Vision

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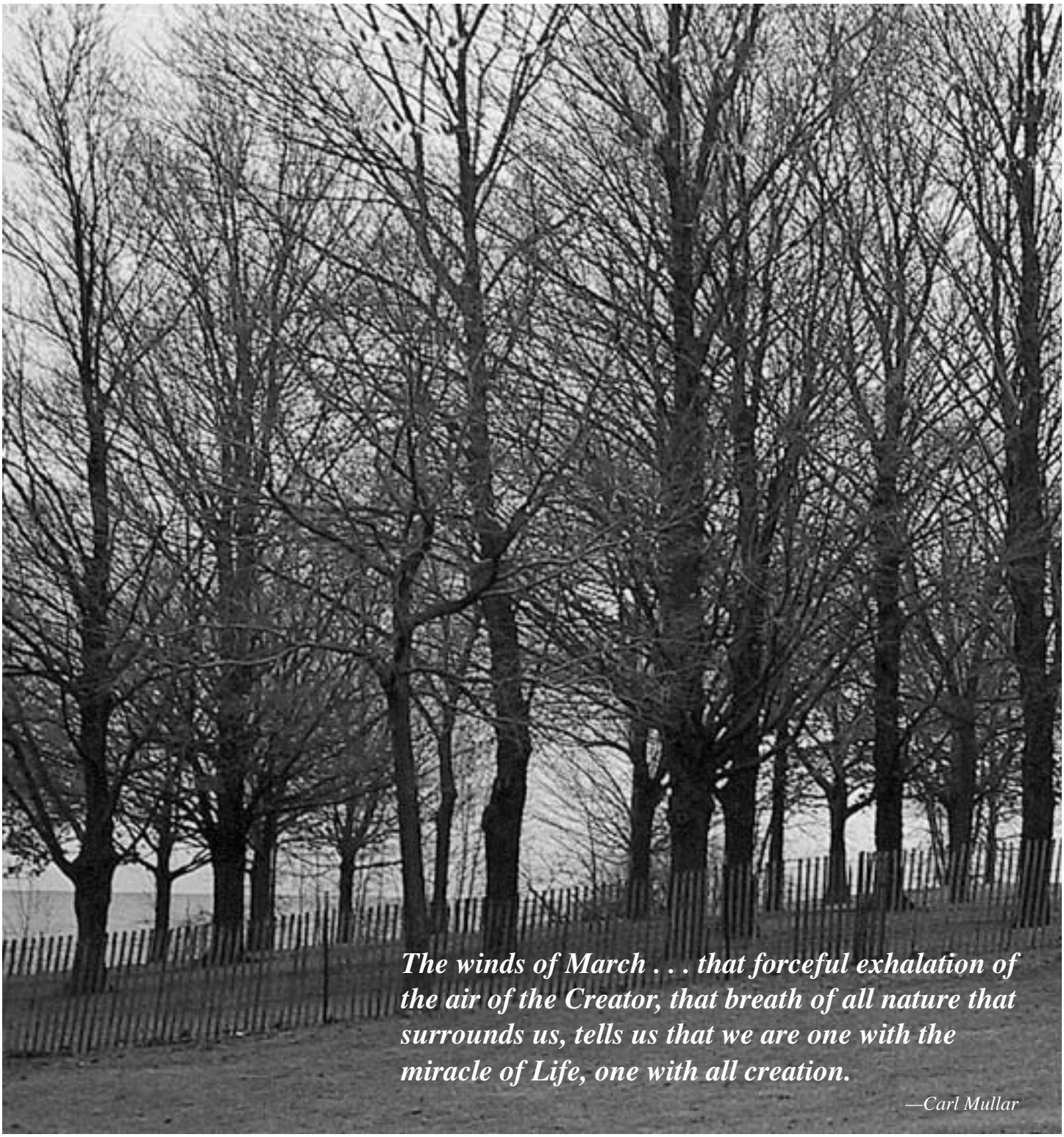
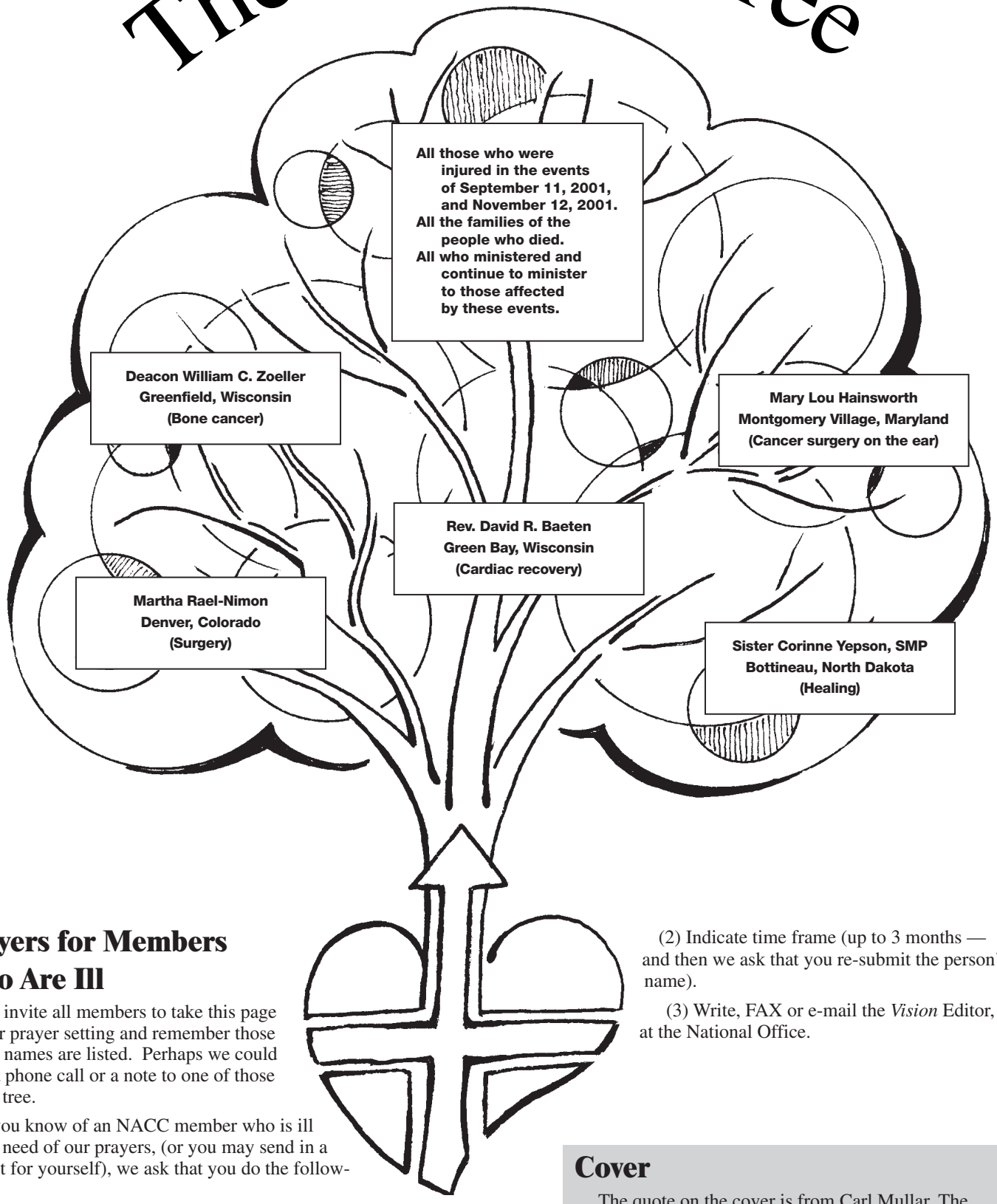
The National Association
of Catholic Chaplains



The winds of March . . . that forceful exhalation of the air of the Creator, that breath of all nature that surrounds us, tells us that we are one with the miracle of Life, one with all creation.

—Carl Mullar

The Healing Tree



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.

Cover

The quote on the cover is from Carl Mullar, The Sunday Times Mirror Magazine, February 1, 1998.

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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Space and Structure: What They Say About Values

In speaking with Father Joe Driscoll recently, I was telling him how impressed I was with both the space given for chaplains to do their work and for the organizational structure present at Providence St. Vincent Medical Center here in Portland, Oregon. I also spoke of my concerns of the national trend I see regarding professional chaplain's space and organizational structure issues. He encouraged me to write for *Vision* addressing these concerns.

For many years, I worked in parish ministry and during that time was given the opportunity to work with a faith community as they went through the year-long process of designing a new worship space. They met with a liturgical consultant and a local architect often as they tried to discern what a "tent" would look like which would best express who they were as a faith community and how this space could serve their worship and community outreach needs. It was a wonderfully creative process and definitely heightened the sense of community and ownership of this new space. Every value and need of this community was taken into account as their "tent" gradually took form.

So what does this have to do with hospital ministry? One of the lessons I learned through this worship space design process with Blessed Sacrament Parish is the importance of both space and structure and what that says about values. In the last few years, I have seen some trends within our Catholic health care facilities that are very troubling to me. They have to do with space and structure issues but speak to me also of values.

Often I hear administrators speak of valuing the role of spiritual care within their organizations and may even have strict standards regarding the certification of their professional spiritual caregivers. And yet they do not provide them with adequate office space where they can have confidential conversations, adequate computers for documentation, etc., nor adequate space in the clinical units and emergency room for meeting with families who are in crisis. Private space is needed for families to have a place to weep, make funeral arrangements, view their loved one's body, and so forth. Not having appropriate space in which to do their work can be frustrating and lead chaplains to feel devalued.

The other concern I have is in regard to reporting structures. There seems to be a trend within our institutions of healing to move the Spiritual Care Director further and further away from the administration team. They have become once or twice removed from sitting at the table where decisions for the organization are made.

In some facilities, the former Spiritual Care Director position has been demoted to a Manager position. This has happened without lessening the qualifications or expectations of this person who will take on the spiritual leadership role within the organization. Often this places a person in a position of reporting to someone who has less education and no understanding of the standards or certification process of a professional chaplain.

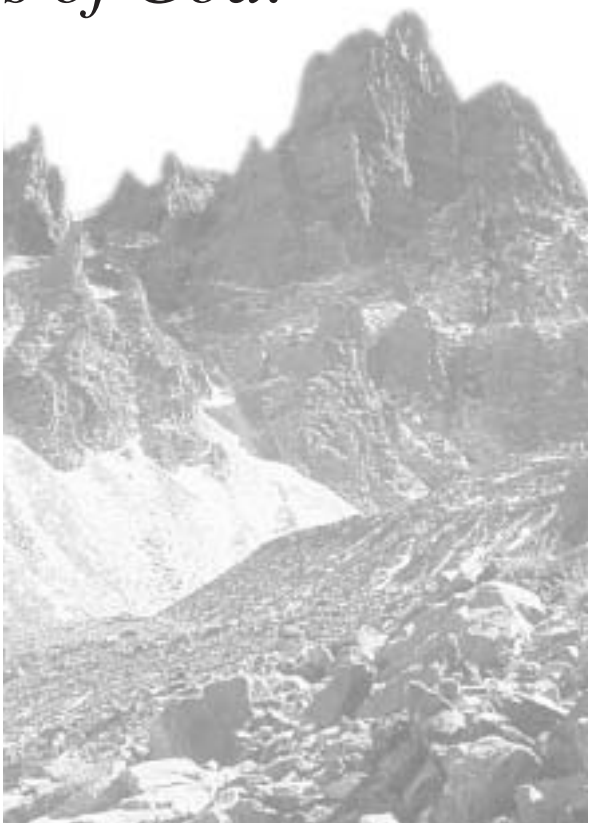
All of this is happening at a time when spirituality in the role of healing and spirituality in the role of employee satisfaction are becoming recognized as essential. Medical professionals are more often reading articles in their journals regarding the important role of healthy spirituality and healing. Organizations are relying on spiritual caregivers to teach them how they can incorporate spirituality into their workplace culture because they realize it is this component that gives employees meaning and satisfaction in their work, motivates them to want to perform their best, and positively impacts retention statistics.

I work at Providence St. Vincent Medical Center in Portland, Oregon. My title is Director of Pastoral Services. I am considered a member of the administrative team and directly report to the administrator of this facility. I participate in all the decision-making discussions to which I add my perspective. We have in our facility a Director of Mission. This person also sits at the administrative table and participates in decision-making discussions. She reports directly to the administrator.

(Continued on page 11.)

The Closeness and Kindness of God: A Theological Reflection

Father Joseph J. Driscoll
NACC President and Chief Executive Officer



Denver, Colorado, has a spectacular view of God. And God, a spectacular view of Denver.

And when we are in the arms of those majestic mountains, inhabitants and strangers both, God, a spectacular view of us.

I look to the psalmist who looks to the mountains and asks, "From whence shall come my help?" And while inhaling the air at so high an altitude, the answer comes as naturally as the next breath: "My help is from the Lord, the Maker of heaven and earth."

The truth is our God lies hidden behind the highest range of sheer mystery in creation far and wide. And at the same time, the truth is that our God, in the light of faith, is seen over and over in the rising and setting of a constant love peeking through scriptures old and sacred, with a tender and touching look into lives ever new and precious.

A God towering so high above us that the wind and storm blow and frighten our sensibility as we look up to a language that can somehow hold on to our shaking faith. And at the same time, a God standing so near right in front of us that flesh and bone draw close and cling in a feeling that can somehow relax in a secure faith.

So to call God kind, at first, seems a long fall from the majesty of grace. Kind seems so simple. Too simple. The Nobel committee does not give an award for kindness. The ritual for entering "the ranks of educated men and women" does not include an honor of magna cum "kind." Men and women will not be compensated six-figure salaries and bonuses for kindness.

But stop and think about it. If someone was standing in the funeral home summing up your life before your most human remains, what would it mean to have him or her say that you were a kind person? Is there anything more worthy than kindness?

My reflection on kindness came down the mountain and into the city of Denver in a much too simple act late on a Saturday evening breaking into a Sunday morning.

My reflection on kindness came down the mountain and into the city of Denver in a much too simple act late on a Saturday evening breaking into a Sunday morning. The night was cold and crisp and clear, and so I decided to stroll the long 16th Avenue outside mall enjoying the solitude and quiet of an abandoned earlier bustle of shoppers and tourists. No sound but the echo of my own footsteps. The town was all mine.

Then I noticed the figure of a tall man partially hidden behind the pole of the public telephone that he was apparently using. He was young, nicely dressed with a long coat and a full head of dark curly hair. I noticed him in passing and continued glancing up at the old buildings, and even higher up at the brightly lit stars in the sky. Just as I was approaching him on the sidewalk, he hung up the phone and started walking. His footsteps were now joining the echo of mine.

Then he stopped. Having just passed him, I instinctively turned around to see him stopped and standing seemingly dazed. I knew something was wrong. I hesitated, then walked back toward him and asked, "Is something wrong?"

He looked up at me with eyes near tears and said, "Yes."

"Is there something I can do?"

"No," he said, and then forcing a smile continued, "but thank you."

I think I said something about hoping things would be okay and then continued on.

I was about a block and half away and I had looked back several times and he was still standing there. With a rush of adrenaline, or perhaps it was grace, I turned around thinking, "I can't just leave him there." He was obviously hurting, and I thought, badly.

As I turned around, so did he, and as I closed the distance between us, a thought, no, a conviction, crossed my mind: this is the right thing. He watched me as I walked toward him. "Would it help to talk?" I asked. He smiled again, shrugging

his shoulders. "Would you like to go for a cup of coffee?" I continued. "That's the problem," he said, "nothing is open." I hesitated, obviously assessing my safety needs. "I have a coffee machine in my room at the Hyatt if you want to go there." He hesitated, probably doing the same assessment. "Okay, I will go, but I might change my mind." "That's fine," I said.

We walked in the cold night and he began his story. He and his wife had a fight and she stormed out of the nightclub many hours earlier and he had been calling home repeatedly, but there was no answer. He was frightened, sad, and bewildered since she had never done this before. He talked about some problems in their one-year marriage.

By now we reached the hotel. He decided to have a cup of coffee, use my phone to call home again, and figure out what he should do. We talked for some time. Finishing his second cup of coffee and getting ready to leave, he looked up at me and said, "When I turned around and saw you coming back, I couldn't believe how kind a person you were. Thank you so much." I smiled. "Oh," he went on, "look what time it is and I have kept you up this long."

Earlier he talked about his faith—he was a Buddhist, though he didn't need to tell me that he was raised a Catholic with a name like Ryan. As he left I told him I would pray for him and for his wife. He looked up and in an endearing, somewhat awkward return he said, "And I will keep you in my meditation."

I smiled as I dozed off with a dawning insight that perhaps the only reason I was to be in Denver this cold first weekend in February was to be kind to Ryan. Oh, I had lots of important meetings, accomplished some important tasks in my work for the association, but none of these will probably be recorded in the book of the living, save the cup of water, or in this case the cup of coffee, I gave to the least of the little ones.

I am not a particularly kind person. I would like to be. But in truth, when whoever remains in conversation standing before my most human remains speaks of me it will not be that he was a kind person. I say this with no false humility, but that attribute is reserved I think for God and for a few saintly ones.

My majestic experience of kindness in Denver is a good one. Hopefully, we all come down occasionally from our own mountains of self-importance and do a random act of kindness, because when we do, I believe, we are doing a random act of God.

Praying the next day on my drive to the airport while watching the snow-capped mountains recede further and further in the background, this notion of kindness nagged my consciousness with something that someone wrote or told me about the kindness of God. I thought, "I think it was a bishop." Now I talk to a lot of bishops in my work but not usually about kindness, God's or ours. I wish we talked about kindness. I think we talk kindly. The brain computer search drive was on.

And then hours later it struck me! In my monthly mailing from the Archdiocese of Boston, the recently ordained auxiliary bishop, Walter Edyvean, had written something about the kindness of God in taking his turn in writing a "monthly spiritual reflection." I called and had his secretary FAX a copy to me.

In reflecting upon this past Advent and Christmas season, he offer the insight that "the Catholic vision is marked by this conviction, in faith, that God is close and kind." Bishop Edyvean quoted from the office of readings wherein a Gentile convert is trying to persuade his friend to move toward Christianity. He quotes the "Letter to Diognetus" (Office of Readings for December 18) wherein he says that "God, the Lord and maker of all things . . . has always been, is, and will be: kind, good, free from anger, truthful."

In Walter's own words, "God's closeness and kindness are what human beings desire. Should we think that the modern world, however unspecified its quest, is looking for less? Or that we ourselves desire less?"

Closeness and kindness from God. Yes, that's my quest. That's my desire.

Closeness and kindness of God. How does this come about? I think God's closeness and kindness come in close and kind acts incarnated day and evening, yes even late into the evening and early into the day. Whose close and kind act—mine, or Ryan's? Who felt the warm breath of God on his ear in the whisper of prayer riding away from the spectacular view of our God in Denver?

Who among you feels the warm breath of God in a close and kind act with a patient, a parishioner, a client, a family member, one of the staff, a neighbor, or a stranger?

I hope Ryan and his wife are okay. I hope they will be okay. I hope that kindness will beget kindness just as grace begets grace. I hope that I may do more random acts of kindness since in doing so I get a spectacular view of God.

I smile when I think of the "monthly spiritual reflection" meeting my "living human document" this past weekend in the conversation called prayer. Such an encounter reminds me of a crusty old man coming in for a Mass card over 20 years ago sharing a bit of wisdom that stuck in the mind of this zealous newly ordained priest. "Father," he said. "I am here at Mass every Sunday. No offense, but I don't get much out of the priests' sermons [he must keep missing my Mass]. But if I hear one word, or get one thought that touches my soul one out of those 52 Sundays then its worth sitting through the other 51!"

So, in a second act of kindness in one week, I appreciate this one monthly reflection that touched my soul out of the I don't know how many monthly reflections that I sit through. [For any *Vision* readers from Boston who have written a "monthly spiritual reflection," I must have missed yours.]

This one reflection framed my picture of a spectacular view of God one night below the majestic mountains surrounding Denver. ▼

Who among you feels the warm breath of God in a close and kind act with a patient, a parishioner, a client, a family member, one of the staff, a neighbor, or a stranger?

A Decade of POLST in Oregon

The **P**hysician **O**rder for **L**ife **S**ustaining **T**reatment Program

(Editor's note: The following information is excerpted with permission from a brochure prepared by the Center for Ethics in Health Care, Oregon Health & Science University, Portland, Oregon. For more information about POLST, see the web site: www.ohsu.edu/ethics.htm.)

An elderly woman with pneumonia is rushed from a nursing facility to the hospital in the middle of the night. The distraught family arrives the next morning, horrified to find their mother on a ventilator in the intensive care unit. In an advance directive, the patient had explicitly stated that she did not want aggressive, life-sustaining treatment of any kind. Unfortunately, no one knew anything about her advance directive and a written, signed Do Not Resuscitate (DNR) order did not accompany the patient.

Sadly, less than a decade ago, stories like this one were all too common. It was difficult for health care providers to ensure that patients' wishes for care were honored when patients were unable to speak for themselves. Advance planning documents were often not useful in emergency situations and many patients received more aggressive care than they wanted because universal, transferable physician orders about life-sustaining treatment did not exist. Health care organizations used forms unique to their setting that could not be honored in other settings. Advance directives, while helpful, were not physician orders and, therefore, could not be followed by emergency medical technicians (EMTs).

The Physicians Order for Life Sustaining Treatments (POLST) Task Force formed in the fall of 1991 with the goal of providing improved care for patients at their greatest time of need—those facing the end of their lives. Physicians, nurses, nursing home representatives, and ethicists from across the state [of Oregon] converged to find a way to ensure that patients' life-sustaining treatment wishes were honored, even in cases when patients were unable to speak for themselves.

After extensive testing, the task force launched the first version of the POLST form—an immediately recognizable, two-sided pink form, which details a patient's life-sustaining health care wishes and is signed by his or her physician. The POLST form was created to ensure that patients' wishes for care are honored in the event that they are unable to speak for themselves. For patients who are unable to make medical decisions, surrogate decision-makers may communicate treatment preferences so that the physician can complete the form.

The POLST form was initially tested primarily in nursing facilities. It has evolved based on feedback from health care providers across [Oregon] and from research studies. The current version clearly spells out directions for resuscitation, medical interventions, antibiotics, and artificial feeding. Although use of the POLST is optional, it has been widely accepted throughout Oregon.

The POLST form is designed for individuals with serious or life-threatening illnesses. The following examples based on real-life experiences demonstrate the important role of the POLST form.

Ida is an 86-year-old nursing facility resident with severe dementia who does poorly in new environments. The physician completes the POLST after consulting Ida's daughter about her mother's wishes. Ida never wanted to be dependent on others for care and did not want aggressive, life-sustaining treatment. Accordingly, the POLST indicates that Ida is DNR, should receive comfort measures only, and should not be transferred to the hospital unless the nursing home is unable to provide for her comfort. When Ida falls and breaks a hip, she is transferred to the hospital to have the hip pinned. Her POLST form accompanies her when she goes to the hospital and also when she returns to the nursing home. In accordance with the POLST form, antibiotics are not administered when pneumonia develops, and Ida dies peacefully in her sleep at the facility.

Howard is a 73-year-old with a total knee replacement who is admitted to a nursing facility for rehabilitation. His physician signs the POLST on admission, indicating his wish to be resuscitated, receive full treatment, antibiotics, and tube feeding if necessary. When he develops a pulmonary embolism, he is immediately transferred to the hospital and given aggressive care to stabilize his condition.

Taylor, a 10-year-old with Ewings Sarcoma, has failed several rounds of chemotherapy and has developed lung metastases. Her oncologist has recommended that it is not in her best interest to attempt resuscitation and her parents agree, but want her to otherwise receive full treatment so that she will be with them as long as possible. When she develops a pain crisis at home, EMTs are called and Taylor is transferred to the regional hospital for intervention. Once her pain is controlled, she returns home with hospice care and, several months later, dies at home with her family at her side.

As these examples illustrate, the POLST program makes it possible for patient wishes for care to be honored. The POLST form:

- ***Promotes*** patient autonomy by documenting and coordinating a person's treatment preferences through physician orders;
- ***Enhances*** the authorized transfer of patient records between facilities;
- ***Clarifies*** treatment intentions and minimizes confusion regarding a person's treatment preferences;
- ***Reduces*** repetitive activities in complying with the Patient Self Determination Act;
- ***Facilitates*** appropriate treatment by emergency medical services personnel; and
- ***Allows*** parents of minor children, or guardians of minors or protected persons, to express wishes and intentions for treatment.

POLST: Leading the way for improved end-of-life care

Initially, POLST was available [in Oregon] on a limited basis. The form was implemented in 1995 by selected long-term care facilities in the Portland area, in Bend, and in the coastal community of Coos Bay. Since that time the POLST program's popularity has spread across the state, reaching patients and their families

in both rural and urban areas. Currently the form has been ordered by providers in almost every community with more than 5,000 residents statewide, and its use continues to expand.

The success of the POLST has caught the attention of health care organizations across the country. Requests for informational POLST packets have been made by individuals in 40 different states and abroad. In Wisconsin, The Gunderson Lutheran Medical Foundation has developed a POLST form that closely models Oregon's form. The form is currently being distributed in a four-county area in western Wisconsin. The states of West Virginia and New Mexico have also looked to Oregon for its end-of-life care leadership in developing forms for use in their own states.

POLST development and research

The POLST form was developed by a multidisciplinary group of health care professionals using data gathered from health care providers representing medicine, emergency services and long-term care who participated in focus groups throughout Oregon.[1] After pilot testing and the initial implementation, research was conducted at eight nursing homes across the state to examine the effectiveness of the POLST form. Of 180 nursing home residents who requested comfort measures only, transfer to hospital only if comfort measures fail, and do not resuscitate, two percent were hospitalized to extend their lives, but none were resuscitated against their wishes.[2]

In a more recent study of 58 older adults enrolled in an all-inclusive care program, the medical treatments administered matched the POLST instructions for CPR, antibiotics, IV fluids, and feeding tubes more consistently than previously reported for advance directive forms.[3] The available data suggest that the POLST form is more effective than other methods in honoring patient care preferences. Ongoing research is planned to assess and monitor the efficacy of the POLST form, and revisions will continue to be made when their usefulness is documented.

When a person is at home, the POLST form should be placed in a red envelope on the refrigerator so that it can be easily located by emergency workers.

Frequently asked questions

■ Who should have the original POLST form?

The original POLST form should be with the patient at all times. If the patient lives at home, the POLST should be in a red envelope on the refrigerator. Family members and caregivers should know where the form is located. In a nursing facility setting, the POLST should be kept at the front of the resident's medical chart.**(See the sample POLST form on pages 8 and 9.)**

■ Why doesn't the POLST form require a patient signature?

The POLST is a physician order form about life-sustaining treatments. It is not an advance directive, which does require a patient's signature. The POLST form specifies the wishes of the patient/resident or surrogate decision-maker (for those unable to make medical decisions). An individual can have both an advance directive and a POLST form. The POLST form turns the wishes expressed on the advance directive into action and provides orders in a format respected by EMS workers.

■ What if a patient has an advance directive?

If a patient is no longer able to make his/her own medical decisions, an advance directive may provide information about a designated surrogate decision-maker. This surrogate must be consulted about the patient's treatment preferences when a POLST form is being completed. This surrogate has the same legal authority to make medical decisions as the patient, even if the patient has other family members or friends who disagree with the decisions. Additionally, an advance directive may provide information about patient preferences that could be helpful in completing the POLST.

■ Can the POLST be used to guide daily care decisions?

Yes. For example, the POLST is frequently used to guide decisions regarding transferring patients/residents with advanced dementia and pneumonia (see Sections B and C on the form). It is also used to make decisions about the placement of a feeding tube (see Section D). The POLST is not just for patients in cardiac arrest.

■ Does the physician or nurse practitioner need to fill out the POLST form?

No. Nursing or social work staff can fill out the POLST form with patient/residents or surrogates. To activate the form, the physician/ nurse practitioner must review and sign it.

■ Can the form be filled out without a conversation with the patient or surrogate?

No. The POLST form cannot be filled out or changed unless there is a conversation with either the patient or the surrogate decision-maker (for those unable to make their own medical decisions). Section C documents with whom the orders were discussed (for example, patient/resident, spouse, health care representative).

Notes:

1 Dunn, P.M. et al. (1996). A method to communicate patient preferences about medically indicated life-sustaining treatment in the out-of-hospital setting. *Journal of the American Geriatrics Society,* 44, 785-791.

2 Tolle, S.W. et al. A prospective study of the efficacy of the (1998) Physician Order Form for Life-Sustaining Treatment. *Journal of the American Geriatrics Society,* 46, 1097-1102.

3 Lee, M.A. et al. Physician orders for life-sustaining treatment (POLST): outcomes in a PACE program. Program of All-Inclusive Care for the Elderly. (2000). *Journal of the American Geriatrics Society*, 48, 1219-1225.

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

Physician Orders
for Life-Sustaining Treatment (POLST)

This is a Physician Order Sheet. It is based on patient/resident medical condition and wishes. It summarizes any Advance Directive. Any section not completed indicates full treatment for that section. When the need occurs, first follow these orders, then contact physician.

Last Name of Patient/Resident	
First Name/Middle Initial of Patient/Resident	
Patient/Resident Date of Birth	

Section A *Check One Box Only*

RESUSCITATION. Patient/resident has no pulse and is not breathing.

☐ Resuscitate ☐ Do Not Resuscitate (DNR)

When not in cardiopulmonary arrest, follow orders in Sections B, C and D.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS. Patient/resident has pulse and/or is breathing.

☐ **Comfort Measures Only.** The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. The patient/resident is not to be hospitalized unless comfort measures fail.

☐ **Limited Additional Interventions.** Includes care above. May include cardiac monitor and oral/IV medications. Transfer to hospital if indicated, but no endotracheal intubation or long term life support measures. Usually no intensive care.

☐ **Full Treatment.** Includes care above plus endotracheal intubation and cardioversion.

Other Instructions: _____

Section C *Check One Box Only*

ANTIBIOTICS. Comfort measures are always provided.

☐ **No antibiotics**
☐ **Antibiotics**

Other Instructions: _____

Section D *Check One Box Only*

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION. Comfort measures are always provided.

☐ **No feeding tube/IV fluids**
☐ **Defined trial period of feeding tube/IV fluids**
☐ **Long term feeding tube/IV fluids**

Other Instructions: _____

Section E

Discussed with:
☐ Patient/Resident
☐ Parent of Minor
☐ Health Care Representative
☐ Court-Appointed Guardian
☐ Spouse
☐ Other:

Summarize Medical Condition

Physician/ Nurse Practitioner Name (print)	Physician/ NP Phone Number DAY: EVE:	Office Use Only
Physician/ NP Signature (mandatory)	Date	

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

When This Form Should Be Reviewed

This form (POLST) should be reviewed periodically and if:

- ☐ The patient/resident is transferred from one care setting or care level to another, or
- ☐ There is a substantial change in patient/resident health status, or
- ☐ The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review **Sections A through F**.
2. Complete **Section G**.
   If this form is to be voided, write "VOID" in large letters on the front of the form.
   After voiding form, a new form may be completed.
   If no new form is completed, full treatment and resuscitation may be provided.

Section F

Patient/Resident (Parent of Minor Child) Preferences as a Guide for this POLST Form

I have given significant thought to life-sustaining treatment. I expressed my preferences to my physician and/or health care provider(s). This document reflects my treatment preferences. The following have further information regarding my preferences:

Advance Directive	☐ NO	☐ YES
Court-Appointed Guardian	☐ NO	☐ YES

Please review these orders if there is substantial change in my health status such as:

Close to death
Extraordinary suffering
Improved condition
Advanced progressive illness
Permanent unconsciousness

Signature of Patient/Resident, Parent of Minor, or Guardian/Health Care Representative (optional)

Signature of Person Preparing Form	**Preparer Name** (print)	Date Prepared

Section G

Review of this POLST Form

Date	Reviewer	Location of Review	Outcome of Review
			☐ No change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form
			☐ No change ☐ FORM VOIDED, new form completed ☐ FORM VOIDED, ***no*** new form

SEND FORM WITH PATIENT/RESIDENT WHENEVER TRANSFERRED OR DISCHARGED

E-MAIL: ethics@ohsu.edu
WEB SITE: www.ohsu.edu/ethics

Being Present as a Chaplain

A Story about the Lighter Side of Pastoral Care

Theresa Mallahan

I tell this story on the slight chance that there just might be some soul out there questioning whether God has a sense of humor. This story will surely put that question to rest.

I was making my way through my second unit of CPE at Holy Family Hospital in Methuen, Massachusetts, when I landed my first job as a per diem chaplain at Saints Memorial Medical Center in Lowell. Oh boy, was I excited. With one unit of CPE completed, my second unit near completion, and my background as a nurse, I thought there was no stopping me. It was chaplaincy or bust.

I went through my first few weeks of employment without a hitch. I thought I was pretty good with this chaplaincy stuff. I believe it was then that God decided to, ever so gently, allow me to stumble. I can picture it now, all the angels and saints gathering together to join in on the joy of watching God's gentle reminder of humility.

My future in chaplaincy seemed to vanish before my eyes when suddenly the patient looked at me and in a very kind manner asked, "How's Eddie?"

It was somewhere around 10 a.m. in the morning when I made my way to the telemetry unit. I approached a patient's room and, while knocking on the door, observed an elderly woman sitting up in a chair next to the bed. She looked my way and motioned for me to enter. I greeted her and told her my name was Theresa. I was, as I told her, "one of the chaplains." It was then that she gave me a very big and warm smile. She tilted her head to the side and softly said, "Isn't it wonderful of you to come and visit. Won't you please sit a while."

Now, I'm thinking she already feels happy by my simply being present. I pulled up a chair and sat next to her but I wasn't prepared for what she said next. The woman continued with her smile and said, "You must be the baby." Now, I must tell you that this hospital is a small local hospital where many of the patients have, over time, come to know the pastoral staff. Being aware of this fact and quickly running through the other chaplains in my mind and realizing that at 36, yes, I am indeed the youngest, I was able to look back at the elderly woman and reply, "Yes, I guess you could say that I am the baby."

The patient went on from there to tell me all about her diagnosis and her fears with hospitalization. She talked for approximately 15 minutes. I was being an attentive listening presence and I thought things were going quite well, when out of the blue it happened. My future in chaplaincy seemed to vanish before my eyes, when suddenly the patient looked at me and in a very kind manner asked, "How's Eddie?"

Eddie?

All of my thoughts of how well things were going suddenly disappeared. I got a sinking feeling in my stomach as I grasped on to a tiny little bit of hope that perhaps there was a past pastoral employee named Eddie. So, while still trying to be the eternal optimist and the ever-present chaplain, I very calmly and appropriately responded, "Eddie?" To which she responded, "Yes, Eddie." I collected my inner wits and said, "I'm not sure whom you're talking about." My worst fears materialized when the patient responded, "Eddie, your father, Eddie Chaplain!"

It took a bit to get straightened out as I fumbled to figure out a way to explain that I was in fact a chaplain but not a Chaplain. Later, after being brought down a few pegs, I confided in the two full-time chaplains for support and, much to my delight, received roaring laughter. Surely God had a laugh that morning, especially when I received my new trade name of BC (baby chaplain). I am truly blessed to be a chaplain and experience God in the most unexpected of ways.

(NACC member Theresa Mallahan, is a chaplain at Saints Memorial Medical Center in Lowell, Massachusetts.)

Pastoral Care Network for Social Responsibility

Barbara Arnesen, CND

It has been some time since I last wrote an update for *Vision* about the Pastoral Care Network for Social Responsibility. The year 2002 is the last year of my second term representing the National Association of Catholic Chaplains on the PCNSR National Board. As many of you know, it is an international organization. Information about it can be found on the web site: www.IPCNSR.org. (See also Editor's note below.)

At the end of this year I also will be completing my two-year term as chairperson for this Board. When I accepted this responsibility last January, I had no idea how involved and energized I would be or how September 11 would regenerate the organization both at the national and international levels. As Howard Clinebell, one of the founders of the IPCNSR put it: "This devastating disaster confronts all of us pastoral care specialists with an unprecedented situation. We now have challenges and opportunities to become proactive in helping to lead efforts to shape constructive responses to this huge tragedy."

The terrible tragedy of September 11th heightened communication for us both nationally and internationally. We received reflections from members, which were poignant and thought provoking.

One of the first received was from Jim Farris, chairperson for the IPCNSR, who lives and teaches in Brazil. It is a moving account of his personal reaction to hearing the news about the attacks. He was in Basel, Switzerland, that day. You can read this letter on the IPCNR web site under "Responses to September 11." You can find other responses there, too, including one from U.N. Ambassador John D. Negroponte.

Interestingly, a task force of five of us from the National Board had a revisioning meeting in Oklahoma City in September 2000, where we suggested and the full Board approved our taking the issue of violence, in whatever form or place, as our focus. Jim Farris wrote an article "Pastoral Perspectives on Violence," which can be found on the web site under "Central Theme: 2001-2002."

On the international level, I have in my file responses from Germany, the Republic of Congo, France, and India, including a response from Arun Gandhi, grandson of Mahatma Gandhi, and Guatemalan Nobel Prize winner Rigoberta Menchu's open letter to President George W. Bush. She wrote expressing condolences and solidarity to all the people in our country; the following are some excerpts from her letter.

Nevertheless, Mr. President, upon listening to the message you gave to the Congress of your country, I have been unable to overcome a sensation of fear for what may come of your word. . . . You declared that every nation in every region has now a decision to make: Either you are with us or you are with the terrorists. . . . At the beginning of the year 2001, I invited the men and women of the planet to adopt a Code of Ethics for a Millennium of Peace sustaining that:

There will be no Peace if there is no Justice

There will be no Justice if there is no Equity

There will be no Equity if there is no Progress

There will be no Progress if there is no Democracy

There will be no Democracy if there is no respect for the Identity and Dignity of the Peoples and Cultures.

(For information about or copies of the above, contact me. My e-mail address is Srbarbaradob@aol.com.)

If any one wishes to join or renew membership with the PCNSR, please send $25 to Lerrill White, PCNSR Treasurer, Chaplain's Office 4-184, St. Luke's Episcopal Hospital, 6720 Bertner Avenue, P.O. Box 20269, Houston, TX 77225.

(NACC-certified chaplain Barbara Arnesen, CND, ministers for the Diocese of Brownsville, Texas, and is the NACC special representative to the PCNSR.)

Editor's note: The International Pastoral Care Network for Social Responsibility, IPCNSR, is a network of Pastoral Care Specialists working together to foster and promote spiritual, emotional, and environmental health for all persons, institutions, and the planet. There are members in more than 50 countries and on every continent. Each regional section of IPCNSR is a separate organization. They work together to develop communication among pastoral caregivers through the exchange of news and views in a quarterly newsletter, through cooperative action on behalf of justice-centered peace making, through periodic international theory-building conferences, through network gatherings in conjunction with other pastoral care and counseling conferences, and by issuing and publicizing statements of concern on significant issues of justice, peace and the integrity of creation.

Heartbeat

(Continued from page 3.)

The statement I believe this particular structure makes is that we value mission and spirituality at Providence St. Vincent as much as we value finances, building projects, etc. We consider mission and spiritual values as foundational to who we are and what we are about. These two areas are woven intimately into the fabric of our identity.

I write this not in the spirit of telling everyone how lucky we are here at St. Vincent, but more in sharing my concerns with my colleagues regarding the future of our profession within our medical organizations. I also write to encourage all of us to continue to be prophetic voices within our organizations regarding the value of spirituality and the need to express this value in space and organizational structure.

Monica Anderson
Director of Pastoral Services
St. Vincent Medical Center
Portland, Oregon

Helping People Cope with the Events of September 11

A Reflection from the Johnstown, Pennsylvania, Area

Rev. Dr. Joseph Maurizio

What follows are a few reflections on September 11, how it affected some of the people we serve in the Conemaugh Health System (CHS), and how it impacted their life, faith, and religion. I consulted with some of our staff chaplains and other members of the pastoral and spiritual care staff.

Here in CHS, we take a holistic approach to care that includes not only the medical and emotional aspects of healing, but more important to me is the spiritual care as well. We have as many as 75 people working in this department, and we try to have contact with every patient that enters our facilities.

I think those of us in this department are all in agreement that everyone is and has been affected by the events of September 11. Everything in our world seems to be moving so fast and the lives of most people appear not to be settling down in ways that bring them the inner peace we all seek.

The Pastoral and Spiritual Care Staff at Memorial Medical Center, Johnstown, Pennsylvania: (left to right) NACC members Sister Dorothy A Kline, RSM, Sister Rose Vogel, CSJ, and Rev. Dr. Joseph Maurizio, Director.

The most fear we still see in parents as well as others, particularly mothers, is fear for their children. Those with small children think terrorists care little as to whom they kill or hurt, as long as they can do maximum damage to Americans. In the past, it was usually believed that women and children were respected and not targeted for terrorist attacks. Most feel with the anthrax attacks, no one is really safe. Many of the people we talk to do not want to fly or let their children fly either.

Parents with older children are fearful that they may have to go to fight in the war and their children could get killed. No one knows how long the war will continue and what is going to happen after it is over.

We generally feel people are now more serious about making end-of-life decisions, for example, living wills, personal wills, children's wills, and who would take care of their children if something happened to the parents. There is a change of outlook on mortality and how death could happen to anyone at anytime.

People we talk to seem to indicate that the material things and objects of this life are not as important as they once were. They are secondary and the family comes first. Some even expressed interest in purchasing less at Christmas and working harder at making more family-centered activities.

Many of the people we talked to tended to have more questions concerning their own faith life and spiritual journey. People are hungering for spiritual guidance and direction. They are seeking out whomever they can find who will help in this need.

Here in the Johnstown area, we were particularly hard hit and influenced by the terrorist attacks. United Flight 93 crashed in our own backyard, Shanksville, Pennsylvania, about 15 miles from Johnstown. The first words out of many people's mouths when they heard about the crash were "Oh my God!" So many were asking, "Where was God?" and "Why did God allow this to happen?" Faith was shaken and people were searching for signs from God that said we were not forgotten.

A big news item in the Johnstown area that seemed to have helped many people with their faith crisis, fear, and confusion had to do with a newspaper article that appeared on the front page of the *Johnstown Tribune Democrat* (October 22, 2001, Tom Lavis) "Symbol of faith. Bible survives fiery Flight 93 crash." Dozens of people have mentioned this story to me and others. They read it in the newspaper or their pastors preached about it at Sunday Mass. It helped many with their faith, to know God was still with us. All found it a comfort at this time of high stress.

Here at CHS in one of our memorial services for the victims of September 11, I also preached about this story of finding a bible at the crash site. People found it helpful to hear this story tie in with their own personal faith journey.

Most of us do not need miracle stories to remind us God is with us and will always be with us, but many people are searching for some meaning to the life situations of today. This is a faith question and it affects almost everyone today.

(Father Joseph Maurizio is Director of the Pastoral and Spiritual Care Department of Conemaugh Health System in Johnstown, Pennsylvania.)

(Editor's note: This reflection was originally published in *Hospital News* and is reprinted with the permission of Memorial Medical Center.)

Ministering in a Parish Setting

Articles Invited for June 2002 Vision

For the June 2002 issue of *Vision*, we are planning a special section on the topic: Ministering in a Parish Setting. The decision to focus on this topic has been reinforced by a number of respondents to the recent *Vision* readership survey who have requested articles on this topic.

Those of you who are involved with parish ministry should consider writing an article for this special section to share with our readership some of the innovative and effective ways that you are carrying out your ministry.

Please consider the following format for a possible article:

1. Think of one intervention or program that you judge effective in your parish ministry.

2. Explain how that intervention or program got started.

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

4. 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 Wednesday, April 17, 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 Susan Cubar, *Vision* Editor: e-mail: scubar@nacc.org; fax: 414-483-6712; or via regular mail to the national office. Please feel free to contact Susan with any questions you may have.

Thank you for considering writing about your experiences in parish ministry for NACC Vision.

– Joe Driscoll

Celebrating Pastoral Care Week 2001: Valuing Life's Passages

Sister Charitas Elverman, SDS

We used the information supplied by the Pastoral Care Week committee to assemble a special bulletin board that was set up in the chapel and dedicated to pastoral care and the pastoral care ministers, and that reflected this year's theme. It was a joy to see many people stop to read the information and view the photographs displayed.

During Pastoral Care Week, we held the following activities:

Sunday, October 21 – At 2:30 p.m. we held our annual ecumenical memorial service for our residents who entered the Peace of Christ during the year. A family member or a person designated by the family received a flower in honor of their deceased loved one. A simple reception of cookies with punch and coffee was held afterwards.

Monday, October 22 – Mass was celebrated for all pastoral care ministers throughout the nation.

Tuesday, October 23 – Mass of appreciation was celebrated for all at St. Ann's Salvatorian Campus (administration, staff, residents, volunteers, benefactors). At the entrance of the Home, a counter was prepared with cookies and coffee, which were offered to all at the Home and to all who came for visiting or other purposes, as an expression of our gratitude for their collaboration with our pastoral ministry.

Wednesday, October 24 – A dinner of appreciation was served at one of the local restaurants for our celebration of pastoral care week with the administrator, assistant administrator, pastoral care team, and pastors of various religious denominations who gave conferences to our resident throughout the year. During this time we also confirmed their schedules for the coming year.

Thursday, October 25 – Pastoral representative attended the XVI Values & Vision Seminar, sponsored by the Catholic Health Association at Green Lake, Wisconsin.

Friday, October 26 – Mass of thanksgiving celebrated for the blessings of the past year and for continued blessings upon our pastoral ministry.

All in all, it was a wonderful week and celebration. We received much positive feedback regarding the activities of the week. We have much for which to be thankful.

(Sister Charitas Elverman, SDS, is a member of the pastoral care team at St. Ann's Salvatorian Campus, Milwaukee, Wisconsin.)

In Memoriam

Please remember in your prayers:

Sister Mary Elizabeth Riney, RSM, who died on July 30, 2001. She joined the NACC in 1977 and was certified in 1978. She most recently ministered at St. Mary's Medical Center in Knoxville, Tennessee.

John E. DeTurck, PhD, who died on October 20, 2001. A permanent deacon of the Diocese of Allentown, Dr. DeTurck served as a member of chaplaincy services of The Reading Hospital and Medical Center in Reading, Pennsylvania. He was certified in May of 2001.

Barbara Bossus Bohrer, who died on January 4, 2002. She was the coordinator of lay spiritual formation at St. Paul's Seminary and a chaplain at various hospitals and organizations. Most recently she trained spiritual directors at Sacred Ground Center for Spirituality and walked with many as a spiritual director. She was certified in 1984. Sister Dorothy Wenzel writes that "Barbara was a compassionate responder to everyone in total acceptance of who and where you were in your life journey."

Sister Chaplains: Two NACC-Certified Members Share More than Their Ministry

At the symposium in Baltimore last year, NACC members Kathleen Fallon and Jeanne Murphy had more than collegial reasons to celebrate Jeanne's certification. Besides being fellow NACC members, Kathleen and Jeanne are sisters.

Born and raised in a family of five in the Bronx, both sisters now live and work in the West, with Kathleen in Salt Lake City, Utah, and Jeanne in Dallas, Texas. Each points to a family experience that started their respective journeys towards chaplaincy. For Kathleen the death of their father when she was 13 caused her much personal sadness and repressed grief. The result of the therapy that she pursued was that she experienced a sincere motivation to bring comfort, counsel, support, and presence to others, especially children who are experiencing pain and loss.

As the single member of her family, Jeanne cared for their mother, who suffered from Alzheimer's for 18 years, and who spent her final years at a Catholic nursing home in the Bronx. During that time her mother was very frightened because she could not remember where she was. Jeanne was so grateful for the loving care provided by the staff to her mom and to each member of the family. She shared that "it was there I realized if I could alleviate the fear of one elderly patient, my life would be fulfilled. That was and is my reason for becoming a chaplain."

Before she became a chaplain, Kathleen was a stay-at-home mom, spending her time and energy on her three children and husband. She worked part-time at her church as a wedding consultant and enjoyed it. Kathleen joined the NACC in 1991 and was certified in 1992. Jeanne had a long career in the corporate environment before coming to chaplaincy. She worked for 29 years for an insurance company from which she retired to a fundraising position for the United Way of New York City.

Jeanne said that "knowing that Kathy was a chaplain and how her ministry brought her walk with God so much closer certainly was influential in my decision. I was still living in New York, my apartment flooded, and I remember going to bed thinking 'what am I going to do?' By 6:00 a.m. I was on the phone with Kathy asking what she thought of my moving to Dallas and attending the University of Dallas as she had done. She was delighted and the rest is history."

Jeanne is presently a chaplain at Presbyterian Village North in Dallas, which is a retirement community with four levels of care and 630 residents. During the week she provides seven interdenominational worship services and often a Sunday vesper service. She also serves on the ethics committee and as a member of the interdisciplinary team at the resident care conference. She is often called on to officiate at funeral services, graveside services, and memorial services. Ongoing pastoral care with residents and families and follow-up during hospital stays are part of her weekly routine. She also co-chairs a support group for families of the Alzheimer's residents and is an on-call chaplain for Parkland Health and Hospital System, a trauma center for patients of Dallas County.

Kathleen reports that her situation has dramatically changed since the symposium; her position as Director of Chaplain Services for Utah Heritage Hospice was terminated due to downsizing at the end of December. She had been hired to develop a pastoral care team; however, the CEO decided to cut costs and utilize community clergy in place of trained chaplains. She is also a member of the Utah Pastoral Care Association, a local agency committed to the hiring of trained and competent chaplains within the state and is concerned about the local trend of eliminating chaplain positions.

Kathleen characterizes her ministry as "calm, compassionate service, providing a comfort zone or a warm cup of tea to those who are weary and fragile. I believe that real ministry happens when two people find within each other that sacred place where thoughts and feeling can be shared, affirmed, and accepted." She serves her parish as a Eucharistic minister and member of the liturgy committee, and assists the pastor with bereavement counseling. In preparation for the Olympics, she's trained with the American Red Cross as a member of the local spiritual team in case of a disaster.

As transplanted New Yorkers both sisters have acclimated to life in the American west. Jeanne said that she finds "it amazing to be a Catholic in Texas." She relates the experience of really standing out in a crowd with ashes on her forehead on Ash Wednesday in Dallas, while in New York, it seemed as though the reverse were true. She's learned that people observe her as "a Catholic," when one co-worker remarked, "I didn't know Catholics were like that." In her experience she's found that "there is more that unites us than divides us."

Kathleen and her husband, who is now retired, are planning to move back to Dallas, where their children are located, and she hopes to find new opportunities to ministry there. She likes to think that she had some influence over Jeanne's decision to become a chaplain. "I think seeing the delight and joy I experience both within my own spirituality as well as my ministry encouraged her. Jeanne has always been very involved in community and social projects; her skills were a natural for her interest in chaplaincy."

NACC Welcomes More ACPE Supervisors

Dr. Margaret K. Hover of New York City and **Rev. James J. Creighton,** SJ, of Chicago, Illinois, have met all the requirements as ACPE Supervisors to become certified by the NACC according to the agreement between the two organizations.

HORIZONS

BOOK REVIEW

Genetic Turning Points

The Ethics of Human Genetic Intervention

James C. Peterson. William B. Eerdmans, Grand Rapids, Michigan, 2001. ISBN: 0-8028-4920-2. Softbound, xvi + 364 pages. $22.00.

Reviewed by Richard M. Leliaert, OSC

The events of September 11th temporarily disrupted the national attention being given to genetics issues, especially cloning and stem cell research. President Bush's national TV address on August 8, 2001, gave guidelines for stem cell research, but actually provoked even more controversy. So the contents of Peterson's book will continue to be germane for quite some time. This book, the second in a series on bioethics being planned by the Center for Bioethics and Human Dignity, has the advantage of being comprehensive in addressing gen-ethics issues of interest to chaplains, even though its viewpoint is specifically Christian.

Yet Peterson's approach is very adaptable to humanistic as well as religious perspectives. For example, when he discusses genetic drugs and a family's children in Chapter 11, he proposes four standards for appropriate genetic intervention(s). The intervention(s) should be (1) safe and (2) a genuine improvement for the recipient; furthermore, the intervention should (3) increase capacity for a more open future (especially in making moral decisions involving children) and (4) provide the best available use of limited resources (p. 253).

In some ways, Peterson notes, these four standards parallel the famous ethical principles of Beauchamp and Childress: autonomy, nonmalificence, beneficence, and justice. These are derived from our common morality and our medical tradition, as well as from specifically Christian principles. So chaplains used to these principles in ethical counseling, say, in end-of-life issues, will see parallels in future challenges in the ethical counseling of patients and families regarding genetics issues.

Chaplains can benefit from Peterson's treatment in Chapter 3 of the purpose of technology from a Christian perspective; namely, to sustain, to restore, and to improve. Keeping in mind that gen-ethics will not simply be current bioethics writ large, so to speak, this book can help us chaplains to determine how we need to make some qualitative leaps in ethical decision making. For example, informed consent in genetic intervention must take into account not only the immediate situation, but the impact on future generations, especially on one's children and grandchildren.

There's much already being written on gen-ethics. How can we find all we need in one place? While any book or article can't say everything we need to know, this book for the moment anyway can be as good a source as any for the unified and balanced treatment of gen-ethics we desire. Key issues are compacted into specific chapters/sections for quicker reference. Topics range from genetic research and genetic drugs to genetic testing and genetic surgery. Its language is easy to understand, and its insights challenging. It's worth reading, even when we disagree, or if we find some startling omissions, for example, direct treatment of key issues like stem cell research.

Author James C. Peterson is the C.C. Dickson Associate Professor of Ethics at Wingate University, Wingate, North Carolina, and is a Ranked Adjunct Professor of theology and ethics at Gordon-Conwell Theological Seminary's Charlotte, North Carolina, Campus.

(Richard 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.)

IN BRIEF

New CD-ROM Helps Individuals Approach the End of Life

A new CD-ROM from Michigan State University helps people who are living with advanced illness address the important issues faced as they approach the end of life. Health care professionals and multimedia designers from MSU, along with partners from the Henry Ford Health System in Detroit, have spent more than two years creating this comprehensive resource on end-of-life issues. *Completing a Life* provides a wealth of information on topics such as pain management, emotional needs, advance directives, and reaching closure in personal relationships. It was produced with grants from The Robert Wood Johnson Foundation's "Promoting Excellence in End-of-Life Care" National Program Office, Michigan State University, the Henry Ford Health System, and the Michigan Department of Community Health.

Completing a Life costs $29.95 and can be ordered at: www.completingalife.msu.edu.

End-of-Life Care Education Brochures Available

A working group of physicians and patient advocates with the American College of Physicians and the American Society of Internal Medicine has developed three brochures designed to help patients live well with serious illness near the end of life. "Living with a Serious Illness: Talking to Your Doctor," "When You Have Pain at the End of Life," and "Making Medical Decisions for a Loved One at the End of Life" are designed to facilitate conversations between physicians, patients, and their families. They are companion pieces to three end-of-life care papers prepared for physicians.

Download or order the brochures at: www.acponline.org/ethics/patient_education.htm.

Online Resource Reviews New Approaches to Palliative Care

The Center to Advance Palliative Care (CAPC) announces a new online resource that explores an innovative trend in end-of-life care. The report, *Hospital/Hospice Partnerships in Palliative Care: Creating a Continuum of Service*, offers the first-ever review of new approaches to palliative care emerging from hospitals and hospice programs The report was developed by the CAPC and the National Hospice and Palliative Care Organization (NHPCO).

This report is designed for senior management and clinical leaders of hospitals and hospice organizations. Nine hospital/hospice partnerships case studies demonstrate community-based solutions in a broad range of settings. Containing legal, policy, and financial analyses, the report is a resource for fostering hospital/hospice partnerships and enhancing the care of patients and their families.

The complete report is available on the CAPC web site at: www.capcmssm.org. Free print copies can also be obtained by calling the CAPC at (212)201-2671.

The CAPC is a resource to hospitals and other health care settings interested in developing palliative care programs. It is a national initiative supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Mount Sinai School of Medicine, New York.

Pastoral Reflections: An Inspirational Video

Catholic Health Association. 1/2 inch VHS. 45 minutes. 1990. $75.00.

To be a hospitalized patient is not easy. Feelings of isolation, fear, loneliness, and being out of control are normal. In some cases, the hospital environment exacerbates those feelings. And yet frequently a healing environment can be supportive and conducive to better caring for the patient. The benefits of music and art have for a long time been well documented as a significantly therapeutic tool within the healing process.

With this in mind, the Catholic Health Association developed a video that may be used by institutions as a part of their in-house television programming. This 45-minute video seeks to soothe the patient by providing images of peace and relaxation. This video, used either by itself or with other reflective videos, offers the patient an alternative to much of the network programming which is broadcast into the patients' rooms all day long.

The video utilizes several forms of music—instrumental, solo, and congregational singing. The music itself blends old favorites with newer melodies. At the same time the viewer experiences the music, he or she will see pictures of stained glass windows, hillsides, waterfalls, flowers, mountain tops, sunsets, and numerous other scenes of nature. An institution could use *Pastoral Reflections* not only for mood settings at various meetings, but also for other forms of inspiration and meditation to be broadcast into the room when the patient desires. Suggested uses for *Pastoral Reflections:*

- In-house television programming.
- Moments of reflection at institutional meetings and services.
- Patient viewing on a personal basis.

For more information on this video, contact The Catholic Health Association of the United States, 4455 Woodson Road, St. Louis, MO 63134-3797; phone: (314)253-3458.

EDUCATIONAL OPPORTUNITIES

Duke Institute on Care at the End of Life

Spring 2002 Events

The Duke Institute on Care at the End of Life, which is based at the Duke Divinity School in Durham, North Carolina, is

- Committed to including religion and faith in the conversation about improving care for the dying,
- A community of scholars from divergent fields who have joined together to improve care for the suffering and dying, and
- Committed to include diverse groups, particularly those who have been previously underrepresented and underserved.

The Duke Institute has a full schedule of spring events. On April 30–May 1, the Institute will co-sponsor "End-of-Life Care: A Timeless Model" with the National Hospice and Palliative Care Organization in Washington, DC. On May 23, the Institute will hold its third annual spring symposium, "Magnified and Sanctified: Jewish Perspectives on Care at the End of Life," at Duke University

Further information is available at www.iceol.duke.edu, by e-mail to iceol@duke.edu, or at (919)660-3553.

Respecting Choices

Gundersen Lutheran Programs for Improving End-of-Life Care

Respecting Choices will help you take better care of your patients at the end of life by showing you what a quality advance care planning program looks like, how it can work in any community, and what a difference it can make for millions of people struggling with end-of-life decisions. Nationally recognized as one of the premier end-of-life programs in the country, *Respecting Choices* has been featured in *Archives of Internal Medicine* (2/23/98, Vol. 158) and on Good Morning America, and has been recognized as one of the best practices in the nation by the National Coalition on Health Care and the Institute for Healthcare Improvement.

National conference dates and locations:

■ April 21–24, 2002: Indianapolis, Indiana

■ June 2–5, 2002: La Crosse, Wisconsin

■ October 13–16, 2002: Austin, Texas

Registration is limited. For more information on the course, contact Linda Briggs (800)362-9567, ext. 5279; e-mail: labriggs@gundluth.org; for registration information, call (800)362-9567, ext. 5243. Visit the Gunderson Lutheran Program, Improving End-of-Life care web site at www.gundluth.org/eolprograms.

Joint Conference of the National Council on Aging and the American Society on Aging

April 4–7, 2002
Denver, Colorado

Crossing the Great Divide, A call for compassion and creativity is the theme of the joint conference of the National Council on Aging and the American Society on Aging. It is taken from the Denver locale and because aging in America today is marked by great divides: the divide between heights of affluence and depths of poverty; between resource-rich cities and suburbs and resource-poor rural areas; between poorly paid caregivers—often foreign-born or ethnic minority women—and the predominantly white older people receiving their care; between those who espouse different beliefs on the role of government versus individual responsibility for providing for elders in our society; between the generations; and between the promise of biotechnology-driven life extension and the reality that old age is still a time of dependency, frailty and uncertainty. The conference poses the question: How will we cross these great divides to build a society where all of our later years are as vital as they can be?

For more information, contact the American Society on Aging at 800-537-9728; e-mail: info@asaging.org; www.agingconference.org.

NALM Annual Conference

May 30–June 2, 2002
Chicago, Illinois

The National Association for Lay Ministry is holding its annual conference May 30–June 2 in Chicago. For more information, contact NALM: (773)241-6050; nalm@nalm.org; www.nalm.org.

Celebration 275: United in Faith, Committed to Justice

August 3–6, 2002
Chicago, Illinois

In August, the Catholic Health Association and Catholic Charities USA meet jointly at the Sheraton Chicago Hotel & Towers to celebrate the 275th anniversary of the common founding of Catholic health care and social service ministries. The joint meeting begins on Saturday, August 3 and will conclude at noon on Monday, August 5. CHA's abbreviated 87th assembly will start at noon on Monday, August 5 and conclude by 2:00 p.m. on Tuesday, August 6. Questions? Call CHA at (800)230-7823. www.chausa.org.

Department of Veterans Affairs Palliative Care Fellowships

The Department of Veterans Affairs is working to develop leaders with commitment to better end-of-life care by offering fellowships in palliative care at six sites in 2002. Between July and September 2002, each of the six training site will select up to four fellows/trainees from a pool of candidates in health care disciplines involved in the practice of palliative care. Applicants are expected to include physicians, nurses, social workers, pharmacists, psychologists, and chaplains.

Deadlines for applications vary from facility to facility.

For more information, visit www.va.gov/oaa/fellowships/palliative.asp or contact James Hallenbeck, MD at jameshallenbeck@med.va.gov.

Pediatric Chaplains Forum

May 2–5, 2002
Orlando, Florida

The Pediatric Chaplains Network is holding a Forum on "Deepening Our Practice," May 2–5 at the Canterbury Retreat and Conference Center in Orlando, Florida. Forum topics and events include:

■ Pastoral care with patients and family in hematology/oncology.

■ Spiritual care of adolescent patients.

■ Case presentations: (1) Pastoral care following suicide and (2) Use of toys in pastoral work with hospitalized children.

■ Pediatric chaplaincy: a physician's perspective.

■ Networking opportunities with colleagues in pediatric chaplaincy.

■ Renewal activities to revitalize attendees personally and professionally.

■ Worship and recommissioning to pediatric health care ministry.

For more information, contact Dr. Steve Irwin, e-mail: stevei@cookchildrens.org or visit the web site: www.pediatricchaplains.org.

The Institute for Religious Education and Pastoral Studies (REAPS) at Sacred Heart University

The Institute for Religious Education and Pastoral Studies (REAPS) is an expression of the catholicity of a university whose mission is rooted in faith, compassionate in heart, and educational in mind. REAPS provides accessible, affordable, and adult-centered learning designed for busy people. Serving laity, religious, and clergy with user-friendly learning opportunities, REAPS programs enhance educational skills, renew theological perspective, give training in religious education and pastoral care, and embrace the spiritual journey.

REAPS offers a Certificate in Spiritual Direction, a four-year program with a one week annual intensive study session, which leads to skills in Spiritual Direction. For cost and formal application process, please contact REAPS. It is offered at: Villa Maria, Pennsylvania: June 9–15, 2002, and Fairfield, Connecticut: July 7–13, 2002

For more information about REAPS, contact Msgr. Gregory M. Smith, Director, 5151 Park Avenue, Fairfield, CT 06432; phone: (203)371-7867; fax: (203)365-4798; e-mail: reaps@sacredheart.edu; web site: http://reaps.sacredheart.edu.

Positions Available

▼ **The Village at Manor Park, Milwaukee, WI** – CPE RESIDENCY IN GERIATRIC MINISTRY. September 4, 2002, to May 9, 2003: nine-month residency in geriatric ministry. $17,500, plus health insurance and other benefits – tuition scholarships. The Village is an award-winning geriatric care facility offering all levels of care, including hospice. Minimum of one CPE unit required. A theological degree and some pastoral experience are preferred. Apply to: Chaplain Chuck Weinrich, The Village at Manor Park, 3023 South 84th Street, Milwaukee, WI 53227-3798; telephone: (414)607-4100, x2355; e-mail: charles.weinrich@VMP.org. Web site: www.vmpcares.com.

▼ **Providence Hospital, Mobile, AL** – OB/GYN CHAPLAIN. Providence Hospital, a member of Ascension Health System, is a 349-bed acute care hospital serving the health care needs of Gulf Coast residents for over 147 years. The National Research Company's 2001 survey rated Providence the "Hospital Choice" for the past five years. The candidate we seek to join our interfaith pastoral care team will be a certified member of the NACC, will have an MA in pastoral ministry or pastoral studies, and will possess ecclesiastical endorsement. When you become a member of the Providence Pastoral Care Team, you will enjoy an environment that encourages your spiritual, personal, and professional growth. Salary and benefits are competitive with national surveys. Send cover letter and detailed resume to: Human Resources, Providence Hospital, 6801 Airport Blvd., P.O. Box 850429, Mobile, AL 36685.

▼ **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. EOE M/F/D/V.

▼ **Hospice of Lenawee, Adrian, MI** – SPIRITUAL CARE COORDINATOR/ CHAPLAIN. Hospice of Lenawee seeks qualified person to join team. Part-time primary responsibilities include providing holistic care to patients and families. The candidate will have degree in divinity, theology, or pastoral counseling and education from accredited institution. Requirements include minimum of one to two units of CPE in acute care setting, ecclesiastical endorsement, two years' experience in a ministry setting, direct ministry to dying patients, experience with grief support. Send resume to: Hospice of Lenawee, 415 Mill Road, Adrian, MI 49221. For questions, call (517)263-2323 between 9 a.m. – 5 p.m., Monday through Friday only.

▼ **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; e-mail: grunklee.mavis@mayo.edu.

▼ **Saint Francis Medical Center, Grand Island, NE** – FULL-TIME CHAPLAIN. Saint Francis Medical Center has an immediate opening for a full-time chaplain to join our healing team. The chaplain will have opportunities to share gifts and talents. Pastoral/spiritual care is valued in our medical center. Candidates will need to be certified or in the process of certification with NACC or APC. Saint Francis Medical Center is a member of Catholic Health Initiatives. For more information, please call (800)353-4896 ext. 5621 or visit our web site at www.saintfrancisgi.org. Please send resume to: Regina Rathman, Human Resources, Saint Francis Medical Center, 2620 W. Faidley Avenue, Grand Island, NE 68803 or fax: (308)398-6561 or e-mail: rrathman@sfmc-gi.org.

▼ **Sacred Heart Health Systems, Pensacola, FL** – CERTIFIED CHAPLAIN wanted for full-time position at Sacred Heart Health Systems to complete pastoral care staff of two Catholic priests, four full-time chaplains, and three part-time chaplains. Sacred Heart is a member of Ascension Health and consists of a 431-bed acute care hospital, which includes a women's and children's hospital and a 120-bed skilled nursing home. Benefits include competitive salary, paid time off, and retirement package. Sacred Heart is an Equal Opportunity Employer. Direct all correspondence to: Sister Elaine Jordan, Director of Pastoral Care, Sacred Heart Hospital, 5151 N. Ninth Avenue, Pensacola, FL 32504 or fax resume to (850)416-4802.

▼ **Catholic Health Service of Long Island, Melville, NY** – DIRECTOR OF CHAPLAINCY SERVICES. Individual will oversee and ensure that the department is aware of and provides for the evolving needs of spiritual care in its health care facilities. Duties will include the selection, evaluation, and ongoing education of chaplains, maintaining regular contact with chaplains, including visits to assess local situations and areas of concern and developing programs and providing responses to needs. The ideal candidate will have a bachelor's degree (master's) preferred, be an active and certified member of the NACC and possess a background in the areas of administration, counseling, sacramental/ moral theology and/or medical ethics. Must also be sensitive to the needs of the sick and the elderly and have a minimum of three years' pastoral experience in a health care organization. Please send resume and salary requirements to: Catholic Health Services, Human Resources Department, 992 N. Village Avenue, Rockville Centre, NY 11570; fax: (516)705-1879. Equal Opportunity Employer.

▼ **AlmaVia of Camarillo, Camarillo, CA** – CHAPLAIN. Affiliated with Elder Care Alliance, AlmaVia of Camarillo, is a new 78-unit not-for-profit assisted living and dementia care retirement community. We seek a part-time (15–20 hours/week) chaplain to provide, coordinate, and evaluate activities related to the spiritual life and well-being of our residents, including liturgical and pastoral care needs. Master of Divinity or related degree preferred, minimum of two years' experience in providing services to older adults. Mail, fax, e-mail your resume, or give us a call. AlmaVia, 2500 Ponderosa Drive, North, Camarillo, CA 93010; fax: (805)388-2665; phone: (805)388-5277; e-mail: pparfitt@eldercarealliance.org. EOE.

▼ **Covenant Healthcare System, Inc., Milwaukee, WI** – REGIONAL DIRECTOR SPIRITUAL CARE. Covenant Healthcare has an opportunity for an accomplished professional to contribute to Covenant Healthcare System's effort to live out its mission and values within the larger context of Catholic identity. The ideal candidate will demonstrate progressive experience in spiritual care (5+ years) in a health care setting as well as strong organizational, administrative, and management skills. Requires an undergraduate degree in theology, religious studies, psychology, or related field; graduate degree preferred. NACC certification required. Excellent verbal and written

communication skills and the ability to team with other professionals in an interdisciplinary environment are required. For immediate consideration, please send your resume with cover letter to: ihuppetz@covhealth.org; fax: (414)256-5566, or mail to: Ildiko Huppertz, Director Strategic Staffing (interim), 11020 W. Plank Court, Wauwatosa, WI 53226; phone: (414)256-5564. EOE.

▼ **St. Mary Medical Center, Langhorne, PA** – DIRECTOR OF SPIRITUAL CARE. St. Mary Medical Center, member of Catholic Health East, has an opportunity for an accomplished spiritual care professional to contribute to the medical center's commitment to live out its mission and values within the larger context of Catholic identity. Requirements: three-to-five years' administrative experience; chaplain certification; graduate degree. Demonstrated abilities for organizing and implementing spiritual care program that serves within a continuum of care setting. We offer competitive salary and benefits. Please fax resume and cover letter to (215)750-5190 or e-mail: srohn@cheeast.org. EOE.

▼ **St. Catherine Hospital, Garden City, KS** – a leader in health care, is seeking a FULL-TIME CHAPLAIN or a FULL-TIME PRIEST CHAPLAIN. This position offers the opportunity to join an ecumenical staff of spiritual caregivers of both paid chaplains and volunteer clergy. Our team approach involves a multidisciplinary creative approach to meeting the spiritual needs of patients, families, staff, and outreach ministry to the surrounding communities of Garden City, Kansas. The successful candidate must be committed to personal health and healing, to development of required professional skills for innovative approaches to spiritual services, and to ministry, consistent with the mission and values of St. Catherine Hospital. Teaching skills and an understanding of holistic ministry are preferred. Bilingual skills are a plus, with Spanish preferred. Candidates must have a current ecclesiastical endorsement, have current NACC or APC certification or eligibility, and be willing to pursue certification. St. Catherine Hospital is ideally located just hours away from the mountains, desert, and high plains of western United States. St. Catherine offers a competitive salary, excellent benefits, and opportunities for continuing professional education. For consideration please send a resume to Valerie Funari, Recruiter, Human Resources, St. Catherine Hospital, 410 E. Walnut, Garden City, KS 67846; (620)272-2557; 1-(800)565-6486; fax: (620)272-2528; e-mail: human_resources_gck@chi-midwest.org.

▼ **St. John's Hospital, Springfield, IL** – a 600+ bed teaching hospital, is seeking an active Catholic of the position of DIRECTOR OF PASTORAL CARE. This individual will direct an ecumenical staff in ministering to the emotional, spiritual, and psychological needs of patients, their families, employees, and students. The Pastoral Care Department assures that meaningful liturgical services and sacramental ministry are provided at St. John's Hospital. As Director, you will be responsible for providing leadership to the Pastoral Care staff in meeting these duties. To qualify for this important position, you must possess previous training and experience in counseling and theology, especially in the area of dealing with the sick and dying. Certification as a chaplain by the NACC/APC. A minimum of a bachelor's degree, preferably in counseling/theology/education is required. A graduate degree is preferred. Previous experience as a hospital chaplain. Individuals interested may apply to the Personnel Department, St. John's Hospital, 800 E. Carpenter Street, Springfield, Illinois 62769; (800)419-2296; (217)525-5644; fax: (217)525-5601; www.st-johns.org. An Affiliate of Hospital Sisters Health System.

▼ **Covenant HealthCare, Saginaw, MI** – RESIDENCY POSITION AVAILABLE. Covenant HealthCare, a 709-bed teaching hospital located in beautiful east central Michigan, is now accepting applications for a nine- or 12-month residency. Specialization offered in pediatrics, surgery, cardiology, oncology, physical rehabilitation, and outpatient care. A previous unit of CPE is required. Nine-month stipend is $17,250. Twelve-month stipend is $23,000. Health insurance benefits and vacation days provided. Moving allowance available. Tuition is $300 per quarter. Application fee is $30. Please direct inquiries and applications to Rev. Larry J. Smith, Covenant HealthCare, Dept. of Pastoral Care and Education, 1447 N. Harrison, Saginaw, MI 48602; phone: (989)583-6042, or e-mail: lsmith@chs-mi.com.

▼ **Franciscan Communities, North Central Indiana Region** – REGIONAL PASTORAL CARE & MISSION DIRECTOR. Seeking a caring professional to join our team! In this role you will be responsible for providing pastoral care services to residents, families, and associates in our four local senior service communities. Use your expertise to aid in developing and integrating programs supporting our mission and values. As a Catholic, non-profit, expanding senior service provider we offer competitive wages and outstanding benefits. Qualified candidate will posses a bachelor's degree, with 3+ years' relevant experience, and will be certified by NACC (or in the process). Send resume to: Franciscan Communities – H.R., 160 Sagamore Pkwy. W., West Lafayette, IN 47906; phone: (765)463-6745; fax: (765)463-4131. www.franciscancommunities.com.

▼ **Park Nicollet Health Services (PNHS), Minneapolis, MN.** PNHS, an integrated health care system based in suburban Minneapolis, is seeking a CLINICAL PASTORAL EDUCATION SUPERVISOR to administer and promote the Association of Clinical Pastoral Education (ACPE) program. Responsibilities include conducting CPE programs under ACPE standards, maintaining accreditation, developing curriculum, and coordinating the selection, orientation, and supervision of students for the CPE program. The CPE supervisor will also share chaplaincy and on-call responsibility with other PNHS chaplains for the delivery of spiritual care to patients, families, and staff. The CPE supervisor reports to the Director of Spiritual Care. Qualified candidates will have a master's degree in divinity, theology, or a related field, ordination or ecclesiastical endorsement, and certification as a Supervisor in Clinical Pastoral Education (ACPE/NACC). Must possess three years' experience in the supervision of clinical pastoral education as well as three years' chaplaincy experience, ideally in a health care environment. We seek a professional with demonstrated leadership skills, the ability to function as an integral part of an interdisciplinary team, an understanding of health care issues and familiarity with employment laws and regulations. PNHS offers a competitive salary, excellent benefits, and supportive professional environment. Submit resume to Human Resources — KB, Park Nicollet, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; fax: (952)993-1638; or e-mail: bohlkr@parknicollet.com. EOE. www.parknicollet.com.

Position Wanted

▼ NACC member, completing fourth unit of CPE residency in May 2002, seeking position in or around San Jose, California, in hospital or hospice. Margaret Truxaw Hopkins, mtruxawh@aol.com.

Positions Available are posted weekly on the NACC web site: www.nacc.org.

CALENDAR

April 2002

24–27 ACPE Conference
Pittsburgh, Pennsylvania

29 Copy deadline
June 2002 *Vision*

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

Board of Directors

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