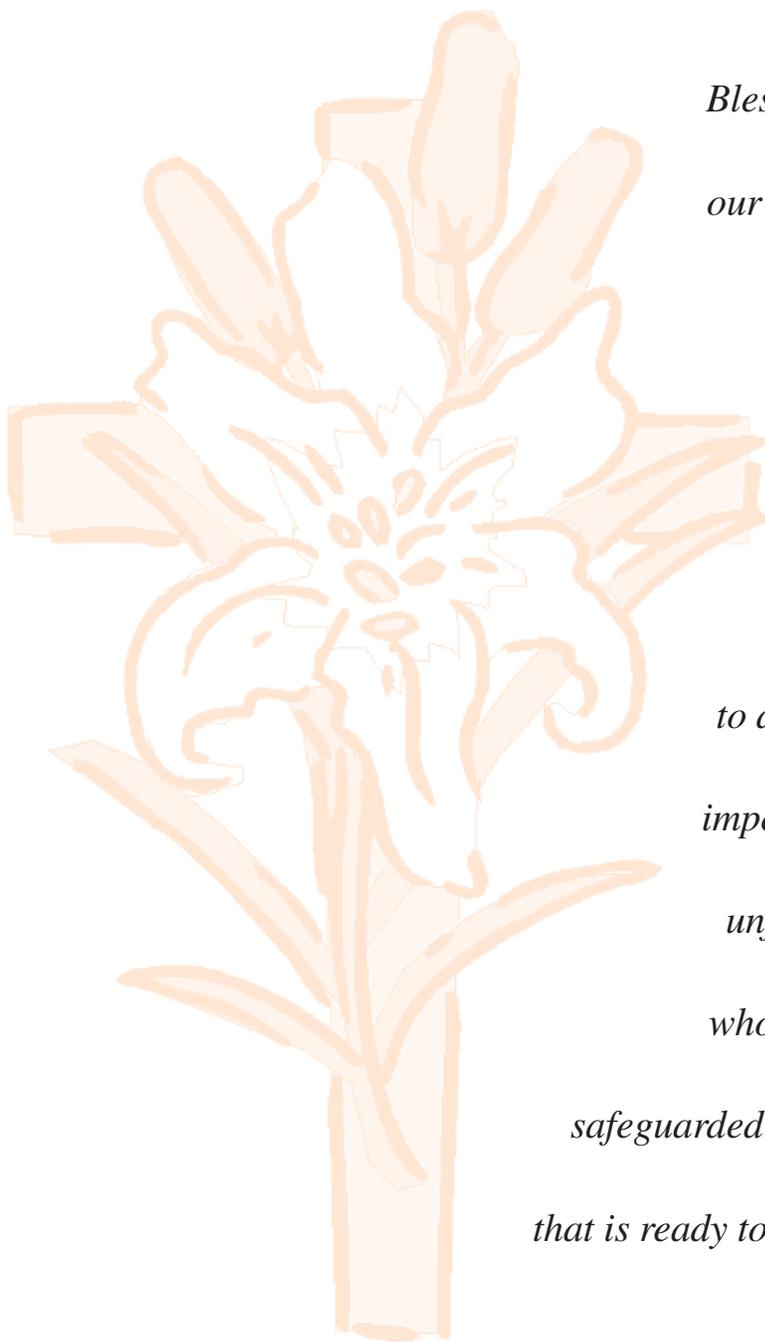
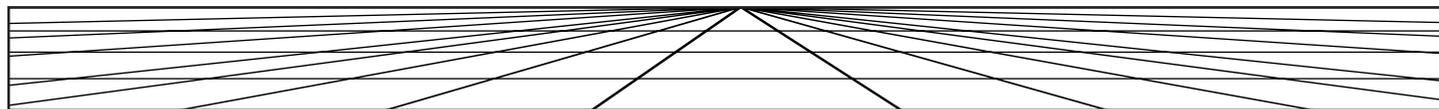


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The National Association  
of Catholic Chaplains

# Vision



*Blessed be the God and Father of  
our Lord Jesus Christ, who in his  
great mercy gave us a new  
birth to a living hope  
through the resurrection of  
Jesus Christ from the dead,  
to an inheritance that is  
imperishable, undefiled, and  
unfading, kept in heaven for you  
who by the power of God are  
safeguarded through faith, to a salvation  
that is ready to be revealed in the final time.*

*1 Peter 1:3-9*



## Comprehensive Spiritual Care for Our Sick and Dying

A National Pastoral Strategy

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*For the most current information on the symposium, go to [www.nacc.org/conference.htm](http://www.nacc.org/conference.htm).*

# Vision

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The National Association of Catholic Chaplains is a professional association for certified chaplains and CPE supervisors who participate in the healing mission of Jesus Christ. We provide standards, certification, education, advocacy, and professional development for our members.

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A section of dialogue

## Specialized Ministry

Dear Colleagues,

I recently spoke with Father Driscoll about my new ministry to my brother, and Father Driscoll suggested that I write about my needs in *Vision*. My orphaned, 50-year-old brother has Down's syndrome, is Hispanic and does not speak English. I just started this ministry because our Lord gave

it to me; there is no one else to see after him. I am a certified chaplain, and I would like to know if there are other chaplains in California, especially in Los Angeles or San Diego, doing this type of ministry. I would like to hear from you if you have a similar ministry.

Blessings to all of you.

**Sister Carmen Figueroa**  
4170-B Mount Alifan Place  
San Diego, California 92111

## Ministering to Family and Friends after a Suicide

*Articles Invited for the August/September 2002 Vision*

Surviving the suicide of a loved one is one of the most difficult challenges one will ever face. The survivors, the ones whom suicide leaves behind, are besieged with intense grief. Pastoral care ministers play a crucial role in helping friends and family to survive and cope at this time of devastating tragedy. For the August / September 2002 issue of *Vision*, we are planning a special section on the topic: Ministering to Family and Friends after a Suicide.

Those of you who have had experience in ministering to suicide survivors are invited to write an article for this special section in order to share with your colleagues the ways in which you have carried out this ministry. Please consider the following to guide your writing:

■ Think of one intervention or program that you judge effective in your ministry to family and friends after a suicide.

■ Explain how that intervention or program got started.

■ Illustrate the effectiveness of the intervention or program through a story and explain what learning this provided for you.

■ Limit your article to 850 words. (This will be about one page in *Vision*.)

If you're looking for examples on how to write or structure such an article, consult the October 2001 issue of *Vision*, the special section on Spiritual Needs in Long-term Care Communities. We will also consider longer articles if your topic lends itself to a more in-depth treatment (see the article on St. Joseph's Manor in the same issue of *Vision*.)

The deadline for these articles is Monday, July 1, 2002. Photographs and artwork where appropriate are appreciated. (You may want to consider sending a head and shoulders photograph of yourself to accompany the article.) Please send articles to me—e-mail: scubar@nacc.org; fax: 414-483-6712; or via regular mail to the national office. Please feel free to contact me with any questions you may have.

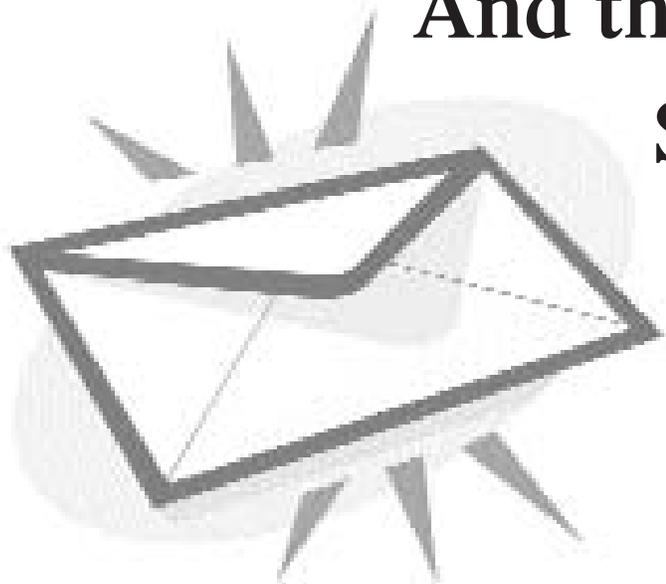
Thank you for considering writing about your experiences for NACC *Vision*.

– Susan Cubar  
Vision Editor

# And the Nominees Are . . .

## Spiritual Care

## Pastoral Care



**Father Joseph J. Driscoll**

**H**eads turned at the sound of the raspy voice of the old man as he began speaking while he glared at me on the dais from his place dead center in the packed auditorium.

You say that the language is changing from pastoral care to spiritual care because it better defines who we are and what we do as chaplains. Well, let me tell you, I was around 30 years ago when we changed from spiritual care to pastoral care for precisely the same reason!

Spiritual care was too confining; it seems to connote religious concerns, but chaplains did more than that. We provided support and comfort to religious and non-religious people alike. Pastoral care came from a tradition that reflected this broad-based professional care at times of healing and opportunities of reconciling.

I remember thanking him for the history of which I had no knowledge. I went on to indicate that I think language needs to be contoured to the time and situation and what might best express the reality as it needs defining now. I noted that I believe this is one of those times for a change in language just as he and his colleagues did some 30 years before.

I then returned to my argument that spiritual care better focuses on the dimension of a person's being that the chaplain's skills are uniquely intended to address. Spiritual care may or may not include religious care. At a time in society where spirituality and spiritual issues are at the fore, it seemed to me that *spiritual* was the word we needed to claim for our profession.

Actually it was not my thinking alone. In the early 1990s, the Catholic Health Association, through Father Joe Kukura and Larry Seidl, had convened a "summit" of pastoral care leaders a few months before the above incident wherein we spent hours arguing the merits of both expressions. It was quite a representative group and the dialogue was lively. We went home from that Chicago meeting pretty much in agreement that—to use a timely metaphor—when our colleagues opened the sealed envelope the declared winner would be . . . spiritual care.

And so a lot of us began writing and speaking about spiritual care, and many of you locally would change the name of your institutional departments from pastoral care to spiritual care.

I am smiling now almost a decade later. Do you know why? I think we should return to *pastoral* care.

During my sabbatical while working on a manuscript for an upcoming book on spirituality and medicine, I was delineating a "menu of spiritual care services" so that others on the health care team could understand exactly what we offer to our patients, residents, parishioners, or clients. When I came to choose a term for "patient visitation," the regular interaction with those to whom we minister (in contrast to more specialized services such as "ethical consultation" or "ministry to staff"), I realized the power of the term pastoral care.

Here's what I wrote.

. . . I would like to distinguish pastoral care provided by the profes-

sional chaplain from spiritual care provided by all members on the health care team. Pastoral care is specific in its history, ecclesiastical or congregational authorization, training, skill sets, licensure, and patient focus. Spiritual care is general in that all have some greater or lesser responsibility for the spiritual dimension of the person's well being and health. Pastoral care is one specific kind of spiritual care.

I also reference the theological tradition out of which the term *pastoral care* has grown. Orlo Strunk, the managing editor of *The Journal of Pastoral Care*, in giving a history of pastoral counseling noted the three-fold dimension of ministry, "poimenics, homiletics and catechetics," corresponded to the caring, preaching, and teaching dimensions of the Christian mission.\* Pastoral care has deep roots in the tradition.

In addition to history and tradition, I have come to realize that if everyone is offering spiritual care, then what defines what the chaplain does that others on the team are neither called nor skilled to perform? For a long time some of us spoke of *professional spiritual care* in contrast to a general concept of spiritual care. My recent experience, however, particularly with the Harvard program, Spirituality and Medicine, is that the nurses, and now even physicians, will strongly claim that they are doing spiritual care, and further, at times, will not even reference the chaplain, never mind his or her unique competence in the field.

On the other hand, none of these professions can or do lay claim to pastoral care. Pastoral care emerges from the religious traditions, historically Christian, but now clearly interfaith in the ranks of the professional bodies.

Pastoral care is also highly symbolic. It is not simply the tending to the spiritual needs of a person. The pastoral care person, the chaplain, represents the religious tradition before he or she ever says a word or offers a gesture of support. The patient, resident or client (or even parishioner who is inactive or alienated), whether religious or not, knows that the provider is not merely a single individual with listening and responding skills, but the provider is also a whole community with traditions and rituals.

Our departments could still remain *spiritual care* departments, for pastoral care is one specific mode of offering spiritual care, albeit at the level of the professional chaplain. We still oversee the spiritual care resources for the institutions in which we serve, that is, volunteers, Eucharistic ministers, and so forth. Certainly all

of this needs ongoing discussion at this time in our history.

So perhaps we need not wait the 30 years for the next change. Perhaps we need to realize that the ongoing challenge is to keep our minds and hearts open and lively in thinking, reflecting, and dialogue.

I indicated above that I smiled as I found change happening in my own thinking, reflecting, and dialogue. Though I don't want to admit it, I think I was a bit smug when I was responding to the old man. I felt quite self-assured. After all I was a participant in this "summit" and we thought we had the answer. I also thought I handled his comment well—unspoken—that was good then, time to move on.

But I didn't realize my own words would boomerang a few years later. The answer then may not be the answer now.

And perhaps the term should remain *spiritual care*, though I am no longer of that opinion.

Living in the optimism of the 1960s of great change and great hope in the Church and in society, many of us struggled with those that refused to change. A shadowy fear in my life has been that one day I could be that resister to change. I have always marveled at older men and women whose hearts and minds are still having visions and dreaming dreams. Men and women whose hands never cling and claw back to a rock-solid golden time, but rather whose hands let the waters of innovation and creativity flow over them and wash them anew.

One of our priests in the association is that kind of person. Now in his late 70s, he has probably been a part of the fight for spiritual care, then pastoral care, then back to spiritual care. But he will read this and probably say, "You know, it is time to change again." Do you know why? He's a man who in his retirement contracted for spiritual direction with a lay woman, something unheard of in his earlier formation and priesthood. His enthusiasm and enjoyment are evident as he shares how rich the gift of insight and inspiration he feels he receives from the perspective of a woman guiding him and his life of prayer.

And perhaps 30 years hence—or even 10—that old man on the dais may be me standing there telling the same story as the next generation puts forth spiritual care with confidence and conviction.

And the envelope, please.

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\*Strunk, O. "A Prolegomenon to a History of Pastoral Counseling" in Wicks, R. et al. *Clinical Handbook of Pastoral Counseling*. Paulist Press, New York, 1985, p. 14. ▼

*If everyone is offering spiritual care, then what defines what the chaplain does that others on the team are neither called nor skilled to perform?*

# Preliminary Responses to the 2002 Readership Survey

Susan Cubar



*Vision editor Susan Cubar at her computer in the NACC Office.*

As I write this, readership surveys continue to arrive. We've had a great response: To date we've received 379 surveys. We mailed 3,560 copies of the January *Vision* to members and *Vision* subscribers, so our response rate is 10 %, which is very good.

Thank you to all who took the time to complete and send back the surveys. Thirty respondents took advantage of filling out the form online.

I have begun sorting and compil-

ing information from the surveys, which I hope will provide valuable information to help us refine the content of *Vision* and the NACC website. As this process will take a while, I'll be sharing with you some of the information from time to time, instead of waiting and publishing it all at a later date.

In this issue of *Vision* I'm sharing information we've collected on Internet usage and the NACC website, as well as answering questions that respondents asked on the survey.

## Internet Usage and Website

We asked five questions about using the Internet and the NACC website. Our purpose was in assessing where our members are in relation to these avenues of communication so that we can make informed decisions about how to best use the Internet to communicate with members.

### Question 6. Do you have access to the Internet?

Of those who answered this question, only 18 % indicated that they did not have access. 82 % indicated they had access either at home or work or both.

### Question 7. If you have access to the Internet, do you use e-mail?

Of those who answered this question, 55 % indicated that they used e-mail frequently (several times a day/week); 29 % indicated they use e-mail sometimes (several times a month); 7 % indicated rare use (once a month) ; and 9 % indicated they have never used e-mail.

### Question 8. If *Vision* were available in its entirety in an electronic format, would it be useful to you?

Of those who answered this question, 35 % marked yes and 65 % marked no.

Please note that we are not considering phasing out the hard copy version that you receive in the mail. We are considering offering more of *Vision* through the website, because people would find it useful.

### Question 9. Do you go to the NACC website ([www.nacc.org](http://www.nacc.org))?

Of those who answered this question, 49 % have not been to the website.

40 % have been to the website a few times.

8 % have been to the website one to two times a month.

3 % have been to the website more than twice a month.

### Question 10. If you go to the NACC website, what are you usually looking for?

The top four answers to this question were

- Conventions/ meetings/ symposium
- Positions available
- Certification information
- Events/ news.

## Q & A

A number of respondents used the survey to ask questions about the website and *Vision*. Their questions and our answers follow.

### **Q** I was surprised to find so much information on the NACC website. How often is it updated?

**A** We're trying to improve the NACC website every month by adding new information and by redesigning parts of it so that our members will find it easier to use. At a minimum, the Positions Available page is updated weekly, and educational opportunities are added to the Event Calendar soon after they are received.

*If you have not yet visited the NACC website, you should make it a priority to do so.* It contains a dynamic wealth of information, and we gladly consider suggestions by members for improving the site.

The following is an outline of the information on the NACC website.

#### Home Page

- Mission, Vision, Values
- Scrolling News Items Box: HIPAA, etc.
- National Outreach in Time of Tragedy

#### About NACC

- Leadership: Board of Directors – photographs, short biographies, e-mail addresses
- Office Staff: photographs, job descriptions, e-mail addresses
- Contact Information: addresses, telephone and fax numbers
- History: a short history of the early NACC

## Membership Information

- Membership Categories: description of categories and dues information
- Change Your Address: submit address, phone, and e-mail changes online
- Membership Directory: access the NACC membership directory – members only

## Certification

- About NACC Certification
- Equivalency Policy
- USCCB-accredited CPE Centers
- Certification Commission Meeting Schedule
- Certification Commission Membership Roster
- NACC Standards
- Newly Certified NACC Members
- Certification Interview Dates
- Request a Certification Application: full members only

**Symposium 2002:** theme, dates, and locations

**Positions Available:** positions are listed for 60 days; updated weekly; information on how to list a position on the site and in *Vision*

## Event Calendar

- Symposium 2002
- NACC Educational Events
- Certification Calendar
- Chaplain Network: Advent, Lenten, and ongoing gatherings
- Other Educational Opportunities: conferences, workshops, seminars, retreats, etc.
- Academic Opportunities: college, university, institute programs; lifetime and long-distance learning

## Community Forum

- Message Forum: post questions/comments, solicit feedback, offer suggestions
- Chat Forum: real-time conversations scheduled by the national office

## Vision

- Issue highlights: of back issues for 2000–2002.
- President & CEO's column: a collection of Father Joe Driscoll's most recent reflections
- Subscription information

## Documents

- NACC standards
- Message of the Holy Father: World Day of the Sick

## Resources

- Links to websites of interest to chaplains; for example, there is a link to the Pastoral Care Week web site in this section.

## Q How can I get current names and addresses of NACC members?

**A** Since October of 2000, NACC members have been able to access the NACC membership directory online through our website. The directory is available only to current members of the Association, who are required to use a password to access this restricted information.

To access the NACC Membership Directory, follow these steps:

- Enter [www.nacc.org](http://www.nacc.org) into your web browser's address/location text box. This will take you to the NACC home page. Click on the Membership button on the membership page.
- Click on the Membership Directory button. On the page that opens, you'll find instructions on how to access and use the directory. Once you have entered the required information, you will then receive a copy of your user name and password by e-mail. Your user name is your NACC six-digit membership number, and your password is something you have chosen.
- Return to the Membership Directory page and click on the View Membership Directory button to enter the online directory. A new window will pop up prompting you to enter your username and password.

To correct or update your own directory listing, use the online address change form. On the Membership page, click on the Change Your Address button, fill out the form, and click on the Submit button. We will use this information to update the directory and your membership records in our database.

In late June of 2001, the national office produced and mailed a membership directory to all members. Additional copies of this directory are available to members for \$5.00 each, to cover postage and handling. Call the national office.

## Q I lost my password to access the membership directory. How do I get another one?

**A** Because passwords are unique to the user and are encrypted, NACC staff cannot look them up. If you've lost or forgotten your password, you'll have to have your previous registration deleted from the site and then you will have to reregister. Use this process:

1. E-mail Robert Kopchinski at the national office ([rkopchinski@nacc.org](mailto:rkopchinski@nacc.org)) explaining that you've lost your password. Include your full name and NACC membership number.
2. Robert will delete your previous registration from the directory site, and will notify you of this via e-mail. He'll also send you the information that you'll need to reregister.
3. Reregister on the NACC directory site.

## Q About how many hits does the NACC get on its website?

**A** We have recently reset our master counters for the website. For the month of February 2002, we had 2,512 hits on the NACC home page; 1,037 hits on the Positions Available portion; 381 hits on the Certification portion; 222 hits on the Membership portion; 235 hits on the Links portion; 113 hits on the *Vision* portion; and 295 hits on the Message Forum.

For those unfamiliar with the Internet, "hit" means accessing of a database or Internet file; it is an instance of a user retrieving an item from a database or contacting a file for example, a home page, through the Internet (from Encarta World English Dictionary).

**Q Are there any plans for creating listservs for NACC members?**

A A listserv is an Internet service for user discussions. Essentially it is a mailing list. It is a way of having a group discussion by e-mail and distributing announcements to a large number of people. This means that the conversation comes to you in your e-mail box. Each time you or any member of the list posts a reply to the conversation, it is distributed to the e-mail box of every member of the list. All of the traffic is automated. This is an excellent way to stay in the know by sharing information.

NACC is hoping to develop several listservs this year. It is our hope that this will foster communication between chaplains in urban and rural areas, and foster communication among chaplains in different health care settings.

**Q Where can I find information about Pastoral Care Week?**

A Pastoral Care Week (PCW) is sponsored by the PCW Committee of the COMISS Network. The NACC provides support to the PCW Committee by helping to maintain the PCW website and handling the annual PCW mailing. To find the most current information about PCW, go to the website: [www.pastoralcareweek.org](http://www.pastoralcareweek.org).

**Q I want information on Pastoral Care Week and Positions Available, but I don't have a computer. How I can access the NACC website?**

A I suggest that you contact your local public library. Many public libraries now have computers with Internet access that are available to the general public, and the librarian can show you how to access the NACC website. Make sure you take our address with you: [www.nacc.org](http://www.nacc.org). Note that because this is a popular service, you might have to sign up for computer time in advance.

**Q When I call advertisers for positions available published in Vision I find that many of the positions are already filled.**

A We offer our advertisers for positions available placement on the NACC website and in *Vision*. What usually happens is that an institution or ad agency submits an ad which they want posted to the NACC website as soon as possible. We tell advertisers that we usually post an ad within seven days of receiving it. The ad remains on the NACC website for 60 days and it also appears in the next available issue of *Vision*. Because we post ads to the NACC website each week (usually on Fridays), the most current ads will be found there. Advertisers rarely call us back and ask us to pull an ad from *Vision* for a position that has been filled.

**Q What are the NACC's current demographics?**

A The following numbers are taken from the February 2002 Monthly NACC Statistical Report, which is generated from information supplied from membership applications and renewals:

**Summary**

Total membership: 3,327  
 Total certified: 2,366  
 Percent certified: 71%

**Membership – Certification Distribution**

Membership Level	Certification Level				
	Supervisor	Assoc. Supervisor	Chaplain	Noncertified	TOTALS
Life	3	0	29	63	45
Full	53	6	1,829	610	2,498
Affiliate	0	0	0	141	141
Emeritus	18	0	369	76	463
Student	0	0	0	117	117
Inactive	20	0	31	3	54
Missionary	1	0	7	1	9
TOTALS	95	6	2,265	961	3,327

Average age: 62

Total *Vision* subscriptions: 144

**Membership – Lay / Religious / Ordained**

Sisters: 1,499 (45 %)

Lay women: 842 (25.3 %)

Priests: 567 (17 %)

Lay men: 227 (6.8 %)

Deacons: 106 (3.2 %)

Brothers: 48 (1.4 %)

Non-Catholics: 38 (1.1 %)

Total: 3,327

**Membership – Institutions & Responsibilities**

**Institution type**

General hospital: 2,013

Other: 352

Long-term care / retirement home: 331

Parish: 290

Hospice: 172

Academic: 73

Mental: 41

Prison/corrections: 35

Rehabilitation: 20

**Institution affiliation**

Catholic: 2,597

Other: 321

Local: 228

State: 84

Protestant: 65

Federal: 28

Jewish: 4

**Chaplains' main responsibility**

Chaplain: 1,877

Director: 437

Retired: 350

Other: 218

Parish ministry: 185

Administration: 121

Educator: 65

Student: 60

Nurse: 14

## Q What is the news from the Cognate Groups?

A The NACC Board of Directors has appointed three representatives to a new task force for the cognate groups. These representatives are **Monica Anderson**, Providence St. Vincent's Medical Center, Portland, Oregon; **Brother Felipe Martinez, fsp**, St. Vincent's Hospital, Los Angeles, California; and **Father Joseph Driscoll**, NACC President and Chief Executive Officer. The vision is that this group will replace the steering committee that provided the leadership direction these past several years.

## Q Are we to be using the term spiritual care instead of pastoral care? Does NACC have a position on this?

A During the last 10 years, leaders in the pastoral care movement have engaged in continuing discussion about whether the term *pastoral care* should be changed to *spiritual care* as a definition for our profession. This discussion has resulted in some institutions changing the title of the department from pastoral care to spiritual care. It appears that the question is still a live one in the movement.

At the end of August 2001, the Pastoral Care Week (PCW) Committee of the COMISS Network surveyed 700 randomly selected people on the PCW mailing list. They posed the question: Should Pastoral Care Week be renamed Spiritual Care Week? They received 416 replies: 212 preferred Spiritual Care Week; 164 preferred Pastoral Care Week; and 40 indicated no preference. The committee decided to give further attention to this proposal and will also explore offering a choice of *pastoral* or *spiritual* in the PCW materials used by each group.

(Father Driscoll reflects on this topic in this issue of *Vision*. See pages 4 and 5.)

## Q How do I submit an article for Vision?

A We welcome articles for consideration at any time.

*Vision* is dedicated to providing information about standards, certification, education, advocacy, and professional development to our members. Our goal is to offer information through articles about current movements in pastoral care, health care, new skills for pastoral care givers, ongoing models for theological reflection as well as examples of best practices in a variety of settings.

Three to four times a year, articles in *Vision* examine a special area of providing pastoral care. In 2001, there were special sections on Spiritual Needs in Long-term Care Communities (October), Sacrament of the Anointing of the Sick (August/ September), and the Role of Pastoral Care in Postmortem Care (June). Topics for the special sections are typically announced in *Vision* at least three months in advance of the publication date.

Short articles on "best practices" are always of interest. These articles typically run about 300 to 500 words, about a half page in *Vision*, and illustrate innovative and effective ways that a chaplain, department, or institution is improving care in the institution. For an example, take a look at the Best Practice article on page 21 of the January 2002 issue entitled, "Pastoral Care Introduced to New Employees at Orientation."

Submissions via e-mail are preferred; send to [scubar@nacc.org](mailto:scubar@nacc.org). Please send as a Word document attachment. Manuscripts submitted by surface mail should be typed double spaced and sent to the Editor at the national office. Short articles typically run 500 to 800 words, which is about one page in *Vision*. Photographs and artwork to accompany articles, where appropriate, are appreciated. Longer articles will be considered as well, depending on the topic and space available. We also invite submissions of original poetry, photography, and artwork, which we publish if and when space and content allow.

If you'd like to write for *Vision*, but haven't done any writing lately or don't know where to begin, please contact me. I'd be happy to give you some guidelines and help you through the process.

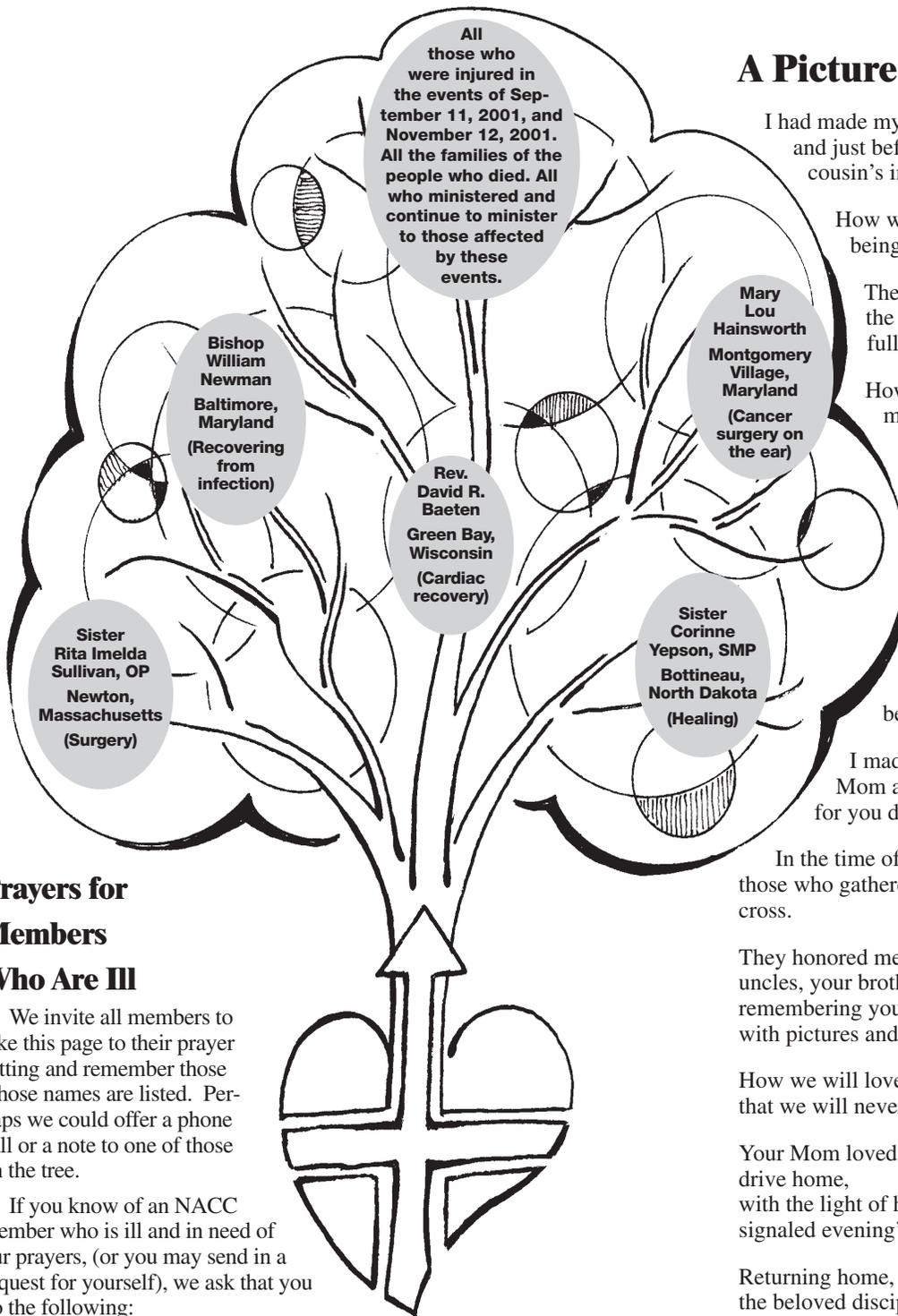
If you like to read, and are willing to write a book review, please contact me. I have a number of books available and I'll provide you with some guidelines. ▼

### Newly Certified Members

Congratulations to the following NACC members who were certified as SUPERVISORS at the Certification Commission meeting held in Milwaukee, Wisconsin, February 28 - March 2, 2002.

Sister Mary Anne Gallagher, OSF  
Rev. Dr. Fidel P. Palisoc, STD

# The Healing Tree



## A Picture of Ryan

I had made my plans to visit already, and just before I arrived you were born, my cousin's infant son.

How we loved you in those first days of being with you!

They honored me, your Mom & Dad, with the gift of holding you quietly and carefully as you slept in the morning light.

How my heart leapt, and I knew for a moment the heart of Mary's cousin, Elizabeth.

I had no great gift to give them or you, but with my camera I captured a sacred image of you and your Mom in soft twilight.

In the moment of mailing your Mom and Dad that picture, I felt like the artist I'd always dreamed of being.

I made plans four years later to join your Mom and Dad with the gift of my sorrow, for you died the day before I left.

In the time of going to be with them, I felt like those who gathered with Mary at the foot of her Son's cross.

They honored me, your Mom & Dad, and aunts and uncles, your brothers and cousins, with the gift of remembering you with tears and laughter, and prayer, with pictures and stories to share.

How we will love you always, knowing in our hearts that we will never be without you!

Your Mom loved me to my car as I began that long drive home, with the light of her heart piercing the darkness that signaled evening's close.

Returning home, I know the sadness and the hope of the beloved disciple I've always dreamed of being.

— Rev. Thomas G. Landry, III

*(Rev. Landry is an NACC-certified chaplain at UMass Memorial, Worcester, Massachusetts. This piece was written for a course in the Program of Studies for the Doctor of Ministry, Andover Newton Theological School.)*

## Prayers for Members Who Are Ill

We invite all members to take this page to their prayer setting and remember those whose names are listed. Perhaps we could offer a phone call or a note to one of those on the tree.

If you know of an NACC member who is ill and in need of our prayers, (or you may send in a request for yourself), we ask that you do the following:

- (1) Ask permission of the person to submit their name and a brief word about their need (cancer, stroke, surgery, etc.)
- (2) Indicate time frame (up to 3 months — and then we ask that you re-submit the person's name).
- (3) Write, FAX or e-mail the *Vision* Editor, at the National Office.

# NCHPEG's Annual Meeting Carries Genetics Issues Forward

Richard M. Leliaert, OSC

As I reported in the April 2001 issue of *Vision*, the NACC is a member of the National Coalition for Health care Professional Education in Genetics (NCHPEG). There are about 110 professional health care organizations that comprise NCHPEG, but the NACC is the only religious or spiritual organization that joined to advocate specifically for the ethical/spiritual aspects of genetics.

Our allies in NCHPEG comprise a network called ELSI, the Ethical-Legal-Social Implications of the Human Genome Project (HGP), a network carefully supported by Dr. Francis Collins, the Director of the HGP. Dr. Collins is very aware of the NACC's presence in NCHPEG, and has commended us for being forward looking in engaging genetics issues as an essential component of the health care of the future. He is not just being polite, since a lot of groups are still in what he calls "denial" of what's coming up ahead.

As chaplains we will play a significant role in helping patients, families, and health care providers respond to gen-ethics issues. At NCHPEG's 5th Annual Conference held in Bethesda, Maryland (January 30–February 1, 2002), a panelist remarked that we will need a significant paradigm shift (haven't we heard that term before?). Genetics simply cannot be set alongside of other aspects of medicine; it simply pervades everything in medicine. We need to absorb this as we prepare for enhanced health care ministry in the years ahead.

A simple glance at the literature and the media tells us just how all-embracing genetics will be—legally, socially, ethically, medically. Even as a lot of the initial hype about cloning and stem cell research and gene therapy, etc., abates, we need to be prepared to engage some emerging issues that will challenge us toward a qualitative extension of our spiritual and ethical outlook.

NCHPEG has developed a set of core competencies in genetics for health care professionals. We in NACC may need to integrate these competencies in a standard or set of standards in the future. (See page 12 for a list of the core competencies. If you have Internet access, go to NCHPEG's website at [www.nchpeg.org](http://www.nchpeg.org) for more information.)



Father Richard Leliaert, OSC, and Dr. Francis Collins of the Human Genome Project.

I attended NCHPEG's 5th Annual Conference as the representative of the NACC, and I'm responding to Father Joe Driscoll's suggestion to share with you some highlights from this interesting and productive meeting. The plenary sessions were well done and alerted me to how important (and difficult) it is to keep updated in a rapidly changing area.

The key session was Dr. Collins' talk entitled "Genetics, Health Care, and NCHPEG: The Future Is Now." Therefore, he said, we need to enumerate specific ways that health care providers (and we can add chaplains) can integrate genetics into practice NOW. So he suggested each discipline develop a "top ten" list, using family practitioners and clinical psychologists as examples. What should be on our NACC "top ten" list for integrating genetics into practice NOW? (For a full view of Dr. Collins' slide show, go to [www.nchpeg.org](http://www.nchpeg.org) and click on the box for viewing the slides. Hopefully it will still be there when this article is published.)

Dr. Wayne Grody, of UCLA's School of Medicine, spoke about "The Science and Technology of Genetic Testing." His forte is the research aspects of genetic testing as a member of the Association for Molecular Pathology. He indicated four current areas of application of molecular diagnosis: infectious diseases; neoplastic diseases; genetic diseases; and identity testing (such as for the victims at Ground Zero or airline disasters, this latter being of interest to

those of you who attended SAIR training programs through the Red Cross).

More specifically this technology impacts specific areas of molecular genetic testing of concern to chaplains: clinical diagnosis or confirmation; carrier screening (important for chaplains in areas of genetic counseling); prenatal diagnosis (with ethical implications for preimplantation genetic analysis); presymptomatic diagnosis/predisposition screening (with a view toward potential gene therapy and its ethical dilemmas).

Developments in technology could make community and individual screenings much easier and cost effective. For example, DNA and/or genetic information can easily be gleaned from buccal epithelial cells obtained by ordinary mouthwash. These screenings could help identify cystic fibrosis, Alzheimer's, HIV/AIDS, and other diseases in mass screening techniques (much like we do mass inoculations like flu shots). I can't say I understood all the technical information, but Dr. Grody advised us of just how much potential, for good or ill, there is already in the technology that exists or is on the verge of realization, for example, far advanced gene chips and electrical analysis. If it's any comfort, he did say that genetic practitioners are not keeping pace with the knowledge. Sound familiar?

Then Ellen Wright Clayton of the Vanderbilt University School of Medicine approached genetic testing from its ethical, social, and legal implications. Though her focus was primary care physicians, her cases and reflections were very applicable to chaplains. Whether chaplains work in a health care setting or not, the ethical impact of genetic testing on individuals both inside and outside the health care system, communities and populations, can be very trying. Dr. Clayton gives an example of a woman diagnosed with a genetic-related disorder, alpha-1-antitrypsin. She was asymptomatic at the time, and was started on an enzyme replacement that currently costs about \$1000 a week for a small adult. Shortly thereafter she was fired by her employer, for insurance and benefit-related reasons. (Note that the rate of Medicare reimbursement for this drug is also under scrutiny.)

There are obvious ethical/social/legal impacts of genetic information on deciding

whether or not to be tested, on confidentiality, and reproductive choice (for example, cases involving screening of cystic fibrosis or Huntington's disease carriers—should I marry? Should I have children?). Dr. Clayton referred to cases wherein genetic diagnoses have implications for family members. What do physicians tell their patient(s) about all these implications? Should physicians go out and try to contact the relatives on their own? Why would physicians want to do this? What would this mean for physicians' relationships with their patients? The potential damage/risk to confidentiality and trust could be quite significant.

Applying this to chaplains, what would be our duty to warn? If we are privy to genetic information from someone, information that could have serious consequences for family members, what do we do? When we consider the implications, say, of the famous Tarasoff case in California in the early 1970s (a psychiatrist did not warn a woman, and her family, that she was in danger of being killed by her boyfriend), the dilemma of our duty to warn could be problematic. Not just the carrier, say, but generations to come could be affected.

Furthermore, what are the ethical implications of this in view of the upcoming HIPAA regulations regarding patient privacy and access to medical information? An article in the October 2001 issue of *Vision* helped to get us thinking about the implications of HIPAA for chaplains. Should genetic information be included in the patient charts? If so, what would we do if our access to this information in the chart(s) raised some thorny ethical questions, or if a pedigree chart raised some troubling information about a patient's parentage?

Although incorporating genetics into our clinical or spiritual care practice does present some new ethical challenges, as one speaker noted, most of the issues are similar to the ones practitioners like ourselves already face in our everyday ministry. However, speaking for myself, I think we need to realize that there is a significant paradigm shift taking place, as we were told at the conference, and that we should not get lulled to sleep by simply thinking that gen-ethics issues are simply current issues writ large. There is a qualitative difference, say, in the ramifications of informed consent; what's at stake is not just an individual's decision, but the impact of

this decision on future generations (the somatic-germline distinction, or, the non-hereditary versus hereditary distinction).

Even granting that all this might shift as we move further into "the era of the gene," as chaplains we can take the lead in forging timely ethical response(s) to genetic issues, especially their impact on confidentiality, informed consent, potential gene therapy, medical treatment decisions, and preimplantation genetic diagnosis for such diseases as Alzheimer's. Would these be specific items in our NACC "top ten" list as I mentioned above?

In the March 2002 issue of *Vision*, I reviewed James C. Peterson's book entitled *Genetic Turning Points: The Ethics of Human Genetic Intervention*, which treats in significant detail how complex these questions can become, and how we might develop an adequate Christian/interfaith response. Such resources as this book would also help us develop our "top ten" list.

(Richard M. Leliaert, OSC, PhD, is Manager of Spiritual Support Services at Oakwood Hospital and Medical Center, Dearborn, Michigan. He is Chair of the Board of Directors of the NACC.)

## NCHPEG Core Competencies in Genetics

(Editor's note: The following information was taken from the NCHPEG website: [www.nchpeg.org](http://www.nchpeg.org) with permission.)

The National Coalition for Health Professional Education in Genetics (NCHPEG) endorsed these core competencies on February 14, 2000. NCHPEG is an interdisciplinary group comprising leaders from approximately 120 diverse health professional organizations, consumer and voluntary groups, government agencies, private industries, managed-care organizations, and genetics professional societies. NCHPEG is a national effort to promote health-professional education and access to information about advances in human genetics, to improve the nation's health.

If you have questions about this document or would like information about NCHPEG, please contact: Joseph D. McInerney, Director, 2360 W. Joppa Road, Suite 320, Lutherville, MD 21093; phone: (410)583-0600; fax: (410)583-0520; [jdmcinerney@nchpeg.org](mailto:jdmcinerney@nchpeg.org).

### Purpose

The impetus for developing the ideal competencies related to genetics was to encourage health care providers to integrate genetics knowledge, skills, and attitudes

into routine health care to provide effective care to individuals and families. The Core Competency and Curriculum Working Group of NCHPEG recommends that all health professionals possess the core competencies in genetics, as identified in this report, to enable them to integrate genetics effectively and responsibly into their current practice.

Competency in these areas represents the minimum knowledge, skills, and attitudes necessary for health professionals from all disciplines (medicine, nursing, allied health, public health, dentistry, psychology, social work, etc.) to provide patient care that involves awareness of genetic issues and concerns.

Each health care professional should at a minimum be able to:

- Appreciate limitations of his or her genetic expertise.
- Understand the social and psychological implications of genetic services.
- Know how and when to make a referral to a genetics professional.

### Background

During the last decade, the evolution of

scientific discoveries from the study of genetics has provided information with potential for tremendous influence on health care. Understanding the role genetics plays in health and disease provides the means to integrate such information into diagnosis, prevention, and treatment of many common diseases and to improve the health of society. Genetic discoveries are already making their way into mainstream health care. Patients are beginning to ask providers about genetic services. Primary-care professionals face economic, institutional, and professional opportunities and challenges in managing persons at risk for inherited conditions.

As outlined by the Institute of Medicine Report on the Future of Public Health (IOM, 1988), public health agencies will have an increasing role in assessing the health needs of populations, working with the private sector in ensuring the quality of genetic tests and services, and evaluating the impact of interventions on medical, behavioral, and psychosocial outcomes. Ultimately, health care providers, regardless of specialty area, role, or practice setting, will face questions about implications of genetics for their patients. The fast pace of genetic advances and the paucity of professional training in genetics leave many

providers without up-to-date answers for their patients.

## Implementation

It is essential that persons and groups responsible for continuing education, curriculum development, licensing, certification, and accreditation bodies for all health care disciplines adopt these recommendations and integrate genetics content into ongoing education. The competencies provide direction for curriculum content that can be used in the design of seminars, workshops, and academic preparation. There is a need for commitment on the part of all educators to incorporate genetic information into all levels of professional education. Enhanced genetics competency will help us to meet the changing demands of the health-care system and promote human benefit as a result of discoveries in genetics and genetic medicine. Although this list may appear challenging, it is important to prepare for the reality of tomorrow and not only for the needs of today.

This document is a work in progress, because it is likely that the knowledge produced by the Human Genome Project and related activities will create an ongoing need to assess and revise expectations. Although the list is extensive, NCHPEG believes that the recommendations provide a useful tool for organizing the teaching of basic genetics in many educational settings and can be modified for a particular discipline.

Those health professionals involved in the direct provision of genetics services may require additional training to achieve an appropriately higher level of competence.

## Recommendations

Note: Throughout this document, the term “clients” includes individuals and their sociological and biological families.

## KNOWLEDGE

All health professionals should understand:

- 1.1 – Basic human genetics terminology.
- 1.2 – The basic patterns of biological inheritance and variation, both within families and within populations.
- 1.3 – How identification of disease-associated genetic variations facilitates development of prevention, diagnosis, and treatment options.
- 1.4 – The importance of family history (minimum three generations) in assessing predisposition to disease.
- 1.5 – The role of genetic factors in maintaining health and preventing disease.
- 1.6 – The difference between clinical diagnosis of disease and identification of genetic

predisposition to disease (genetic variation is not strictly correlated with disease manifestation).

1.7 – The role of behavioral, social, and environmental factors (lifestyle, socioeconomic factors, pollutants, etc.) to modify or influence genetics in the manifestation of disease.

1.8 – The influence of ethnoculture and economics in the prevalence and diagnosis of genetic disease.

1.9 – The influence of ethnicity, culture, related health beliefs, and economics in the clients’ ability to use genetic information and services.

1.10 – The potential physical and/or psychosocial benefits, limitations, and risks of genetic information for individuals, family members, and communities.

1.11 – The range of genetic approaches to treatment of disease (prevention, pharmacogenomics/ prescription of drugs to match individual genetic profiles, gene-based drugs, gene therapy).

1.12 – The resources available to assist clients seeking genetic information or services, including the types of genetics professionals available and their diverse responsibilities.

1.13 – The components of the genetic-counseling process and the indications for referral to genetic specialists.

1.14 – The indications for genetic testing and/or gene-based interventions.

1.15 – The ethical, legal, and social issues related to genetic testing and recording of genetic information (e.g., privacy, the potential for genetic discrimination in health insurance and employment).

1.16 – The history of misuse of human genetic information (eugenics).

1.17 – One’s own professional role in the referral to genetics services, or provision, follow-up, and quality review of genetic services.

## SKILLS

All health professionals should be able to:

- 2.1 – Gather genetic family-history information, including an appropriate multi-generational family history.
- 2.2 – Identify clients who would benefit from genetic services.
- 2.3 – Explain basic concepts of probability and disease susceptibility, and the influence of genetic factors in maintenance of health and development of disease.
- 2.4 – Seek assistance from and refer to appropriate genetics experts and peer support resources.
- 2.5 – Obtain credible, current information about genetics, for self, clients, and colleagues.

2.6 – Use effectively new information technologies to obtain current information about genetics.

2.7 – Educate others about client-focused policy issues.

2.8 – Participate in professional and public education about genetics

*Skills 2.9–2.17 delineate the components of the genetic-counseling process and are not expected of all health care professionals. However, health professionals should be able to facilitate the genetic-counseling process and prepare clients and families for what to expect, communicate relevant information to the genetics team, and follow up with the client after genetics services have been provided. For those health professionals who choose to provide genetic-counseling services to their clients, all components of the process, as delineated in 2.9–2.17 should be performed.*

2.9 – Educate clients about availability of genetic testing and/or treatment for conditions seen frequently in practice.

2.10 – Provide appropriate information about the potential risks, benefits, and limitations of genetic testing.

2.11 – Provide clients with an appropriate informed consent process to facilitate decision making related to genetic testing.

2.12 – Provide, and encourage use of, culturally appropriate, user-friendly materials/media to convey information about genetic concepts.

2.13 – Educate clients about the range of emotional effects they and/or family members may experience as a result of receiving genetic information.

2.14 – Explain potential physical and psychosocial benefits and limitations of gene-based therapeutics for clients.

2.15 – Discuss costs of genetic services, benefits, and potential risks of using health insurance for payment of genetic services, potential risks of discrimination.

2.16 – Safeguard privacy and confidentiality of genetic information of clients to the extent possible.

2.17 – Inform clients of potential limitations to maintaining privacy and confidentiality of genetic information.

## ATTITUDES

All health professionals should:

- 3.1 – Recognize philosophical, theological, cultural, and ethical perspectives influencing use of genetic information and services.
- 3.2 – Appreciate the sensitivity of genetic information and the need for privacy and confidentiality.

(Continued on page 14.)

# Taking Action

## *A message from the Hospice Foundation of America and Last Acts*

**H**ospice Foundation of America (HFA) and Last Acts share with you a commitment to improve the lives of family caregivers and offer the following suggestions for actions that can make a difference for family caregivers and those for whom they care. Whether you are a nurse, physician, social worker, chaplain, or clergy; whether you run a business that employs five people or 500; whether you are an educator or a policy maker, you CAN improve the policies, programs, and practices that affect family caregivers.

Listed below are 10 action steps that you can take on behalf of family caregivers. Some of these steps can be taken today; some may take more time. All these action steps are based on the enormously important idea—inherent in the hospice philosophy—that the patient and family are an essential part of the health care team and must always remain at the center of care.

1. Learn more about the Administration on Aging's **National Family Caregiver Support Program** and how it affects your state and local Area Agencies on Aging. Make sure the caregivers with whom you work are getting the most out of these programs. Go to the Administration on Aging's website at [www.aoa.gov/carenetwork](http://www.aoa.gov/carenetwork).
2. Find out about existing **employee benefits** at your workplace that help family caregivers including sick leave, hospice coverage, bereavement leave, flexible spending accounts, and flexible scheduling. Work with your Human Resources Department to add new benefits or restructure existing ones. Get a copy of the Last Acts' Workplace Tool Kit with ready-to-use policies, benefits, and activities for your employer by contacting Barksdale Ballard and Co. at [lastacts@aol.com](mailto:lastacts@aol.com).
3. **Contact your senators and representatives** and tell them about the valuable work of family caregivers and about their needs. Send a telegram, make a call, or write an e-mail encouraging them to sponsor or support legislation that will improve family caregiving. For contact information go to: <http://clerkweb.house.gov/106/mbrcmtee/members/teledir/members/mcapdir.htm> or call the Congressional switchboard at (202)225-3121.
4. Conduct a **staff training seminar** about the needs of family caregivers and how professionals can help. Contact HFA at (800)854-3402 to purchase books, videotapes, and newsletters about *Caregiving and Loss: Family Needs, Professional Responses*.
5. Organize a **Caregiver Fair** at your workplace, place of worship, or local university to educate family caregivers about the resources in your community. Read about organizing a Caregiver Fair on HFA's website: [www.hospicefoundation.org/caregiving/](http://www.hospicefoundation.org/caregiving/).
6. Join **local and state initiatives** focusing on caregiving and end-of-life care. Find out about Community-State Partnerships through the Midwest Bioethics Center at [www.midbio.org](http://www.midbio.org). Join your local steering committee formed to promote discussion of *On Our Own Terms, Moyers on Dying*. For more information send an e-mail to: [steeringcommittees@bballard.com](mailto:steeringcommittees@bballard.com).
7. Conduct **ongoing assessments** to determine the needs of your patients and family caregivers. Go to [www.hospicefoundation.org/caregiving/](http://www.hospicefoundation.org/caregiving/) to find information about assessment tools.
8. Encourage family caregivers to acknowledge and identify their **strengths and challenges** and to draw upon their own networks to support them. Ask families to create a list of people on whom they can rely for specific support (for example, those who are good listeners, good doers, respite providers).
9. Help family caregivers **identify formal support** groups, respite programs, and bereavement support by contacting groups such as local hospice programs, chapters of health care organizations, and the area agency on aging. Compile a Resource Directory for your community. Find local sponsors to help make it widely available to the families with whom you work.
10. Recognize the ways that **culture can affect access** to care, support, and caregiver's expectations. To find links and resources on diversity and multicultural issues, use the search engine at the Last Acts web site: [www.lastacts.org](http://www.lastacts.org) or the Growthhouse website: [www.growthhouse.org](http://www.growthhouse.org).

And most important . . . take pride in what you are doing for family caregivers!

(This information was provided by: Last Acts, A national coalition to improve care and caring near the end of life, National Program Office, 1620 Eye Street, NW, Suite 202, Washington, DC 20006-4017; (202)296-8071; [www.lastacts.org](http://www.lastacts.org), and Hospice Foundation of America, 2001 S Street, NW, Suite 300, Washington, DC 20009; (800)854-4302; [www.hospicefoundation.org](http://www.hospicefoundation.org). The NACC is a Last Acts partner.)

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### **Core Competencies** (Continued from page 13.)

- 3.3 – Recognize the importance of delivering genetic education and counseling fairly, accurately, and without coercion or personal bias.
- 3.4 – Appreciate the importance of sensitivity

- in tailoring information and services to clients' culture, knowledge, and language level.
- 3.5 – Seek coordination and collaboration with interdisciplinary team of health professionals.
- 3.6 – Speak out on issues that undermine clients' rights to informed decision making and voluntary action.
- 3.7 – Recognize the limitations of their own

- genetics expertise.
- 3.8 – Demonstrate willingness to update genetics knowledge at frequent intervals.
- 3.9 – Recognize when personal values and biases with regard to ethical, social, cultural, religious, and ethnic issues may affect or interfere with care provided to clients.
- 3.10 – Support client-focused policies. ▼

# A Healing Service in a Hospital Setting

Carey Landry

“I would like to pray for my husband who is dying of cancer.” “I would like to pray for my father who is undergoing heart bypass surgery right now.” “I would like to offer a special prayer for reconciliation in my family.” “I would like to pray for our baby who is seriously ill.” “I would like to pray for one of my fellow staff members who is having personal difficulties right now.” These are some of the kinds of prayer requests we receive every Tuesday afternoon, at 12:30, at our weekly healing service in the St. Vincent Hospital chapel.

I have been in the ministry of music since 1967 at the local, national, and international levels. Songs that I have written and recorded, such as “I Will Never Forget You,” “Peace Is Flowing Like a River,” “Hail Mary: Gentle Woman,” “Lay Your Hands,” “Only a Shadow,” to name a few, have been used in the ministry of healing and grief for many years. When I was hired as chaplain at St. Vincent Hospital, Indianapolis, Indiana, in 1995, I came on board as both chaplain and liturgical music minister for the hospital system. I began immediately to look for ways that music could be better integrated into our patient care.

Another chaplain and I began conducting a weekly healing service at St. Vincent Hospital in November of 1995. The service has continued steadily throughout the years. Other chaplains from our pastoral care department assist me in leading the service. It has proved itself to be a valuable service for patients, family members, staff associates, and volunteers.

As the service is taking place in the chapel, it is simultaneously being televised and shown in patient rooms throughout the

hospital and at the satellite facility where I am chaplain, St. Vincent, Carmel, Indiana. We announce the service about half an hour prior to it and attendance is usually between 10 and 25 people. Even if attendance is very low, we conduct the service because it is being televised.

We have found that those who attend appreciate hymns and songs from a variety of sources, with an emphasis on ecumenical hymns. There are times when only instrumental music is used as a gentle background to the meditative setting of the service.

The mood of the service is quiet and reflective. Even though each chaplain who conducts the service is free to choose an order of service, the service usually follows this ritual:

Welcome and Opening Prayer  
Theme Song (usually two verses)  
Scripture or Responsive Reading of a Psalm  
Guided Meditation  
Theme Song (another two verses are sung)  
Prayer Requests  
Anointing (optional) (with music in background)  
Closing Prayer  
Sharing of Peace

Led by the chaplain, the **Guided Meditation** is a reflection on the Scripture or the Psalm. It is not meant to be a “sermon.” It is a guided meditation in which we invite all to center within and reflect on the meaning of the Word of God, which has been read at the service.

The **Prayer Requests** are spoken aloud by those present, with a common response, such as “Lord, hear our prayer.”

The **Anointing** is completely *optional*. The chaplain who began the service with me is a member of the Disciples of Christ. He felt led to do an ecumenical anointing based on the text of James 5:14. This anointing is *not* the Roman Catholic Sacrament of the Sick, and this is made clear to all participants at each service. We clarified that with the Archdiocese when we first began the service and we received permission to continue it as an ecumenical anointing. Care must be taken

to clarify this with your own local diocese before proceeding.

We use scented oil in a simple glass container. We invite those present to come forward. If they wish to be anointed for their own healing, we anoint the forehead. If they wish to be anointed as caregivers for others, we ask them to extend the palms of their hands and we anoint their palms. In either case we offer a prayer for healing or compassionate caregiving over each one as they come forward.

Those who have attended the service have found it very meaningful. It provides them with an opportunity to ritualize their love, care, and concern, as well as their anxiety and grief. Many have never participated in such a quiet, reflective service and they find it to be refreshing and comforting.

Our associates and volunteers come to the service as a source of peace in the midst of an often chaotic day. We have found that having it at lunchtime allows them to have lunch and then attend the service. Many staff members have told me that even though they may not be able to attend the service, the fact that we are having such a service every week is a source of comfort for them.

Preparation of the service on a weekly basis can be demanding. You may want to begin with a monthly service. If responsibility for the service is shared by several chaplains, then it is much easier for each one. I have found that one song used throughout the service as a theme song works very well. It is not necessary, however, to have sung music at the service. Many instrumental recordings are available to help provide a meditative mood.

Because I am a liturgical musician and composer, the service has led me to compose new music for healing services. That music is found on the new recording, *O Healing Light of Christ*, published by Oregon Catholic Press. There is also music on this new recording for memorial services and bereavement groups. Much of the music of *O Healing Light of Christ* is recorded instrumentally on the new *Gentle Sounds 4* compact disc.

May the peace of Christ sustain you in the healing ministry we share.

(NACC-certified chaplain Carey Landry can be contacted at [jclandry@stvincent.org](mailto:jclandry@stvincent.org) if readers have questions about the healing service.)

# The Tragedy of the World Trade Center: *A Perspective and Reflection from the City*

Cesar G. Espineda, SVD

*I have been a beneficiary of New York's warmth and kindness. I have yet to meet a soul who has not stopped and showed me where to go when I needed directions.*

Tuesday, September 11, 2001, 8:48 a.m. is etched in my memory. I was in my study, thumbing through Tolstoy's *War and Peace*, a classic I have been promising myself to read this summer, when I heard that American Airlines Flight 11 from Boston to Los Angeles crashed into the first or north tower of the World Trade Center. At 9:04 a.m., I witnessed live on television the second guided human missile, United Airlines Flight 175 from Boston to Los Angeles, as it hit the second or south tower. In horror, I watched both towers as they burst into flame and collapse into a pile of rubble. I froze. "Oh, my God! How could this happen . . . here?"

What follows are my reflections on being in New York during this time, written during the week following September 11.

The World Trade Center was a familiar landmark for us all. Three years ago, I was at the observation deck and appreciating the panoramic scenery of the City of New York. I recall how peaceful and serene it was from above. In the busy and noisy streets of the city, the open space on top provided a quiet corner from which to view the different vistas of New York's five boroughs: The Bronx, Brooklyn, Manhattan, Queens, and Staten Island.

Just last month, I was on the ground floor of the towers in Borders Bookstore poring over books. Just last month, in a large open arena surrounding the base of the towers, tourists and citizens of the city were enjoying a free concert, a delightful sight in New York during summertime. At the back of the twin towers in another huge open courtyard people of all walks of life were sitting down enjoying their food, coffee, and leisure time. New Yorkers and visitors alike were taking in the views of the State of New Jersey, the Hudson River, a marina, and the imposing presence of Lady Liberty. Not far from the courtyard, Battery Park City's residential apartments have risen in the last few years. Understandably, the view and quality of the neighborhood were factors to live there. On many Saturday mornings, I have enjoyed the fresh air, walks, and runs along the long stretch of parks and benches of the area. It is difficult to imagine that the quiet neighborhood is barricaded and a restricted zone. It is near ground zero.

On September 12, the day after the darkest hour of the city, I walked toward ground zero and noticed that the streets were desolate. The more than 10,000 yellow taxis that ply the traffic of New York were nowhere to be found. This was not the sight that I was accustomed to seeing. In fact, from atop the twin towers, the color yellow was always the most distinguishable feature of the city. The few people that I did see walked with their heads bowed, in silence. Though it was not the time to glance directly at the faces of my fellow city residents, I could not help but notice that they were blank and dazed. I could sense the hurt, the questions, and the confusion. New Yorkers are exuberant people and proud of their city. This day was a rare sight. I was bereft and felt the air of sadness, of sorrow. The atmosphere was disturbing and eerie. To take photos would have been vulgar. The moment begged for absorbing; for pondering; for joining humanity's painful procession of grief. I wept.

The unspeakable tragedy of September 11, 2001, has given New Yorkers a feeling of vulnerability and mortality; a sense of patriotism and the sacred. Outside our church stands the American flag and, next to it, the cross. They are two fitting and significant symbols of the city and the country in these trying times. The tragedy that occurred in the twin towers and its aftermath will be a collective memory; a powerful reference point on how to live one's life and how one's perspective and understanding of the world outside can be comprehended from within. How does one relate with others and not lose sight of God in the face of such evil?

New Yorkers have found a way to do both. There are moving sights mushrooming in the City of New York. Firefighter ladder companies, police precincts, public parks, bus stop sheds, and other available spaces are now altars and walls of prayer and remembrance. Burning candles are in perpetual light. Pictures and descriptions of missing persons as well as words of compassion are posted in every conceivable public arena. Now, walls of missing persons stand side by side with walls of consumers' designer products. The missing faces are noticed with full attention. The walls have become altars of repose. Flags, flowers, toys, letters, and poems venerate these walls of the human race. Inspired songs and prayers of solidarity,

justice, and peace spontaneously emerge from the city's lips.

The peace symbol that was so visible and popularized in the 1960s is back in full view. Souls of different generations are clinging and advocating for the symbol as the appropriate response to the horrific tragedy. The citizens have turned public parks and street corners of New York into holy sites and holy grounds. In Union Square on 14th Street, near New York University, the students from all sections of the city and beyond gather faithfully in candlelight vigil in solemn silence, prayer, and song. They speak different languages as they view the countless missing faces on the available pavements and walls. They continuously guard the flames of the burning candles—all in the name of communion; in heart-rending solidarity with wounded humanity.

In a way, these are the newest places of the sacred; places of pilgrimage. In these assemblies, the people of the secular city have not lost their faith in God. These places have been turned into gatherings of renewal and hope; of belief in God and humanity. Here expressions of varied spirituality are openly expressed. These sites are tangible signs of a wandering people—people who are bewildered, lost, angry, or hurt; people who have not failed to long for a God; people who are seeking an open community to grieve, mourn, and love. Collectively, New Yorkers are capable of such poignant display of human and spiritual emotion. The past days have seen hundreds of New Yorkers, faith-filled and faith-less alike, fill up churches, synagogues, mosques, and other houses of worship to offer prayers, supplications, petitions, and thanksgiving to God.

New York gives the impression of a city full of cold, fast, and arrogant persons; as an unsafe place. I smile now when I recall that friends and parishioners in New Zealand warned me to be careful when they came to know I was permitted to pursue graduate studies at Fordham University. I am privileged to be in the midst of this momentous occasion in the lives of the people of New York. This is my sixth year in the city. I have lived in the South Bronx and Manhattan. I have tried to adapt, understand, and incorporate into my studies the city's culture/s. My research studies have taken me to the other boroughs and their communities.

On several instances, I found myself lost on the streets and subways of New York City and the other boroughs looking for directions. I have been a beneficiary of New York's warmth and kindness. Honestly, I have yet to meet a soul who has not stopped

and showed me where to go. The inhabitants of the city are always in a rush, but when they sense a need they extend a hand. They become good Samaritans. They stop, feel, and connect with humanity.

In March and April, while I was conducting research interviews, three strangers gave me directions to reach Brooklyn by subway. One of them commuted with me. In our conversation, I found out that she was a forensic scientist. She works for John Jay College, an institution that educates and trains men and women who are engaged in law-enforcement activity. When we parted, she wished me "good luck" for my research. On one Friday evening, after my classes at Fordham on board the subway train, a woman was distraught and could not hold her tears. One of the men across the aisle without any hesitation took out his handkerchief, gave it over to her, and said nothing. She thanked him, he acknowledged her, and he got off the next station. That simple gesture somehow eased her pain. I talked to her and left her my name and phone number.

Anyone who lives in or visits New York must be observant and immersed in the city's life and culture/s. Many of the stories surrounding the tragedy may remain untold and kept by the people who own them, much like my own until now. The untold stories of kindness, friendship, and hospitality paint a human face to sometimes what out-of-towners have conjured up as frozen images of New Yorkers. The firefighters, police officers, emergency personnel, and ordinary men and women of all stripes are now at the forefront of the city—risking their lives, trying to rebuild, reaching out, and working hard to get the city back on its feet again. In the cultural and religious diversities and complexities of the city, the residents have learned to live in peace, to be tolerant, and respectful of others' time and space.

On Friday, September 14th, at the candlelight vigil along Second Avenue across from our church on East 47th Street, the young and old gathered in reflective silence in remembrance and spontaneous singing of patriotic and religious songs. One of the mothers in our parish, Janet, whose baby I baptized last year, escaped the horrors of the north tower from the 18th floor. Her cellular phone went dead and she could not reach her husband, Marlon. She managed to get out unharmed. Her body still shook as she shared her story. Peter, who worships in our church, is missing. I have seen him playing with his young son, Benjamin, across the street in the park. On Sunday, September 16th, before the 10:00 a.m. mass, Peter's girlfriend, Naomi, approached me and requested that Peter's

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name and description be announced to the congregation. Somehow the announcement helped her cope but, at the same time, she knew she had to start planning for a memorial mass.

Maria, another parishioner, had an interview on the day of the disaster. She went in early but was told that her scheduled interview was moved to a later time. She decided to visit Episcopal's Trinity Church near the vicinity of the World Trade Center. On her way in, she heard what sounded "like bombs" and felt the streets shake mightily. She rushed inside the church with 20 other persons. They huddled together and trembled in fear. The priest led them into ardent prayer. He got some towels and soaked them in the baptismal font to wet their mouths and rub their faces. Maria thought it was the end of her life.

Being familiar with the Wall Street area, she led three others to the East Side of Manhattan under a dark sky, sprinklers of dust, and scattered debris that enveloped the vicinity. She walked all the way to our church, unmindful of the miles she clocked that fateful day. She thanked God, not on her knees, but lying face downwards. One night, with the assistance of a trained psychologist-parishioner, I managed to facilitate a grief-counseling forum in our parish. Maria was there and she broke down again as she shared her "extreme moment of fear." Many memories are triggered now and then. There seem to be no right buttons, for now, to forget or delete the traumatized memories.

The other day, I was invited to co-lead an interfaith prayer service at the United Nations chapel. The assembly heard ministers from different faith denominations on the theme of mourning, healing, and justice. A representative from the Greek Orthodox archdiocese and Asma Society of New York gave reflections on suffering. The president of the Hindu Temple Society and the vice president of the Rabbinical Assembly of the International Association of Conservative Rabbis comforted the participants by their traditions' prayers on healing. The representatives of Won Buddhism and Roman Catholic faiths uttered the call to peace and justice.

The gathering provided a dignified space for the United Nations employees to deal with grief and express their solidarity with the victims, their families, and friends. Similar prayer services are celebrated in the different houses of worship and sports arena of the city. These days, the funeral services for the bravest and finest men and women are ongoing rituals before New York's eyes. The services are accompanied by the haunting sound of bagpipes and drums. When the flag-draped

caskets are ushered outside, they are saluted by the living mortals and mourned by young widows and children. The road to healing and recovery will be a life-long process.

Dominic and Jean are a young and lovely couple whom I married last year. Dominic worked in one of the twin towers and Jean in the neighborhood. Dominic escaped unharmed, but 70 of his colleagues did not. Jean shares the grief of Dominic. Both are devastated. They are in shock and want to see me today. Norm, a retired firefighter and a parishioner, lost most of his friends in the tragedy. The Engine 8 Ladder 2 Company on East 51st Street between 3rd and Lexington Avenues, the nearest fire station in our neighborhood, lost 10 of its men. The Engine 54 Ladder 4 Company on West 48th Street and 8th Avenue lost 15 of its 16 bravest. I visited both fire stations to offer my condolences and support. I thanked them for their unwavering commitment to their job. The survivors and newly assigned men in the stations, in the midst of their grief and mourning, continue to carry the call of their duty. As ever, they are determined to find their lost comrades and save lives.

On the walls of these fire stations, the photos of lost firefighters are prominently exhibited. The living found time to construct a makeshift memorial where passersby could light their candles and lay flowers to honor the memory, bravery, and heroism of the lost lives. Those who are immortalized in these Ladder Companies were among the first firefighters who responded to the scene of the towering inferno. While people were running out, they were running in—to help every person on the scene. Their mission is articulated in the prayer of an unknown firefighter: "When I am called to duty, God, wherever flames may rage, give me strength to save some life, whatever be its age . . . And if, according to my fate, I am to lose my life, please bless with your protecting hand my children and my wife."

There are hundreds of empty seats in the tables and homes of New York and outside the walls of the city. Humanity once again has added to its list the faces of widows and orphans. They are taken cared of now by their families, friends, and neighbors; embraced by the whole nation. To date, around 63 countries have lost citizens in the evil deeds of the suicide hijackers. Humanity is bleeding. God weeps and suffers. The attack on the World Trade Center was an attack on humanity and God by determined extremists, who for some time must have even lived next to us—as neighbors; they must have even looked like us. The big difference is that they harbored a

distorted image of God and a sense of life and freedom that was misguided and confused.

To understand is to “stand under.” New Yorkers will need some time to understand. The feeling of having been violently intruded upon one’s safe turf is and will not easily escape the human psyche, nor it will be forgotten. For many, the searing images of American Airlines Flight 11 and United Airlines Flight 175 hitting the twin towers, American Airlines Flight 77 hitting the Pentagon, and the crashed United Airlines Flight 93 in Pennsylvania will remain forever. But, right now, New Yorkers are “standing under” with the rest of their fellow citizens. They are standing tall and courageously sending a message that they shall overcome. They will rebuild their lives and their city. The loss of blood of their families, friends, co-workers, and fellow citizens has meant the loss of lives to thousands. Residents and concerned citizens have started to pump blood back into the lifeline of the city. They have lined and waited patiently to enter hospitals and clinics to give blood. Days after the savagery, there was still a line. I joined them and was glad that I could also donate blood. This was the least I could do.

New Yorkers and concerned citizens have not only donated blood, but also queued and waited for days in front of the Javits Center, an international conference center that has been turned into a processing center—this time to volunteer their skills and expertise; their time, energy, and resources. The twin towers have been twisted, pulverized, and demolished. There are hundreds of fallen heroes in the ashes, but there are also countless souls who are standing steadily. The countless souls are the new towers now. They are towers of courage, strength, and faith from civic and church communities that have blossomed in the city.

On the West Side of Grand Central Station on 42nd Street, the thick pillars give strength to the heavy structures of the subway system. There are numerous photos of the missing and dead persons posted on these solid pillars. Grim as the scene may be, the collage of faces appears to shoulder and carry the pillars of the subway. A powerful symbol of the spirits of the missing and dead; beckoning the spirits of the living above the subway to lift the injured and broken of the city. The challenges are great and many, but so are the possibilities.

New York City embraces an array of ethnic and racial mix, new and old-line families, and a broad spectrum of rich and poor. The solid foundation that was laid down by the

old and new immigrants, of the rich and poor, of the world’s humanity go much deeper than the 70-foot foundation of the twin towers. The inhabitants of the city are resolved to rebuild their lives and show the world that New York will come out of the rubble; that they and their city will rise again. Yes the twin towers, one of the city’s cultural landscapes, are now ghost limbs. And recently enterprising business owners and street vendors have multiplied souvenir copies of the standing towers in black and white and colored photographs to cater to the demands of tourists. For the city residents, the photos are icons in the walls of their living memory.

Truly, New York is a vibrant city where every day one has an immense opportunity to learn and encounter the various people, cultures, and religions of the world. John Paul II, during his visit in 1995, called New York the capital of the world. And rightly so. There are about 280 nationalities present in the United States. One does not have to look far to find them. They are right here in the City of New York. In Greenwich Village on the West Side, there are around 400 restaurants, which cater to the discriminating tastes and hungry palates of the residents and visitors.

The imposing statue of New York’s Lady Liberty has been a guiding light and the wide gate of the “tired and huddled masses” to America since the late 1800s. Today Lady Liberty, an emigrant herself from France, continues to stand uninterruptedly in the day-lights and dark nights of the harbor of New York. She is a hopeful figure to behold from near and far, even in the midst of destruction and death in her city’s most inhuman history. Her giant and welcoming stature is an eternal sign and a reminder to New York, America, and the world of the value and cost of freedom and democracy. The events of Tuesday, September 11, 2001, and the succeeding days may have altered the human psyche of New Yorkers and Americans, but not America’s indomitable and resilient spirit. I have no doubt New Yorkers and Americans are willing to sacrifice for the well being of their country. They are also ready to uphold and defend the values of liberty, democracy, and diversity.

*(NACC member Father Cesar G. Espinosa, SVD, ministers at the Church of the Holy Family, 315 East 47th Street, New York, NY 10017. He wrote this reflection and originally shared it with his confreres and friends in Australia, Manila, New Zealand, and Rome. Father Espinosa earned a PhD in church leadership and supervisory at Fordham University in 2001.)*

## BOOK REVIEW

### Catholic Ethicists on HIV/AIDS Prevention

James F. Keenan, SJ, Editor. Continuum, New York, 2000. ISBN: 0-8264-1230-0. Softbound. 332 pages plus index. \$24.95.

Reviewed by Sister Susan Pohl, OSB.

The HIV/AIDS epidemic, girding our planet with its devastating and deadly consequences, is proving to be the greatest pandemic in human history. For those of us seeking to meet the ethical and moral challenges facing all who look to our Catholic tradition for guidance in offering effective prevention measures, this book presents, in a scholarly, yet readable style, a comprehensive overview of the diversity of issues existing in a variety of pastoral contexts throughout the world.

A glance at the table of contents will assure the reader that this book goes well beyond a narrow focus on needle exchange programs and the distribution of condoms. Insightful essays by 35 international Catholic moral theologians highlight the roles played by cultural and social conditions including the inferior status of women, social attitudes, and the structural sin leading to the poverty that provides a breeding ground for these global ills.

The book is well organized, making it an excellent study/discussion text. It is divided into two parts. Part 1 contains 26 cases by Catholic ethicists from around the world. These cases put human faces on the topic of HIV/AIDS prevention, and the reader is drawn into a dialogue with the complexity of the cultural and religious problems in some regions of Africa, South America, India, and other countries. Each case is followed by a thorough analysis of the problems involved as well as a systematic, compassionate, and carefully nuanced application of Catholic moral principles relating to the cases. Part 2 contains seven essays presenting fundamental moral issues for HIV prevention.

Given the variety of Church documents and other publications cited, the reader will find the footnotes, concise in style,

and well placed at the bottom of the page on which the relevant quotations appear. Besides an index listing topics, phrases and persons, there is also an alphabetical list of authors with information regarding their current positions and publications. One weakness, acknowledged by the editor, is the fact that women ethicists and contributors from Europe and Asia could be better represented. (Some selected contributors withdrew for reasons cited by the editor.)

As the introduction states, the purpose of this book is to demonstrate that Catholics *can* be actively involved in HIV/AIDS prevention. "... our two-thousand year old tradition has resources to address the pandemic . . ." One essayist cites the words of Pope John Paul II (*Centesimus Annus*, 1991), calling our tradition as treasure "always living and always vital." The Pope uses the image of the householder in Matthew 13:52 who "brings out of his treasure what is new and what is old"—a creative fidelity approach enriching our tradition as the life of the church and world unfold. In my opinion, this purpose is well achieved and will provide a valuable practical resource for Catholic chaplains, pastors, church leaders, ethics committees, health care workers, social workers, counselors, educators, and all involved in ministry to those living with HIV and AIDS.

*(Susan Pohl, OSB, is a NACC-certified chaplain with 10 years' experience as a hospital chaplain. Currently she is serving as a chaplain in Hospice of the Hills and at Rapid City (South Dakota) Regional Hospital, is a member of the hospital ethics committee, and is involved in ministry to persons with HIV.)*

## EDUCATIONAL OPPORTUNITIES

### Gerontological Pastoral Care Institute (GPCI)

July 15-26, 2002  
St. Paul, Minnesota

The eighth annual Gerontological Pastoral Care Institute will be held July 15-

26, 2002, on the campus of Luther Seminary in St. Paul, Minnesota. The GPCI is jointly sponsored by the Association of Professional Chaplains (APC), the American Association of Homes and Services for the Aging (AAHSA), the National Association of Catholic Chaplains (NACC), and the Center for Aging, Religion and Spirituality (CARS).

The program includes two summer sessions, each one is of two weeks' duration. A supervised clinical experience takes place during the months between the two summer sessions. **Session 1:** July 15-26, 2002; Winter Session: Clinical experience; **Session 2:** July 14-25, 2003. A pre-conference day is planned for July 13, 2002: "All God's Children: Older Adult Ministry in a Pluralistic Society." Information on housing at the St. Paul Benedictine Center will be sent following application. For more information, send an e-mail to cars@luthersem.edu. Or please call: (651)641-3581, Monday-Friday during normal business hours and leave a message. [www.aging-religion-spirituality.com](http://www.aging-religion-spirituality.com).

### Mayo Spiritual Care Research Conference

November 7 & 8, 2002  
Rochester, Minnesota

The Mayo Clinic announces its 2002 Mayo Spiritual Care Research Conference. *The Contributions of Spiritual and Religious Research to the Science and Practice of Medicine* will be held November 7 and 8, 2002, at Mayo Clinic in Rochester, Minnesota. The conference will provide a forum for the sharing of research and practice innovations in spirituality and religion. Paper presentations will focus on completed research and approaches to clinical practice. Featured faculty are Martin E. Marty, PhD, the Fairfax M. Cone Distinguished Service Professor Emeritus at the University of Chicago and Harold G. Koenig, MD, MHS, director and founder of the Center for the Study of Religion / Spirituality in Health at Duke University Medical Center and an associate professor of psychiatry and associate professor of medicine.

For more information, contact Mayo Continuing Nursing Education (800)545-0357; e-mail: [cne@mayo.edu](mailto:cne@mayo.edu).

### Please remember in your prayers:

**Emeritus member Sister Ursuline O'Brien, CCVI**, who died on July 31 in Texarkana, Texas. Since the mid-1990's, she

ministered in pastoral care positions at CHRISTUS St. Michael Health System in Texarkana. Most of her career was spent as a registered nurse and ASCP laboratory supervisor in Texas and Louisiana. She was certified as an NACC chaplain in 1982.

## Positions Available

▼ **Baystate Medical Center, Springfield, MA** – is seeking a ROMAN CATHOLIC PRIEST to serve as staff chaplain. Licensed at 599 beds and a tertiary care referral and Level One Trauma Center, we are the largest health care provider in western New England. To provide both pastoral and sacramental ministry to Catholic patients and families. To collaborate on the pastoral care team with interfaith chaplains and CPE students. On-call responsibilities will be shared with a diocesan priest. Celebrate Mass weekly. Eucharistic ministers (50+) help with daily distribution of communion. As both the flagship hospital in Baystate Health System and the Western Campus of Tufts University School of Medicine, this teaching hospital places keen emphasis on learning and growing. This is a dynamic and appreciative environment for the role of spirituality in the healing process. We are looking for an experienced priest with effective interpersonal skills and a strong commitment to holistic care. Western New England offers natural beauty and distinctly marked seasons with activities unique to each. Artistic, cultural and academic opportunities abound. Qualifications include ordination and a master's degree from an accredited school of theology, four units of CPE, certification through the NACC or APC. A competitive wage and benefit package is offered. Resumes may be sent to: Doris Rodriguez, Recruitment Office, Baystate Health System, 280 Chestnut Street, Springfield, MA 01199. Questions may be directed to Chaplain Mary Lewis Webb, Department of Pastoral Care, (413)794-0112.

▼ **Mayo Clinic Hospital (The), Rochester, MN** (Rochester Methodist Hospital/ Saint Marys Hospital) offers RESIDENT POSITIONS IN CLINICAL PASTORAL EDUCATION beginning September 3, 2002. Residents are offered a broad array of clinical opportunities, which include medical and surgical sub-specialties, diverse intensive care unit ministries, organ transplantation, a children's hospital, a psychiatric hospital, and a regional trauma center. The resident stipend is \$23,000.00 for 12 months, four consecutive quarters of CPE. Mayo Clinic health benefits are available at special rates. For program information or application, write or call: Chaplain Roger Ring, Rochester Methodist Hospital, 201 West Center Street, Rochester, MN 55902; phone: (507)266-7275; fax: (507)266-7882; web site: [http://www.mayo.edu/hrs/hrs\\_programs.htm](http://www.mayo.edu/hrs/hrs_programs.htm); e-mail: [grunklee.mavis@mayo.edu](mailto:grunklee.mavis@mayo.edu).

▼ **Howard Young Health Care, Woodruff, WI** – CATHOLIC CHAPLAIN. A progressive Northwoods health care facility is seeking a chaplain to assure the availability of services to meet the spiritual needs of our patients. Qualifications include: Undergraduate degree or graduate degree in theology, documentation of CPE, certification by NACC, and ability to articulate and support the ethical and religious directives for Catholic health care services. Please send resume to: Human Resources, Howard Young Health Care, 240 Maple Street, Woodruff, WI 54568; (715)356-8036; [swiftr@ministryhealth.org](mailto:swiftr@ministryhealth.org).

▼ **Stamford Health System, Stamford, CT** has a YEAR-LONG RESIDENCY PROGRAM IN CLINICAL PASTORAL EDUCATION beginning August 2002. Chaplain residents will provide patients with continuity of care and follow them through the entire

health care delivery system, which includes acute, long-term, rehabilitative, and home care. The program consists of three units focused primarily on clinical experience. Completion of at least one previous CPE unit is required. Stipend is \$24,000/year plus benefits. Interested individuals should contact: Rev. Dr. William T. Scott, Jr., Director of Pastoral Care, Stamford Health System, P.O. Box 9317, Stamford, CT 06904-9317; phone: (203)325-7584; e-mail: [wscott@stamhosp.chime.org](mailto:wscott@stamhosp.chime.org). EOE M/F/D/V.

▼ **Providence St. Peter Hospital, Olympia, WA** – MUSIC THANATOLOGIST. Currently seeking candidate for full-time position in spiritual care. In partnership with the chaplain, provides music ministry for the needs of the terminally ill and their families. We offer a competitive salary and a comprehensive benefits package. Applicants must have bachelor's degree; master's degree preferred. Graduate of the School of Music Thanatology, Missoula, MT, required. Certification as a music thanatologist preferred. Send resume to: Providence Health System Human Resources, 413 Lilly Rd. NE, Olympia, WA 98506; fax: (360)493-7442; e-mail: [hremployment@providence.org](mailto:hremployment@providence.org). [www.providence.org/swsa](http://www.providence.org/swsa). EOE.

▼ **Mayo Clinic, Rochester, MN** – CHAPLAIN. Ministers to spiritual needs of patients, families and Mayo Clinic employees. Participates in a team ministry with other members of the department. Assists in sacramental ministry as appropriate; provides referral to ordained chaplains for sacramental ministry as needed. Works cooperatively with other members of the Chaplain Services Department in planning and providing a total program of pastoral care. Serves on committees within department, and other hospital committees as needed. Supports and participates in the educational programs of the department. Assists in orienting new personnel to Chaplain Services. Prepares and maintains records for assigned areas. Documents patient care activities in the medical record. Records patient care activity in the department Chaplain Activity Electronic Record. Advanced theological degree from an accredited seminary and a minimum of four units of accredited CPE. Ordination and endorsement for service as a chaplain by appropriate church body. Certification with one or more of the following: APC, NACC, Supervisor of ACPE. Minimum of three years' parish and/or general hospital chaplaincy experience. Chaplain must have skills in the areas of sensitivity to others' physical, psychological, social, and spiritual well being. Must be able to give priority to the needs of the other person. Must have the capacity to build trust through listening, empathy, and appropriate self-disclosure. Must have skills in discerning and clarifying needs, resources and options. Capacity to relate to others of a variety of races, cultures, religions, opinions, and orientations. Must be able to work with and under emotional stress. Must be able to work evening, weekend and on-call coverage. Mayo Clinic offers an excellent salary and benefits package. Please send resume, referencing job posting #01-1096 NACC to Renae Syverson, 200 First St SW, OE 4, Rochester, MN 55905; e-mail: [careers@mayo.edu](mailto:careers@mayo.edu); fax: (507)266-3167; phone: 800-562-7984.

▼ **Affinity Health System, Appleton / Oshkosh, WI** – CHAP-

## Positions Available

LAINS. Affinity Health System, the nation's 18th top Integrated Health Care Network, currently has career opportunities for certified chaplains. Affinity chaplains serve as a liaison to the clergy, community, and medical team in regard to the spiritual care to patients, residents, families, and staff of Affinity Health System. Certification by the NACC or APC is required or pending. Both full- and part-time opportunities available at St. Elizabeth Hospital in Appleton and Mercy Medical Center in Oshkosh. Affinity Health System is a Catholic, mission-oriented regional health care network. For more information, please call 1-800-242-5650, extension 0594; e-mail: [sdemick@affinityhealth.org](mailto:sdemick@affinityhealth.org); or submit resume to: Affinity Health System, Human Resources, P.O. Box 3370, Oshkosh, WI 54903-3370. [www.affinityhealth.org](http://www.affinityhealth.org). An AA/EEO Employer.

▼ **Avera Sacred Heart Hospital, Yankton, SD** – DIRECTOR OF PASTORAL CARE. Avera Sacred Heart Hospital, a not-for-profit, 331-bed Catholic institution, is seeking a director of pastoral care. Qualified candidate will meet the requirements of the Ethical and Religious Directives for Catholic Health Care Services, certified by NACC, have a BA or BS from an accredited college and postgraduate work in CPE, four of which are in a one-year accredited CPE Residency Program. Must have experience as a hospital chaplain, previous experience as a Director of Pastoral Care in a health care setting is preferred. Please send letter of interest and resume to: Avera Sacred Heart Hospital, Human Resources, 501 Summit, Yankton, SD 57078; phone: (605)668-8331; fax: (605)668-8637; e-mail: [jmiller@shhservices.com](mailto:jmiller@shhservices.com).

▼ **Alexian Brothers Behavioral Health Hospital, Hoffman Estates, IL** – An expanding, 94-bed facility in Chicago's northwest suburbs, part of Alexian Brothers Health System, seeks FULL-TIME STAFF OR PRIEST/CHAPLAIN to plan, organize, and implement pastoral care with ecumenical perspective. Through an interdisciplinary team approach, you will assess spiritual needs and offer support to patients, families, and staff of all faiths. Requirements: knowledge of diversity in religious practices; experienced in leading spirituality groups and worship services, coordinating sacramental and liturgical needs, contributing to staff education, and mentoring CPE and clinical students. Qualified candidates will have pastoral care experience in health care setting (acute mental health preferred); master's degree in ministry with background in psychology or counseling; three to four units of CPE; certification (or eligibility) with NACC or APC; and ecclesiastical endorsement. Mail resume with cover letter to Stan Kedzior, Director of Mission Integration, ABBHH, 1650 Moon Lake Blvd., Hoffman Estates, IL 60194; e-mail: [stanley.kedzior@abbhh.net](mailto:stanley.kedzior@abbhh.net).

▼ **St. Joseph of the Pines, Southern Pines, NC** — is seeking a VICE PRESIDENT, MISSION. We provide long-term care, home health care, and hospice care. The position has oversight for Mission, Pastoral Care, and Ethics. Please send resume to Mr. Russell Pait, Human Resources, St. Joseph of the Pines, 590 Central Drive, Southern Pines, NC 28387 or e-mail: [hr@sjp.org](mailto:hr@sjp.org).

▼ **St. Mary's Health Care Services, Inc., Evansville, IN** – SPIRITUAL CARE DIRECTOR. St. Mary's Health Care Services (SMHCS, Inc.) is a 600+ bed health care facility that includes a nursing home. The primary duties of the Spiritual Care Director position include planning, organizing, and directing the activities of the SMHCS, Inc., Spiritual Care Department in close coordination with all other Mission Health Systems, Inc., entities. Also responsible for providing management oversight and direction to assure implementation of spiritual care services through the department staff, assuring effective integration of the Mission Health mission, vision, and values. A successful candidate will possess a master's degree in theology, spirituality, or a related field. He or she would have three to five years' ministry experience within a large health care setting, with

three to five years' experience in the spiritual (pastoral) field being desirable. Previous hospital ethics committee work desired. **Clinical pastoral certification in NACC or APC and four units of CPE required.** Qualified applicants can apply on our website at [www.stmarys.org](http://www.stmarys.org); or fax: (812)485-6735; or mail to St. Mary's at 3700 Washington Avenue, Evansville, IN 47750.

▼ **CHRISTUS St. Elizabeth Hospital, Beaumont, TX** – DIRECTOR OF SPIRITUAL CARE. CHRISTUS St. Elizabeth Hospital seeks a leader who is eager to join an innovative health care organization. At 497 beds, we are the largest hospital between Houston and New Orleans. We are currently recruiting a full-time director of spiritual care who will possess the leadership and management skills necessary to organize the department in accordance with administrative guidelines in order to provide spiritual care to our patients, their families, and staff. Qualified candidates must be practicing Catholics, have a master's degree in theology, spirituality, or related field, be certified by the national Association of Catholic Chaplains or the Association of Professional Chaplains and have five years' spiritual care experience in a hospital setting. We offer an excellent benefits package and competitive salary. To apply, submit resume to: Human Resources Department, St. Elizabeth Hospital, 2830 Calder, Beaumont, TX 77702; fax: (409)899-7697; phone: (409)899-7165. EOE.

▼ **Baptist St. Anthony's Health System (BSA), Amarillo, TX** – is seeking a PRIEST/CHAPLAIN to work day shift with rotating call. Join an ecumenical team of eight chaplains in a 450+ bed, 2,900 employee facility, rated in the top 100 hospitals, that is committed to providing quality health care in Christian love, service, and dignity. Candidate must have four units of accredited CPE completed or in progress. Candidate must be certified or board eligible by the ACPE or NACC with a master's degree from an accredited seminary in theology, pastoral ministry, counseling, or related field. The successful candidate will provide compassionate, skilled pastoral ministry to patients, family, and staff; collaborate with department staff and volunteers to enhance performance; facilitate healing through assessing needs, building trust, and making appropriate interventions; and embrace a spirit of growth in personal spirituality. A minimum of two years' parish and/or general hospital experience is preferred. Stimulating work environment, competitive wages, and excellent benefits. Qualified applicants can contact Human Resources at (806)212-2530; fax resume to (806)212-2853; or mail to 1600 Wallace Blvd., Amarillo, TX 79106. Applications available online at [www.bsahs.org](http://www.bsahs.org). EOE.

▼ **Holy Cross Hospital in Chicago, IL** – is currently seeking a DIRECTOR OF SPIRITUAL CARE. This person will work with leaders, associates, founding congregation, physicians, boards, volunteers, and the community in developing and promoting the understanding and integration of Holy Cross Hospital's mission and values. He/She provides leadership of the Spiritual Care Department and Mission Integration, including strategic planning, the development and implementation of a comprehensive program of pastoral services for patients, their families, and staff. Qualified candidates will have a dedication to meeting the spiritual needs of the hospital community: patients, families, and staff. The ideal candidate will have strong experience in hospital pastoral care, as well as a good background in ethics and bereavement. This person must be compassionate, understanding, and have the ability to work with a diverse group of people from different cultures and religious faiths. This is a wonderful opportunity to work with a dynamic and committed organization that is dedicated to serving the community. If you are interested in learning more, please contact Martha Bermingham, Principal, at Quick Leonard Kieffer, 233 S. Wacker Drive, Suite 6820, Chicago, IL 60606; phone: (312)876-9800; e-mail: [mbermingham@qlisearch.com](mailto:mbermingham@qlisearch.com).

▼ **Greenwich Chaplaincy Services, Greenwich, CT** – CATHOLIC PRIEST CHAPLAIN. Seeking a full-time priest who desires to work in long-term care setting. GCS covers the pastoral care needs of three long-term care facilities and an assisted-living facility in Greenwich, Connecticut, 25 miles from New York City. Primary responsibilities would include regular celebration of Mass at each facility, Sacraments of Reconciliation and Anointing on a regular basis, pastoral care and support of residents, staff, and family and working with a Protestant chaplain in a team ministry. Must be an ordained Roman Catholic Priest with experience in a pastoral care ministry and NACC, APC, or ACPE certification. Send resume to: Lloyd Gravengaard, Greenwich Chaplaincy Services, P.O. Box 1679, Greenwich, CT 06836-1679; phone: (203)618-4236.

▼ **St. Luke's Medical Center, Milwaukee, WI** – NIGHT CHAPLAIN. Provides professional spiritual care services to patients and families on the night shift. Makes referrals of patients in crisis situations. Contacts clergy as requested by patients and families. Provides continuing education workshops to Clinical Pastoral Education residents and interns. Candidates must possess a graduate theological degree from an accredited seminary, and be active and in good standing with their denomination with ecclesiastical endorsement. Must be Board Certified or eligible for certification by the Association of Professional Chaplains, the National Association of Catholic Chaplains, or the Association of Jewish Chaplains. A minimum of four completed units of Clinical Pastoral Education and one year of related hospital experience, especially with emergency department patients, also required. Apply to [ellen.demos@aurora.org](mailto:ellen.demos@aurora.org).

▼ **Mount Sinai Hospital, Chicago, IL** – EMERGENCY DEPARTMENT CHAPLAIN. Mount Sinai Hospital is based on Chicago's west side at the nexus of two of Chicago's neediest and most underserved neighborhoods. A 432-bed teaching, research, and tertiary care facility, it is a Level One Trauma Center. We are seeking an evening emergency department chaplain (3:30 p.m.–midnight) who will work Tuesday through Saturday. The chaplain will provide pastoral care to victims of urban violence and trauma, their families, and the staff of the ED. Bilingual (English/Spanish) or willing to become bilingual. Requirements: MDiv or equivalent, ecclesiastical endorsement, four units of CPE, certified chaplain or eligible for certification by the APC, NACC, or the NAJC. Send your resume with salary history to: SR, Human Resources, Mount Sinai Hospital, California Avenue @ 15th Street, Chicago, IL 60608-1797; fax: (773)257-6290; TDD: (773)542-0040; e-mail: [rays@sinai.org](mailto:rays@sinai.org). EOE. m/f/d/v.

▼ **Presbyterian Healthcare Services, Albuquerque, NM** – has an immediate opening for a board certified chaplain (APC or NACC) to join the pastoral care team as HOSPICE STAFF CHAPLAIN. PHS is the largest not-for-profit, religiously affiliated health care system in New Mexico. The successful applicant will minister to the PHS Hospice patients, families, and staff and will serve as a liaison with area faith communities. In addition, they will mentor and partner with a CPE resident in coordinating pastoral services to Hospice. Qualifications include a master's degree in theology from an accredited theological institution, ordination, or commissioning in a recognized faith group, APC or NACC certification, and three or more years' experience in hospice chaplaincy. PHS is an equal opportunity employer. Interested applicants should mail or fax their resume to Cynthia Webler, Professional Recruiter, Presbyterian Healthcare Services, Human Resources Department, P.O. Box 26666, Albuquerque, NM 87125-6666; (505)923-8745; fax: (505)923-8759.

▼ **Saint Francis Hospital, Resurrection Health Care, Evanston, IL** – is seeking a ROMAN CATHOLIC CPE SUPERVISOR (or Associate) who is certified by the United States Conference

of Catholic Bishops / National Association of Catholic Chaplains or the Association for Clinical Pastoral Education, Inc. This individual will supervise units of Clinical Pastoral Education (CPE) as well as provide direct spiritual care to patients, families, and staff. Supervisory and entrepreneurial skills are essential. This Supervisor must be able to actively and creatively attract and recruit students by outreach to outside communities and seminaries. Salary and benefits are competitive. Position begins as soon as possible. Send inquiry / resume to: Barb Del Moro, St. Francis Hospital, 355 Ridge Ave., Evanston, IL 60202; fax: (847)316-2167; e-mail: [bdelmoro@reshealthcare.org](mailto:bdelmoro@reshealthcare.org).

▼ **St. Vincent Mercy Medical Center, Toledo, OH** – a 500+ bed tertiary care and level I trauma center is seeking an experienced ADMINISTRATIVE DIRECTOR – PASTORAL CARE to be responsible for developing, organizing, and directing department activities pertaining to the provision of pastoral care, guidance, and training patients, families, and hospital staff in accordance with the philosophy, mission statement, and objectives of Mercy Health Partners. Requires professional certification by either the APC or the NACC. Must be ordained or professed in a religious community or possess equivalent theological and pastoral education or experience. Requires demonstrated management experience in health care. Requires a master's degree in ministry or equivalent degree in related fields (e.g., pastoral counseling). Interested candidates, please send resume to: Eileen Lyons, Recruitment Manager, Mercy Health Partners, 2200 Jefferson Avenue, Toledo, Ohio 43624; phone: (419)251-1492; fax: (419)251-7749; e-mail: [Eileen\\_Lyons@mhsnr.org](mailto:Eileen_Lyons@mhsnr.org); web site: [www.mercyweb.org](http://www.mercyweb.org). Equal Opportunity Employer.

▼ **St. Vincent Mercy Medical Center, Toledo, OH** – a 500+ bed tertiary care and level I trauma center is seeking an experienced CHAPLAIN/ROMAN CATHOLIC PRIEST to be a part of a diverse and gifted pastoral care team of professionals to minister to patients, visitors, and hospital staff, in accordance with the philosophy of Mercy Health Partners mission statement and the objectives set forth by the Pastoral Care Department. Requires professional certification by either the APC or the NACC. Requires a master's degree in ministry or equivalent degree in related fields (e.g., pastoral counseling). Interested candidates, please send resume to: Eileen Lyons, Recruitment Manager, Mercy Health Partners, 2200 Jefferson Avenue, Toledo, Ohio 43624; phone: (419)251-1492; fax: (419)251-7749; e-mail: [Eileen\\_Lyons@mhsnr.org](mailto:Eileen_Lyons@mhsnr.org); web site: [www.mercyweb.org](http://www.mercyweb.org). Equal Opportunity Employer.

## Position Wanted

▼ Chaplain position wanted in the Southeast. Full- or part-time. Six years' experience as a part-time volunteer chaplain in a Tennessee state mental institute. One unit of CPE and lay member of NACC. Retired from a Level 1 trauma center as a medical technologist after 27 years. Extensive post graduate work in the field of medical technology and education. Liberal arts education at undergraduate level, includes moral theology, logic, philosophy, and psychology in the Thomistic school. Salary negotiable. Complete CV available on request. References on request. Open to an internship in the right locale. Carolyn Luetgens, 4730 Briarwood Circle, Chattanooga, TN 37416; (423)892-6412; e-mail: [luetgens@att.net](mailto:luetgens@att.net).

**Positions Available are posted weekly on the  
NACC web site: [www.nacc.org](http://www.nacc.org).**

# CALENDAR

# Board of Directors

## ■ May 2002

- 2-4 AAPC Conference  
Snowbird, Utah
  
- 4-5 Certification interviews  
Los Angeles, Milwaukee,  
and Orlando
  
- 13-15 King's College Conference  
on Death & Bereavement  
London, Ontario, Canada
  
- 18-19 Certification interviews  
New York City and  
St. Louis
  
- 27 Memorial Day Holiday  
National Office Closed
  
- 30 NALM Annual Conference  
Chicago, Illinois

## ■ June 2002

- 27-30 Certification Commission  
Meeting  
Milwaukee, Wisconsin

## ■ July 2002

- 1 Materials for fall  
certification interviews  
must be in the NACC office
  
- 4 Independence Day  
National Office Closed

### EPISCOPAL LIAISON

Most Rev. Dale J. Melczek, DD  
Bishop of Gary  
Merrillville, Indiana

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Manager, Spiritual Support Services  
Oakwood Hospital and Medical Center  
Dearborn, Michigan

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Associate Director of CPE  
Catholic Health System of  
Western New York  
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President and Executive Director  
SC Ministry Foundation  
Cincinnati, Ohio

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Director, Master of Arts in Health Care  
Mission Program  
Aquinas Institute of Theology  
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Milwaukee, Wisconsin

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Joan M. Bumpus  
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St. Vincent Hospital & Health Center  
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Lansing, Michigan

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President and Chief Executive Officer  
The HealthCare Chaplaincy, Inc.  
New York, New York

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## PCNSR Update

The e-mail address for Barbara Arnesen, CND, which was published in the March 2002 *Vision*, has been changed to Bar-nesen@cdeb.org.