Caring for enspirited bodies/embodied spirits

Don Yost and the staff of Maple City Health Care Center

If zombies showed up for dinner, most of us would count it as a not-so-good day. This image of soul-less bodies reminds us that disintegration is the stuff of nightmares. Conversely, biblical images of the reign of God connect powerfully with our human longing for (re)integration—of our bodies and spirits, of ourselves within the larger body of a healthy community in which all care for the well-being of others. No wonder, then, that we here at Maple City Health Care Center see integration as a key to accomplishing our mission of fostering community health.

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Maple City Health Care Center is a twenty-seven-year-old experiment in community health. Our community is a stressed but resilient neighborhood on the north side of Goshen Indiana. Many people in the neighborhood work in recreational vehicle factories. Many speak Spanish. About a third of the families in the community are unable to obtain insurance. About a third live on incomes below poverty. Primary health care is the setting for the center's efforts to foster community health. The center hires doctors, nurses, and support staff to create a medical home and to offer affordable health care for people in the community. In the context of providing health care, we foster healthy community.

In 1 Corinthians, Paul uses the image of a body to talk about the unity of the church. In the same way that arms, legs, and a head are integrated into one body, separate individuals are unified into the body of Christ. Here at Maple City Health Care Center we have learned that the health of our bodies is related to our being integrated into the community: studies clearly show that loneliness and social isolation are risk factors as strongly associ-

ated with illness and premature death as smoking, obesity, elevated blood pressure, and high cholesterol. Strong relationships within a healthy community are as valuable as penicillin or flu shots in maintaining the health of individuals.

In what follows, we offer three stories about integration—stories about the integration of mind/spirit/body in individuals and stories about individuals becoming integrated into a community.

Bad milk

When Maple City Health Care Center started in 1989, most of the people in our community were immigrants from Appalachia. Over time, however, people from Central and South America moved into the low-cost rental houses in our neighborhood.

As more and more Latinas who were pregnant sought obstetrical care at the health care center, we became increasingly aware that many of them felt isolated. These women came from cultures in which women experience pregnancy and birth surrounded by mothers and aunts and sisters and grandmothers. They found themselves thousands of miles from friends and family, in a foreign country, and at the mercy of a strange medical system. We began to see how social isolation contributed to anxiety during pregnancy and to postpartum depression. Poverty and other social stresses exacerbated the challenges these young families were facing.

In response, we began to explore an approach to prenatal care in a group context. The model, known as Centering Pregnancy, had been pioneered at Yale University's midwifery school. Centering Pregnancy integrates medical care, education, and support as women whose babies are due at about the same time meet together eight to ten times, throughout the course of their pregnancy. Each woman brings the gift of her life experience to the group. The result is that the women learn at least as much from one another as from the physician and nurse who are present.

As we began to explore this model for offering prenatal care, we realized that it entailed a paradigm shift. Medical professionals would need to move away from seeing their role as that of offering technical expertise and information. Instead, the role of medical staff would be to facilitate a group process that elicited the gifts of women who were unsure that they had anything to offer.

In the beginning, we intended to offer a Centering Pregnancy group for English-speaking women and a different group for Spanish-speaking women. But we were operating on a small scale and we didn't have enough women expecting babies at any one time to offer two groups, one in Spanish and another in English. We considered starting a bilingual group, but people who had experience with Centering Pregnancy were skeptical. They warned that the cross-cultural dynamics and language barriers would interfere with group dynamics.

Despite misgivings, we decided to try assembling a bilingual, cross-cultural group. At our first session, we began by acknowledging that these Anglo and Latina women probably did not have much contact with each other. But these women were forming a group in order to prepare to receive babies. Their babies would soon grow into children who would play together and go to school together and perhaps eventually make new families together. Part of our task would be to begin to form a healthy community where these children could flourish.

Our interpreter translated everyone's words. Surprisingly, we found that the translation put us all on equal footing as we all struggled to make sure that we spoke clearly and listened well. But in spite of our care in speaking and listening, it felt like language was failing us when some of the Latina women began talking about bad milk.

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For years, Maple City Health Care Center physicians and nurses had promoted exclusive breast-feeding as the best way to provide newborn nutrition and encourage mother-baby bonding. We repeatedly observed that Latina mothers wanted to mix bottle feeding with breastfeeding. Unlike their Anglo counterparts, however, the Latinas often succeeded in maintaining breastfeeding even though they mixed it with bottle feeding. None of the physicians or nurses understood why Latinas wanted to mix feeding styles or why they were successful at it.

During one Centering Pregnancy session, the group began a discussion of breastfeeding. Beth, our midwife at the time, and James, our physician, asked the expectant mothers why one might consider introducing bottle feeding. A woman from Mexico

responded, "So you have something to give the baby when your milk is bad." Puzzled, Beth asked, "Why would your milk be bad?" The response was, "If a mother is angry or upset, her milk is bad, and she should discard it until she's calm again."

All the Latinas around the circle nodded in agreement with the explanation. All the Anglos looked puzzled. Yes, the Anglos could see an emotional link between an upset mother and an upset baby, but milk turning bad? The idea that milk was a substance that could transmit dis-ease to the baby seemed like folklore.

As the conversation continued, Beth and James began to realize that medical care providers tend to see breast milk as a nutritional commodity that offers calories, nutrients, and immunity to disease. The Latinas saw breastfeeding as an expression of the relationship between mother and baby, as participating in the dynamics of the relationship. When a mother is upset, continuing to nurse means risking conveying that turmoil to her infant. To nurture her child well requires waiting to nurse until her tranquility is restored.

Beth and James came away from that conversation with a new respect for the relationship breastfeeding fosters and expresses, a new sense of the way mother's milk, such an ordinary substance, can be infused with extraordinary qualities in the context of a calm and nurturing interaction.

When we began our experiment with pregnancy groups, cultural diversity seemed like a barrier to prenatal care and a strain on our resources. Instead that diversity has become a vehicle for learning at a deeper level and for building a more integrated community. Our reluctant embrace of change has, through the faith of those who have participated so generously, made all of us more whole.

A place of belonging

Bert lives with obesity, hypertension (high blood pressure), and hyperlipidemia (too many lipids in the blood). As if these conditions weren't enough, tests show that he is pre-diabetic.

Before 2016, Bert faced these problems on his own. On the day in March that Bert became a patient at Maple City Health Care Center, he became part of a team. Like every other Maple City

patient, Bert's patient care team included a physician, a nurse practitioner, a nurse health coach, a nurse care coordinator, a behavioral health provider, a dietitian, a social worker, medical assistants, and a health insurance navigator.

At Maple City Health Care Center, we have organized our care around patient care teams because we see our patients as a complex mix of physical, mental, and spiritual characteristics. Each patient needs the help of specialists in each area, but the specialists also need interaction with the other members of the team.

Bert's patient care team helped him with tests, medicine, and education. They helped him with coaching and encouragement. But Bert's team got bigger than just his patient care team. It grew to include other patients.

Almost all people who make a big change in the way they live make that change with the help and support of other people.

Bert joined one of Maple City Health Care Center's healthy living groups. Members of the group faced problems like Bert's—obesity, hypertension, and diabetes. Members of the group all needed to make changes in the way they lived. Ingrid, one of our dietitians, notes that almost all people who make a big change in the way they live make that change with the help and support of other people. The members of the healthy living group met for eight weeks. Members set goals, told stories, held each other accountable, and shared victories and frustrations.

At first, Bert dominated the group. The words seemed to pour out of his mouth—which was even more of a problem than usual because all of the rest of the members of the group spoke Spanish. An interpreter had to turn everything Bert said into Spanish.

Maybe it was because of the interpreting, which tends to require speakers to slow down and speak more carefully. Maybe it was because of a sense that people were listening and responding. Or maybe it was because the tangible support of the group diminished Bert's sense of loneliness. Whatever the reason, by the third group session Bert was speaking less and listening more. Bert engaged in conversation. He asked questions. He stuck to the topic at hand.

In remaining sessions, Bert offered stories and wisdom that came from his experience as a recovering alcoholic. He brought a

copy of the serenity prayer to share. His new Spanish-speaking friends asked to have the prayer translated. Bert set goals for himself, but he didn't feel judgment from the group when he occasionally missed a goal.

At the end of their time together, the members of the group celebrated what they had accomplished. Bert lost twenty pounds and lowered his blood pressure from a reading that was a cause for concern to a reading that was normal. His risk for diabetes diminished.

For Bert, a group of people from a different culture who spoke a different language became a place of belonging. In the midst of this small community, Bert not only found the physical, mental, and spiritual strength he needed, but he also assisted others in their struggles and found a way to contribute to the overall health of our community.

Breaking in

Although the health care center is located in a low-income community and we store lots of medications on site, we have never had much trouble with break-ins. But some years ago, when we were in the midst of a building expansion, someone broke in one night. The next morning we arrived to find dirt and glass shards on the carpet inside the back door.

Just as our construction project reached completion, we arrived one morning to find a new—expensive—metal door ruined because someone had pried it open with a crowbar. We decided the time had come to put a stop to the break-ins.

Several nights later, a window was broken and a few dollars were stolen from the cash drawer. We notified the police, but the break-ins continued. The intruder toyed with our otoscopes (tools for ear exams), rummaged through our collection of books on pregnancy and childbirth, and played with our microscopes. We were unsettled and wondered why this intruder was breaking into a community health center, of all places.

Then the break-ins stopped for several months. But just as our construction project reached completion, we arrived one morning to find a new—expensive—metal door ruined because someone had pried it open with a crowbar.

We decided the time had come to put a stop to the break-ins. We weren't inclined to barricade the place, but we did improvise a security system. We kept a telephone line open inside the back door so the health center director could use her home phone to listen to what was happening at the center during the night.

A couple of nights later, our director awoke to the screech of metal on metal. The sound was coming over her phone as our night visitor again used a crowbar on the center's metal door. We called the police and they apprehended Tony, a seventeen-year-old high school student who was one one of our patients. Tony had significant hearing loss and was struggling socially and academically. His parents had been aware of his earlier nighttime roaming and had installed an alarm system at home to alert them when he tried to leave his room. After several months without problems, they had turned the alarm off. That was when our break-ins resumed.

Tony's break-ins eventually convinced us that we had not succeeded in addressing his need for a more complex kind of healing. Tony was on a quest and he kept intruding into our space to tell us so.

Dan, one of our board members, often volunteered at the center. Dan had a son who had been in some trouble with the law as a teenager. Dan pled with us to refrain from just turning our intruder over to the legal system. With our blessing, Dan worked with the prosecutor. The court eventually sentenced Tony to two hours a week of community service—at the health care center. A sullen Tony showed up and half-heartedly did the tasks we assigned: cleaning gutters, picking up litter, pulling weeds, and doing yard work.

Because we knew that social isolation has been identified as a big risk factor associated with poor health and early death, we had been trying to address the isolation of some members of our community by identifying activities they enjoyed and inviting people (patients) who enjoy similar activities to do them together. We had identified several people who liked to cook and had invited their families to meet in the health center's kitchen/community room on Wednesday afternoons to take turns cooking for each other. Some people in the group spoke English and some spoke Spanish. Some were beginning to learn each other's language.

One week Tony showed up to do his community service on a Wednesday afternoon. A member of the cooking group noticed him and invited him to join them for their meal. Tony disappeared, but reappeared a few minutes later with some banana bread he had brought from home.

From then on, Tony did his community service on Wednesday afternoon, and he stayed for the shared meal. His disposition changed from sullen to sunny and he began to do his chores wholeheartedly. Before long, Tony had completed his required community service, but he kept coming each week to volunteer and to eat with the group. We were amused when he told us one day that he'd started to patrol the area at night with his dog so there wouldn't be any trouble with people breaking in.

One week Tony announced that he'd made the honor roll at school for the first time. We had a party to celebrate with him. Tony finished high school on schedule and went on to study at a local community college. He now has a job in our community.

Our contributions to Tony's healing were not the result of our program as much as the fruit of impulses among people—mostly volunteers and patients—who came together to reach out and include one another.

As a staff, we started out by feeling resentment about the intrusion into our space and the messes we had to clean up. Now we rejoice in Tony's success and feel pride in him and have an investment in his future.

Although health care center staff had been providing standard medical care for Tony for years, his break-ins eventually convinced us that we had not succeeded in addressing his need for a more complex kind of healing. Tony was on a quest and he kept intruding into our space to tell us so. We perceived his way of getting our attention as an offense, but Dan's compassion and Tony's response to what flowed from it gave us the opportunity to see Tony as someone in search of integration, connection, and community—the ingredients that got him through a rough patch in his young life.

Our contributions to his healing were not the result of our program as much as the fruit of impulses among people—mostly volunteers and patients—who came together to reach out and include one another. In the end, our staff simply watched as

patients and volunteers took Tony in and gave him a sense of belonging and purpose.

Our stories, your stories

We are determined to resist the temptation to extrapolate theories from these stories. Instead, we trust that the stories will offer you their wisdom and remind you of the stories you know—stories about people individually and collectively becoming more whole and sharing in the astonishing gift of a community of abundance, imagination, and shalom.

About the author

Don Yost is chief storyteller for Maple City Health Care Center and for Vista Community Health Center in Goshen, Indiana. Vista Community Health Center is Maple City's new sister site. You can read more stories at www.mchcc.org. Names have been changed to protect patient privacy.