

*When congregations are faithful to the example and mandate of Christ, they are, by definition, communities of health and healing. In the current revolution in health care, congregations are in a unique position to improve the health of the communities in which they worship and serve.*

# Congregations as Communities of Health and Healing

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**DR. DAVID SATCHER**, director of the Centers for Disease Control, is urging public health agencies to form partnerships with churches, especially in medically underserved African-American and Hispanic neighborhoods. In an address to religious leaders and public health officials, former Surgeon General Joycelyn Elders said: "We've always talked about separation of church and state. I want us to talk about the integration of church and state. Let us begin to integrate those things that we each do well, put them together and begin to make things happen." The Robert Wood Johnson Foundation is investing twenty-three million dollars in a program to support interfaith coalitions of congregations that provide care for needy persons with chronic physical and mental conditions.

Why this interest in churches on the part of national health leaders? Because improvements in health, especially among at-risk populations, depend heavily on lifestyle changes and volunteer caregiving that can be promoted more readily by churches than by hospitals. People go to hospitals when they are sick, but when they are well, they congregate in churches. Churches are concerned

about the health of their members and the health of the communities in which they are located. Churches are the most stable and respected institutions in troubled communities, where the burden of poverty and the fear of crime make life oppressive and where health risks are high.

Health leaders recognize that future improvements in health will come about only as people assume greater responsibility for their health and for the health of their communities. This is a spiritual problem calling for changes in behavior, not a medical problem calling for a scientific breakthrough. National health leaders are challenging churches to rediscover their commitment to health and healing, a commitment that is deeply embedded in the tradition of Christianity. When faithful to their mission, churches address the personal and social moral issues that people face, including issues of health and social justice. As Christians committed to the promotion of better health for persons and communities, we share a common mission and core values with health leaders and should recognize in their challenge a call to service and cooperation.

The church has a narrow window of opportunity at this juncture of our national history to assume a leadership role in the health-care revolution. Congregations are in a pivotal position in an emerging faith and health movement to reshape public awareness of health as something more than the absence of disease. Medical scientists are committed to the cure of disease, but they cannot produce magic bullets for lifestyle diseases as they did for infectious diseases. The "something more" beyond the eradication of disease has to do with healthy attitudes and behavior, healthy communities, spiritual values, a purpose for living, and social justice for the poor and underserved. Who is better situated to promote this "something more" than congregations?

Congregations promote health through community building, enhancing the meaning of life, nurturing core spiritual values, and sponsoring health-related programs. Yet the average member of a synagogue or church is not likely to associate health with congregational activities. One may do one's own informal survey by asking people who are active congregational members, "Where do you go to get your health needs met?" Most people will answer, "Doctor's office," or "Hospital." Why? Because they automatically think of health as the absence of disease, a doctor as the expert in recognizing symptoms of disease, and a hospital as the place where disease is treated.

Try this exercise to help people redefine health as something more than the absence of disease. In a congregational group (any group, any age), ask those attending to write down their definition of health. After dividing them into small groups of three or four and asking each group to arrive at a consensus definition, reconvene the total group and compare definitions.

People begin to realize through this process that everything the congregation does is related to health. One can arrive at the same conclusion by starting

with the faith side of the faith/health relationship. For example, it is frequently noted that one third of the Gospels are devoted to healing stories. Actually, all the biblical stories that have to do with salvation are about health and healing, about God's promise of wholeness for all of creation.

### **Health and Healing: Mission Of The Church**

This essay is devoted to praxis, not theory. The theological grounding for practices of health and healing will be addressed more directly by others.

Suffice it for me to say with minimal supporting argument that health and healing ministries are an expression of the church's mission. All of God's creating and redeeming activity is related to health and healing.

At the risk of oversimplification, all of scripture can be understood as a drama of salvation in four acts. The first act is the creation of the world as God intended it to be. The creation stories provide us with the norm of health, though we can capture the beauty and wholeness of creation only with clouded and distorted images. The second act in the biblical drama is the story of brokenness, beginning with Adam and Eve and continuing throughout history and affecting everything that God has made. The third act is the mending of creation, the restoration to wholeness, the climax of which is the ministry, death, and resurrection of Jesus. The last act is the realization of salvation (wholeness), partially now and completely in the eschaton.

The drama begins with wholeness and ends with wholeness, making it clear that wholeness is what God intends. But we were not in on the wholeness that came at the beginning of the drama, and during this lifetime we will never fully experience the wholeness that is promised for the future in images like that of the heavenly feast. We know more about brokenness than we do about wholeness, so it is not surprising that the dominant emphasis in scripture and tradition has been on healing, saving, and restoration to wholeness. Even a cursory reading of church history makes it clear that the church took seriously the mandate of Christ to heal (Luke 9—10). Individual acts of mercy abound, as well as institutional responses to the needs of the sick and the suffering. Hospitals and other caretaking institutions were built. Medical missions transformed evangelism into something more than saving souls. Such denominations as embrace Christian Science, Pentecostals, Mormons, and Seventh Day Adventists were formed with health and healing at the very center of their mission.

Health and healing are the mission of the church. Though some denominations give it more prominence than others, I know of none that would regard health and healing as outside the ministry it is called to provide.

## Contextualizing Congregational Practices of Health and Healing

Both congregational practices and theological reflection on those practices differ depending on the historical and cultural context. For example, healing ministry has been more prominent than health ministry in the history of congregational practices. Why? The answer is that healing is what Jesus did and mandates us to do. At a more experiential level, it is healing that we yearn for in our brokenness. When we are sick, we want to know what will make us well, and we turn to physicians and therapists as experts in healing. When we are conscious of our sinfulness, we want to know how we can be saved, and we turn to the great physician for the healing of our souls.

We know from the Gospels that Jesus healed both soul and body without making sharp distinctions between the two, the same Greek word (*sōzō*) being used to describe both kinds of healing. It is healing rather than health promotion that is at the center of the narratives about Jesus' ministry, just as it is the forgiveness of sins rather than the maintenance of moral integrity that is at the center of the gospel proclamation of salvation. This emphasis on healing is even more obvious when contrasted with the much stronger emphasis on health in the Old Testament, health of both body and soul, health to be maintained by dietary and moral prescriptions.

Throughout Christian history the emphasis has remained on healing rather than health ministry. One can see it in the Acts of the Apostles, in the healing practices of the ancient church, in the practice of confession and later pastoral counseling, in the development of Christian hospitals, in the history of medical missions, faith healing, and Christian Science, and in many other practices that have healing as their intent.

Although healing is important and indeed central in scripture and in the history of Christian ministry, a different emphasis is called for today. In an age of lifestyle illnesses, a new question has emerged: "What keeps us healthy?" Why is it that, among a group of people who are all exposed to the same viruses and carcinogens, some people stay healthy?

Many scientific studies exploring the relation of mind and body suggest that spirituality plays a central role in maintaining health.<sup>1</sup> Spirituality, as distinguished from religion, is what sustains our faith, our hope, and our purpose in life. Religion has always been regarded as the ultimate source for fulfilling spiritual needs. Spirituality has survival value for people in situations of dire stress, such as a death camp or a devastating flood. Those with hope and a sense of meaning and purpose are more likely to survive. What keeps us whole spiritually keeps us whole in mind and body as well. Healthy souls make for healthy bodies. Spirituality and health will be as important to the future of health care in the twenty-first century as medical science and healing were in the twentieth century.

Without disparaging healing as a ministry of the church, a strong case can be made for health ministry as the greater need for today. If the future reduction of premature mortality is more dependent on prevention than cure, and if spirituality is the key to effecting change in lifestyle, then the church needs to assume a role of leadership in the promotion of health. We have solid evidence that we are killing ourselves in this country by the decisions we make concerning such things as smoking, diet, and exercise. The good news in this sad story is that we can control the major causes of premature death.

The ten leading medical causes of death in the United States are: heart disease (720,000), cancer (505,000), cerebrovascular disease (144,000), accidents (92,000), and chronic pulmonary disease (87,000), pneumonia and influenza (80,000), diabetes (48,000), suicide (31,000), liver disease, cirrhosis (26,000), and AIDS (25,000). These statistics tell how people die, not why. In an article in the *Journal of the American Medical Association* on "Actual Causes of Death in the United States," J. Michael McGinnis and William Foege did an analysis that went beyond the primary pathological conditions at the time of death to the root causes.<sup>2</sup> Their analysis reveals that lifestyle factors lead to half of the deaths: tobacco (400,000), diet, sedentary lifestyle (300,000), alcohol (100,000), infections (90,000), toxic agents (60,000), firearms (35,000), sexual behavior (30,000), motor vehicles (25,000), and illicit drug use (20,000).

Most of the nine hundred billion dollars the United States spends on health care each year goes toward the treatment of conditions that are the secondary causes of death. The annual investment in prevention of root causes is estimated at less than five percent of the total annual health-care cost.

The United States Public Health Service has been mapping a national strategy to achieve realistic goals for disease prevention. *Healthy People 2000* lists three broad prevention goals for this decade: increase the span of healthy life for Americans; reduce health disparities among Americans; and achieve access to preventive services for all Americans. To help meet these goals, three hundred specific objectives were set in twenty-two separate priority areas. Priorities for health promotion are: smoking, misuse of alcohol and drugs, nutrition, physical fitness and exercise, and control of stress and violent behavior.

The broad goals of *Healthy People 2000* reflect values that are shared by every faith tradition: improving the health of all people, with a particular concern for groups of people who bear a disproportionate burden of suffering compared to the total population. Many of the specific objectives of *Healthy People 2000* in the areas of preventive services and health protection are best addressed through public health agencies, not only because technical expertise (e.g., for services such as immunization) is needed, but also because agencies do a better job of reaching those in greatest need.

The role of leadership in the promotion of health, however, belongs with

congregations, with support from public health. Changes in behavior call for spiritual interventions, and intervention in spirituality should come from the church. Healthy congregations promote solidarity, give meaning and purpose to life, inspire hope, pursue social justice, and serve those in need wherever they may be. Regular public gatherings for worship, social activity, and service deepen the spirituality of congregational members and motivate them to serve as ambassadors for health in every sphere of life. There is nothing within the structures of the United States Public Health Service that can begin to match the resources within congregations for the promotion of health. Public health leaders recognize this. It is time for the church to respond to the challenge by giving prominence to health ministry in defining its mission for the coming century.

### **Current Assessment of the Faith and Health Movement in the U.S.**

There was a time when faith and health were two distinct arenas, one the turf of churches and synagogues and the other the turf of medicine. The line of demarcation is eroding and both sides are moving toward common ground. From the side of health, we see an increasing interest in spirituality. Bill Moyers's PBS series "Healing and The Mind" continues to reach a wide audience. Numerous studies offer empirical evidence that health can be improved through spiritual practices like meditation. Alternative medicine is no longer dismissed as quackery. From the side of faith, we see an increasing interest in health ministry, particularly in parish nurse programs. Public health leaders are encouraging this development, because they recognize that congregations are social institutions with great potential to effect lifestyle changes for health promotion. The wide variety of perspectives and the lack of a unified vision make it premature to speak of a full-blown faith and health movement, but it is clear that religious and health leaders are eager to join the forces of faith and health in order to realize a common vision for improving health.

An early sign of this common concern was the convening of a conference in 1989 cosponsored by The Carter Center and Wheatridge Ministries on "The Church's Challenge in Health." Religious leaders from major Christian denominations and other faith groups (Jewish, Native American, Islamic) were challenged by health leaders such as C. Everett Koop and William Foege to respond to the overwhelming scientific evidence that health promotion reduces premature mortality.<sup>3</sup>

This timely conference spawned a number of significant programs, among them the "Interreligious Health Care Campaign."<sup>4</sup> Challenged by those attending the conference to develop a resource center for information about faith-based initiatives, The Carter Center initiated the Interfaith Health Program in 1992, and I currently serve as its Associate Director. The mission of Interfaith Health is to encourage faith groups to improve the individual and collective

health of their members and the local and global communities they serve.

If the current health-care debate were focused more on health *outcomes* than *access* to medical treatment, the discussion would immediately move toward disease prevention and the promotion of health. Faith-driven health promotion is the mission of the Interfaith Health Program, and the strategy for accomplishing their mission is based on an analysis of five critical gaps that prevent the improvement of health.

Gap one is between what is already known about health promotion and what is applied. During the past fifty years the science of public health has documented the spread of infectious diseases and developed methods to limit future outbreaks of dread diseases. When that knowledge is applied, dramatic improvement in health results, such as the worldwide eradication of smallpox and the elimination of polio from the Western hemisphere. The complete eradication of polio is possible by the year 2000 if the international community can find the funds and political will to apply what we know.

We know what kills people. Over four hundred thousand premature deaths each year can be attributed to tobacco. The knowledge that tobacco is a killer has lessened its use in this country, but the greed of tobacco companies and the addictive power of nicotine are powerful forces that impede the closing of this gap between what we know and what is applied.

The same can be said about handgun violence, which is now widely viewed as a health issue. Almost nothing of what is known about reducing handgun risk, even from the lives of children, has been implemented. Finally what kills us is what we do to ourselves through bad health habits: poor diet, too much stress, and too little rest and exercise. We know this, but our behavior does not reflect it.

The second gap is between what we as people of faith affirm about social justice and health and what we do. Health and healing practices are close to the center of the Christian mission. They are not simply good things to do among many choices; they are of the very essence of the gospel. And congregations everywhere recognize the mandate to care for the sick, the poor, and the oppressed, an ethic shared by every faith tradition. We are impelled to act, but we must confess that we fall short of what our faith so clearly calls us to do.

The third gap is between successful working models and general application in other communities. After visiting sixteen cities and meeting with over five hundred community health leaders who are actively seeking ways to promote the connection between faith and health, we have come to believe that nearly everything worth doing is being done somewhere by a church, synagogue, or mosque. In city after city, however, we found it rare for successful models to be recognized beyond a rather narrow circle of relationships. Information sharing and networking are the most effective ways to narrow this gap.

The first three gaps are perpetuated by the fourth: faith groups working in isolation from each other and from those promoting health in the public sector. There is such richness in particularity and diversity to be shared when we find ways to cross the traditional barriers of religion, race, and culture. It is a difficult gap to overcome, even among those with the best of intentions. The fourth gap is perpetuated by narrow vision, empire building, a mentality of us versus them, suspicion born of mistrust, and a failure to see that there exists, beyond differences, a common concern for social justice and the improvement of health.

The fifth gap is between future need and present greed. It is difficult to identify with persons from whom we are separated by expanses of time and distance. One of the reasons why the concern for environmental health has such a hard time getting on the agenda of congregations is that it calls us to make sacrifices now for the health of our children and generations yet unborn. A good illustration of this gap is the campaign against the use of tobacco. Although we have restricted marketing practices in the U.S. and banned smoking in many public gathering places, our government supports aggressive marketing of tobacco products overseas. Gap five reflects our spiritual immaturity, our inability to see the breadth and the depth of our participation in a created order that links all of us in a common humanity that bridges the barriers of time and space.

We have found the five-gap analysis to be a useful tool for understanding barriers to better health in individuals, congregations, cities, nations, and on the planet earth. It is based on the best information we have from science and the deepest insights we can draw from the riches of our spiritual tradition. A challenging way for a congregational health committee to renew its mission would be to ask these five questions: What do we know that we are not applying? What do we believe that we are not acting on? What models could be adapted here? How can we reach beyond ourselves to learn and collaborate with others? Can we find ways to curtail our greed and honor the need of future generations?

## **Implementation of Congregational Health Ministries**

The five-gap analysis of what is preventing the improvement of health is useful in identifying practices that are successful in narrowing these gaps. Prominent among those practices are congregational health ministries. One of the objectives of the Interfaith Health Program at The Carter Center is to locate persons and programs that are effective in improving the health of congregations and communities.<sup>5</sup>

They are not hard to find. Health and healing activities are part of the ministry of most churches. According to a National Council of Churches survey of one hundred thirty-two thousand Protestant congregations in 1992, seventy-eight percent were addressing at least one health concern, while half were



addressing three or more.<sup>6</sup> Relatively little is known about the thousands of health ministries being done by congregations, even when the congregations are in the same city.

The exception is parish nursing. The idea of a nurse as the health minister of a congregation is less than ten years old. It started with Granger Westberg, a Lutheran minister who has done more than any other single person to promote health ministry in congregations. Parish nursing began as an offshoot of an ambitious plan by Westberg in the 1970's to create holistic health centers. Located in churches with a staff of three professionals (physician, nurse, and pastoral counselor), these centers were exemplary models of whole-person health care. Though most of these centers became self-sustaining and some continue to operate, it was soon obvious that few congregations had the resources of time, talent, and money to develop holistic health centers.

"Nurses in churches," the term used by Mennonites, come at a fraction of the cost of holistic health centers, with many nurses serving on a volunteer basis. Parish nurses began to appear everywhere, in every region of the country and across denominational lines. It is an idea whose time has come, sparking interest in health ministry on the part of clergy, congregational leaders, members with an interest in health, and especially nurses who see this ministry as the vocation for which they have been searching.

For most people nurses embody whole-person health care. They have the training and experience to do nearly everything that is needed to promote health in congregations. Parish nursing comes in many forms. Some nurses are volunteers; others are paid. Some work full-time; others part-time. Some are linked with other parish nurses in a hospital-based program; some serve more than one congregation; and some serve special populations, such as the elderly. The diversity of programs and functions is one reason why parish nursing has grown so rapidly.

Westberg negotiated with Lutheran General Hospital to provide the first continuing education for parish nurses in the Chicago area. That has grown into the Parish Nurse Resource Center, which hosts an Annual Westberg Symposium on Parish Nursing and conducts orientation workshops for parish nurses who are beginning or wish to begin a ministry as parish nurses. This center also has excellent resources (books, videos, and other materials) for parish nursing, including a quarterly publication.<sup>7</sup>

Training programs for parish nurses, in both clinical and academic settings, are available throughout the country. Most of them use a workshop format and are based in hospitals that are seeking connections with community agencies like congregations. The most intensive and thorough clinical model for training parish nurses was developed by Chaplain David Carlson at Iowa Lutheran Hospital in Des Moines as an adaptation of clinical pastoral education for parish

nursing. Also in Iowa is a program established by Jan Striepe for parish nursing in rural congregations. So prominent is parish nursing in Iowa that in 1993 its governor officially declared a health ministry month. Master's level programs in parish nursing are presently available at two universities: The School of Nursing at Azusa University in California and The School of Nursing at Valparaiso University in Indiana.<sup>8</sup>

As training becomes more sophisticated, those who are concerned about enhancing the professional role of the parish nurse have been developing standards of practice that would lead toward recognition of parish nursing as a subspecialty within the nursing field. There are others, however, who argue that health ministry should not be limited to parish nursing, that lay people (neither religious nor health professionals) can be effective health ministers. Village health workers in developing countries and lay health advisors in this country have already demonstrated that lay people can effectively promote health.

The Health Ministries Association (HMA), an interfaith membership organization of health ministers throughout the United States, was begun in 1989 by a group of parish nurses to promote health and healing in congregations. In the early history of HMA, parish nursing and health ministry were synonymous, and developing standards of practice was a high priority goal of the organization. In the current promotional material of HMA, "health minister" is defined broadly as any person exercising leadership in health ministry, with the parish nurse being one model.

With the aid of a grant from Lutheran Brotherhood, a fraternal insurance company, HMA has developed a successful model for providing consultation to congregations that are interested in beginning a health ministry program. Under the capable leadership of the project director, Joni Goodnight, fifty HMA members who are experienced in health ministry have been recruited and trained over four years to serve as consultants for about two hundred congregations. MAP International, widely known in international health circles for providing lay training and free medications to church clinics in developing countries, has collaborated in this project by providing technical assistance in training. Resource development and evaluation are provided by the Interfaith Health Program of The Carter Center, a second collaborative partner.

Consultation is provided to a congregation that requests it at no cost to the congregation. An initial presentation by the consultant is scheduled for those who are interested, a gathering that must include the pastor and three council members. The congregation can continue to receive the services of a consultant at no cost by signing a covenant of congregational participation. The consultant assigned to them is available for a period up to two years for counsel and direction in the building of a health ministry program. Most consultation is done by telephone between the consultant and the congregational contact person, though consultants are available for further meetings if that is deemed advisable.

All congregations signing the covenant of congregational participation receive a free copy of a health-ministry manual developed by HMA.<sup>9</sup>

An initial evaluation of the program after two years by both consultants and congregational contact persons has shown promising results. There is wide interest in health ministry at the congregational level and a recognition that much can be done without adding another professional to the staff. The consultant program has been limited to Lutheran congregations by a stipulation of the grant received from Lutheran Brotherhood, but a collaborative partnership of HMA, MAP International, and the Interfaith Health Program is seeking funding for a replication of this model that would make consultants available to any faith group, including those of different racial and ethnic origins. Many examples of innovative health ministry in congregations could be cited. I limit myself to the one with which I am most familiar, Atlanta Interfaith Health, which directs a program that aims at forming coalitions of faith groups in urban Atlanta for both congregational and community-based health ministries.

The first goal of this program is to create healthy congregations. Congregational members who are natural helpers have been recruited and trained as congregational health promoters. They serve as health agents in the congregation; they assess health needs through listening and the use of assessment tools; and they work with the health committee of the congregation to enhance programs already in place and generate new programs to meet identified needs, such as support groups, health education, or referral to local health agencies.

Healthy congregations can and will be a vital force in creating healthy communities. Congregations participating in this program already have community-based health ministries in place, but for the most part they have been working in isolation from each other and community health agencies. Coalitions of faith groups, in collaboration with local health agencies, can overcome that isolation and work closely with those who share a common vision of a healthy community.

Each of the coalitions in the Atlanta Interfaith Health program has the assistance of a staff network coordinator (half-time). A Health Ministry Council, consisting of representatives from each of the congregations and local health agencies that have health promotion as their mission, determines what will be done jointly by the interfaith coalition to address the needs of persons in the community who are underserved and at risk. Collaboration and empowerment are the two most important principles in this model, and I am confident that the evaluation of this project will demonstrate their importance in implementing congregational and community-based health ministries, especially among the poor.

Poverty is generally accompanied by inadequate housing, poor diet, substance abuse and violence, all factors that contribute to a high incidence of

premature morbidity and mortality. Churches are not only the most stable institutions in poorer rural and urban regions, but their commitment to health makes them natural allies with other health agencies seeking to improve the health of impoverished communities.

Health ministry is needed in every congregation and community, but the need is particularly great among those who are underserved, undernourished, and more vulnerable than the rest of us to the great killers of our time. Jesus is our model for such ministry. His parable of the Last Judgment (Matt. 25:31-46) makes it abundantly clear where our priorities should be in the ministries we perform. In the light of this parable, it is unsettling to note that public health, and not the church, consistently uses social justice as a criterion to determine where resources should go.

We have a window of opportunity at this juncture of history to make a major contribution to health reform by recommitting ourselves to health ministry in congregations and communities and by giving priority to the needs of those who bear the greatest burden of suffering from preventable diseases. We can meet the challenge with both vision and hope, confident of the presence and power of the One who said, "I came that they may have life, and have it abundantly" (John 10:10).

#### NOTES

1. *Mind/Body/Medicine*, ed. David Goleman and Joel Gurin (Yonkers, NY: Consumer Report Books, 1993). The best journal for mind-body health is *Advances*, published by the Fetzer Institute. To subscribe, write to *Advances*, P.O. Box 3000, Denville, NJ 07834.

2. J. Michael McGinnis and William H. Foege, "Actual Causes of Death in the United States," *JAMA* 270, No. 18 (November 10, 1993), 2207-11.

3. An excellent five-part video on this conference is available from Wheatridge Ministries, 104 S. Michigan Ave., Suite 610, Chicago, IL 60603-5904. Segments of this video can be used in an adult forum to stimulate a discussion about congregational health ministry.

4. This is an interfaith coalition that speaks for the religious community in identifying the moral and spiritual values that should undergird health care reform in the U.S. Under the direction of Sarah Naylor, the office is located at 110 Maryland Ave. NE, Box 26, Suite 504, Washington, DC 20002.

5. For more information about the faith and health movement in the U.S. as well as more specific information about successful faith-based health practices, write to The Interfaith Health Program, The Carter Center, One Copenhill, Atlanta, GA 30307. Reports, special publications, and a regular newsletter are available.

6. National Council of Churches of Christ in the U.S.A. & National Center for Children in Poverty, *Church Involvement in Health: Findings from a National Survey* (NCC, 475 Riverside Drive, New York, NY 10115).

7. Especially helpful is *Parish Nursing: The Developing Practice*, ed. A. Solari-Twadell, A. Djupe, and M. McDermott (Park Ridge, IL: Lutheran General Health System, 1990).

This book and other materials can be obtained by writing directly to this address: Parish Nurse Resource Center, 205 Touhy Ave., Suite 104, Park Ridge, IL 60068.

8. Dr. Marsha Fowler, who established and continues to direct the program at Azusa, is a national leader in the parish nurse movement. Georgetown University no longer offers a Master's program, but the University of Colorado is developing a curriculum for a graduate-level program. Other universities are offering elective courses or continuing education opportunities at both the graduate and undergraduate level.

9. This is by far the best manual available on how to begin a health ministry program. Purchase of the manual includes future updates, which can be inserted in a loose-leaf binder in which the materials are assembled. The cost of the manual is \$75 for members and \$100 for nonmembers. It can be ordered from Maureen Ahrens, 10381 Kukui Dr., Huntington Beach, CA 92646.