: Alright.

AG: Yeah, I'd say about 30, about 30 deaths a week is average.

NF: So my next question is maybe a little bit more detail about the types of care that you provide. You talked a little bit about the teamwork. I wonder if there's… How would you categorize, like a list or if there's a better way to describe sort of the scope of what your department does?

AG: Well, we get a ton of referrals now. That's the thing.

NF: Okay.

AG: Because we're now known, we get lots and lots of referrals, and so people can call. We have a television in-house station that scroll through Spiritual Care, and it has a small, little video that I worked on last year, actually with Lynn Underwood.

NF: Um-hum.

AG: She interviewed a bunch of us, and we wrote a script together, and I did the voiceover, and it was just kind of… It's on an in-house television channel that's sort of… I can send it to you if you want.

NF: Sure.

AG: I could send you the link, and it sort of tells what we do, what we… what we're here for. And we have actually recently a couple of volunteers that are starting to go make introductory visits to the department… on behalf of the department to new admissions, with a card and a little flyer about what we offer and so forth. So, patients can refer themselves. They can leave us a message. They can page us. Nurses and doctors are starting to. We have lots of physicians just starting to put us in as an automatic referral, just as a routine include us in the care, in the plan and…

NF: So, what are the different ways or the different types of care that a patient can receive from your department?

AG: Well, that's going to be the healing services visit. If it's a healing services visit, they're going to go talk to them, and they're going to see if they want Reiki, do they want guided imagery, do they want to refer it out to art-and-music therapy, do they need other relaxation techniques. If it ends up being a spiritual care visit, they make a referral to Spiritual Care, and a chaplain goes, and they make up I guess a fairly traditional spiritual care visit.

NF: Okay.

AG: And, on the other hand, all the chaplains are all cross trained in Reiki, so someone might call for a chaplain and get… and the person might get there and realize the person doesn't want to do a ton of talking, they actually are going to respond better to some

Reiki or some guided imagery, and they might end up doing that instead, but it would still be a traditional spiritual care assessment and all-that visit. So, it's mainly… So we get a lot of referrals. We get the census. I mean, it's very systematic. We get paged constantly. Someone is carrying the pager 24/7.

NF: Right.

AG: And then all that team that I just mentioned have their own routine assignments, so some of them are the primary chaplain for particular floors, so the staff gets to know them and trust them, and that's just who they call. So there's a variety of ways we might get called upon. And that's what we do.

NF: Okay. And I don't know if this question will be redundant or not with other things that you've said, but I wonder if you could talk for just a few minutes about what makes your work religious or whatever words you'd like to use, faith-based, what's the religious basis of the work that you do?

AG: Well…

NF: Including all of the…

AG: We're chaplains.

NF: Yeah.

AG: So, chaplains are by definition religious professionals. We're trained in seminary, and they might… we might be from any number of religious traditions. I think that's changing as we… as our world becomes more diverse. Historically for certified chaplains, it's a very Christian sort of in its origin profession, but then Jewish chaplains sprang up probably about 50 years ago, which is a few decades after sort of the Christian world had started. I would say that Catholicism… within Christianity, Catholicism maybe

had it all along in terms of understanding hospitals. I mean, Catholicism was much more focused on building hospitals, and so seeing health and faith as connected. So, as chaplains, and I'm very adamant us keeping our name as chaplains. I'm not… There are lot of places where you become spiritual care coordinators or something. It sounds a lot more watered down to me. I want to keep the name chaplain in spite of the problems that it creates because I don't want people to think we're not religious professionals, and it takes a lot of training. Like people go to seminary 3 to 5 years, depending on their tradition, and get ordained in their tradition or their denomination, and then they do years of clinical training on top of that, so people often will call me up and say, I worked in the cafeteria, I want to be a chaplain, and I'm like, well, you've got to finish a Master's degree, and then you got to finish clinical training, and I think most people are shocked at how professionalized it really is and how much work it really takes to become one. So, my statement about that is always I don't want people who come in and say, well, I'm not really very religious, and I'm just kind of new-age year. I have my own beliefs, and I want to be a chaplain. I don't think that that's a great starting point for it because I think it needs to be people who are grounded religious professionals, who really are grounded in their own tradition but, then, are not driven by the need to spread that or driven by the need or by the beliefs that theirs is the only right religion. I always tell people your faith can be your motivation. It can't be your agenda. So, it has to be people of faith from a variety of traditions who are open to the perspective of others. They're open to the idea that God is bigger than all of our religions. If people think mine is the only right one, then go and set up a tent and hang your shingle on it and let the people who want to only be with people just like them come to you. That's fine and that's much more, to me. It's not

all about congregational ministry. I love congregational life, and I'm a good church member, but people go to church to feel alike and to belong and to believe similarly. They don't go to church in order to meet as many people from different traditions they can possibly meet in one day.

NF: Right.

AG: In the clinical setting, you're not there primarily to promote a particular religious tradition. You're there to be grounded in one so that you have some place in which to stand and some place for which to speak, but you're not there to promote that. You're there to help other people find their resources, as well as to be a real resource, like people who are grounded in solid religious tradition and then well clinically trained are able to be really good diagnosticians and say to people, it sounds like your spiritual… it sounds like maybe this is what you're wrestling with spiritually, and they have some… they have some authority with that. They have some resources with that. It's not just nice people holding hands, tell me about your day. We're real practitioners who might be able to say, this sounds like guilt, which is a spiritual condition. It cannot be medicated. And, then, here's how… Do you have a tradition, and, if so, here's what your tradition teaches about it. If you don't have a tradition, here's what some other traditions teach about it. It's real important for your health to know about it. It's really important for your health to know about anger, know about grief, know about… a lot of things that I would say are spiritual conditions. And, then, so if you don't have a religious… If you don't have a professional-trained person who's got some resources, then you just have nice people holding hands, which a lot of patients think chaplaincy is, and, frankly, in a lot of places, that is what chaplaincy is. It's just nice people holding hands, and there's… I guess there's not

anything wrong with that. I, as a hospital administer, wouldn't pay for it. I'm not paying for…

NF: Right.

AG: … nice people to hold hands, so. I don't know if that answer your question, but that's the simplest…

NF: Absolutely, it does.

AG: … simplest. Okay.

NF: And it makes me think of new questions, which is what makes any really good answer should make me think of new questions.

AG: Good. Yeah, yeah.

NF: I know that you're…

AG: That's part of my definition too.

NF: I know that you're out of time for today, and I appreciate your talking with me. Is there anything else you'd like to add or anything that…

AG: No. I appreciate your good questions, and also just how well you listen and synthesize. That's refreshing. You know, if you want to call me back, do. I don't mind. You know, if you can think of what else you would want to know from me, but I would check in with these other 2 folks and then see where you get. If you have any further questions for me in particular, email me or call me back. Otherwise, best of luck. I'd love to read what you come up with in the end.

Rabbi Micah Greenstein, 6 NOV 2014

NF: So, I was talking to Marvin Stockwell over at… Do you know Marvin by chance?

MG: Yeah, I do. Sure.

NF: Okay.

MG: At the Church Health Center, uh-huh.

NF: Yeah. I haven't been able to talk to Dr. Morris. Just the timing hasn't worked out, although I'd love to someday separately from the thesis, but Marvin seems to have such a really good handle on the history and the organization and was able to give me such good information, and he had mentioned that you and Temple Israel also were big supporters of the Church Health Center.

MG: Yeah, Scott is probably my closest friend outside of Temple and live in the same community. Yeah. And Temple, it was actually seeded, the Church Health Center was seeded by a Jewish foundation here, the Plough Foundation, and were the benefactors of our synagogue.

So, it's pretty cool that a placed called… I always say the Church Health Center, if you look behind the name, it's the most Jewish place I know. Because it's faith in action, and Scott points out that if you look at our Hebrew Bible, I don't even know about the New Testament, but a third of all scripture is about healing. It's about that nexus, and whether it's Tazria, which we avoid, but which is all about the priests and the ra-… The healer and the religious leader were the same person.

NF: Yeah, yeah.

MG: And, that bridge, and I think we all walk this talk. I mean, we all say we all talk about this, but I'm not sure we really practice mind, body, you know it's all one as well as

they do there, and it's… that's why it's a model for all safe communities, and really cities come in to observe it. You know, in the Jewish world, we tend to be more highly educated, the doctors, and even in public schools, it's only the elite public schools, it's not the ones you wouldn't be caught dead in. Right? So, we're highly evolved or tend to be more so than the general population with health issues. So, if you go to the Church Health Center, for instance, we have a faith network. I spend a lot of my time in South Memphis with the poor, not… just because I learned there's a woman at the Church Health Center, every time I go there, we'll call her Sheila, "how you doin' Sheila" and not realize she doesn't have money. Her family situation is bad; her body is more broken than yours and mine; but you ask her how she's doing, and she says, "Fine, I'm blessed," and she means it, not in some self-righteous way.

NF: Yeah.

MG: It's not like a white evangelical church in Colorado Springs where there's a guy in his mid-50s when you walk in the door, and he's like, "Hi, my name is Joe. I found Jesus. You need to find him, too." Right?

NF: Yeah.

MG: And you're thinking to yourself, okay, 2 thoughts are going through my head: 1) I'm really happy for you that you found God.

NF: [Chuckle]

MG: 2) I hope you aren't an axe murderer who just got forgiveness for finding your savior [laughter].

NF: [Chuckle]

MG: This is a different… The Church Health Center …[coughing]… Are you there?

NF: Yeah. Sorry, I was just coughing [chuckle].

MG: Oh, I'm sorry. The Church Health Center is an urban ministry with application to all houses of worship. It's more challenging not just for synagogues but for better-off churches to understand how much we have to learn. For instance, like, everyone knows about Race for the Cure and Susan Komen's Breast Cancer Walkathon, right?

NF: Right.

MG: But how often do we beyond singing Debbie Freeman's Mi Shebeirach do we link intentionally the oneness of God with the oneness of our body. Jews, like Craig Taubman and I were talking how you go to Yoga class in LA and there are all and these Jews, like 400, on a Shabbas morning, right [laughter]?

NF: [Laughter] Yeah.

MG: You try doing Shabbat alive and telling us that they don't come. It's like there's a bifurcation even though we talk as though we practice it. So, that's why I think this is such an important area, and it's so exegetically grounded. Ivdu et hashem b'Simchah. I mean people who are predisposed with joy and who with hope get better faster and stay well longer. I do not know the Duke Study and all these studies. I've had cynical doctors tell me they're not statistically sound or they're… But, anecdotally, that's why I never left Memphis. I'm so inspired by the people at the Church Health Center and congregations who live it.

NF: Yeah. And, I think, by the way, I think that the medical research is very convincing. I think that… I mean, I'm not a medical doctor, but I… Well, you studied economics as well. You know how to read research, you know critically. So I find it convincing personally. I think that there's a large enough body of research that… But,

even without the research, I think that there are… there's so much anecdotal evidence that that in itself is convincing. When you talk to people about their lives and about chaplains about the work that they do, I think it's clear.

MG: Right. I'm with you. Um-hum.

NF: So, let me ask, beyond the unity of mission that you're describing or vision, what can you tell me about the relationship between… Really, I guess I want to ask about 2 things: First the relationship between the synagogue and the Church Health Center and, secondly, what happens inside the walls of the synagogue, inside the synagogue in terms of healthcare, and I'll go into a little bit more about what I mean by that when we get there, but can you tell me about your relationship with… even your relationship with Dr. Morris and how that has had an impact on what you do or what he does?

MG: Absolutely. First of all, hospitals are highly competitive, and we know with the Affordable Care Act, the shift is going from doctors to hospitals, right? So, there are hospital wars in every city. I don't know what's going on there, but they're very competitive, different specialties are. The one thing that all the hospitals in Memphis agree on – Baptist, Methodist, St. Francis – is the Church Health Center because what he does is inspire physicians, nurses, other healthcare professionals, and people with time who want to volunteer to buy into this model for providing healthcare. It used to be for the working poor, but it's not for the working, so the working uninsured.

NF: Right.

MG: And they could be a professor who has just been terminated because the department. It could be a mother of 3 kids who works but at the end of the month has to pay for rent, food, kids clothes, and healthcare. You know, one of those has to go. And,

so, the link with Temple Israel, Nathan, is we have a lot of doctors and a lot of nurses and a lot of 90-somethings. We have 70 people over the age of 90 in our large congregation, who in their 80s were very vibrant. They used to have a dispensary for pharmaceuticals that they've since changed, but it's like 3-million dollars' worth of medicine, right, if you couldn't get the meds you needed, you go there. It's not a handout, though. It's probably doesn't get any government money.

NF: Wow.

MG: It's all faith based.

NF: Yeah.

MG: So as the largest synagogue in really the region, and we're the largest synagogue in the State of Tennessee. We take care of Mississippi and Arkansas all alike, a hub for Judaism, and our mission is not just to be a sanctuary for prayer and inspiration and a vibrant center for Jewish learning and a congregational hub, it's also to be a force for good for the world. So, in terms of the betterment of the world and mending, I don't know if you want to translate Tikkun Olam, so it's really… we put a lot of our eggs in that basket because it fit, because it's faith based too.

NF: Okay.

MG: So, that's the skinny on how we're engaged. We probably have over 100 people. The other thing they have is a wellness component that you can look up. It's called Church Health Center Wellness, and that's about prevention, right?

NF: Yeah.

MG: The body is a temple, take care of it, and we… and have a workout facility, but it's not wa-… I don't know how to describe it. It's spiritually laden and it's also, the pool

there for instance. You ever notice like when you go to pools, I never noticed this, they tend to be cold, but if you have arthritis where you're dealing with physical recovery, you need warmer temperatures. So everything there is calibrated to the healing of the body and the soul.

NF: Sure.

MG: So we have members who belong to Church Health Center Wellness. It's also where I and Scott bring religiously, just together, we convene on matters related to moving the needle on poverty or childhood obesity or ways that really impact the population.

NF: Things that…

MG: So…

NF: may be directly or indirectly related to health?

MG: Absolutely. Yeah. I'll give you another example. I think a lot of what we're doing is trying to mainstream what is categorized as alternative. So, let me give you one example. We had a recovery ministry. One of the people involved would… He's a minister at St. John's too, and there's a service Fridays at 6 o'clock. It's called the Way. It's an amazing service led by a former music, like major dude. If you know music, John Kilzer, K-I-L-Z-E-R. He was also a basketball player yada, yada, yada. Anyway, so he and James Taylor were particularly close, and JT is a big part of this recovery deal, right? So, when you think about recovery, you think about the whole AA crowd, right? It's like [chuckle] I have an alc-… I'm in a 12-step program. We have an AA group that meets here at Temple, by the way, so we think of it as those people who have issues with alcohol abuse or heroin or whatever it is. What the Church Health Center is doing and

what I'm really into is helping everyone understand that we're all in recovery. We're all works in progress. We all…

NF: Yeah.

MG: … have been only given 1 body in this lifetime.

NF: Yeah.

MG: I mean, we're all spiritual beings with a house that's called a body. We're not physical bodies with a soul, and it's not just a cliché, it's… that's what the Church Health Center and I think Judaism suggest, that whether you call it Betzelem Elohim, whether you call it the Neshama. The rest is just anatomy. I mean, your hands, your genitalia, your organs, it's just anatomy [laughter], right? So, we are called by God, put in this body, this soul that's housed in this body to take care of it, and, so, everything revolves around that. So prayer is important. Meditation is important. The Pilates that's offered there is different than you get at your 24-hour fitness. You ought to come and take a visit. Whenever dignitaries come, I take 'em by there. They're always… And, now this nursing international organization that Scott told me about before they came, and you just identified it through your research.

NF: Yeah.

MG: I'm trying to think a different word than holistic, but that's what it is, and I find it so affirming Jewishly as opposed to the way we institutionally go through the motions, and we have "Teffilah," you know, the frozen chosen [laughter].

NF: [Laughter].

MG: It's not as… So, it helps me. It helps me as much as I give to it. Not just be a better rabbi but be a more cognizant Jew, if that makes sense. So that's how I'm involved. That's how Temple is involved and…

NF: Can you…

MG: It's evolved. Because, it started off as a clinic. Oh, by the way, but you know abuse… When I said a recovery, I didn't just mean substance…

NF: Yeah.

MG: … and, again, you can drink wine and still go to this service, it's just. It's about moderation, right, and then sexual abuse, physical abuse. Scott taught me that when… He's an internist, a family medicine doctor, but a third of all the women that he's seeing, for 20 years he's practicing medicine, and they're having abdominal pain. He never asked them the question – Have you ever been sexually abused before." And it's like half of them have, and so…

NF: Hum.

MG: … you understand that almost all the issues that people bring to doctors have a nonphysical component to them, that you can prescribe the medication, which we'll do, but that won't take care of the pain, so he has pastoral counseling that works as a team. Sometimes I work with him on cases. If that makes sense. So that's why when we think of a health clinic that's faith based, it's not like Doctors Without Borders only trying to solve Ebola, it's ongoing care for the body and soul, and the other thing that's really wonderful that I just… You know like we need Shabbat more than ever with this wired world. I mean, check our phones every minute.

NF: Um-hum.

MG: You know, we need Shabbat. We need to unplug front the wired world. Similarly, in medicine, everything is technology driven now, right. I mean it's all faster, get the files on the same sheet, this gadget, that gadget, but we're not getting healthier.

NF: Uh-huh.

MG: So what the Church Health Center does is it returns us to the idea of Shabbat, of human connection, and it's restorative that way, and the results are also better. People feel better. They're healthier, and they're empowered because it's not just about a machine, not just this technology. If you got cancer, he'll get you an oncological surgeon or if… You know, the other thing is just unbelievable, you're just stirring all these thoughts, people who need jobs, what's the one thing that gets in the way when people interview. If you have bad teeth [laughter]… I mean, I never thought of this.

NF: Huh.

MG: You and I go to a dentist, but…

NF: Yeah.

MG: … a lot of people they got terrible teeth, they try to smile in an interview and people, psychologists show that you don't get the job, so he has dentists who help people have a better appearance. That's one thing. The same with eyes, with the ophthalmologists. You can look it up, but it's an amazing footprint now in the city.

NF: So, let me refocus a little bit here.

MG: Yeah. I'm sorry I'm rambling. Yeah.

NF: No, it's… I can tell that you're… I'm thinking there's a marketing term called a… evangelistic marketing, where you have key people who just really believe in the product so much that… It sounds like you're one of those people. I can tell that…

MG: It's probably true.

NF: That you're… That's a service that you provide to the Church Health Center, I can see that you're happy and willing and enthusiastic. Does that translate or, rather, how does that translate in your synagogue? So, you've mentioned that you're physically, including the Church Health Center and their facilities by bringing different faith leaders there and organizing meetings there on different issues, and you've mentioned that there are a lot of doctors who are in your congregation, doctors and nurses and so forth, that are participants. Do you bring that sort of evangelizing, if you'll forgive the term, into the synagogue? Do you ask the doctors and so forth in your synagogue to check this out or volunteer their time?

MG: Oh, yeah. They almost naturally do because we partner all the time with programs, and… that's just one. I mean, Yom Kippur, I've been passionate about keeping people engaged all day so you don't hafta to go home. So we have hundreds and hundreds of people stay from the morning service during the Elul, and we have all types of music and all types of discussion groups, and we… Scott has been one of them, so on Yom Kippur, he was key note where we get the Five Wishes. You know about that?

NF: No.

MG: In terms of a living will, The Five Wishes…

NF: Oh, yeah, yeah, yeah.

NF: The living will, yeah?

MG: Yeah, yeah. So, the Five Wishes, which is just a beautiful document that is legally valid in, I think just about every State but like South Dakota or Wyoming, one of those. So, Scott came and we talked about… we didn't call it Dying Well, we called it Living

Well. So he came and that was part of the Church Health Center. And you may think about it like, "Well, why would a church health center…" It's to save people the agony at the end of their lives and to get them talking about what matters most to them, you know what they treasure most, what they value. It's almost like an [chuckle] ethical will, right?

NF: Yeah.

MG: That was generated from this place, and, so, Scott is a frequent temple goer and speaker, and he was the Yom Kippur keynote. I also have taken him to Israel, him and his wife, along with, I took 5 African American and 5 white friends, who happened to lead large congregations in Memphis, and they're also involved in the Church Health Center world. It's like that book Ron Wolfson wrote that everybody is talking about, Relational Judaism, that I'm sure you all have been at least discussing, right?

NF: Oh, absolutely.

MG: It's… Down here, it's like, D-U-H. I mean, duh. Like…

NF: Yeah.

MG: Everything is relational here. You can't do portfolio approaches. It's not institutional. It's all relational, so when you ask about Scott's input here, he is a frequent temple face and we have some really deep Torah sessions with him. He also, he did… He was an amazing pitcher in Atlanta, and he pitched a no-hitter against Georgia Tech, right? And on Yom Kippur, the way he broke the ice, before we got into this deep discussion about death, and dying well and living well… You know the story about Sandy Koufax not pitching on Yom Kippur, right?

NF: Yeah.

MG: Well, here's the part that I didn't know: In his place on Yom Kippur, this is how Scott started his talk, a guy named Drysdale was the pitcher. So Drysdale goes out there, and during the first 2 innings, Nathan, he gives up like 7 runs. So the manager comes out to get… to take the ball from Drysdale and bring in a new pitcher, and Drysdale said just one thing to the manager. He said, "Bet you wish I was a Jew now."

NF: [Laughter]

MG: Isn't that hilarious?

NF: Yeah.

MG: That's Scott's personality …[laughter]… and then he gets into his Torah.

NF: That's wonderful.

MG: Anyway. So hopefully that answers that question better.

NF: So, yeah. So, you mentioned, for example you're personal relationship with him and some of the relationship between the synagogue programming. I wondered, do you have other health-based or rather wellness-based, to put it more broadly or more… Do you have other wellness programming that you do at the synagogue this is independent from Church Health Center.

MG: Yeah. So, we did yoga… We did Shabbat yoga in the afternoon, and we have… For staff, we have a Pilates class here. We also sponsored a 5K for many, many years with a premier youth organization to ra-… It was a walk/run, you know, family, called the EJ's 5K. So, we also have, for youth…

NF: And what did that benefit?

MG: Oh, it benefitted early learning.

NF: Okay.

MG: It benefitted the use of Temple and the use of the City. We have a… It's just complicated, but, okay, this is actually worth mentioning. In early childhood, Nathan, there's something called a National Association of… for the Education of Young Children – N-A-E-Y-C. It's like the platinum accreditation in the early learning world, Early Learning Center.

NF: Okay.

MG: Our director has a doctorate in this, and she became the, like guru of early childhood, and this is… I'm not educator and even if I was an educator, I wouldn't be this smart, but there's something called…

NF: [Laughter]

MG: … toxic stress. Do you know about this? Like kids, as we know, the early years are the most important but beyond what we realize in terms of when they experience great learning but also when they experience trauma, the effects on them. So what's the point? The point is, we got this N-A-E-Y-C accreditation, and we helped a number of the other Jewish and non-Jewish. Early learning centers rise to this caliber of accreditation. Scott Morris' Church Health Center started a preschool like 20 years ago, no, maybe not that long ago. You can look it up. Called Perea, P-E-R-E-A.

NF: Yeah.

MG: And, if you're following me, among the 5 black ministers and the 5 white ministers is my twin. His name is Keith Norman. He's a tall African-American First Baptist Church preacher, just a brilliant guy. He says we're twins, only he's tall, dark, and handsome; I'm short, white, and aging.

NF: [Laughter].

MG: So, Keith, if you're following me, Keith's wife is the director of Perea. Now, what is Perea? Scott had this crazy idea, but he's a visionary, to start an early learning center for kids who come from households that earn $10,000 or less, which means, no dads pretty much, and the moms may be living with aunts or grandmothers or whatever, anyway, long story short, I introduced, because of our friendship Alicia, who is the director of Perea, and Susan, who is our guru over here, and it has not been a paternalistic relationship of like a wealthier suburban temple, because the people who are serving Perea now are poor, you know what I mean? Like, they're just like TFAs, just educators who care about kids, especially the most underserved kids. So we just got N-A-E-Y-C accreditation. In other words, an early learning center with kids who come from families under $10,000 is as objectively high-level of the most privileged private academy of any city, and that's all because of the relationship our teachers and their teachers do in-service together. We train, and they train together, Temple and… So, Perea and Temple, and that leads to identifying victims with child abuse. It leads to our whole staff here getting trained in sexual-abuse prevention here with the Child Advocacy Center. And what's the relevant of that? One out of every 4 women have been sexually traumatized, and 1 out of every 6 men, and it's led to me, I didn't realize I was opening this can, adults who have hid what happened to them. You know what I mean?

NF: Yeah.

MG: And they found healing here. So, it's just this web, not just of relationships but of a program that leads to wellness and not compartmentalized ways but in very deep ways. So Perea and our preschool are sister schools, and what started off as a mentoring has led

to a complete partnership. So I spoke at Perea. Scott came and spoke here at our early learning center.

NF: Wow. Okay. That sounds amazing.

MG: It is. It is and I'm so proud of him.

NF: Marvin had… Oh, sorry.

MG: I'm done.

NF: Oh [laughter]. I was just going to say Marvin had mentioned the Early Learning Center, but didn't have time to get in to so much detail, so that sounds like a really amazing thing. Let me ask you to imagine, maybe somewhat artificially, the walls of the synagogue sort of closed off. What happens inside the synagogue with the congregation in terms of programming? You had mentioned that there was yoga. Is that no longer going on?

MG: No. Yeah. It is no longer going on.

NF: Okay.

MG: And the reason is people are still doing yoga, but they don't feel they needed to come on Shabbat afternoon.

NF: Sure.

MG: You know, there are a lot of members who instruct and who teach. But, like I brought in… Oh my God, I can't believe I'm forgetting his name. I had the Three Series with him. He's British. He does the yoga, Jewish yoga. He's actually an ordained Modern Orthodox Rabbi. So we've done… If I jog my memory, we're always thinking about programs that combine wellness. There are different… Okay, for instance one of the things Scott does is he tries to teach these churches to cook healthier.

NF: So how many programs would you say inside the synagogue sort of or how quickly, rather, do you… would you say you cycle through them? If there's yoga and that's sustainable for I don't know a year…

MG: It was available for a few years.

NF: …or 2 years or a few years. And, then, there's a new…

MG: Of the EJ 5K, we did for like 5, 7 years, and the reason I'm a believer like you hold onto things and then you let go of them when there's…

NF: Sure.

MG: … like a 5K. You know, we achieved our purpose, and then we moved more deeper into the relationship with the Perea School. And…

NF: So, let me ask…

MG: Um-hum. So, if you think of a program seen, like to the year, like when we talked about the Five Wishes, who thought who would be the best person to introduce that. It was Scott Morris.

NF: Okay. Are there other healthcare organizations in Memphis that you work with in terms of bringing people in for education?

MG: Yeah. I mean, yeah because… I don't know how to describe this, but we're very connected to the 2 primary hospitals here. Administratively, medically, the School of Nursing. We have a lot of research here with cancer with the West Cancer Clinic that… So, I'd say whenever we vision program, invariably something related to health comes up, whether it's screenings. Oh, I mean, we just won the gold medal, this Pekuach Nefesh in giving blood for all the faith… for all the churches in Memphis, it's the synagogue got the award from Life Blood. Now, how is that related? You know, we're constantly talking

about saving life, that 1 pint can save up to 4 lives, so that's also part of the larger picture, I think.

NF: So how do you make, so for example, the blood drive, how did you make that happen? Is that something that you talked about from the pulpit? Is that something you… Was there a taskforce or a committee that was put together on that? Like, how did you… What were the steps, if you would walk me through it, of reaching that point?

MG: There would be no Church Health Center without Scott Morris. And there would be no blood drive without Julie Klein.

NF: Okay.

MG: It's all about shoulder tapping and finding the leader.

NF: Okay.

MG: How to find.

NF: Okay.

MG: So, yeah, I talked about it from the pulpit. Yes, talked about and we started it because a member of our congregation there wasn't the right blood for him for a surgery. He died because of that. This was years ago.

NF: Awww.

MG: And we always had had, like limited blood drives, but now… and then we reached out and found nurse practitioners and other engaged members who have… who are connectors, you know what I mean?

NF: Yeah.

MG: And then… So that's how… And then, drawing the attention of the community and winning the award at the National… at the annual gala. We had no idea that the

Temple Israel was leading, and then elevating this and showing why this is Jewish, and they all know what Pikuach Nefesh means now. So, that's how.

NF: Okay. So, there was programming or educational programming and, I guess, inspirational programming, maybe we'll call sort of leading up to that, and, as you said, the right people or in this case, the right person sort of holding in the centrifugal force.

MG: I think that's well said. Um-hum.

NF: Okay. So, I'm just trying to sort of generate in my mind a picture of what's happening inside the synagogue, and you mentioned food, which I think is something that I think comes up in every conversation. Can you talk to me a little about the food in the synagogue and how that's changed or if that's changed based on health concerns?

MG: [Sneezing] Yeah, I don't know if I would attribute it to the Church Health Center, but we're… We have chefs in the congregation who we've tapped to… We cook for not homeless shelter, but a community of people getting back on their feet again, called a Simple Place.

NF: Okay.

MG: So, and we're still a sister… We still have a very strong women who perform Judaism who keep food friends and how to make Shabbas chicken a hundred different ways. So, it's… there's a health consciousness.

NF: So, did…

MG: That's just part of it. Um-hum.

NF: Do you feel like that health consciousness came out sort of a… of a natural change in culture of broader American culture or in the City or do you think that there's

something special about how health is treated inside Temple Israel that sort of led this change?

MG: That's a great question. I haven't thought about it. I think it may be something… may be part of a broader culture, but the Jews who are affiliated here and who are engaged here bring that too, like so I have a conversion student who wants to study it in an area, and she's a former sushi chef, you know [laughter] and studies kashrut and studies ethical echo kashrut or ethical eating and, you know, the whole sensitivity to the gluten-free population and because of our early center the peanut allergies…

NF: Yeah.

MG: It's just that I think we have a more educated population. The beautiful thing is when they connect it to their Judaism. So, I'm not sure it's because of Temple culture; it's because of who's here.

NF: Okay. Now, I've… The reason I'm asking these types of questions here, not about just the church health center but about your synagogue and your culture is, as I said, the ultimate goal of this thesis is to create something that could be implemented in any synagogue in any city, and as far as I've been able to find, there's really only 1 Church Health Center. It's really sort of this sui generis entity, although there is certainly a movement of people who would love to do a similar thing. It seems like Memphis is pretty unique in having that. So that's why I'm curious about what's sort of happening inside Temple Israel.

MG: So, what happens is like when Nashville or Atlanta or Albuquerque come to visit us, and I sometimes will go out in to talk to them. You know, these communities, they want to replicate the Church Health Center. It's not always replicable, but it's definitely

adaptable, and I think that is possible for high-functioning synagogues who have a consciousness and intentionality to health and wellness. So, I'll give you an example. You're making me think. If you look on our website or just Google, like, Katie and I, my colleague here, Katie Bowman who's just a gem, and she and I talked about healing. You know, we talked about how do we… That was the theme, and she devoted her Yom Kippur sermon to that where she talks about a body image and think about all the areas, the kids with eating disorders, we talk about… America… I think the 2 best-selling books are cookbooks and diet books. [Laughter] We're just neurotic. Right?

NF: Yeah.

MG: Jews on steroids. So, it's a good example, and now I think about it every year. Last year Scott Morris spoke. This year Katie and I talked about it. She was… that was just beautiful, and I thought she just nailed it about, about… And it was about mainstreaming, again that was the subtext. It's not about those people, it's about all of us. I mean, if Judaism is all about self-improvement and the aim of a life of Mitzvah is the refinement of human beings, we all should get in the game, right? So, I think looking for the synagogues that do the best programs is really not a good way to look at it. It's where are the spiritual leaders conscious of this and linked with others in this communally and within the synagogue, and Memphis is a unique laboratory for that, as I said before, so you may find congregations that do great programs, and then, okay, then they're one-hit wonders, so what do they connect to. The same with our Church Health Center, we have an ongoing pipeline of volunteers, but we also have an exchange when we talk about the newest things in healing or in medicine or that technology is missing or in screenings or in all the things we talked about …[background noise]…

NF: I see. So it sounds to me like you're saying if I'm talking about taking something that can be implemented in a synagogue. That thing is not programmatic necessarily, that's it's not about…

MG: That's right.

NF: … having the right, doing, for synagogue meetings based around healthier, having weekly… having a nurse come out every Shabbat or programmatic or policy things, that's it's more about having and maintaining a relationship with other organizations that share that mission in the way that members of your synagogue have a relationship with Church Health Center and you have a relationship with Scott Morris?

MG: I would agree. And it starts…

NF: Okay.

MG: Yeah. But it has to also be the clergy team. It has to be… You know that old phrase that funding follows vision; vision doesn't follow funding? You know, everybody likes looking for money, but if you don't have a vision. I mean, if you have a great idea…

NF: Yeah.

MG: … then people will support it, but you have to come up with a great idea. So…

NF: Yes [chuckle].

MG: The program will not create an ongoing attention to the unity, to the yachadut of mind-body experience. It has to be not just nurtured and cultivated but reenergized. You need, I think, like Ahad Ha'am. One we did, we were in Israel talking about Zionism, Diaspora and Israel says 2 wheels reenergizing-… You know, the spokes in the wheels. You probably had that same diagram? Do you know what I'm talking about? You know, like the 2 centers of Jewish life.

NF: Yeah.

MG: It's not either or, they invigorate each other.

NF: Yes.

MG: And that's really what the Church Health Center does for us and what we do for them. It's not just a think tank. There's some practice to it, yes. Some programs may come from it, but the minute we start with a program, I think we've forgotten why. Why are we doing the program? So I think the impulse in our reformed Jewish world is to look for the program rather than… And we all talk about changing the culture, but you can't just change the culture, you have to gradually think about… Okay, with prayer beyond your prayer for healing, with programs beyond the 1-hit wonders, relationally who are you bringing in and what are you… and how are you… Almost like concentric circles. We talked today about the Early Learning Center and senior staff and Joe or Jane congregant who wants to volunteer, and it's also bringing people to parts of the community they may not have been part of. It's getting outside the synagogue and living that mission for being a force for goodness and being a part of that. So, yeah. I'm not going to be duplicitous. We always love to hear what great programs are, but that's not what it is. And, you know, also preaching about it. On the holiest day of the year, I mean, I think the last 3 years, we've always done something on healing, whether it was Scott or Katie this past year, 2 years ago did something else I think.

NF: I think that's…

MG: I'm not sure I've been helpful, but I'm happy to talk again.

Marvin Stockwell, 15 OCT 2014

NF: So I guess I'd like to start off with just who you are, your role, and then we'll get into little bit of history and then some more details of

MS: Right so yeah, I have worked at the Church Health Center for right about 10 years, just a week shy of 10 years. I am the communications director; I have been present for a period of great growth here at the Center, system-wide, but not only system-wide, but also in my own work area. Back in '04 it was just me and a twenty-hour-a-week intern. And now we have a team of six people.

NF: So what does your role look like?

MS: Yeah, as communications director, I am in charge of all public relations, marketing, advertising, social media, and internal communications, and branding. So that entire suite of communications "stuff" for lack of a better word is what I'm ultimately responsible for.

NF: From the beginning have you had that role, or has it changed over time?

MS: It has, because I've been able to, as I've grown my team, I've been able to sub-specialize more. Back in two thousand four social media was only starting to get on everybody's radar as in, "you might want to kick the tires of this." Flash forward 10 years and it is a got-to-have staff position. In 2004, I was barely on social media at all. It was just something that college kids did. I was starting to get on Myspace because of music stuff, but at any rate, yes, when I was a one-person office, I had to be a generalist and so I managed to work within the time constraints of what was possible as a one-person office. I leveraged my background as a journalist to really tell the story of the Center, both in our

newsletter and in other ways, through the stories I pitched to the media that ended up in newspapers, etc., and by doing that I educated myself on what the Center did in all its variety. I had a series of interns after that first intern. I got a full-time intern for three subsequent people in a row, for yearlong stints, the last of whom I hired. because in communications, it's great to have the baseline skills of understanding of how to write a press release and how to be effective in speaking bullet points when you're on TV, etc., but one of the tools in your toolkit as a communicator is also the store of knowledge about the ministry that you have. What was frustrating about having a new intern each year is that I would have to start over from Ground Zero to build that set of knowledge. It really set me back each year I would essentially have to start over. I finally said, "Can we just keep the person we have? He's great." Thankfully he has been part of the team ever since. My colleague Jeff Hewlett, who is our communications manager at this point. I don't know how much detail you want on the development of the communications office, but suffice it to say, as certain different pieces were added, at a certain point, it made sense for Jeff to be promoted to supervisor so that he could help me run the team. Then his promotion to manager really signified... He was the counterweight to me being promoted to the director realm, so that I can focus more on leadership work and syncing up with the other areas of the Center on the overarching work. Jeff works on that stuff, too, but he also principally runs the team. He controls the flow of the work product; he makes sure that we're doing everything we should be doing. He has taken over the lion's share of the media booking work and media pitching. Not that I don't pitch in on that stuff myself as well, but it allowed me to delineate our duties. We tackle thing in ways that we couldn't when we didn't have a graphic designer. Now we have a full-time

graphic designer. Now we can knock out specialty fliers. Graphic design is a subspecialty that's really unique. Did I have rudimentary pagination skills? Yes, I did, but I was by no means a true graphic designer. The work product under my tenure, when I would have been graphic design was not nearly as pro as it is now. When you're talking about representing your brand faithfully in the marketplace of ideas, if you yourself are a cutting-edge organization that is one of top nonprofits in the city, but you still have graphic design that looks kind of mickey mouse, that look like you have somebody working out of your house, it just doesn't sync up. It doesn't properly display the quality that you're delivering.

NF: Yeah, that absolutely makes sense. Now, let me ask about the message that you are trying to deliver with that and move into more of the history and the sort of past, present and future of the Church Health Center. Why don't we start with the present? Describe to me what the organization looks like today: the physical facilities, the people who are involved...

MS: We operate out of about 14 different buildings. We are growing at a rate that's... over the last three years we've been really exploding in growth, not only in terms of patient base, but also in terms of just scope of work. For instance, addiction and recovery work, and moving into behavioral health is something that we realize is something we ought to go do in a more robust way. That took promoting someone to be the director of that area. Starting to consider... We took over me being the fiscal agent of the Memphis area prevention coalition. We are now essentially running that organization under our auspices. All of that takes a lot of coordination. A good way to say why this is the way that it is, is to start at our mission statement. Our mission statement says the Church

Health Center seeks to reclaim the church's Biblical commitment to care for our bodies and our spirits. The longer I work here, the more I realize how broad that is. And when I say the church, I don't mean one particular church, and honestly, when you look at the coalition of Christians, Jews and Muslims that we have put together, you could even say the "church" is the broadest coalition of people of goodwill. We've got people who are our supporters who are atheists. For them, you could argue that they were formed by living in a Judeo-Christian nation that shaped their values, and even though they don't believe in God, they are ethical people. They want to live a morally grounded life and they care about humanity. That's all wonderful. So our mission statement is broad. If you look at us as the little clinic that could, that started here in September 1 of '87 and then you go to your next logical step, it's all organic growth. We realized early on that dispensing pills and having access to medical care was only half of the equation. What responsibility do we have to teach people how to remain healthy? How to be good stewards of their own health? that was the impetus for our Wellness Center, which started in a small midtown house right next to our original building and then moved to its current 80,000 sq. ft. location just four minutes' walk away. if you look at that, if you realize that our mission statement is broad - to reclaim the church's Biblical commitment to care for our bodies and our spirits - Gosh, if we're going to care about our bodies and our spirits, our bodily health and our spiritual health and our emotional health, well then you can see fairly clearly. Once you will grow to a level that you can take it on, you want to press farther into behavioral health and think about depression and have a counseling office, then expand on that. That's been the undergirding, navigatory philosophy, if you will, that has propelled us forward. That, and it bears stating: just a truly prophetic leader like

Doctor Morris, who is just nose to the grindstone, indefatigable, and just resolute that he has been put on this earth for a finite period of time and God expects him to, and he expects of himself to be a good steward of his life and his abilities. So that's what really propelled us forward. We have a medical clinic, we have a dental clinic, we have an eye clinic, and we have subspecialty clinics within our clinic, staffed by volunteer subspecialists. we also have a volunteer network of hundreds and hundreds of doctors who see patients in their own offices, through what's called our MEMPHIS plan, who are referred out and who are our regular clinic patients. We have a faith community outreach office that does nothing but work with area congregations on issues around health. That office in and of itself, in the last few years has grown to encompass stewardship over the international parish nurse resource Center. Which is itself a 40 year old organization with faith community nurses in many many many countries, thousands of them, with a curriculum taught in universities in countless cities. Not just in the United States, but Canada, Europe and elsewhere. The more we work towards reclaiming that biblical commitment to care for our bodies and our spirits, what you're really getting at is like the foundational underpinnings of why people of faith have been caring about health since time immemorial. You should realize if you look at the scope of history that the recent phenomenon of subspecializing in medicine and divorcing it from a faith view is actually a recent phenomenon. When I say recent, we're talking about the 1800s. Or more specifically and more emphatically than the advent of Medicare and Medicaid and the creation 110, 115, 120 years ago of faith based hospitals. Hospitals were founded to serve the poor. It was only later that the rich who could afford to have doctors come to their own house realized that the poor were getting better health outcomes. Then they wanted

the same level of care. Over time when you professionalized medicine and over time, it became divorced from the concept of faith because of two things: A concept put forward by Plato and furthered by Rene Descartes, which is called Cartesian dualism, which states that the body and the spirit are separate. What I think humanity is coming back to, and what is the underpinning main belief of the entire faith-health movement, is that is a false dichotomy. We're only one organization among many is starting to wake up to the fact that not only are those two things obviously connected, but what would it look like if we were proactive about really reconnecting those things in a robust way? Intentionally, not just happenstantially.

NF: Let me ask about how the organization operates today. You have fourteen different buildings I think you said. Are those all clinics or different offices?

MS: No. I'd say we have one main medical clinic, but we also now have a medical clinic over at our Wellness Center so that's a second clinic. The eye clinic is embedded in our main medical clinic. Our dental clinic, however within the last two years has moved off-site just so that it can become bigger. Once that moved offsite from our main medical clinic we re-categorized that space and made it our on-site subspecialty clinic. I guess those are our only clinics. We're just about to start an acupuncture clinic at our Wellness Center early next year. That will be kind of embedded in our Wellness Center, so I don't even want to consider it an extra clinic. The rest of those are buildings for our HR and our information systems folks.

NF: So these are all buildings nearby one another, like a campus? I am picturing…

MS: Pretty much. I mean we have our dental clinic is really just down the street. It's about a two minute bike ride away – or one minute bike ride, if you are really pedaling hard.

NF: [laughing]

MS: Yeah, they're all in relative close proximity to each other. However, and this is another whole can of worms and we don't have to develop it, but it's important to at least make note of at the outset. We have a plan in place to move to a renovated Sears crosstown building in two years because we want to capture the efficiencies, of – not just efficiencies, but, ability to work together, more completely in a more knit together way with all of our services being together under one roof.

NF: Sure. Efficiency doesn't have to be a bad word. [laughing] I…

MS: You know, actually, we all thought it was a fine word. But then, efficiency can be read with a negative connotation in terms of like slash and burn cost cutting to prepare something for sale and with disregard for humans. I get that. We actually learned now that we were kind of blind – not blind… but, we were unaware that efficiency can mean draconian cuts, without concern for people and that's not how the Health Center is. That's the reason it's kind of a blind spot for us, but, we're – we're choosing our words more carefully now.

NF: I can appreciate how that reaction might've come about, and might've been a little bit of a surprise and certainly, far from what you meant. You meant efficient in terms of being able to work together.

MS: You know, we had, in the public sphere, it was the feedback we got from our board members who were business people. You know, it was in a faith base, but, I didn't foresee that. You know it allowed us to respond really before that public messaging was out long release.

NF: So, let me ask about now what happens within these buildings, you know, in particular the clinic. It seems like that most of what happens, in the organization, happens in that place. That that's sort of the heart.

MS: Yeah. I would disagree with that, because we do have an eighty thousand square foot Comprehensive Wellness Center with a teaching kitchen, Pilates, yoga, cycling, spin classes, weight room, basketball, handball, heat therapeutic pool, herb garden, meditation garden…

NF: Well, this is starting to sound like a community center.

MS: We're all that too – a humongous family size bag of chips. [Laughing]

MS: We got a preschool too Nathan.

NF: This sounds to me like a community center. Like a – a JCC or a YMCA. Does it have that kind of role?

MS: It does encompass those aspects but, by the same token, our medical clinic is a patient centered medical home certified clinic that has a robust Church Health Scholars Program for people who are studying to go to medical school where we cycle young people learning to become doctors and nurses. But, at its core, our medical clinic… last year we saw forty-six thousand patient visits to our medical clinic. So that's not

insignificant. That's a ton of people. We have a dental clinic that, we had to move to another building so we could go from three to ten chairs because the need's great. You know, I'd say we're starting to make inroads in the eye clinic field. But by the same token, one of the ways we'll address that, is that once we move to Sears Crosstown. The plan at least is in place for us to be embedded close to the Southern College of Optometry so then you could see we might leverage faculty and students to expand our work, in a way, that's working smarter, not harder, if that makes sense. I mean, I think we will eventually grow our eye clinic personnel. Like, I think we will ultimately move past one optometrist plus volunteers, which is our footprint right now.

NF: Okay, so when that move happens, will the dental clinic and the Wellness Center and the main clinic all be combined…

MS: Yes.

NF: … sort of back into one? I see.

MS: I forget what, the individual robots were- were called before they formed Voltron, but all the robots formed the giant intergalactic crime fighter or whatever the heck I am trying to say. Yeah, that's when the spaceship really gets put together in an interesting way. The only asterisk next to that, so we say, "lock, stock and barrel – "moving' in lock, stock and barrel – all programmatic areas." The asterisk next to that is, we will likely keep our original building, some access to it for historical tours. And the other piece of that is our preschool is currently embedded in a public school that is very close to the crosstown building we're going to be located in. So, we will probably keep the preschool situated at that public school. But, barring those two relatively small, when you consider

the larger scope of things - lock, stock and barrel is the way we are couching it to be. So what will become of the facilities we are vacating? That's a natural question that people usually come to. We are giving that thoughtful consideration and we want to respectfully leave those buildings in the hands of perhaps other nonprofits perhaps other NGO's. One idea is that the burgeoning local food movement in all of its variety doesn't really have a home base or an area in town, but it makes sense for Grow Memphis and you know urban farms.

NF: That would be interesting.

MS: Oh, yeah. All that suite of things which also we care about, 'cause locally sourced food and farming the earth and…

NF: Has a lot to do with what we care about as well.

NF: Yah.

MS: Not to mention food grown locally has more vitamin content, all that stuff, directly tied to health.

NF: Yeah, absolutely. Just creating green spaces even if you're not eating the food.

MS: Right.

NF: Anyway, I don't want to get into the studies.

MS: Right.

NF: I know you know all this stuff. [Laughing]

NF: I find it exciting, and I'm sure you do too. It's why you got into this work I would imagine.

MS: Well this is an exciting place to work even before things got really exciting. You know, really, it's like if all we did was carry forward our service lines that are more historical, like the classic lines of service, it's something that a man of faith like myself could absolutely put his whole heart behind. The fact that we are not a static organization, that we are constantly saying, "What trail should we continue to blaze? How can we contribute to the on-going dialogue around about how we cooperate with, in fact, face it, the paradigm shift in health?" We believe fundamentally that the faith piece is a missing piece in the larger health and health care dialogue. I think we have an unbelievably strategic opportunity around the Affordable Care Act and implementing a greater footprint for faith community nurses worldwide, especially in the United States. Many hospital systems are starting to look at that. I'm sorry. I'm totally going off on a tangent.

NF: It's not a tangent. I would like to get into all that stuff. I want to set some time aside, in a couple of minutes, but I want to sort of get a clearer picture of a couple of things, in terms of what the organization is right now. I know sort of where it's come from and where it's going is all a part of what it is right now.

MS: Yeah.

NF: But you mentioned, for example, you have one optometrist and volunteers. What is the breakdown of the people who serve in the organization between staff and, medical professionals and volunteers?

MS: Yeah, well the optometry realm, that's the one thing that I'd have to say that I'd get back to you on. But it looks something like this. But, I know that, in the past…

NF: [coughing] I was just using that as an example….

MS: yeah, so as an example, I know this is a couple of years dated, but I think the overall ratio should probably still work. We have two staff dentists and probably fifty volunteers. Our dental clinic it's worth noting, started with all volunteers and only after a while did we bring on a staff person in that position. Our medical footprint started with just Doctor Morris as the only staff doctor.

NF: So who are those volunteers? Like what kind of peo - are they also dentists? Are they nurses…

MS: Oh yeah. They're volunteers of that specific type. So fifty volunteer dentists. Yeah, so if you look at our physician ranks we got, maybe ten full-time equivalent physicians and nurse practitioners. But, we've got, you know, Doctor Morris and a thousand volunteers. I think maybe not quite a thousand overall just physicians. But, I think if you look at the various ways that people volunteer both on-site and off-site, I think it's probably between eight-hundred and nine-hundred. I mean there is almost a hundred volunteer doctors for each staff doc.

NF: Yeah, that's really sort of mind blowing, I think. But, let me ask, if I'm one of these…

MS: We're the largest health care organization of the type in the country.

NF: If I'm one of these, you know nine-hundred volunteer doctors, what does my week look like in relation to the organization?

MS: Yeah, now that's a great question. I will say this, we learned early on that what you don't want is to burn anybody out.

NF: Okay. Sure.

MS: So we start very, it might be we have volunteer doctors who come and volunteer one night a month. You know we have – and then take the case of the doctor who says, "Oh gosh, you know, my practice is way out in the suburbs and like -". The whole genius idea of Doctor Morris coming up with the Memphis Plan was how do you get around the fact that we only have so much capacity here to volunteer at our brick and mortar clinic. And then simultaneously how do you solve the problem of the doctor who says, "Gosh I'd love to help, but I can't make it. I have hospital rounds after I get off from my practice and I'm all the way out in Collierville", and which is just a bunch – that's like a thirty minute drive, forty-five minutes with traffic. And so, it's just not worth it to them. They want to help. So, part of the way we remove that barrier is to say, "What if we took away all the paperwork nightmare for you and all the sub-referrals and just assigned what we call our MEMPHIS Plan patient to your office. And when they come in, no one else except you knows that they're any different than anybody else. People sitting right next to them would assume they had health insurance, that's their doctor's office. No big deal. But the difference is, when you as the provider look at their paperwork and you see, oh, this is a MEMPHIS Plan patient. This is a person that I agreed to take on and do the work for free. And then you just – we take care of the paperwork. We take care of the impediment or the barrier that says "I can't get to where you are." We'll send them to you

and we'll do all the paperwork. And so that left them with just being able to say, "Oh okay, well then sure". Yeah and…

NF: That sounds incredible.

MS: … so a MEMPHIS Plan doctor might agree to see two patient visits a week are MEMPHIS Plan patients. If you divvy up those over that many docs, that are still able to see and give robust care to our patient base.

NF: Yeah, hundreds of patients a week I'm sure, or more.

MS: Yeah. I mean, just to give you a sense of what thousands of patient visits a year breaks down to, it's like seven hundred and fifty a week.

NF: Yeah.

MS: And then if you think about what those patients need might be from a subspecialist and then you look at the fact that, they might, see a subspecialist on-site. That has increasingly become a growth area for us, on-site subspecialty. That's probably boring to you. You probably don't care. But, like, I could tell you why that is.

NF: I'd love to hear.

MS: Yes, it's because we've had over a twenty-eight year organization, right? A young doctor in their forties in eighty-seven is now a doctor who's retiring, right? Well, they've been with us for years and years and they love serving our patients. And for the very same doctor who used to say, "It would be more convenient if you would send the – the patient to me so I could see them in my clinic." Well, what happens when the doctor retires but they still have years of capable service left? Let's say it's a doctor who left his

office at age sixty, but they still have their health. They're still in perfectly good health and they have years of service to contribute. And subspecialty care is expensive. So, if you've developed a rapport with those people and they want to keep helping your patients, but they don't have an office and they don't have a support staff, then all of a sudden what we realized we had to reorient our clinic to do was to say, "Great, you can still volunteer. We've made a space for you to volunteer here at our clinic" so that we can continue to capitalize on that good will and that capacity to serve.

NF: So, it's flipped essentially. Instead of them needing to have their own facilities out of…

MS: Then again, we still have brand new doctors who have the original concern of our doctors twenty years ago. So, we still have a pathway for them as well. You know, the change has been, we had to grow when it became an issue where all of a sudden we've got a subspecialist who would love to volunteer if and when they had space to work. That happened to gel at the same time that we realized, "oh gosh, we need to grow our dental clinic." And thankfully, one of our long-time volunteer dentists, who is actually my dentist, who is right down the street. So what is funny is, there is the lower half of a building, and the space originally had been built out as dental space, but years ago, the whatever competitor they moved out or whatever, and our dentist still owned that half of the building. Well when he heard, "oh gosh, that Church Health Center really needs to grow their dental capacity, he's like, "you know, I'm sitting on my hands with this empty side of this building. Why don't I just donate it to you and you all come inhabit the other half of this, and then grow your dental clinic and move it off-site to here." And it's right down the street, so we did. And in doing so, now that's a wonderful blessing in and of

itself. It just goes to show that how, over time the more people helped you and are your friend, well they find different ways to help you. And so, when he did that, we realized, okay, well, if we off-load our current dental clinic to down the street and expand it, we could re-harvest. We could take that vacated space and dedicate it to subspecialty care and grow our on-site subspecialty. And that's what we did.

NF: Now I'm curious, and this may not turn out to be core to what I am actually looking at, but, I'm curious, how this relationship with the doctors is built and maintained. Like, what kind of, recognition or what kind of community building or…?

MS: Yeah, alright. Sure. Well, first of all, it is a relationship of trust and it's founded on love. It's founded on, more often than not, some variant of faith. I mean, many of these dentists, doctors, they're contributing because they're reading the same holy books that we're reading that, from the Christian's perspective, you know, Jesus said, "Whatever you do for the least of these, you do it for me." I think most Christians can hang their hat on that. I have grown, a little bit in understanding anyway, of the Jewish concept of being responsible for the repair of the world. That some of our Jewish volunteer physicians that share the faith are probably, mostly in my mind that's not precise to Judaism at all but…

NF: Judaism is not a very precise religion. Or rather, it's so precise, that it's a mess. [Laughing]

MS: But, yeah, but I mean, you are talking to a Catholic here. So, when you're talking about a faith tradition that's an absolute train wreck, a loveable amazing train wreck of goodness and badness, right?

NF: Right.

MS: I was going to say any system of human faith isn't perfect.

NF: you know, another part of this thesis I'm working on is exactly that, looking at what is the Jewish foundation for this type of work, and Marvin, you know I would be happy to send that off to you once it's completed.

MS: I absolutely hope that I get a chance to read this. and I don't know where all this is leading you to and what you might be gearing up to do with your life's work once you complete the kind of academic exercise.

NF: Right.

MS: But, I certainly hope going forward that we keep in touch and I think there are things that we can learn from each other going forward, I think. And, I'm sure I am ignorant of, other parts of the larger faith health, dialogue and service going on across the country that would be going on in Jewish circles I'm sure exist.

NF: It's not as much as I would hope.

MS: Yeah. I shared with you that was kind of Doctor Morris's founding dissatisfaction that caused him to say, by God, I'm going to church this. You know, that was his basic dissatisfaction. He took a look around at the work of the church, and saw that we didn't – we prayed for the sick and then we had hospitals and churches attached but no real connections to congregations and he called BS on that. He said, "We got to do better than that". And, that became his life's work.

NF: So let me ask a little more about that. I have a couple more questions about sort of the structure of the organization…

MS: One real quick thing to say.

NF: Yeah.

MS: the relationship of our doctors is founded on love, trust and mutual respect. It's undergirded by a shared faith, vision of some sort. Again, we are a motley bunch, no particular religious persuasion. But it's underpinned by a faith or at least a desire to do good. But then, you'd also asked about recognition.

NF: Yeah.

MS: We partner with the local medical society. And, each year, at their awards dinner, the doctors who are our volunteers, they get a special pin. And many of them proudly wear it on their hospital ID's, just so people know that. I mean, they're very proud to say, "I'm part of the work of the Church Health Center". We recognize them in our newsletter. We take different opportunities to celebrate, invite them to mixers etc., because, obviously, some of those doctor volunteers have also crossed over into our donor ranks. And, and they give us their money as well.

NF: Yeah.

MS: So, yeah, so, there is a complex and multi-layered way that we relate with our physicians. But, at least the way that the Center currently is comprised, Doctor Morris still figures very prominently in the connection to the medical community. One of the things that's very advantageous about having a CEO who is an ordained United

Methodist Minister and a board certified family practice physician and that he wears both hats, leadership hats. Both in the ranks of clergy, and in the doctor realm, peer to peer asks are very important. You know, doctors only speak to doctors. You know, like, you can only have certain conversations if you're in the club.

NF: Sure.

MS: and, the fact that he wears both of those hats has served us well. Now, anyway…

NF: So, he'll, or at least certainly while it was building, I would imagine, still would go out to hospitals or family practice clinics or what have you, and have a meet and greet with a new doctor or new, practice?

MS: Yeah. You know, honestly, I really think with his current duties, he's starting to butt up against – he would probably tell me I'm wrong about this, but I would suggest, like it's like soon – it's quickly approaching, - you ultimately cannot just simply live with him and we're in the stage of growth where we have to say, how do we unpack some of his duties and help him with them? More than in just, in an assist kind of way. How do we systematize those duties? But that said, yes, he still, to my knowledge, receives – then again this is a collusion with the Memphis medical society. When people join the medical society, if they are a new doctor in town, we get their contact information. Doctor Morris makes a call on them.

NF: Okay.

MS: You know, we, we have a director level, a chief level person at the practice manager's association. All of the different subspecialties within medicine, we have people at the table of influence, such that we're essentially knit into the fabric of our

medical community. We have a larger kind of umbrella medical organization called Healthy Shelby. Shelby County is the county we are in. Doctor Morris is the person who, frankly, you know, called for its creation in one sense. And, it's a big long shaggy dog story that I don't probably have time to digress about, but, the Institutes for Health Care Improvement in Boston, puts forth this idea, about - called the triple-lane. How do you improve the patient experience in health care, improve outcomes over a population and lower costs all at once?

NF: Okay.

MS: You have to be like: it's doable. And if you can do all those things, you will truly reimagine heath care delivery in America. Doctor Morris was the guy that said Memphis ought to pull together a group to work on these goals. And Lo and behold because we enjoy this position with all the area medical entities and all the hospitals and we are the safe neutral ground upon which all of them say, "Oh well gosh, we are helping the Church Health Center". We're not trying to beat Methodist and not trying to beat Baptist to the punch to have a seat at the hospital to beat them out of business. They've got their hand on the same pile. They're working to help our patient base in one shape or form. They're using that marker of trust. We've pulled together this larger coalition called Healthy Shelby to take a run at the aims of the triple-lane. Now that we have that larger umbrella group convened, and we're working on, say – hypertension, chronic disease, end of life issues, teen pregnancy, because we've convened a larger working group around overarching health concerns for our community, it's like we are constantly collaborating with every medical entity in the city. so everyone knows our suite of issues and what we do and so at every turn we try to take advantage of that.

NF: [coughing] Okay. So, let me ask a little bit more about, I would like to know more about the relationships with some other organizations. I don't know how much time we'll have so I want to put that to the side for now. Now you serve patients – do you serve exclusively patients who are in financial need?

MS: We serve exclusively uninsured patients from the medical perspective. That does not touch the wellness side. Our Wellness Center is open to all people. You know, our curriculum development efforts. Obviously, we sell books to any person. You know, but restricting the question strictly to our medical footprint, and our dental and our eye care footprint. Oh and our counselling office and our social work are part of our medical clinic. Those suite of services are for the uninsured.

NF: Okay. So, anybody who is uninsured walks in the door…

MS: And working.

NF: Uh?

MS: You know, there is an uninsured… There is a twenty hour work requirement guideline.

NF: Okay.

MS: And then you can say, "Well, it's discrimination against the unemployed". If we had the capacity to take all comers, we would. And in the earliest days, we did. But, what we found was that unemployed people took up a majority of the appointments. So, we were effectively penalizing working people. So, we instituted the work requirement to make our numbers manageable. Now in the last two years, we – it used to be, if you're a

man, you have to work at least thirty hours a week; if you're a woman you have to work at least twenty hours a week; and if you're the sole caregiver of a child six or younger, regardless of your gender, there is no work requirement. That used to be our old thing.

NF: Okay.

MS: we recently retooled that to say twenty hours a week no matter if you are a man or a woman. They have to work at least twenty hours a week.

NF: Is there still the caregiver – the sole caregiver of a child?

MS: Yes, yes.

NF: Okay. [Coughing]

MS: Yes, right.

NF: Just the twenty and the thirty were equalized so it's twenty across the board.

MS: That's correct.

NF: I see.

MS: And then, we do have a geographic requirement. You have to be a Shelby County resident.

NF: Okay.

MS: Yeah. There is an asterisk even next to that. We also have a walk-in clinic where there is no geographic restriction. And the only requirement is: I'm sick today and I don't have health insurance. It's thirty-five bucks. There is a walk-in clinic that is literally open

to just anyone who has an emergent need and has thirty-five bucks. And honestly, it is up to our discretion to waive that if we think it is necessary.

NF: Okay. And the walk-in clinic is just on certain days? It's like Monday and Wednesday, right?

MS: It's Monday to Friday. First come, first served. Seven-thirty in the morning.

NF: Here, I was looking at something else. Okay.

MS: And oftentimes that is an entry point for a person who is perhaps… a friend of ours today, a buddy of ours, who's a photographer, like so many guys, who's like, "health care? I mean, you know, I'm fine – I'm fine." You know, there is a reason why us men live shorter lives than women, because, again this whole tough it out mentality is just, you know, kicks butt. But like our friend, he's like yeah I mean I'm fine and then he fell and broke his hand and even then he'd been like "it's sore, but, I think its fine." Finally his wife badgered him and he's like you know, you're hurting and you can't even take photos. Call Jeff. And not that you have to call the PR guys, but since they knew us, they called Jeff. And, you know, Jeff said, "dude, go to the walk-in clinic". So he went to the walk-in clinic. He got a splint. He got some advice. You know, this, that and the other thing. You know they took an X-ray. They did all the basic stuff. And, then, as so often happens, He's like, I could become just like a regular patient here. Whenever I have a medical need, I could make a same day appointment. Yeah, he's uninsured. You know, he is a Shelby County resident. He works at least twenty hours a week here in the family. So he would move on to be a regular patient an established patient.

NF: Okay. Now, you mentioned paperwork just now. I'm curious what the paperwork looks like both from the end of somebody walking into the clinic, what they see, and then, sort of what happens behind the scenes.

MS: Yeah, this is where the PR guy's information may break down a bit…

NF: Okay. [Laughing] Fair enough.

MS: … but, I can tell you that, when they go through an orientation, they do have to present a pay stub and you know, they have to present documentation that they're working. Now, a lot of times, you know, people will come to us and say, "Well, gosh, you know, I kind of work for my Dad and I'm a caregiver for my aging aunt and also, I do this that and the other." And we're like, "You know, look, we didn't set these rules up to find a way to exclude you". So we're more like, "Okay, list what you do, and for whom, and have the people that employ you, even if it is like six hours here, three hours here, eight hours there. And then have the letter notarized, and then, that's good enough for us and we'll put it in your file and we'll move forward. So, the paperwork is not designed to find reasons to exclude people. It's just so that we can feel like we have some type of process by which we can say, "We're putting working people at the front of the line" as a basic way of making our lives possible.

NF: Okay. I think that makes sense.

MS: but as to exactly what forms get - this, that and the other, I mean, gosh, I'd have to get back to you on that. I couldn't tell you, "oh yeah, we give a 403B dash 17 to [unintelligible few words]". I have no idea.

NF: I mean, I imagine that in one of those fourteen buildings must be a medical billing, you know, your accountants.

MS: Yeah. We do have a finance office, for sure.

NF: Who understand the forms and the medical forms and so forth for the doctors through the Memphis Plan.

MS: Yeah, I mean, they have to have referrals. Referral paperwork and prescription pads – all the basic kind of building blocks stuff of a medical entity.

Marvin Stockwell, 20 OCT 2014

NF: So, I think, I mean we covered a lot the last time that we talked in terms of what really sort of, where church health is right now and sort of where it's coming from and where it's going.

MS: Yeah.

NF: But I want to reach a little bit deeper into sort of the leadership structure that we started to touch on. And then reach further back into sort of the beginning of the program and some of the early successes and challenges and things like that. So…

MS: Yeah.

NF: Let me start off with the "boring stuff."

MS: [Laughter]

NF: Which is, maybe very interesting. But can you tell me a little bit about the leadership structure of the organization?

MS: Sure. It's worth saying at the onset that it is a, the leadership structure is somewhat being, well it's being evaluated.

NF: Okay.

MS: And may change. About two years ago, we moved from a structure that was, Dr. Scott Morris was the executive director and my boss in Langston was the director and really they served as the kind of top two folks running the organization and it had been that way for years. Well, with the stages of growth of an organization, you eventually reach a size that just doesn't work anymore. And they recognized that we would do a strategic planning process and identify the need for a different structure and we moved to a structure with Dr. Morris as the CEO and then a president under him and then three

chiefs. A Chief Administrative Officer, a Chief Creative Officer, excuse me, Chief Strategic Officer, that's Ann Langston who used to be the director so she used to be the two of the 1-2 punch and now she's one of three chiefs under both the president and the CEO.

NF: Okay.

MS: Lastly among the chiefs is a Chief Administrative Officer, no Chief Administrative, Chief Strategic and Chief Operational Officer.

NF: Okay.

MS: Yeah.

NF: Now you mentioned…

MS: And then below that a group of about 17 directors of which I'm a part.

NF: Okay.

MS: Before that change, I was a manager and before the strategic planning process kind of like gave us a new look on things we, director level positions were only for programmatic areas for whatever reason.

NF: Okay.

MS: The strategic planning process exposed, that was, didn't make any sense and that you needed director level folks for even the non-programmatic areas and so…

NF: What would be an example?

MS: I was an example.

NF: Okay.

MS: I was a manager and somewhat cut out of the information loop. On paper, it was like well your boss will tell you things you need to know but the top communication

person obviously, if they're not there at the genesis point they're missing certain nuance. The HR manager was also not at a director level. Our information systems, our IT manager, was not at a director level and our finance manager was not a director so kind of all in one fell swoop all four of us moved up to director in that strategic change. So that was our first stab at trying to put a better more suitable leadership structure a top the organization to do better work and to spread the burden of leadership over more people. Quite frankly, my boss Ann Langston was doing just way too much. She was in charge of way too much and it was, we are fortunate that she is still such a capable woman but it was too much to ask of anybody. What made sense 10 years ago when certain work areas were small and she could manage it all but as those sub-areas like say for instance our Faith Community Outreach Office. At the time, she was helming it 10 years ago it was like three people doing some health education within congregations okay but today it's grown to be a signature congregational health promoter program. We have a men's health summit, we have an annual clergy conference, we hold the Westberg Symposium, we're in touch with Faith Community Nurses all over the world. Ultimately, that's just way too much bandwidth-filling activity to channel up to a person who's also over HR and communications and development.

NF: Wow.

MS: So the kind of structural change of two years ago did go a long way toward alleviating some of that workload but in that time, after we kind of set that structure in place was when we met and got to know Anthony Sheehan who is our current president. He was the second in charge of the British National Health Service under the Blair Administration. He is a guy who could work just about anywhere, one and two on either

coast and as luck would have it or as we view it God would have it he got wind of the Church Health Center through work that we were doing which I could elaborate on if you're interested but a project that we were working on that he was working on as part of his year being a Harvard fellow in the Institute for Healthcare Improvement in Boston and he got to knowing about us and what was going on in Memphis and he got intrigued and he came down to Memphis for a site visit, saw the Church Health Center, fell in love with our mission at work and then the rest is, well, it wasn't easy. We had to get him work papers and it was a long drawn out process that would require way more patience than people have but ultimately he decided this is what his whole life was building up toward, was to, he was kind of an academic of the highest order who didn't do tons of high profile stuff. He managed large scale hospitals in Britain and, but he saw this in Memphis at the Epicenter…

NF: Yeah.

MS: Of mental health and of just of civil rights and just all sorts of things and yeah he just decided this is where God wants me and thankfully we were able to retain him. And he's been a boon ever since and he really is honest to god at the end of the day, he is the guy who has the managerial structural experience and he's like one of those Six Sigma Black Belt in operational efficiency guru types.

NF: Okay.

MS: That will I think has the capacity to take us to the next level.

NF: Okay.

MS: And another thing to say at this stage is…

NF: Yeah.

MS: Like now he really wants to take another step in terms of analyzing the leadership structure tweak it further and we are bringing on a consultancy firm which one of our board members and good friend is a principal of. A group called People Cab to kind of give us a birds-eye view, they work with companies to restructure in all sorts of different industries. This is their business model and so they're going to give us some advice on exactly how else we might modify not only our leadership structure but our meetings, our schedule of meetings and how to be, so we can be our most productive.

NF: Okay. I'd like, if we have time, I'd like to follow-up more on that 'cause I feel like there's a lot of good rich detail there.

MS: Yeah.

NF: But I'm also curious about some other, more general things. How would you describe the funding or the finance of the organization?

MS: Sure. It is, we don't rely on government funding.

NF: Okay.

MS: We're not a federally qualified health clinic. We have, our last annual budget came in at 18.2 million dollars. We are one of the largest stand-alone, in other words not affiliated with the National Charity in Memphis. We're comparable to the Memphis Zoo in terms of scope and budget size. We are donor supported. What else to say? We, we're a four star charity, Navigator Charity which means we use donor funds efficiently and effectively. We've been evaluated by Charity Navigator as a charity who's frugal in the way that we carry out our work so we're good stewards of our donor dollars for sure. We're, I think increasingly we are an easy to back charity because health care access is such a basic need and, yeah, Memphis has responded and the real challenge will be as we

grow toward moving into Sears Crosstown in two years. The challenge will be moving our annual fundraising, to move from 8 million dollars a year to 12 million dollars a year. That is a significant jump but if we want to get into our new space which will provide for example 92% more medical capacity and 75% more wellness center capacity, we're going to have to step up our fundraising game period. Like no doubt about it.

NF: So you're almost doubling in capacity it sounds like, almost doubling.

MS: Oh gosh, I'd have to reckon up all the square footage…

NF: Okay. Okay. I won't make you [laughter].

MS: By any stretch it's a significant move so that's the challenge for us. We got to convince our donors and would-be donors that moving to Crosstown makes sense not just because of its capacity enhancements but because we're going to be able to serve people in better and newer ways. Because of the building partners that will be embedded with. I just had a meeting with my boss and she was telling me about a great meeting that they just had with the Southern College of Optometry. Well, one of the things we need to grow is our eye clinic. And the amount of patients we can serve for eye care and glasses and stuff. Well Southern College of Optometry they pretty much said oh we want to just be embedded with you. We want our space to be right next to your eye clinic. We want to share a front desk clinic. We want your scholars that are coming through that are studying to become, they're considering being optometrists or ophthalmologists that they would embed with us and go on rounds with us. They basically said we want to be locked, we want to lock arms with you and be better together. So and I think you will see that throughout.

NF: Now I…

MS: So this is just, this isn't just about oh we'll have more capacity to do what we've always done it's, we'll have more capacity and we'll be right next door to partners in those various spaces that will enhance what we do.

NF: Yeah, I definitely would like to ask you more about different partner organizations but I'm just curious about the, what is your donor base look like? How would you describe, I mean are there one or two or a small number of big donors that shoulder a lot of the annual funds? Is there a, is there a fund that you maintain through other investments? Is it mostly small donors? Is it a lot of medium sized donors? You mentioned last time we talked for example that many of the doctors who volunteer also become donors or are active donors. So how would you…

MS: Sure. Firstly, all charities have major donors so of course we have donors with more giving capacity than others. That said, we have a pretty, our donor base is like, is pretty huge and it's everything from your faithful woman who sees that one of her friends has died and sees in the paper that memorials are being asked to be sent to the Church Health Center and she sends a $25.00 check. It's, we just have a legion of those people. So our donor base, yes it has its larger donors. I'd say that we're better, we have built an individual donor base that I think a lot of charities who are more tied to corporate donors would be envious of. Corporate donors are often the first ones that people go after because they're bigger pots of money but what we've done over time is just build, is just leverage the good will over 28 years and slowly build up this legion of individuals. If anything, I think we have room to grow on the corporate donation side.

NF: Okay.

MS: Whereas, I think that's typically the opposite problem for a charity. They're too beholding to corporate dollars and they haven't done the hard work of building an individual donor base. I think that's the strength of the Church Health Center.

NF: So how much of that 8 million give or take just to ballpark it I don't expect you to have the numbers in front of you. How much do you think comes from corporations or corporate partnerships?

MS: Oh, very little. Foundation and corporate support is just like, it's down there like 1 or 2%.

NF: Oh, okay.

MS: It's very small.

NF: That is very small.

MS: Yeah, I just can't imagine that it's much more than that. I will have to check on that specifically.

NF: Okay.

MS: Another thing to say here is…

NF: And then how much of that is, sorry, how much of that is the 10 or 20 largest donors?

MS: Yeah, that's where the PR guys have the info breakdowns. Somebody in our Development office would be able to speak to that more clearly.

NF: Okay.

MS: I just don't know that. So maybe put a pin in that question and flag it and maybe at the end if there are things where you stumped me you can send me an email with those questions and I can probably divvy them out to the right people. Excuse me. One

another thing I'll say about our donor base is that it includes us employees. We have more than 250 employees and we are 100%, our staff gives to the Church Health center in some way. So we have a board chair who is great, a real man people kind of guy who has challenged the board to match the employee gift. I want to say last year we raised like $83,000 just from our staff, from staff giving. We do a payroll deduction thing. We also have a segment of donors that are considered what are called our Virgie Shinn donors. Virgie Shinn was a patient of the Church Health Center who, she gave a little bit every time she came to her patient visit beyond her own fees. She would make some type of donation. It could be small. It could be $5.00.

NF: Yeah.

MS: And we, we kind of liked the story of her and the fact that she was giving what she had. And I don't know how familiar you are with the Christian scriptures but I mean there's a story of Jesus. He's teaching his disciples and he observes the three people giving the donation to the temple and he asks his disciples which of the three gave the most and the answer is that it's the tall woman with the two copper coins. Because she gave all she had. There's a lesson there. So, so my way of looking at this is a woman with a two copper coins kind of thing. These, so this donor group are people who have given 100 gifts to the Church Health Center of any denomination. It could be 100, $1.00 gifts to the Church Health Center. That would get this person in the society and they are honored with a luncheon every year just like our larger donors where they're seated at a table, they get a lunch, they hear from Dr. Morris, and Anthony about the state of the center and where things are going. So…

NF: Oh, wow.

MS: I say that because I think it speaks to the heart of the DNA of this place and how we honor every giving level. This is not about, it was be disingenuous to say that we don't have development people who are realizing individuals with great giving capacity and…

NF: Sure.

MS: Because we do that. Every charity has to do that. But there is…

NF: I…

MS: Equanimity about the way we view our donors.

NF: Yeah, look. I've worked for a number of different non-profits mostly in the Jewish role but also beyond so I'm not coming in starry eyed. I understand the realities. It sounds, some of the things that you described sound really innovative. I think that I'm, some day in the future if the opportunity arises I would love to steal that idea 'cause I think that's beautiful and I think that it sends a really powerful message. I think that's incredible.

MS: Right. We'd be happy, we actually give, we have a replication workshop three times a year where people come and study what we do and then more often than not it's somebody who wants to go do something similar but we've actually had people who are doing something that's peripherally related. It's a good work of some sort and they come to our replication workshop just because they're interested in some of our donor mechanisms and stuff. And that's totally A-Okay. If you ever wanted to take a deeper dive into the Church Health Center and all we do we do that three times a year. So just throwing that out there.

NF: Yeah, I see, I think in the future that's definitely something that I will be looking into.

MS: Cool.

NF: So…

MS: That's what I can say about our donor base. I'm not sure whether I answered fully your, every aspect of what you wanted to know.

NF: I think you've given me enough of a picture for these purposes.

MS: Okay.

NF: And if I do have more detailed questions I can follow-up with you by email or whatever.

MS: Gotcha.

NF: Now you started to talk about your relationships with other organizations with the optometry school and so forth. I'm curious what do you think in your estimation are the most important relationships you have with other organizations and how would you, how do those come about? How would you characterize them?

MS: Sure. Well, first of all, we are a collaborating organization just like, as part of our foundation. I mean if you imagine the young 33-year-old Scott Morris coming to Memphis not knowing a soul with this idea this is what's God called me to do and he just, he literally just cold called and wrote a letter to a Methodist pastor in Memphis and says I'm coming to Memphis. I'd like to meet with you. Didn't know him at all. And said I've got this idea for a health center with wide ecumenical support, the church should be doing more about health, can I talk to you about it? I mean literally as he said just came to him selling out of an empty cart. He met reverend Frank McRae who was one of

the two or three white ministers who marched with King in the Sanitation March where he was here in Memphis and ultimately gave his life. So that minister just recently passed away.

NF: I see.

MS: But he took Scott under his wing. And Scott, from day one he's got to collaborate right? He's nobody with no footprint and no funding, just an idea and fire in his gut that this is what God has called him to do. So I mean as he puts it he was too naive to realize that it could fail. He was just so steadfastly sold on the idea that he just didn't give it a second thought. I think it takes that type of bold visionary leader to just jump into the fray like that so we were collaborative from the onset. But to answer your question, obviously some of those early, honestly one of the early wins for the Church Health Center was that okay so he meets Frank McCrea at Saint John's United Methodist Church. Frank McCrea had $70,000 in his pastor's discretionary fund. He liked the idea so much he gave Scott all $70,000.

NF: Wow.

MS: And they bought the house across the street. It's the house I'm sitting in right now. And so okay great that was enough to buy this old dilapidated house to have renovated. He went to two very unlikely people but again these are people that Frank knew and Frank introduced him to and he went to a kind of an Evangelical megachurch pastor and if you knew Scott I mean Scott's a real kind of liberal mainline Methodist kind of guy so not the guy who's theology he'd agree with the most but they ended up with Central Church, ended up giving him some money to renovate the building but the other

partner that he got really the lion's share of the money was from the Plough Foundation which was founded by Abe Plough and it's a Jewish Family Foundation.

NF: How do you spell that?

MS: Sure. P-l-o-u-g-h.

NF: Okay.

MS: Abe Plough was the founder of Schering-Plough, which was a pharmaceutical and cosmetics company very successful. It's now been absorbed by Merck.

NF: Okay.

MS: Yeah, which I think is M-e-r-c-k. And they still have a huge facility here in Memphis but at any rate so from the founding this was a group that knew that it had to reach out and form the broadest coalition possible. So beyond some foundations support at the outset just to kind of get something going of course the connection to the medical community cannot be understated. We enjoy today just really robust multifaceted collaborative relationships with all, virtually all medical partners in the city. But especially Methodist, our Healthcare Methodist hospitals, Baptist Hospital and Saint Francis Hospital and the Med which is, well it's not called the "Med," it's call Regional One Health.

NF: Okay.

MS: It's a charity hospital. Yeah, it's a charity hospital.

NF: Okay.

MS: We, yeah, if we didn't have, if we didn't have the support of and I guess the other collaborative group that was really in our corner early on and it still is that matters hugely is the Methodist Medical Society. And to maybe a lesser extent footprint wise but no less

important the Bluff City Medical Society which as ridiculous as it seems to me throughout my modern sensibilities that we would have a black medical society for black doctors. I mean the organizations have existed since when you needed those and they still exist. But both of them back us. And both of them reach out to their doctors and that is one of the many ways that we get volunteer docs. So if all we did was what we could do with our staff physicians we would not reach a footprint of 46,000 plus medical visits in a given year. We just wouldn't. We got volunteer dentists, we have volunteer optometrists and ophthalmologists. So the volunteer doctor, dentist, eye care person piece cannot be underestimated and it takes having great partnerships with all of those governing bodies. I couldn't tell you who the eye group is but the Memphis group of eye folks, whatever they are. The, so collaboration is just the lifeblood of what we do. And then when you, probably the next significant grouping of people with whom we collaborate with, of course the faith community. I mean we make sense to a lot of people's view of the world whatever their faith habit is, some are more interested in health ministry specifically and have health ministry teams in their congregation and we help train them. Others back us with dollars. So there is a give and a take between the Church Health center and area congregations that is robust and multi-faceted and vitally important.

NF: Okay.

MS: Yeah.

NF: So I wonder if you could give me an example of one concrete thing that's come out of one of these partnerships. I mean I can certainly see sort of the big picture what you're describing.

MS: Yeah.

NF: I wonder what it looks like sort of its street level.

MS: Well okay. Free Emergency Room visits for our patients at Methodist Hospital. Free access to their surgery centers when the surgeons donate their time. We provide continuity and care. We don't just provide like patch-up services of a doctor's office.

NF: Right.

MS: Although actually we have hired our own surgeons so we actually can do some surgery here on site but we have our own staff surgeon who can then be embedded with the different surgery rooms and do more surgeries. Before we had a staff surgeon, we just had volunteer surgeons. Many of them would agree to do the work for either unbelievably cheap or for free. And the partnership they're obviously is with the doctor, him or herself, but also Methodist Hospital giving us the exam rooms and they just don't charge us for it. They don't charge us anything.

NF: Okay. How do they afford to do that?

MS: Well actually they did an internal study. At this point, it's probably five years ago. Now there head of, the head of Methodist Healthcare is a guy named Gary Shore. He is longtime friends with Dr. Morris. He goes to Saint John's himself, is a man of faith and takes seriously that he's supposed to apply his faith to his working life. So there's an altruistic side here to it where for years I think Methodist Healthcare backed our work and it was really on the strength of Gary's friendship with Scott and realizing it was just the right thing to do. But if you look at it I mean even at the onset they realized in maybe a vague way that okay there's a lot been written about Emergency Room abuse. People who don't have access to a doctor they use the Emergency Room as their doctor's office

and the sad thing about that is that they wait for themselves to get so bad that by the time they come they're far worse than if they just had access to a doctor. You follow me?

NF: Yeah. Absolutely. I am familiar with the studies.

MS: So even at the onset the hospital must have understood on some level okay there's a group in town that's going to provide regular doctor access for the uninsured. That's got to cut down on the number of Emergency Room visits by people who let their chest cold turn into pneumonia. They need hospitalization. Then rack up bills which we are duty bound to provide.

NF: Provide the care. Yeah.

MS: And then we have to write it off and we lose that money. So even at the onset I'm sure they realized it's the right thing to do and we should do it and my faith is telling me we should do it and Scott's my friend so I'm going to do it. But it will help us. It will help abate our write-off costs. And then, like I said a few years ago they got very scientific about it and they said you know we know that we've backed the Church Health Center for years and we know that the fact that we give them free access to our hospital up to a certain amount, it's not on check, it's a certain amount, we know that that helps abate our write-off cost. But would supporting them at a larger level providing them X-amount more hospital stays and access to surgery centers. Would backing them at a higher level additionally reduce our write-off cost? And they did a study and found that yes is would. So overnight they doubled their support for us in terms of donated services.

NF: And then in the long run they end up seeing lower cost as a result of…

MS: We're better off financially having us provide a logical organized process of care to the uninsured. Memphis is, we have had hospital heads come here to our replication

workshop but they've connected the dots. They've done the math. They look at what a benefit having an 18.2 million dollar annual budget charity that provides 46,000 patients visits to the uninsured every year. If that's on your doorstep, they realize boy that's got to really save you money. And so we, I mean the typical person who comes to our replication workshop is someone who is a person with a dream that feels called by God to do something kind of like what we're doing. But every once in a blue moon it's a bean counter. It is a hospital admin or group of them who are there in suits going, how do we foster this in our city because we want this on our front door. We want this as part of our health, our health ecosystem if you will.

NF: Are you familiar with any other cities that have been able to duplicate something like this from that point of view?

MS: Oh sure. There are more than 30 what we call replicated clinics across the country. There's one in Nashville. There's one in Knoxville. Of course we're more familiar with the ones that are here in our own state.

NF: Sure.

MS: But there's one in Branson, Missouri. We've been doing this for almost 12 years now offering our replication workshop where people come and learn what we do and then they get to apply it in their city. Now it doesn't always work out. Sometimes they look at other models and they go off in a different direction.

NF: Okay.

MS: Many of the clinics are very close to carbon copies of ours and we share in a kind of very open source kind of way because it's not about selling franchises, it's about, it's

because the resources that exist in a given city, the naturally existing assets are going to be different in a given city. A different faith tradition is going to be more prevalent.

NF: Right.

MS: There was a replicating clinic in New Orleans that came online. Well New Orleans is a largely Catholic city. Well Catholic charities factor in larger than they do here because Catholics are in the minority in Memphis. So it was silly of us to try to say here's your prefab way to do it. We're not opening up McDonald's franchises. We're saying here's kind of the way we do things. We're actually in the process of reorganizing our materials to take a stages of growth approach but they don't think that would actually be more helpful so we're kind of in the midst of re-tooling our replication workshops so they can be more effective in helping people get similar works off the grounds through the other cities.

NF: So, speaking of getting off the ground, I'd like to sort of jump back as it were to you started talking about how Dr. Morris started getting this off the ground with the faith community. Can you tell me a little bit more about sort of how this started with one man and a dream and became the…

MS: Sure.

NF: …the medical system that it is and what's maybe has been the biggest success along the way.

MS: I just think that it's been slow growth, it's been slow sustainable organic growth from day one. I'd just say that the larger we get and the more people identify us as gosh not only the group on the ground doing the work in Memphis but our next stage of growth really honestly is like we're starting to become known nationally. And the

collaborative relationships we're starting to create and foster and take part in are with groups in other cities, like Duke University and stuff. But, excuse me, at the onset it was first get the building. Then find a volunteer doc. Dr. Morris lucked into this guy Dr. Tom White.

NF: Okay.

MS: Who was retired at the time and started volunteering.

NF: Was…

MS: From there…

NF: Was Dr. Morris…

MS: [Inaudible 39:36] the whole thing really.

NF: Was Dr. Morris providing medical care personally at the beginning?

MS: He was the doctor.

NF: Okay.

MS: I mean in the earliest days was Dr. Morris, one nurse and like three other people in an old mid-townhouse. Just punk-rocking it, DIY.

NF: [Laughter]. Okay.

MS: I mean Dr. Morris still sees patients to this day.

NF: Wow, that's pretty remarkable.

MS: Well he's totally cut out of that John Wesley mold. He sees himself primarily as a doctor and he plans to see patients until his dying days. He's just so tethered to being a doctor.

NF: Well God bless him.

MS: And being a clergy member.

NF: Yeah.

MS: He likes to say I'm a pastor who practices medicine. Not a doctor who preaches.

NF: I like that.

MS: Yeah.

NF: I like that. So what…

MS: And his fundamental orientation is being a part of the church and work in the world. You can very much use his life as being faithful to God's call to healing ministry. This is what God has called him to do. He's just one of the most nose to the grindstone, steadfast day in, day out, hardest working guy at the Church Health Center. He's ridiculous. He's indefatigable.

NF: Wow. Does he have a family as well?

MS: No. I mean he's married. He never had any children of his own. But you can kind of just, the church is really his baby.

NF: Sure. That's a little bit of a tangent.

MS: Life's goal? Do what?

NF: That's a little bit of a tangent. I'm just curious.

MS: Yeah.

NF: Picture certain, developing sort of an image of the kind of person that he is.

MS: Yeah. He actually does have an easy going side but you almost never see it here at work because he is so resolute. So focused. So driven on, there's something even within Methodism where John Wesley said something to the effect of, do the most good with the time you have to help the most people and don't spend one extra second on something unless it's like producing value. I really got that wrong. That's not what

Wesley said but it's something like that. And so Dr. Morris is just, he's just steadfast in like making sure that he is producing as much fruit as he possibly can. He's, what helps balance him out is his wife who's a real card and she's hilarious and she's an actress. She's very much in touch with the local acting community and the arts community and the minute Dr. Morris punches out and leaves the building he knows that personal's personal.

NF: Yeah.

MS: And he's always on. He's the face of the franchise right? So I mean if somebody stops him he's got to be Dr. Morris of the Church Health Center constantly. But he also loves college basketball and he loves the Grizzlies in the NBA, he loves baseball so he has his hobbies, he has dogs and so he knows how to relax too. If you go to his house, you see a completely different guy. Very much, he's just very interested in people and he's just fascinated by what's going on. If he's here in the office, you just can't slow him down. If you're at a meeting with him he's ready to get down to brass tacks find the best solution and move forward like ASAP. Like two weeks ago. [Laughter].

NF: [Laughter]. Wow. Well, I hope I'll get to meet him one day.

MS: Force of nature for sure. Do what?

NF: I said I hope I'll get to meet him one day.

MS: Yeah, I hope so too. I mean Memphis is a heck of a road trip destination anyway. Tell me again where you are Nathan?

NF: I'm in Cincinnati right now. I'll be ordained in the spring and then it will be wherever I can find work so to speak.

MS: Now are you, of the three kind of branches of Judaism, what branch are you?

NF: So this is the Seminary of the Reform Movement.

MS: Oh, okay.

NF: Yeah. So…

MS: Well you totally have to come down to Memphis now 'cause probably one of the most prominent, well what do I know as a Catholic, but my understanding is that Rabbi Micah Greenstein is a fairly well known Reform Jewish Rabbi like people even have a…

NF: Yeah.

MS: You know who he is?

NF: He's, after, you had mentioned him in I think our first conversation maybe I looked him up after that and realized that I actually know quite a few people. In fact he was at school here in Cincinnati on this campus so probably at some point in the room that I'm standing in right now.

MS: Well, I mean he's one of Dr. Morris's best friends. And Temple Israel is one of the most supportive congregations of everything we do and Micah does not hesitate to, he has a stump speech that he trots out anytime, he's so helpful to us. One of our biggest local champions honestly. He'll say, in quoting him, I think I'm saying this right, he says being Jewish is not about making the world more Jewish but it's about making the world more human so from my point of view the Church Health Center is one of the most Jewish organizations in the city and every practicing Jew should support it. I mean, he will rattle that off if you give him half a second, half an opportunity. So I mean if you came to Memphis, you'd be, yeah, there's a lot of fun stuff to do here in Memphis. Rock and roll was founded here and stuff.

NF: [Laughter].

MS: But you could come see the Church Health Center. You could probably find some kindred spirits out in Temple Israel for sure. It'd be worth your time.

NF: Yeah. I'll tell you if I can find the time during this year I would love to make that happen. I'll certainly give you a call.

MS: I'll help you set it up and be your travel agent here. No maybe not your travel agent.

NF: [Laughter].

MS: But we'd certainly help make sure you'd get to the right amenities. The Stax Museum. This, that and the other.

NF: Yeah. It may have to be actually…

MS: [Inaudible 46:41] barbeque place if you do that kind of thing.

NF: If it happens it may have to be after I'm done with this thesis that I'm writing.

MS: Sure.

NF: It's, a lot of things have come up here. Let me ask…

MS: Yeah.

NF: You'd mentioned that the strategic planning process that you went through a couple of years ago. I wonder if you can tell me what that looked like. Who was involved? How did that start off and did you bring in an outside group at that point or does that…

MS: We did.

NF: Okay. So how did you come to that decision before bringing in the outside group? I have some sense of how these things generally…

MS: I was actually not part of the leadership group that decided to do that.

NF: Okay.

MS: I was kind of in-flux. I kind of like, the process itself kind of brought me to the director's table if that makes sense.

NF: Okay.

MS: So I was not part of the body that decided to enact that. So but what we did is we engaged this company called the Conciliates Group and they're a consulting group that does this kind of thing and they let us do a process and we came up with kind of individual strategic plans like we were all asked to go away and say what are the little vignettes that you all think you should work on more strategically. We identified things like say for my area a better focus on internal communications and a greater focus on advertising and getting our word out via advertising. That ultimately gave us starting to do some minimal advertising and probably grew to its relation in the fact that we were taking another agency to help us with the re-brand that we were working on. But anyway all of the different work areas came up with constituent ideas that knit together into a larger strategic plan.

NF: Okay.

MS: Now we just use that as kind of our like framework document and we check in with it every once in a while to see how we're progressing.

NF: Okay. So my last question is I guess through the time that you've been with Church Health Center.

MS: Yeah.

NF: What has been the biggest surprise to you? Positive or negative. What's been the most surprising you've seen?

MS: The most, probably the biggest surprise for me was thinking I was coming to a group that was a medical clinic that served the poor strictly. I was excited about that. I saw it as an opportunity to live out my faith. But I came in with an erroneous presumption and that was that anything delivered to the poor would be substandard somewhat. I expected it to be kind of ram shackled and run down honestly. Because I think that's the idea that most people would think. I got to add something for the poor, it's going to be kind of like strung together with pocket lint, duct tape, some erstwhile hopeful souls, just getting it done. And it was not that. And really that goes back to a foundational belief that the uninsured deserve the same level of care as the people who have insurance and we believe in delivering care that's good enough for your mother. If it's not, it's not good enough. We believe that people who come to a well-kept up facility that has well-kept gardens and beautiful works of art, we believe that art can be a conduit of God's healing love and consolation and we feel that if people feel welcome to a top rate facility they'll be encouraged. If a person is encouraged, they're going to stand a better chance at succeeding at recovering, at planning a new healthy lifestyle change, exercising more, eating better. If they feel respected, at its base, it's about respect. And so that was the biggest ah-ha for me and the kind of next piece of that to me is part of one continuum – one cloth – is I guess I also thought well they provide care for the poor and that's wonderful. But I viewed that as very static. The Church Health Center is a dynamic organization that is constantly reevaluating what its mission statement should call it to do. The Church Health Center seeks to reclaim the church biblical commitment to care for our bodies and our spirits. Now the longer I work here I realize that that is a very broad statement. Now when you're a tiny organization you don't have the capacity

to think, oh I'm going to teach a cooking class. But at a certain point you get big enough to where you have donors come forward and back your work and lo and behold you have an 80,000 square foot comprehensive wellness center with a teaching kitchen. Similarly, we didn't have dental at the outset.

NF: Yeah.

MS: But the volunteer dentists saw a need and volunteered and lo and behold over time we grew a dental clinic. Now something more recent. Three years ago, we became the logical new home for the International Parish Nurse Resource Center. So the way that we knit together faith and health and the lessons that we've learned, it just became obvious that we were the ones that could best shepherd a 30 some odd year old organization with 15,000 Faith Community Nurses all over the world to be their guiding star. And to be their leadership organization that could take their program of study that's in colleges and universities all over the country and all over the world to the next level. So we're always open to how our mission statement might be calling us to explore a new area of health in a more robust way. Our model for healthy living. If you've been to our website, you've seen our model for healthy living.

NF: Yeah.

MS: That's the conceptual hook how we see the world. It's not just about oh health care. Oh, go to the doctor. End of story and then it's also not just a duality. It's not just health and wellness. Like okay yeah you should go to the doctor but you should also keep yourself healthy. No, it's about addiction and recovery. It's about the strength of the friends and family unit. It involves social work. Is there a relationship that needs to be repaired that's keeping you back from optimal health? Are you estranged from your

brother or for some odd reason can that be repaired. So now it makes sense to have a nationally distributed faith-health magazine called Church Health Reader that helps congregations think how do I do health ministry in my congregation at a more robust way. How do I do a community garden in a way that brings/fosters communities? All those like softer things that like it's very far flung from our initial grounding in doctors in white lab coats seeing patients in an old mid-town home but it makes absolutely logical sense if you see it as a gradual continuum. And it's all about people growing in better health and having, we know that if they're more bonded together in unions of support and common cause that they're going to be happier. That they're going to be healthier. So all of those things are things, our mission statement once we reached a stage where we could entertain them. We have. So my biggest pleasant surprise is that the organization that I grew into is constantly growing so as a spokesman for the ministry. I am never at a loss for interesting new things to go talk about and now it's really coming into its fruition I think at Crosstown. A million and a half square foot building, it's going to be the most ambitious, one of the most if not the most ambitious mixed-use redevelopment of an historical building in the country for the time. That's like, it's getting national press because we're doing something truly novel. There are 10 such Sears buildings originally built in the country. Some were demolished. Severn or eight of them survived. A few then rehabbed. One is in Seattle. It's the Starbucks Headquarters. Another one is being rehabbed in Atlanta. Every one of them but ours is being re-envisioned as some type of anchor tenant business play. There's a corporate entity that make it their headquarters and it's like retail. Memphis is the only group that is reimaging it Sears building as purely a conglomeration of non-profits doing good works. That's not only exciting, it's

fairly, it's totally unconventional so I mean I though here I'm like oh well kind of like me living a life and wanting to be part of a body of Christ in the world, work in the world. My own personal view is that the body of Christ is Christ is as present as he ever was in his earthly life in the people that constitute his body today. That's my own personal theology. And so it gives meaning to my every action that in varied ways Christ is continuing to reap the world through the work that I am a part of. So I just thought that here I am just going to work to try to live a life that's a life of integrity which is not to say everybody has to go to work principally in doing good work. There are plenty of people who have a job and they give to charity and that's another way to pursue that in your own city. Engage in a footprint there but for me I always knew I wanted to work in doing something that made my heart happy 100% of the time. So here I thought I'm going to work at the Church Health Center and my heart was perfectly prepared to be content and happy with something static but I found something much more exciting and dynamic and ever changing. So that's was probably my biggest surprise and it continues to be.

NF: Well Marvin, thank you so much. I don't have any more questions. I think you've answered just about every question I can think to ask.

Rabbi Eric Weiss, 10 NOV 2014

EW: Have you looked at our website? Do you know much about us already?

NF: So, the… I've looked at the website, and it seems like primarily what you provide is counseling or chaplaincy to sort of a broader community that might not be reached by other organizations. Would you say that that's a good description of what you do?

EW: In part.

NF: Or is that a bit incomplete?

EW: Because… In part because we also like any organization you reflect your own local as well as whatever kind of paradigm you present to the broader Country so to speak or the movement, but… So, the Jewish Healing Center is transdenominational, so we're four rabbis and an executive assistant, and, at this point, 3 of the 4 of us are reformed movement ordained and one reconstructionist. So, we're not… We are no affiliated specifically with a movement… any movement. We're also available to the entirety of our region, so if you know the geography of the San Francisco Bay Area, we serve the West side of San Francisco Bay, which is kind of like the side that you might think of it as the side that lines the Pacific Ocean. So, were serve Sonoma County to the north and then just kind of going south, Marin County, the City and County of San Francisco, and then we go south into an area called Mountain View that's a part of the northern slice of Santa Clara County, so if you're kind of know where Stanford University is, that's kind of like our invisible line in the sand, so that comprises our proactive range of service, and, then, were in the East Bay of the San Francisco Bay Area, which is a rhetoric Berkley, where you see Berkley is and Oakland and, then, also south, farther into Santa Clara County where you might think of sort of like Silicon

Valley, in that area. That's because those are 2… Those are the 3, generally speaking, separate federation region, and we're principally funded… Well, the only federation region that funds us is the federation that's San Francisco based, although they do not fund us 100 percent. They fund a small percentage of our budget, but because they fund us, that defines our range of proactive service. So, our mission is that we provide Jewish spiritual care and support to folks who are ill, dying, and bereaved, and we do it through kind of a 3-pronged approach. One is direct service, one is education and training, and the other one is information and referral. So, technically, what we sort of aim to do is provide direct service and, then, also at the same time build the capacity of the community to also provide spiritual care. And part of what we have been doing for the past many, many years is trying to shift perception and language into a different paradigm so that people understand that spiritual care is its own distinct element, not strictly what you might think of as psychological counseling, not case management, not therapy but that spiritual care is its own particular component of human need that we all live with all the time but that comes to the fore maybe more poignantly or vulnerably or bluntly or, obviously, when people get sick, when people come to die or when people come to kind of fold grief into their lives. So that's kind of like the basic… That's the basic structure of the organization so to speak. Does that make sense to you?

NF: Yeah, but I'd like to add a little… ask a few more questions.

EW: Yeah, go ahead.

NF: Can you talk just a little bit more detail about the funding structure?

EW: Sure, so…

NF: And sort of that relationship?

EW: And that… What was the word you just used?

NF: Your… The relationship there.

EW: Between ourselves and funders?

NF: Yeah.

EW: So we… Like every nonprofit, we write grants and get grant monies and some of that grant money is programmed specific. Some of the grant money is to the core of our organizational functioning. Some of those grants are …[typing]… kind of at hock or for certain periods of time.

NF: Okay.

EW: Some of that money is not necessarily guaranteed as ongoing, but there's a sort of reality is that it gets established as ongoing, and it's a year-to-year cycle like most nonprofits, and, then, we do our own individual fundraising, so, like many other people, we have an annual campaign at the high holy days for example. We have an annual dinner that we just actually finished doing a few weeks ago, and, then, we have what we think of as major donors, so individual folks …[typing]… who have the capacity to support us do, and, then, we also have a legacy society, so to speak, so we have about 25 people at this point who have left the Healing Center in their estate plans in some form or another …[typing]… and we have a formal structural program, and that's part of our development structure.

NF: Okay.

EW: And we see sort of the way we get money a little bit differently than other nonprofits. So, because the nature of being essentially a rabbinic organization and spiritual care issues, people… we sort of value every penny that we get, so it's not to be

naïve of bigger chunks of money and different people's capacity, but we have a lot of donors, who have been with us for decades, who every year send in like, say, $25. Some of those people are actually part of our legacy giving. So people have sometimes… oftentimes capacity much greater after they have died in the framework of their estate plan than they do as what you might think of as disposable income while they're alive, and so we have a very, you might think of it as an egalitarian approach to fundraising overall, and, then, the other… sort of the other aspect to this is that actually just last year, we formally as an organization with our board approval suspended fee for service. So we actually do not charge an individual fee for our services. Everything that anybody gives to us is considered a donation, so… Except for some formal things. You probably saw from our website we have a formal bereavement camp that we do every year, that we've been doing for 19 years, and that has a fee structure attached to it, but we don't charge individual…

NF: That's the Grief and Growing?

EW: … a fee for service and again out of our experience, people really felt that naming a price for our services kind of cheapened the deeper undercurrent of the relationship, and people really felt almost disrespected by that, and so we suspended it and on a business perspective sort of business model perspective. When you kind of look at our balance sheet so to speak, we actually get more money in by not having a fee-for-structure service than by having a declared fee for structured service. So that's kind of how… That's our business model frame.

NF: Okay. And you'd mentioned… I didn't quite catch it, I thought you had mentioned something when you were talking about the region that you serve, that that's tied to your funding through another organization or did I misunderstand?

EW: You know the Country sort of has Jewish community federations throughout the Country, so there are 3 federations in the San Francisco Bay Area, so we're essentially under the same regional boundary of the San Francisco Bay's federation because they give us some funding.

[Typing]

NF: I see. And is that a pretty significant portion of the funding or is that just one of a variety of the different sources you've described?

EW: You know, that's a good question. So it's kind of both ends. So it's on a percentage basis is actually a very small percentage, but it's significant enough that it creates our ability to sort of move forward with getting other fundings, so it's typically… It's really… It's sort of around 10 percent, but it sort of gives the wherewithal to leverage other funding over the long term because people feel like, well, if we're attached to the federation, then there's a kind of equivalent of Good Housekeeping Seal of Approval that most… I think most organizations in the Jewish community sort of understand the relationship of the federation in that way. But our federation also, I think very similar to others …[coughing]… has also a very robust endowment wing, and so we get a lot of money out of individual endowment grants that have been set up by families or individuals that are… that have a little bit of a different control mechanism. So it's money that comes out of the federation, but sometimes the process is a little different, so some of our money comes from like annual campaign money that federations generally have to

give to organizations, and so we get a little bit of money there, so that's kind of literally a community money that people are donating to the federation to be given back out to the agency, but then a larger portion of our funding, though it comes out of the federation, is controlled differently by, say, a donor-advised fund or some other kind of other grantor.

NF: Okay, so it might come through a donor working with a federation or through a specific grant that the federation offers, that type of thing?

EW: Yeah, but also… it will come because we have the primary relationship with that donor, and it just happens that they've housed their fund at the federation. They could have just as well housed their fund at a local bank or at a brokerage firm, like Fidelity, and we get checks from donor-advised funds in that framework too, from people who have just made a different decision about where they literally park their money.

NF: I see. Okay. So, now, you said you had rabbis from different denominations and that you consider your organization to be transdenominational, can you talk to me about what that means at a, I guess a philosophical level for your mission, for your organization? How does that tie into either the decision-making or the day-to-day work or that type of thing?

EW: So, in terms of the mission, just in the basic level, one of our assumptions is that everybody gets sick, everybody comes to die, and everybody comes to live with grief. So these are universal human experiences and, so, in that way our services aren't limited to people who just otherwise choose a zone of relationship or affiliation by say joining a reformed congregation or a conservative or a reconstruction through an orthodox synagogue, and so our services are available to the entirety of the Jewish communities, so that's sort of like part of the philosophical assumption in there. The other part of it is that,

you might know already, but the demographics of Jewish life in the San Francisco Bay Area, if you look at the range of demographics, you see that they reflect maybe 25 to 30 percent of the Jewish community actually formally affiliated with a synagogue.

So, up to 75 percent of the Jewish community, itself, actually does not belong to a synagogue. They're unaffiliated, and the Bay Area has become a place where there's a lot of other kinds of options for feeling that you are articulating a Jewish identify in the way you want to. So people can do a lot of different things. And, in that context people when they get sick or come to die or come to live with grief and want rabbinic support, they don't have what you might think of a natural phone number to call if you belong to a synagogue.

Most people if they belong to a synagogue and they come a point of that juncture in their life, they pick up the phone and call the temple. So, 75 percent of the Jewish community in San Francisco don't have that, in large part by choice. So we are sort of the rabbinic agency available for the entire community, and, so, about 50 percent of our work is with people who are unaffiliated and about 50 percent of people who are affiliated.

NF: So in the emphasis of serving people who are unaffiliated, you sort of come at it from the approach that unaffiliated people generally, at least in the Bay Area, aren't… not only are not affiliated with a synagogue but also are not affiliated with a movement or a branch of Judaism?

EW: Yes, I would say that's true.

NF: Okay.

EW: There's a lot of… Are you, yourself, familiar with the Bay Area, I mean, if you've been here, kind of like had the sense of the life here?

NF: I've been to the Bay Area, and I've been around sort of briefly and seen a little bit of the Jewish community there, so I have a very, I guess, surface-level familiarity.

EW: Yeah.

NF: So, what you're saying makes sense to me. I've seen a little bit of it.

EW: So, probably you've seen that people do everything from temple hop to do a program at another synagogue because for the most part synagogue programming is open to the community. There are any number of JCCs with pretty robust programming of all different kinds. There are different kinds of independent Havurot that develop that are themselves transdenominational.

NF: Right.

EW: So you can… And, then, there are all sorts of different kinds of programs that people have that you can become involved with and not belong to a synagogue. Our agency is an example of it because we have 2 programs that we think of as their signature kinds of programs. They're very unique. They don't exist in most any other part of the Country in the Jewish community, and one is that we have one of the very few Jewish Hospice volunteer programs in the Country, and any number of our volunteers are actually not affiliated with a synagogue, and so their work with us as Jewish Hospice volunteers is absolutely a part of their Jewish identify development. And that we, for 19 years, we have a bereavement camp that is called Grief & Growing. It happens I'm a cofounder of both the Hospice program and the bereavement camp, but the bereavement camp typically has 50 percent of the participants every year are not attached to a synagogue at all, and in many cases, sort of our clientele writ large, but, certainly, with the Grief & Growing participants each, we have any number of folks who come to us in

the context of remission who are otherwise pretty disenfranchised from the Jewish community, maybe benignly so or may because they're just really angry of, you know, some experience they had in the past, and then they're kind of dipping their toe back into the water because they're in a state of vulnerability and kind of yearning for some kind of support in this way. So there's a lot that people can do if they're not affiliated with a synagogue. They don't have to be affiliated with a synagogue. And, so that's our framework. Although, I should say, on the other end of the spectrum, we work very heavily with synagogues, as well, in more formal ways helping them to construct whatever their version of a care and community is and to really support them, and, so, we're sort of both ends of the spectrum, and, so, being transdenominational sort of allows us to go into every corner of Jewish life and just be supportive of people in the context of our mission.

NF: Okay. And can you talk to me a little about… a little more about the volunteers. Are the Hospice volunteers, is that the main volunteer program? Do you have other volunteer programs?

EW: We do but, yeah, that's the bulk of it. I mean the majority of it. So, we do have Shabbat and holiday program volunteers because part of what we do in a more formal sense is to 3 times a year at high holy days, Hanukkah, Passover, we both physically go into about 40 eldercare facilities in the region of different kinds, so it might be everything from a formal kind of a traditional nursing home, so to speak, all the way through to a retirement community to do holiday programming. Physically one of the rabbis goes and does a program of some kind that's appropriate to the level of the population, and, then, we also do holidays in envelope for all of the hospitals in the region, including the

hospitals that have psychiatric units, and then we do a little bit of this for the Jewish inmates in the Local, City, and County jail system.

So, in that context, we sometimes have volunteers and do some of this holiday programming in the eldercare facilities, but the bulk of our volunteers are Jewish Hospice volunteers. So that program is about 9-ish years old now, and it's a pretty… I mean, I'm decidedly prejudice about the whole thing, but it's a pretty unique, amazing program that's designed to provide spiritual partnering with folks at the end of life. So, the philosophy is wherever… whatever end-of-life care choice anybody makes, whether it's to stay at home or to be in a palliative care unit of a hospital or they're in a nursing home or our local Jewish home or hospital or under formal Hospice care, whatever that choice is, if they want a Jewish Hospice volunteer, then they have one through us.

NF: Okay. So, now how many volunteers would you say you have? For example, just in that program, just in the Hospice program?

EW: So we typically have, I think at one time we typically have from a range of like 30-ish volunteers.

NF: Oh, wow.

EW: And we do typically a yearly training. We have a very, very, very high retention rate among our volunteers for a lot of reasons. I can sort of, if you're interested, I can explain to you sort of why, but we typically only lose volunteers if they have some kind of a fundamental life shift, like some volunteers just move out of the area or some volunteers just go on to graduate school, you know, or something like that, so we have an extremely low what you might think of as burnout rate, but we have an extremely high

retention rate. So part of it is because we took a couple of years to plan the architecture of the programming before we launched it.

We sort feel, given our mission, that we need to both discover and imagine and experiment but also spend a lot of kind of discernment time thinking through a program before we launch it, because we kind of feel like given what we do, we can't just launch something major and then just pull it back after a year and kind of say the equivalent of oops, just kidding. We didn't realize whatever. So we do a lot of experimentation before we formally release something, so to speak, out to the whole community. So we spent 2 years constructing the program before we launched it. So it's 9 years old, but it's been in the workings for many, many more years than that. So a fundamental assumption that we have about the program is that people have what I sort of have quote… I mean, a phrase that I kind of made up, which is essentially that everybody has their own natural spiritual hunger that they seek to satisfy. And, so, if somebody is saying yes to us and yes to this kind of work, then however they articulate it, and it might be not very articulable, but their deeper spiritual yearning is at work, and the reason why they're saying yes to us and yes to this kind of work is that they want their spiritual hunger nourished, and that's the primary drive, and so we do a lot in the scaffolding of the training and in the work to continue to nourish and teach to and train to spiritual care issues as opposed to what you might think of psychological case-management kinds of issues or therapeutic issues, and, so, that is a fundamental difference than what a lot of other Hospice organizational structures work with their volunteers, and so we see our work with our volunteers as part of the core of what we're doing as we're attending to adult Jewish identify development in

this context, and that's what we're… that's really why were so successful and why people tell us that they stay.

So, in a logistic way, people agree to… they apply to the program first of all, and they're interviewed and they're accepted, and they pay $200 for the training, and so it's a pretty high volunteer threshold, but we decided that given the nature of the work and what we're asking a volunteer to do that we have to be very serious about we're expecting from somebody, and people need to be really serious about what they're saying yes to, and so it gets a particular kind of a person, but it's a particular kind of person that we want. Because somebody is a volunteer kind of carries the agency on their shoulders, and we're very serious about our levels of integrity and our branding and our reputation and all those kinds of things. And, again, very serious about building the capacity of the community to provide spiritual care in a very serious way and sort of shifting that paradigm of understanding that human need.

So people do accept a 40-hour… If they're accepted, they agree to a 40-hour training and that training is not negotiable. If somebody says, gee I have whatever it is, you know people legitimately have things like my son's graduating from college, you know and I'm going to miss a day, and basically what we say is, then, go to your son's graduation and apply to us next round because you cannot miss anything of the 40 hours. So we have a pretty stringent way of understanding what we're serious about. So, it's a 40-hour training.

People agree to at least a year of service of 4 to 5 hours a week, and every other week, there's a formal training of ongoing training of different kinds, like, actually, I'm going there for over a couple of hours today over lunchtime to do a training around grief and

the holidays, and, then, that's once a month, and once a month, there's the same block of time, but it's devoted to kind of a free sharing processing with one of the rabbis around people's experience, and if people can't come to that group structure because of their schedules, then they have about an hour check-in once a week with the rabbi who heads up the program.

So, I'm not the rabbi who heads up the program. I'm the CEO, and I'm just kind of parachuting in for this particular topic, but Elliot Kukla is our… the rabbi in charge of this program, and, so, he's with people on the phone formally if they can't be a part of the group for an hour once a week and, then, available for anything else that comes along the way down the pike, everything from a logistic issue to a deeper kind of issue that might come up for a volunteer during interaction with somebody whose dying. So… And, along the way, we've done overnight retreats for the volunteers, a kind of supplemental training. So, we very much kind of mottle relationship; we mottle spiritual growth and exploration and everything that we do, because of the relationship theme, is a key. So we're extremely attentive to people's spiritual kind of rumblings as they sort of do the work, and that part of why people stay with us, because they're nourished by that kind of self-reflective experience.

NF: Okay. So, what I'm hearing you say in terms of why the volunteer program has been so successful is that the volunteers are not only providing spiritual care and given very high-level training to be able to do that, but they're also receiving spiritual care through the work that they're doing?

EW: Uh-huh.

NF: And by making it a… have a high barrier to entry and by requiring this intensive training and continued training and meeting with a rabbi, it becomes essentially an elite position… volunteer position in the community.

EW: Um, yeah, I wouldn't say it's an elite position..

NF: Um-hum.

EW: … because it's not it's- There's a standard …[coughing]… You might think of it as a standard of care, but It's not elite in the sense that… Yeah, I think elite is probably one of these words, especially in the US where it sort of has a lot of layers of stuff attached to it.

NF: Yeah.

EW: So I wouldn't call it elite. It depends on if it's a fit or not. We've… And I should say in that context, we have lots of people who are otherwise very well affiliated or situated in terms of leadership in the community, but we have any number of people who absolutely are not, and this is essentially their singular Jewish sort of identity experience. So we don't… So we're really across the board with people of all class, all sexual and gender identity issues, all ages. We have… Our volunteers range from like the mid-20s into the 80s, so it's really the demographic of our volunteers really represents the true diversity of the entire… of the Bay Area. So, yeah, I wouldn't think of it as elite in that way.

NF: Okay. I appreciate the clarification. And my next question was sort of who is your typical volunteer, but I think you've kind of answered that.

EW: [Laughter]

NF: That there isn't one [laughter].

EW: Yeah, our typical volunteer is the demographic of the community, yeah right [laughter].

NF: All right.

EW: I mean, as is our client I should say, you know, as well. Our clients range from folks who are low-income, public-assistance folks all the way to people in San Francisco who come from generationally wealthy, philanthropic families, so it's the whole range.

NF: Alright. So, I'm looking. I've a got a list of some general questions. I'm seeing sort of where we're at, where we've… There's a lot these things you've already talked about. I wonder if we could go sort of back in time for a few minutes and talk about the very genesis of this program? Sort of where did, of the center itself, where did the idea of the center come from and how did it go from idea to where it is today?

EW: That's a great question. So, the Healing Center of San Francisco is the first healing center in the Country, and it's essentially… The Healing Center was essentially founded by Nancy Flam and Rachel Cowan and Susan Friedman are 3 rabbis I… It happens, I was in… We were all in rabbinic school together but in the very late 80… or let's say like in sort of the range between sort of like around 1990, 90, '91, '92, the Healing Center was more formally established in 1992, but in those years, the 3 of them had gotten together to talk about service and notion of Bikur holim and helping people when they get sick and sort of bringing ancient wisdom in to serve the modern era, so I can kind of use that has a headline and very much influenced by their respective first pulpit experiences, although with Rachel in rabbinic school and thereafter very heavily influenced by her experience with her husband, Paul, who was doing of leukemia at the time, so I don't know if you're just rewinding. I don't know if you know that part of the

things, but he was a reported for the Village Voice, and probably you've seen their books, but there's a lot of sort of their life story around their own journeying. Rachel wasn't born Jewish. She converted. She became a rabbi. Paul was more secular, came into Judaism sort of later in life, his exploration, etcetera. So, those are sort of the nascent beginnings, and they put together groups of people that kind of think through that big issue of Bikur Holim in the modern era, and they brought forward this notion of Jewish healing sort of focused on illness, dying, and grief, and then Nancy came to San Francisco to establish with one of the that I was one of the rabbis already here and working behind the scenes with her to help situate it, and, then… So that was in established in San Francisco and then kind of fast-forward, Nancy had hired, I don't know if you know Amy Eilberg, she's a conservative ordained rabbi. Nancy hired Amy to sort of do sort of what was thought of then as sort of the Hospice branch of it, and hired a woman named Marsha Gugenheim, who was the administrative director, kind of helped to create and establish sort of logistically the center here. So, I'm kind of giving you headlines. And then after a couple of years, it just happens that Nancy and Amy very respectively left San Francisco for more personal reasons actually, and then I then more formally came onboard, so then it became, after a year or so, became the first executive director of the Healing Center, and that's been like almost 20 years ago. So, I did not found the Healing Center specifically, but I built it. So that kind of is sort of the beginnings of it. Do you… You might…

NF: So…

EW: Do you already know some of this? Does this sound familiar to you already anyway?

NF: There's a little bit that's on the website, but you're filling in some of the details. I don't know if there's another source where I can find a more complete history, but I don't know a lot about the Healing Center.

EW: Yeah, if you go to… So, there's the National Center for Jewish Healing that's through the Jewish, I'm not going to be accurate in the formal title, but…

NF: Okay.

EW: … it's the equivalent of the Jewish Family & Children's Services in New York, but I think they go for like Jewish Board… It's like JBFCS or something like that, but it's the Jewish Board of Children & Family Services, and if you just Google National Center for Jewish Healing, typically if you'd Google Jewish Healing Center, we'll come up, but if you Google National Center for Jewish Healing, then their website should come up, and so you should see a little bit there because we actually coordinated some of our history paragraphs but you can see that there.

NF: I'm looking it up now, but I feel like I've looked at this before, and I think the website, if it's the one I'm thinking of, has been sort of absorbed into like a the JFS website or…

EW: Yeah, you're right.

NF: … the Federation website or something like that, and I…

EW: Yeah, you're right.

NF: Okay.

EW: Yeah, yeah, you're right. [Typing] They're not… I don't know… I'm not sure if this is on your list, but I don't know if this is sort of important for your thesis work, but just to tell you, The Healing Center in San Francisco is really the on-… is essentially the

only independent Jewish Healing Center in the Country, and there's lots of reasons why we were as successful as we were as opposed to other parts of the Country, but, yes, that it's absorbed into another agency website is sort of structurally accurate, so they're not independent.

NF: Right. Yeah, I've got it here, and I've looked through some of this. Now, I wonder…

EW: Did I answer your question? Is that what you were getting at, by the way?

NF: Yeah, part of that. Now, what's… Well, let me circle around.

EW: Um-hum.

NF: I wonder, given the time and the location, was this at all connected with the AIDS epidemic or in response to? Was that something that was on people's minds?

EW: Yeah, so this is… I mean, you know, this is… I'm actually starting to write, do my own writing on a lot of this stuff now, and I'm actually in the middle of like writing a little piece for the CCAR around it, but, so it's a really great question to ask. So, I would say that in part yes, but not so exclusively because there were lots of different things that were happening in public health at the time, and so, of course, so what we now think of as the AIDS pandemic has historically influenced just whole swath of public reaction to health policy. You know, like the fact that we have breast cancer walks and all the different, quote, walks comes out of sort of gay men response to… gay male response to AIDS. So, of course it was influential there.

Part of what happened also because of just a vulnerability of the issues and the proclivity toward spiritual care at the time is that there were a lot people in 12-step programs, in particular Alcoholics Anonymous and Al-Anon, who were also Jewish and felt kind of

invisible to the Jewish community in that context, and, frankly, I think that demographic still really is, but because 12-step programs at their core talk about spirituality as a core part of sobriety. There's a little bit of a thread of that as a kind of cultural precondition to be why this sort of got hooked into the community, so I think there's a little part of that at work. I think that… You know, I'm a little more naïve around the rest of the Country, but, certainly, in the Bay Area there's just a lot of conversation about the why organizational structures, in particular synagogues and, of course, in the reform movement why we and the reform movement must become more porous and not see synagogues as individualized little bastions and that have, you know, hermetic steel around it where you just get in or don't get in by paying your dues, but part of what was happening was that the community was saying we want to have sort of this is part of our life supported, and why do we have to hooked to a synagogue to get it. So there's a little bit, I think, of good rebellion at work, I think, in the history of it, of kind of pushing at institutional boundaries, to break open rabbinic spiritual Jewish life to any Jew and to break down the kind of politic among movements when it comes to issues of illness, death and dying, and grief. I think a lot of it was just sort of in the world because of classically, just to say it, Elisabeth Kubler-Ross, and grief issues, so think there's a lot of antecedents to sort of pay attention to it, but, at least in San Francisco, a large number of sort of population openness came out of the LGBT community and especially around AIDS issues, so that was like definitely, and it's definitely a part… definitely a kind of an important thread to the havdallah candle so to speak.

NF: Okay. So would say that that was…

EW: And I should say on a more personal level, I… I'm the… I mean, you might know this, but I'm the first openly gay rabbinic student to get into HUC, and I before that was part of the first nascent LBGT Hospice organizations in San Francisco. I lived in San Francisco before rabbinic school when AIDS was just being discovered, so I was sort in the maelstrom of sort of the gay community in those years, and so I, myself, was trained as a Hospice volunteer in some of the earliest gay Hospice volunteer programs that were developed in the Country. I think sort of like simultaneously like the Gay Men's Health Collective in Manhattan and San Francisco and sort of LA kind of like simultaneously kind of popped up, so as a part of that. It's just part of my own personal life.

NF: Okay. So, what I'm hearing you say is that this was part of the atmosphere and the ideas around the changing ideas around healthcare, but it was not necessarily a direct influence on the beginning of the center? Is that fair to say?

EW: Yeah, I would say… I'm just sort of hesitating myself with the use of language, so I think there probably were any number of direct influences, no singular direct influence, but, certainly, this was one of them. I think a really strong influence really was in the very, very beginnings was very strongly the way in which Rachel and Paul were experiencing sort of the Jewish world and what they needed as he was sick, and he, himself… It might be interesting. I don't know how far back you want to go on this level of thing, but if you kind of… I don't know, Nathan, if you can Google this or not, but if you Google like the Village Voice back into like the late '80s, early '90s, you'll see some of his writing, because he actually was one of the earlier writers covering the more personal aspect of gay men's lives as AIDS was coming through the community, and if you look at that, there's some very key notions that actually came out of that world that

he reported on that kind of found themselves into his world as he got leukemia and began to sort of understand the world of illness even though he, himself, didn't have AIDS, but it was illness and life-threatening stuff. So, he was a heterosexual man living in a diverse cosmopolitan area and sort of filtering it through his own life story too, so I guess that's a long way of saying I think there are multiple direct influences, but I'm not sure one necessarily dominates the other.

NF: Okay.

EW: Does that make sense to you?

NF: I think that, that it makes sense. I think it's totally fair. Now, you've mentioned…

EW: If you get some of his earlier articles, you'll see it because he actually covered the AIDS crisis in part.

NF: Okay. Now, you mentioned also AA and 12-step programs, is that a part of your mission? Is that something that you do or help facilitate?

EW: No, it's actually not. I mean, we're very sort of I guess you could say 12-step friendly, but no, we don't… We don't like host an AA meeting or an Al-Anon meeting or things like that. We have great familiarity with it because it's in the world, but I guess maybe what I wanted to say was that because those programs stimulate and kind of expect spiritual life cultivation as part of sobriety, then it makes spiritual care a more well-experienced and sort of an openness among that kind of a demographic in the community. So there was just a kind of natural proclivity around those issues among people in 12-step programs.

NF: Okay. I think that makes sense.

EW: Then, I would say, by the way, it's not… I mean it's certainly there. I don't want to dismiss it in the least, but I would not say it's quite as dominant as it once was historically. It's not as dominant today. It's definitely there, though.

NF: Okay. So, wow, I'm just looking at the time, and there are still a few more things that I'd like to ask you.

EW: Okay. I have like another… Let me just look here, I have like another 15-20 minutes, and I'm happy to schedule more time if you want.

NF: Okay. We'll get through as much as… I think we can cover the questions that I have. [Clearing throat] And you just keep giving such good informa-… You know, a good answer makes more questions [laughter].

EW: Yeah.

NF: So, before we go, I'd like to ask about the maybe one success and one challenge or obstacle that you faced either recently or in the beginning of moving this from sort of those early days of the center that you came in, into this firmly established institution in the Bay Area.

EW: Okay.

NF: So, you can start with, with either a success or an obstacle. Yeah.

EW: One success one obstacle. Gosh one success. I think that… My gosh. I think the greatest success is kind of a big picture kind of an answer, but I think our greatest success is that we actually have presented a new paradigm of Jewish organizational life and service to the community that began as, you know, as a nascent idea and moved into the mainstream, so to speak. Of course, there's always current challenges, but I think that our greatest success is that we actually are a successful model for what I think of an artisan

agency with a very singular focus or mission is a very narrow but deep furrow that has created in its particularity a certain kind of depth of reflection that has a much broader appeal to people as an example of what nourishment of Jewish life can be in its specialization so to speak because a lot of what we do is sort of try to push it how people understand the ways you define spirituality, what are characteristics of spirituality, and then when you come to like a life challenge how are those things in your life able to nourish you in a distinct, legitimate, organic way. So, I think that part of it is really our greatest success, and, then, in that context, it branches out to the way we articulate those values in, say our Jewish Hospice Volunteer Program as a spiritual care program…

NF: Let me ask you, when you describe that success, how do you… can you give me an example of either an anecdote or a moment when you realized or a way that you can sort of objectively know that you've succeeded in that area?

EW: Gosh, there are so many. So, just in a more formal, like maybe traditional kind of a way, you know but the calls we get from synagogue rabbis and synagogues saying, oh, will you come and teach us, we want our Care & Community to be… to have this kind of an element and flavor and understanding, and so we come in and sort of help people rethink how they do bikur holim you know, to be successful in their particular synagogue in this way and help to redefine caring as an example. That's 1 example. Others are, you know, just kind of proof is in the pudding so to speak, not to be kind of cute about it, but we now have over 500 individuals who have come through our Grief & Growing program. We're coming into our 19th year. You know, people come to us and just talk about how it was just life shifting for them, even this many years later. I just was at a… just a local… actually was at a business event, that sort of a secular business event where

I just had a little bit of a connection as a matter of networking, and suddenly there are like 3 people that I knew from the Jewish community there, and all 3 of them had had very significant interaction with the Jewish Healing Center. One of them had come for the weekend many, many years ago, and they were telling other people just how it shifted their entire life focus, you know, or their perception of themselves and sort of brought them through that particular part of their lives in a way that was more definitely devastating but also brought them to a place of the kind of healing integration for moving through life. So there are all sort of little anecdotes like that all along the way. On a financial level, people have left us money in their estate directly because they've been served by us, not because someone suggested it or because, you know there are people who give money to guide dogs for the blind because they just kind of like to do that or they're Red Cross or whatever. You know, everybody who gives us anything is because they've had direct impact by us in their lives, and so that's just another, you might think of it as a business marker so to speak.

NF: Okay. Certainly a big affirmation.

EW: There's lots and lots of things like that. Pardon?

NF: I said that's certainly a big affirmation.

EW: Yeah.

NF: So, now let me ask what is 1 challenge that you face right now or alternately maybe 1 thing that you have tried to do over all of this time that you've spent here, one thing that you've tried to do that did not work?

EW: I can really say 2 things. One is that… I mean, it's going to sound mundane, but I don't mean to be again… I don't mean to be cute about it, but… So, the ongoing sort of

fundraising, you know, we're established, we're mainstream, but we're also relatively young, so notions, like we're just now as a board and as an agency looking really seriously at what does a formal endowment look like so that we secure ourselves forever, you know and not be caught the vagaries of the market or donors. So, I mean like a million and one nonprofits coming through the recession was just horrific, and it happened for us. In our particular case, we had an astonishing donor who gave us a multimillion dollar gift to like move us through the years of the recession.

NF: Wow.

EW: But that was money spent. That's not like money, you know, put away. So there's always that part of it that I think of as sort of in terms of as they are my responsibility for sort of longer-term sustainability as a challenge. And then the other, again, sort of big picture challenge, is what does it mean to… How can I say this? What does it mean to be both mainstream and let's say entrepreneurial at the same time? Like how do you create an affirmed, established culture that also is nimble in an organizational structure, so that's always…

NF: Okay. Can you tell me about its…

EW: Yeah.

NF: Can you tell me about a time where you have specifically felt that tension in a decision or an event or a meeting or what have you?

EW: Well, in our particular community, so is a little political to say to you, but… Hold on a sec. I'm sorry, I was just having a sip of tea [laughter].

NF: [Chuckle]

EW: In very, very early on for lots and lots of reasons this notion of how to bring this notion of Jewish healing into the mainstream, a lot of people felt like that Jewish healing centers and/or programs needed to be housed in larger agencies, like at a JCC or at a Jewish Family & Children's Services in order to give credence to it, in order to give a certain kind of establishment-stability seal of approval to it. That did not happen in San Francisco for lots of different reasons, but in the places where those programs did it, they really in the long-term kind of suffered and in many cases those programs kind of died so to speak, not to sort of use a pun intentionally, but…

NF: [Laughter]

EW: And, what happened was that this effort to mainstream, and I think it was… in retrospect, I think it was a little bit of a misperception. It… There needed to be more room given to organically establish spiritual care and spirituality in a rabbinic voice, its own authenticity and to grow, and that's what happened in San Francisco, but in other places, Jewish healing centers and/or programs got mainstreamed too soon, I think, and put in the context of a social-service agency or a JCC where the dominant culture overrides sort of being able to develop something new organically on its own, and, so, for example, just in concrete terms. You know, in one just urban community somebody found a wonderful, beautiful donor who was willing to give, say, 3-years' worth of seed funding and it was something considered…

[The line was briefly disconnected.]

EW: Okay. So, anyway, so basically what happened was when the funding, let's say 3 years left, then the community didn't necessarily devote the time to sort of otherwise cultivate other forms of income, and then what typically happened was then the donor

dollar to say the agency, let's say it was the JCC, suddenly a Jewish healing program becomes internally competitive because it's not relying on dedicated outside funds and suddenly the donor dollar to the JCC is being split among the senior lunch program or the kids after school program and then the Jewish healing program, and so suddenly you're submerged into the domination of the primary organizational culture, and that typically influences decisions about personal and what you offer and how you offer it, and then you're suddenly sort of faced with drive in that culture that may or may not be conducive to organic development of a Jewish healing center and giving room for experimentation and kind of treating it like a laboratory and kind of seeing what works and so I think that sort of historically speaking this notion of mainstreaming kind of… had a lot of bumps in the road. So I think that that, that's just sort of an example of sort of historic challenge in terms of the mainstreaming stuff, and, certainly, I think in Jewish Family & Children's Services, a lot of what happened was that those programs got subsumed into the legitimate assumptions around a JFCS which are that social work, models, case management, psychological processes dominate because that the nature of a social-service agency, but those assumptions are not necessarily conducive to a Jewish Healing Center perception, and so those things kind of, I think even to this day those things really struggle, but those…

NF: So…

EW: … the Healing Center in San Francisco always was subsumed, I mean we're independent now, but in the earlier years was subsumed under foundations that were not controlled by direct service assumptions, and so the Healing Center was really given kind of the graciousness of developing organically on its own, and that's in part why it became

successful, because there was no competition with donors. We were developing our own donors. If you're like at a JFCS or JCC…

NF: Yeah.

EW: … then usually the assumption is all donors belong to a larger organization, not to a program, and so that doesn't bode well for, oh you want to build something where levels of relationship become so crucial, always but certainly in the beginning.

NF: So, that makes a lot of sense, and it sounds like some of the challenges that other organizations or similar healing centers in other cities have faced. What is a challenge that you have faced in that process?

EW: Oh, well, so for us the challenge has been a little bit of the opposite, which is, yes, we're here, we're an individual agency, we have a particular mission, and we're putting our stake into the Jewish territory, so then people see, I mean this doesn't exist as much anymore , but in the earlier years. I should still this happens a little bit currently too, but, then, other organizations want to sort of duplicate our services, so to speak, but a lot of the way we see it is that we've been successful at filling the capacity of the community, so we want to help people to do that, and then people see us as kind of the prime-… the standard bearer of the work. So other like… I'm sure you see it there too, but suddenly some kinds of vocabulary seem to catch people no matter what the program might really be, so the word healing kind of becomes an important word as an example.

NF: Okay.

EW: But, hospitals are, at least in San Francisco Bay Area and across the Country, sort of use the word healing as a way to encompass a certain kind of program that they're doing. It might be mindfulness-based meditation. It might be visualization. It might be

whatever else they're doing, but so we sort of deal… we deal with like what is the sort of way in which there is a kind of genericization, if I can say that word, of the work and what still maintains our organization. So, but we're very solid in the community now with our specialization, so it's not to say that people don't crop up, it doesn't mean that our local Jewish Family & Children's Services in San Francisco doesn't still pop up with something, but it becomes a kind of political response, sometimes a strategic response. That sort of a thing. So that's sort of where it just becomes complex, but that's been more of our challenge as opposed to struggling inside another agency.

NF: So rather than struggling with, I guess internal political forces, being confronted with external political forces from other organizations has been challenging.

EW: I should say I don't want to overplay it because the synagogues have been great. It's jus-… It's usually more like our local Jewish Family & Children's Service sometimes pops up with stuff, but, on the other hand, we don't hire caseworkers. We don't hire therapists. We don't offer traditional counseling. We don't offer those. We don't offer a food program, that kind of a thing.

NF: Okay. So, I guess my last question, and I know you have to get off the line in a minute here, but what do you see as the religious basis for your work? What makes it religious?

EW: What makes it religious?

NF: Yeah.

EW: Well, every theological assumption that we sort of function on is Jewish. So, for example, we have the Grief & Growing weekend, and so we tell people that anybody can come and it doesn't matter what your sort of religion is or your state of religiosity or your

state of spiritual anything, that really we do everything to kind of make it a little bit more spiritual than specifically religious except that every theological assumption in place that guides us is Jewish, so we do Shabbat in a particular way. For example, and we don't accommodate any other religion. We don't do a mass. We don't have priests onboard. We don't do things that are Buddhist etcetera, and so, you know, we have everything that has to do with Jewish grief structures are essentially Jewish and theological in their assumptions. So it's definitely a Jewish atmosphere, so I would say that that is just a paradigm, but everything that we do as an agency, the theological undercurrent is a Jewish one, so in more subtle ways but more potent ways to an individual. You know the culture is rife with assumptions about spiritual growth and suffering that are essentially Christian that don't exists in Judaism, so a lot of our work with same individual might be to sort of reorient them to a different understanding of their suffering, that and they have a different cast that they may not realize has kind of Christocentric aspects to it just because that's so widespread in our culture, so another part that sort of makes us religious is that we do a lot of realigning of more authentic Jewish perspectives on the experience of illness, grief, and dying as an example.

NF: Okay, I think that makes sense to me. Can you give me an example of a hypothetical?

EW: Well, you know, sort of just to be kind of reductionist about it, the whole notion of Jesus on the cross in Christianity really says that suffering in and of itself is of spiritual value, and, then, depending, I suppose, on what denomination in Christianity you move you to, let's say… I can sort of say more traditional catholic sort of perspective, then suffering is considered the highest form of spiritual growth and that then people move

towards suffering maybe intentionally as a matter of spiritual path and/or accept their suffering as a matter of sort of potency for spiritual growth, and it directly relates to Jesus on the cross as a core Christian narrative, so that kind of suffering kind of doesn't… that notion which doesn't really exists theologically in Judaism, although, in the Bay Area there's a huge Buddhist influence, and so Buddhism also has this assumption that part of your spiritual path is affixation of suffering and so partly why we have mindfulness-based meditation just, again being reductionist is that mindfulness-based meditation moves you away from your inherent organic sufferings, and so there sort of, if I can sue this from a Jewish perspective, those are kind of equivalents, at least in my mind, of kind of theological assumptions of original sin, that just don't exist in Judaism, but those 2 things are just so strongly in the culture in the most subtlest of ways, and they're pretty potent because people don't really examine those things until they get to be saved, they get sick. So, you know, Jewish life, I mean, I would say at its core has everything to do with creation, redemption, celebration, and blessing, so when you suffer, even though, of course, historically the holocaust or, say, Purim as paradigmatic, theological, and historic examples are, of course, Jews have suffered, but our suffering is not considered particularly in the context of a theological spiritual growth requirement. So, we do a lot to sort of help people understand that when you are suffering, there are ways to understand it Jewishly around there's lots of ways to do this with people, but that essentially suffering is not automatically a Jewish theological assumption of what it means to be deeper spiritually or religiously. So I think it probably makes sense to you, I'm sure.

NF: So, what is something that you might say to somebody who seems to have that kind of mindset?

EW: Oh, you know it so interesting you asked me this question. So, not to be too philosophical about it, but sort of having a pre-scripted thing of what you say to somebody isn't sort of the point because what you say to somebody just depends on how you've developed that relationship and your assessment of their spiritual state and where they're moving toward, so I don't… we don't have sort of a stock answer to all the those but rather to sort of understand that framework. So, maybe if somebody is more cognitively intellectually inclined, maybe it's just me talking about an explanation and then just asking them something as simple as, does this make sense to you or what do you think of this and helping them to kind of unpack or sort of unfold that package and see what else there is. So, but if somebody is more religiously inclined, let's say, and texturally inclined, I might pull out one of the many Midrashim about are your sufferings welcome to you. They're not welcome to me, neither they nor their rewards. So, that's a pretty blunt way of saying suffering isn't a theological assumption in Judaism, even though we know it happens. You know, if somebody is more affective oriented, I might move toward where their feelings are around suffering because some people in suffering might be really angry or some people in suffering might feel abandoned or somebody who's been suffering might just feel plain old sad or [inaudible]. So it's… So what I say depends on my assessment of the person kind of in that moment and how I know them at that particular juncture and kind of moving with, again, their spiritual hunger at work and how I'm kind of trying to discern what that is and how I can kind of respond to it.

NF: Alright. I think that that was a very good answer and sort of different. I know there's sort of an artificial sense of asking what you say in a pastoral situation that's… there is no hypothetical pastoral situation.

EW: You're right. You're right. Right, right, right, right, right.

NF: So, I appreciate you entertaining the question, and I appreciate your answer.

EW: Sure. And it’s a reasonable question to ask.

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