The Ministry of Healing

A Nurse’s Reflection

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In her autobiographical reflections, a former nurse provides a narrative of personal discovery that reveals multiple dimensions to the practice of healing. It is often more than the patient who requires attention and ministry by caregivers.

Already a member of a religious community when I first began my college education, I assumed I had to be a teacher since my congregation was primarily a teaching community. After three semesters, the formation director asked me what professional work I wanted to do. My immediate response was, “Be a nurse!” That desire had been sitting unnamed inside me, and I realized that I was influenced by my mother who had worked as a nurse when I was a youth. I recalled her leaving home late evenings to work the night shift as a surgical scrub nurse. I remembered her working in doctors’ offices and being present the first time I needed stitches. And most of all, I remembered the many times we would be home from school, sick with fevers, colds, chicken pox, and measles.

Mom had a way of making us feel better just by creating an environment of healing. She would never have called it that but the little things she did made a difference. For example, she would set us up on the couch with blankets, pillows and TV trays for meals so we would not be isolated from the household action; ginger ale, chicken soup and crackers were served on a special tray; the touch of her hand on our foreheads, the back rubs, the talcum powder after bathing; the ice packs or hot water bottles depending on what was wrong; the music she played from our favorite records, and the stories she would read to us, all made the time go faster. Yes, Mom was indeed a minister of healing.

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Caring for the Sisters

I finished my bachelor’s degree in nursing from Marquette University and began a career which included many years working with our aged and infirmed sisters. They taught me so many things about suffering, humility and dependence on others, about faith in God and acceptance of death. They expressed constant gratitude for things I did for them, and they constantly assured me of their prayers for me.

Working with the sisters laid the foundation for my own understanding of what healing meant. It was a word that spoke not to an outcome but rather to a process. These sisters were in their eighties and nineties. They would not be “healed” of their illnesses and their sufferings.

My role in their lives was to help them experience their days comfortably and in peace, nourishing them not only with daily food, but spiritual food to sustain them on their final journey. My blessing in this ministry was to be a witness to their final days, filled with awe at the transformation that took place as they approached death, and rejoicing as they attained their ultimate goal—to be united with God in new resurrected life.

After several years of working with our older sisters, I recognized another dimension of my ministry. I became aware of the fear that existed in the hearts of other sisters who were anticipating their own personal diminishment. Consequently, they did not like to visit the geriatric floor I was working on. They did not know how to be with their friends, classmates, and/or former teachers, who could no longer remember names, places, or what day it was. They were uncomfortable in the midst of suffering, feeling a desperate need to alleviate it, and knowing they could not. They wanted to be present and pray with the sisters in their final moments, but to sit for long periods of time awaiting the end was difficult. This realization led me to look more closely at dimensions of healing that had nothing to do with medications, treatments, or other medical interventions.

To encourage the sisters to visit our geriatric unit, we began sending out personal invitations to come for a Sunday afternoon visit. During that time there were refreshments and some options for what the visitors could do during their time with the sisters. We recommended wheelchair rides to the different chapels at our Motherhouse, rides outside to see the beauty of the convent grounds if the
weather was nice, and, if the visitor was willing, a ride over to see Lake Michigan right across the street. Words were not necessary during these excursions. But the presence of another and the mutual prayers that were said in the chapels all became moments of healing. Sometimes the visitors would help our elders eat and drink the refreshments. Sometimes manicures were in order. Sometimes letters were dictated and mailed. And sometimes one just sat at the bedside of a sister who was not feeling up to activity. Gradually the fears of the visitors faded, and we did not need to plan special times to get people to come and visit.

Another lesson I learned was the importance of creating a peaceful environment in the room of a sister who was dying. In our health center we were not confronted with weighty decisions about extraordinary means to sustain life. Most of our sisters made it clear that they wanted to go to God when their time came. Our number one priority was to keep the sister comfortable. But more than that, we made sure that the room was neat and clean. We used the brightest and prettiest pillow cases. We dressed the sisters in their best gowns and made sure that they were bathed and nicely groomed. These small details made a difference to those who came to sit with the dying sister. Again, we encouraged visitors to hold the sister’s hand and speak their prayers out loud. If someone was staying a long time, offering juice and breaks became important.

The spiritual journey into death is one taken not only by the person going to God but by the companions as well. The healing ministry includes attention to all those impacted by the sickness or death of a person. And the satisfaction of this ministry is in knowing that, while a person may not be healed in body, certainly all the small efforts toward comfort and a peaceful environment restore one to wholeness in body and spirit.

A Clinical Assistant

After several years of ministering to our aging sisters, I was invited to consider working for a vascular surgeon. This medical professional, whom I called Dr. K., had come routinely to our health center to take care of our sisters. One day out of the blue, he asked if I was looking for a new position. At that time I was the administrator of the health center, and we were going through the very painful process of closing it. Financially, we could no longer sustain the center because we were not licensed. Along with that, the structure had never been built to allow accessibility for wheel chairs. The plumbing was poor. Medical care had advanced way beyond our own ability to provide the necessary treatments and services on our own. So we made the decision to close down and move our sisters into a public nursing home. The doctor’s question came at a perfect time for me. Accepting his offer, I entered into a whole new experience of healing ministry.
In many ways, Dr. K. healed his patients both physically and spiritually. His whole purpose in hiring me was to provide a healing presence to his patients in the hospital. Because his surgical schedule occupied most of his day, he was not as visible as he wanted to be. He was aware that anxiety and fear can disrupt the healing process and he recognized that, in this changing medical environment, nurses and other medical personnel no longer have the luxury of spending quality time with the patients. He was convinced that my role would alleviate these concerns. He was also aware that offering this service to his patients could likely influence future referrals as well.

While my primary role was to care for the patients before, during, and after their surgeries, I became aware of two other groups who were in need of the ministry of healing: family members and hospital staff. The patient population I served under Dr. K. differed greatly from the elderly sisters of my community. Many were financially well established, although some of our patients came from areas of extreme poverty. They were dealing with critical illnesses related to vascular insufficiencies. Most required high-risk surgery and long-term follow-up. This reality led to great fear and anxiety, not only on the part of the patient, but on family members as well.

I quickly learned that my “clients” included not just the patients in the hospital but those who would accompany the patient to the office for the first visit; those who would be waiting for the news after surgery and during the hospitalization, and who would be taking on responsibility for care after discharge. Once again, it was not what I did in terms of procedures and treatments but rather how I did these in a way that diminished anxiety.

The greatest anxiety for both patients and caregivers came from not knowing or understanding what was happening to them. I learned to communicate information as clearly and as often as possible to those involved. I learned that often the patient and/or family members just needed a listening ear. I realized that factors beyond the specific medical problem exaggerated the experience of pain. While we may have been successful with a surgical procedure, therefore, personal difficulties at home or work often prevented healing in a more holistic way.
**The Case of Mary**

Mary was an elderly woman who had at least four major vascular surgeries. She was diabetic, hypertensive, and often in heart failure. Surgical intervention was often delayed until one or the other of these difficulties was brought under better medical control. Mary was well cared for by her daughter and son-in-law. But when they would visit the anxiety level in the room increased, not because Mary herself feared surgery, but rather because her son-in-law Harry had serious vascular difficulties and was avoiding being treated. This distressed both Mary and her daughter. Mary was a real, visible demonstration of what Harry was facing. He feared for Mary, certainly, but mostly he feared his own fate.

In this situation, it became critically important to care not only for Mary but also through gentle and consistent encouragement, to alleviate Harry’s fears. Mary’s experience was going to be a prototype of Harry’s future. So it was important to make sure Mary’s pain was well managed. It was important that Harry clearly understood the surgical procedures, the treatments after surgery, and the follow-up plan. It was important that Mary had confidence in Dr. K. and felt comfortable with my presence to the point where Harry might have the same confidence. And it was critically important that after Mary was discharged, I would make follow-up calls not only to her but also to Harry and his wife as well. It was worth all the extra effort because Harry eventually had the courage to make an appointment with the doctor. He went through vascular surgery successfully, and to this day we stay in touch.

**Caring for Colleagues**

There was a second group looking for healing from me. Although employed by Dr. K., I was not connected with the hospital staff as a fellow worker. Every day, however, I visited several different hospital departments while making rounds on our patients. On any given day I was in the intensive care unit, surgery, the recovery room, day surgery, the outpatient department, the x-ray department, the medical records department, and the various nursing units in the hospital. I got to know the staff members in each of these areas and discovered another need for healing.

Because of the critical nature of the surgery we performed, it was extremely important that any changes in the status of our patients be reported immediately to Dr. K’s office. This led to great tension between the hospital staff and the doctor. Not reporting changes could lead to a stroke, or the failure of a vascular graft, requiring repeat surgery. When this happened, Dr. K. would be upset and the staff would feel his anger. In response, and out of fear of repeating this mistake in the future, the staff would often make phone calls about non-essential things to Dr. K. in the middle of the night. They did not mean to be bothersome but were just concerned about not reporting something important. This also led to upset, and so it was a no-win situation for the staff.
I learned early on that the staff would much rather deal with me, and my constant presence made that possible. They knew I could sift out important information and communicate it directly to Dr. K. if I thought it important. He trusted that when I called, it was something that really needed his attention. I spent a good part of my time reassuring staff of our appreciation of their care for our patients. And I educated them regarding the importance of reading signs and symptoms accurately so that we could prevent surgical complications. I made sure that I was available to help with very complex dressing changes, and was respectful of their time when requesting updates and reports on our patients. I realized that very little appreciation is given to these persons who do the most critical care around the clock. They often work under considerable pressure with inadequate pay, and are often spoken to harshly by both medical personal and family members who are under stress due to the complications of a patient’s illness.

“Healing the healer” is a neglected ministry. We become so busy healing the patient that we forget about those affected by the pain and suffering of the patient witnessed every hour. And “healing the physician” seems like an oxymoron. Yet, as I learned, most of a physician’s upset and anger is related directly to the inability to heal the patient, or the discouragement that arises when a complicated surgical procedure has failed. Having been in surgery many times, I appreciated the constant stress a surgeon deals with. I was privileged to see his vulnerable side as he tried to alleviate pain and suffering, only to realize that he was fallible and sometimes unsuccessful.

Conclusion

Although I am no longer in active nursing, I continue to integrate what I have learned from the ministry of healing in my present ministry as a pilgrim-age guide to Rome and Assisi. I am amazed how the lives of Francis and Clare continue to give me spiritual insight into the art of healing, and I am constantly reminded that the spirituality of healing is a holy ministry. The holiness is the journey into situations that are often difficult, filled with pain, suffering, isolation, and loneliness. On this journey, one is often confronted with an awareness of personal limitations. While one is equipped to do physical things to comfort and
assist a person who is suffering, it is the presence of a listening ear and all the little things one does to create an environment of peace and comfort. Those in need of healing often include people on the periphery who are neither patients nor healthcare professionals, that is, those who are most intimately involved in the life of the person who is ill. They too look to us to receive consolation and peace as they deal with illness and life’s difficulties.

We are all called to be ministers of healing as part of our spiritual journey. One does not need a medical degree or special training in therapeutic areas. What one needs is faith in God, a heart open to listening to the experiences of another and a belief that, together with our Redeeming God, we can all be compassionate healers in an ailing world.