vision

National Association of Catholic Chaplains

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In This Issue:

Billing for chaplaincy: Has the time arrived?

By Linda Piotrowski

Early in my chaplaincy career, the administrator at the Catholic-sponsored nursing home where I worked repeatedly challenged me to learn more about the business of healthcare. He agreed that chaplaincy was of great value, but it cost money. It didn't make money. I needed to understand how administrators think and what the business end of mission requires.

Eight years later, when I became the regional director of spiritual care for a healthcare system, I introduced a method of documentation of chaplaincy services. I met resistance: *You can't measure what we do. Who is going to compile all this data? They will misinterpret the information and cut us from the budget rather than pay us more.* I saw it as a means to increase professionalism and accountability, however, and in the intervening years, such programs have become more common.

At that time, I never dreamed that perhaps someday hospitals could recoup some of the costs of chaplaincy by billing insurance services for the work we do. But I have changed my mind. Billing may represent our next step in professional recognition.

My thoughts in this direction grew from the parallel situation of palliative care, for which I chaired the committee while serving as interfaith chaplain at Central Vermont Medical Center (CVMC). Like pastoral care, palliative care is non-revenue-producing. Doctors, nurse practitioners and therapists can bill individually for their services, but unlike surgical procedures, operating room costs, etc., palliative care has no place in the billing structure. It is a cost-saving rather than a revenue-generating service. This makes it difficult to convince administrators that palliative care programs/services should be a part of the operational budget of a hospital.

At CVMC, our palliative care service was not a part of the hospital's operational budget, and the committee was constantly searching for ways to fund our services. CVMC's director of reimbursement, Mr. Michael Williams, proposed that we begin billing insurance companies and Medicare for our services.

Michael said that billing codes already exist for many of the services we provided, although hospitals do not bill for them as palliative care because the hospitals know they will not be paid. He suggested that we begin billing anyway, because unless these providers begin to see charges for these services, they will remain unaware that such services exist and deserve reimbursement.

At the next month's meeting, Michael handed out sheets with all of the existing codes. As we went through, we noted codes for nursing services, social work services, pharmacy, dietary, and therapies. But I noticed the absence of a code for spiritual care or chaplaincy services.

Michael challenged me to find others in spiritual care who are already billing for their services and to use that code. He found it hard to believe that a code for chaplaincy services did not already exist.

> Billing may represent our next step in professional recognition

But try as I might, I was unable to find anyone who billed for services, either using a real or dummy code. I remembered that a colleague at a rehabilitation hospital said that their hospital placed a charge for spiritual care onto the patient's bill. The charge was then cancelled. The idea was to provide evidence of the cost of chaplaincy services, while at the same time showing that this service was being provided to them free of charge. This is certainly one way to create awareness of spiritual care services, yet it does nothing to create awareness on the part of insurance companies and the federal government. *I do not advocate billing patients directly.*

Like my experience of many years ago, when I spoke to other chaplains about billing for spiritual care services, I was greeted with skepticism and some outright hostility. Most chaplains I talked with believe that billing for chaplaincy services is a horrible idea. Some have a strong philosophical stance, while others

See Billing on page 4

Board retreat examines future possibilities

By Karen Pugliese
Chair, NACC Board of Directors

From left, Karen Pugliese, Sr. Geraldine Hoyler, CSC, Joan Bumpus, and Rev. Tom Landry join the celebration of Mass at the Board of Directors retreat.

Honoring the NACC's vision to initiate continual renewal and transformation, at the Columbus conference the Board of Directors committed to a weekend visioning retreat in July. As the oldest professional ministry organization in the Catholic Church, we celebrated the completion of our seven-year Strategic Plan and sought to prepare for our next 40 years of service to the Church.

We began with a theologically grounded, reflective and prayerful discernment process. Integral components included scanning the current and future environment and engaging the perspectives of partners in health, education and pastoral ministry. Investing time and effort to understand these realities and perspectives will help us to develop strategies to address them.

Rod Accardi, D.Min., CPE Supervisor and Certification Commission Vice Chair, served as our retreat designer and facilitator, leading us in the technique of Appreciative Inquiry and integrating the theme, "See With New Eyes," throughout our prayer, reflection, and song. Before coming together in July, each Board member and Fr. Tom Landry, Kathy Eldridge and Susanne Chawszczewski from the National Office prayerfully reflected on how God is calling NACC at this time.

Weeks before, Bridget Deegan-Krause, Paul Marceau, Suzanne Chawszczewski and I interviewed twelve leaders in the Church, in ministry, mission, transformational development and education. Participants read summaries of the interviews to prepare for a roundtable discussion with four guests who sketched their vision of the future. This lively dialogue engaged us in exploring the collectively desired future for NACC that our energy and enthusiasm envisioned. An empty chair at our round table symbolized the 3,300 members present with us in spirit.

Mr. Hugh Jones, Vice President Strategic Planning-Trinity Health System, highlighted mission and spiritual care in relation to healthcare. Breakthroughs in ministry formation, both in parishes and in academic settings, were sketched respectively by Rev. Eugene Lauer of the National Pastoral Life Center, and Sr. Ann Goggins, RC, of the University of Notre Dame. With the success of the Common Standards as a backdrop, Ms. Josephine Schrader, Executive Director of the Association of Professional Chaplains, offered thought-provoking possibilities for the future of chaplaincy and continuing collaborative efforts to advance our profession.

We discussed expanding membership to other Catholic pastoral ministers, alignments with Catholic lay ministry associations and education programs, and assisting in developing competency-based training and standards. We also looked at issues such as stratifying certification at different levels, expanding and nurturing ministries beyond healthcare, and developing chaplains for leadership, as well as assisting in the formation of leaders in Catholic health systems.

In addition to an expanded vision for Catholic ministry, we considered possibilities for professional chaplaincy alignments which would support collaboration and stewardship. We see great potential for building on the accomplishment of shared projects like our joint conferences and common standards. Sharing resources on salary surveys, advancing pastoral practice, advocacy efforts, research, and grants are of great interest to our professional partners.

We closed Sunday morning with a moving and inspirational liturgy commissioning us to remain open to the art of dialogue, and to continue to "see with new eyes." Fr. Landry's homily reflected on the gift of sight, reminding us we need two eyes to have accurate depth perception. We need to focus both eyes on the future to which we are called — where God seeks to greet us. We need to see with the eye of "vocation" and the eye of "profession." Lacking either, we lose our sense of the true depth of ministry that is ours. Our vocational vision roots us deeply and securely in the ministry of Christ, that is the ministry of the Church. Our professional vision companions us with individuals of many cultures and traditions who also seek to promote advocacy, innovation, expertise, and excellence in spiritual care practice and education.

The retreat launched a process which will involve our members through focus groups, e-mail surveys, regional educational events, and our 2007 Conference in Portland (see p. 7). Building upon the best of the past, and in light of the environmental scan, we have energy and enthusiasm for a preferred future for NACC. There is a clear sense of direction for focused work in advancing our role as a ministry of the Church, and in advancing our credibility and recognition as healthcare professionals. There is a clear call to explore deeper professional relationships and alignments. And clearly, we've only just begun …

vision

Vision is published 10 times a year by the National Association of Catholic Chaplains. Its purpose is to connect our members with each other and with the governance of the Association. Vision informs and educates our membership about issues in pastoral/spiritual care and helps chart directions for the future of the profession, as well as the Association.

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Planes, trains, automobiles

So many more ways to keep in touch today

By Rev. Thomas G. Landry
Interim Executive Director

The world in which we all live and minister seems new almost every day! My ministry as Interim Executive Director has led me to experience planes, trains, and automobiles quite differently from the way I did before June 1, 2006! Planes are now a regular feature of my itinerary. Trains are a reality in cities I visit as they are not back in Worcester, MA! Automobiles frequently are rentals, requiring orientation from destination to destination, company to company, vehicle to vehicle. It takes adjusting, but I'm getting the hang of it!

The same is true of communication. During my childhood at Fort Pond in Lancaster, MA, we were one of only two families who lived there year-round. Summer occupancy around the lake was 100 percent, and telephone lines for all summer occupants were party lines. Sometimes we needed to wait for a neighbor to finish speaking with a relative or friend before we could place our own call. Today, I regularly place calls from four telephone numbers, and two of them are cellular!

Computers, of course, are an important element in this rapidly evolving world of communication. I remember the day in 1968 when Dad took me to his new job site at Fort Devens in Massachusetts, where he worked with one of the first generation of room-sized computers newly acquired by the Department of Defense. The doorways were hung with plastic strips that helped retain the refrigerated air required by these key-punch-card-driven systems. Today, I have access to both personal and work-based desktop and laptop computers.

Phil Paradowski researches and implements new information technology opportunities for all of us in the national office. With the most recent upgrade to our technology, we enjoy many benefits, including a faster and more effective internal network, improved remote access for office staff when we are on the road, and improved security for our NACC website itself. These capacities will lead to additional services for NACC members, committees, commissions, councils, and our Board of Directors.

I encourage you to make the effort required to use systems placed at your disposal. Be in healthy communication with your peers and with your interdisciplinary colleagues. Take advantage of new opportunities for visibility in patient records, especially as they go electronic. Embrace a new opportunity to be available to the wider communities we serve via websites and distance service and learning programs. I encourage you to communicate with all of us within the NACC, via all the means at our disposal, to share your ideas, to answer questions that are posed, to expand all of our horizons with your unique questions and discoveries.

At table, from a boat along the shore, on a hillside, or beneath a roof newly opened by the persistent and the creative, Jesus, at the heart of his mission, proclaimed the transformative power of the coming of God's Reign. We can afford to do nothing less, and we must learn each day to do so in the ways for which others have eyes to see and ears to hear.

Billing raises serious concerns

We are opposed to billing for chaplaincy services for three basic reasons. While additional factors need serious consideration, we call to your attention at least these three issues:

1. Spiritual/pastoral care is as integral to the services provided by a Catholic hospital or long-term care facility as nursing, social work, case management, etc. Paragraphs 10-22 of the *Ethical and Religious Directives for Catholic Health Care Services* assume that such a service is integral to the Catholic identity of the organization. This is not an "add-on" service but integral to the body, mind and spirit approach in how care is delivered in a Catholic facility. Spiritual/pastoral care is simply an integral part of the coordinated response of the facility's interdisciplinary care team.

2. Moreover, chaplains have a symbolic, as well as functional, role in a Catholic facility: namely, they are an organizational symbol of the mission, spirituality and values of a faith-based facility (akin to the role often associated with that of the women religious sponsors in the past). We cannot bill for symbols of our institutional identity.

3. A chaplain's productive time and responsibilities often include a ministry to family members and staff, as well as patients/residents. Where would billing time begin or end?

This is a condensed, succinct summary of our rationale, but for now we simply wish to register our opinion on this issue.

Alan E. Bowman
Director, Spiritual Development
Catholic Health Initiatives, Denver

Rev. Gerard T. Broccolo
Vice President, Spirituality
Catholic Health Initiatives, Denver

Inviting Dialogue

The idea of submitting bills for chaplaincy services is a new and controversial one, and we know that there is more to be said upon the subject.

If you would like to write a letter or article for *Vision* that discusses the idea further, whether pro, con, or in between, please contact David Lewellen at dlewellen@nacc.org or at NACC, 3501 S. Lake Dr., Milwaukee, WI 53201-0473.

Billing

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believe that it is too hard to quantify what chaplains do.

In April 1998, Rev. Joseph Driscoll, then NACC's Executive Director, wrote for *Vision* about charging for spiritual care services. Rev. Driscoll explored the theological and social consequences and challenged spiritual care providers to discuss the realities of reimbursement and how to provide models for this accountability.

I also remember the description of chaplaincy tracking software by Rev. Dean V. Marek, Director of Chaplain Services for the Mayo Clinic in Rochester, MN. (It appeared in the July 2005 issue of *Vision* and can be accessed on the NACC web site.) Dean and the chaplains at Mayo worked together to develop a listing of service types and their verifiable average times, which became a basis for setting the department budget. I strongly recommend reading the article for a more complete explanation. Developing a catalogue of services as well as a cost per unit of service can show productivity in spiritual care. It is helpful in showing administrators the breadth, scope and value of chaplaincy services.

Recently I received a call from a colleague whose chaplaincy position in a community hospital had been reduced to half-time. His hospital community rallied around him and successfully appealed to the hospital's board for the reinstatement of his full-time status. He called me to talk about how he can define and track the services he provides in order to communicate the value and cost-effectiveness of his work to his hospital's administration. Among other ideas, I suggested he read Rev. Marek's article.

"Without the (financial) margin, there is no mission," was a favorite saying of my former nursing home administrator. He demanded accountability. He required clear definitions and accountability for the delivery of my services. He challenged me to learn the language of healthcare in order to communicate with other disciplines about chaplaincy in a way they could understand.

Chaplains are unique in that we hold expertise in theology and pastoral care as well as in the dynamics of disease and health care. If we believe in our status as professionals and the legitimacy of our work, we must develop ways to communicate the value of our services to others. We must learn to hold ourselves to the same fiscal and service standards as our colleagues in other disciplines.

I believe that it is well past the time for chaplaincy to define, categorize, and assign dollar values to our services. After all, we place a high monetary value on our services when we advocate for our rate of pay. We want perks like continuing education funds and payment of professional membership fees. Isn't a corollary of that taking some fiscal responsibility? Or at the very least caring about where those funds come from?

If we as an organization of professional chaplains were to decide upon a system of tracking such as that used at Mayo, it could provide us with a standardized measurement of chaplaincy services. Compiling statistics could give us the data necessary to prove not only the scope of our services but their cost-effectiveness. If we establish a standard of care and meet professional criteria like our colleagues, we could be assigned a billing code like other hospitals. Sent to private insurance companies and the federal government (Medicare), these codes could eventually provide reimbursement for our institutions. This work could also enhance our professional status by placing chaplaincy on a more equal footing with our interdisciplinary colleagues in nursing, social work, dietary, and rehabilitation services.

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Seeking, Finding

What changes when we pray to God?

By Paul Marceau

Why do chaplains (and physicians and other medical staff) pray for and with people? And what difference does it make — to God, to those for whom we pray, and to ourselves? Can prayer change anything?

This article is a reflection on prayer. It is not, however, an attempt to jump into the current controversies about how prayer affects the healing process (or not) and whether meditation affects blood pressure or lowers length of stay. It is about the dynamics of prayer (particularly prayer of petition) and what is really going on when we do it.

In prayers of petition, we bring to God an assortment of needs, anxieties, fears, wants, and hopes. Sometimes we do this in great detail ("for my sister who is a single mom with three children") and sometimes simply generically ("for all women suffering with breast cancer") And then we wait. What do we expect to happen? Will God change anything for any of these people?

Prayer does not change God. Whatever else happens or does not happen, prayers of petition do not change the mind and heart of God. At least I hope they don't. If we really believe that God is eternal, immutable, unconditional love, then why would we want to change God's heart and mind? From unconditional love to what? God cannot love more; God does not love any one of us more or less. God cannot love us more tomorrow than God loves us today. God simply loves us unconditionally.

So what is going on when we pray *for* something or someone? Basically, we are taking the cares of our lives and placing them in the care of this unconditional Love. One by one, in great detail or generic simplicity, until we have emptied our hands and hearts and given them over to God. And then we wait, with open, empty hands.

Some years ago a cousin of mine was in terrible car accident. He lay in a coma with severe brain damage for several days. Each day my mother would call me with an update on his condition. Then she shared her own confusion and said, "I don't know what to pray for, what to say to God. I don't know if I want him to live or die. What should I say?" I didn't have any good advice — and didn't need any. She paused and said: "I guess I just have to put him in the hands of God."

Praying changes us. Prayer of petition is essentially placing ourselves in a posture of trust and abandonment, without any demands for particular outcomes. Prayer does not change God — but it does change us! Returning to God in prayer builds and reinforces an attitude of trust, of returning all things into the hands of God. It re-establishes right relationships with God. The world and all that is in it was created by God, is sustained by God, and forever will be in the hands of God.

But prayer of petition also does something else to us. With empty, open hands we are in receptive mode, attentive to what may come, more sensitive to the needs of the people we have brought to God. And more ready to be selfless in ministering to their needs, to be the hands and heart of God for them. If prayer of petition is a regular part of our lives, then we can develop a keener awareness of and responsiveness to the Spirit of God working in our world.

Praying may change others. If prayer of petition doesn't change God and only changes us, it can be a rather solipsistic exercise. What does it do for them, for those for whom we pray? When we invite others into prayer, we invite them to stand before God with the needs of their lives — *and express them as they see them*. If they want to pray for a miraculous cure, so be it. We don't tell them that they shouldn't ask such a thing of God or that they are tempting the Lord their God with such an attitude. In the process we learn more about their fears and hopes.

We can also help them experience an attitude that it is safe to bring to God anything they want. God cannot do anything but love them, as they are, in their vulnerability. Even their sin and unreconciled relationships are safe with God. They may or may not be able to complete that journey toward God, but in the end, God will do that for them. That's what death is all about: God completing the journey for us, taking us the rest of the way in the way of love that we have not been able to do. In death, we are turned inside out, from selfishness to selflessness and know only the love of God.

We are taking the cares of our lives and placing them in the care of this unconditional Love

Prayer of petition does change things, but it cannot change God. It can change us; it can change others. But we have to be realistic in what to expect. And ready for what God may want to do with us in the process!

Paul Marceau is a member of the NACC's Board of Directors and Vice President of Mission Services and Ethics at Trinity Health in Novi, MI.

Myths and misconceptions

Certification process may be different from what you think

By Michele LeDoux Sakurai

For several years I have been privileged to work with NACC certification. I have seen the efforts of interview teams throughout the country and continue to be amazed at the quality of their work. However, I have become more aware of the myths and misconceptions that candidates carry into interviews. These myths have caused confusion and at times actually hindered the success of the candidates in the certification process. In an effort to aid future candidates' efforts towards certification, here are some of the more common misconceptions:

Myth 1: Everyone who interviews will be certified; the interview is just a formality.

The interview process is an intense review and assessment of a candidate's qualifications. In addition to four units of CPE, a master's degree in theology, divinity, religious studies, pastoral ministry, or spirituality granted or acknowledged by an accredited academic institution, and ecclesiastical endorsement, the candidate must adequately articulate and demonstrate competencies required in the standards.

Myth 2: The interview team certifies.

The NACC, through its Certification Commission, is authorized to certify according to the standards and procedures approved by the United States Conference of Catholic Bishops Commission on Certification and Accreditation. Interview teams provide an assessment of each candidate through a Presenter's Report Part I (a review of the candidate's supportive materials) and a Presenter's Report Part II (a review of the candidate's interview). These reports, along with the team's recommendation to certify or not to certify, are given to the Commission, which then makes the final decision.

Myth 3: If an interview team doesn't like a candidate, the team can choose not to recommend him/her for certification.

All interview teams are trained under strict professional guidelines to be objective members within the process. The Presenters' Reports Parts I and II are reviewed by an Interview Team Educator (ITE) before being submitted to the Certification Commission. The Certification Commission then reviews the reports prior to granting or denying certification. A candidate can be denied certification ONLY if required standards are not met.

Myth 4: The interview team is permitted to continue discussion of the interview after presenting the summary and recommendations to the candidate.

The interview team is required to read the summary (Presenter's Report, Part II) and the vote (to recommend or not to recommend) and then close the interview. If the candidate has concerns about the outcome of the interview, s/he may speak to the ITE on site or wait for the report to be cleared through the Certification Commission; the candidate will be notified of the outcome after the Commission meets in July and November of each year. This notification informs the candidate of the Commission's decision to certify or to deny certification. Standard 610 states, "In cases where an individual feels that standards were violated which resulted in a negative certification recommendation/decision, the right to an orderly appeals procedure is ensured."

Myth 5: It's just a power play for the interview teams; they like telling candidates that they will not be recommended for certification.

Interview teams are invested in the success of the process. It is very painful for team members to inform a candidate that s/he is not being recommended for certification.

Myth 6: "The interview team judged me without knowing who I am."

The interview team depends on the candidate to articulate who s/he is in the context of the standards. The team cannot give a recommendation for certification if the candidate has not successfully made this self-revelation. Remember: it is all about demonstrating the competencies required in the standards.

Michele LeDoux Sakurai, D.Min., NACC Cert., is a chaplain at Providence/St. Vincent Medical Center in Portland, OR, and an interview team educator for the certification process.

Rev. Robert Rochon
Greenville, RI
Hip replacement

Prayers for Healing

If you know of an association member who is ill and needs prayer, please request permission of the person to submit their name, illness, and city and state, and send the information to the *Vision* editor at the national office. You may also send in a prayer request for yourself. Names may be reposted if there is a continuing need.

Mark Your Calendar!

National Association of Catholic Chaplains 2007 Conference

March 17-20, 2007
Portland, Oregon

Please check future issues of Vision *for updated information.*

At the business meeting at our 2006 National Conference in Columbus, the association responded to your needs. The board is committed to a national gathering which brings together diverse and unique members from all over the country to celebrate, to learn, and to grow together with the association.

We are pleased to announce that the 2007 National Conference will take place in Portland, OR from March 17-20, 2007. Ms. Camelia L. Hanemann from Milwaukie, OR, has agreed to serve as our National Conference Chair. Theme, goals, committee, and hotel information will be announced. Please watch future issues of *Vision* and the NACC website (www.nacc.org) as information becomes available. For more information about attractions and amenities in the busy, beautiful, and progressive city of Portland, please visit www.pova.org.

In addition, the Board of Directors has heard your struggle for connection and is committed to reconnecting the NACC with its members. Our current plan is to hold some local conferences in the fall of 2007 to allow greater participation from our members in an atmosphere that supports a more intimate gathering. More information will be coming to you in the next several months.

Portland is known as the Rose City (top) for good reason. The towering presence of Mount Hood (above) provides a dramatic backdrop to the city skyline.

Bike paths along the Willamette River are part of Portland's commitment to enjoying its spectacular natural setting.

Measurement and meaning

Researching religion and health holds pitfalls, potential

By Michael King

Are religious beliefs and practices good for our health?

Until the rise of logical positivism in the humanities in the 19th century, such a question would have been unimaginable or irrelevant. Religious or spiritual research grew rapidly in the 20th century, particularly in North America, but always remained in the wings to the stage of serious academic pursuit. In the 1980s the late David Larson commented only partly in jest on its hazard as an "anti-tenure factor" in the career of academics who ventured into its messy domain. To avoid this upsetting outcome, investigators have usually trodden one of two distinct tracks. The first and most common takes a post-modern, discursive approach in which people's narratives or behavior are recorded and scrutinised in detail. A search for meaning replaces a search for truth in this so-called qualitative approach. The second, which has its counterpart in the physical and biological sciences, is the quantitative or positivist approach, in which observations are categorised as numerical data that are then subjected to statistical analyses of ever-increasing complexity. The second approach brings a comforting sense of accuracy, although validity remains as elusive as ever.

We developed another test of belief. Perhaps we shouldn't have bothered, as there are so many already

What are we doing when we research spirituality and religion? And has this quest any future? Let us be clear at the outset that we do not seek to prove the existence (or non-existence) of God. Metaphysical speculations of this sort were abandoned centuries ago. Unfortunately, however, we sometimes speak a similar language. When we try to define spirituality, we are required to use words like "transcendence" to convey something beyond our subject-object perception of the world, something that conceives of the comprehensive whole in which there is no observer or observed. God is not another object in the world. But this understanding (if we can call it that) cannot be communicated in words; it belongs to a mystical, non-verbal world of experience and has little meaning in a positivist sense. If spiritual perception transcends human experience as subject and the world as object, then it cannot be addressed by science. It more properly belongs to Kant's noumenon about which we can say nothing. In the words of a well-known academic in the area, it is "super-empirical" and, by implication, beyond our grasp (Levin & Vanderpool 1987).

So time and again we stick to religion. We study whether people have a creed or faith, what they believe in, and how they practice those beliefs, in order to assess any impact on their health, mood or reactions to calamities. However, research based on denominational or categorical approaches to religious membership and practice usually gives way to greater sophistication in measurement and to a focus on the process of belief. Do I really believe in God or just pop along to my church or temple to keep in with those who matter? What is my inner world of belief and search for existential meaning? Much of this research has occurred outside the domains of health and psychology. It has paralleled western society's growing interest in Eastern religions and New Age beliefs and practice. In research, it has led to a conceptual separation of religion and spirituality — a division that in many cultures is met with incomprehension.

It is difficult to conduct research into spirituality and health without a consideration of measurement and meaning. Recently we developed yet another pencil-and-paper test of belief. Perhaps we shouldn't have bothered, as there are so many already (Hill & Hood 1999), but measurement in this domain is an evolving thing. There is constant dissatisfaction with how we quantify what people regard as spiritual, and thus constant refinement in our tools.

To develop our questionnaire, we started with a qualitative, bottom-up approach by asking what spirituality (that word again) meant to people who were dying. We judged that people near death may be reflecting on these issues as at no other time in their lives. An analysis of their conversations identified themes that arose repeatedly and could be phrased as statements for use in a questionnaire. We now have a scale which measures what we call "beliefs and values" and which we anticipate might get closer to what people regard as ultimately meaningful (King et al. 2006). We tested its reliability (accuracy) by getting a large number of people to answer it on two occasions about two weeks apart. In that way, we know that people answer it in the same way each time and that it accurately measures something. But how to validate that something is much more difficult. One way is to correlate what people believe in with what they do, but that often boils down to measuring their religious observance and practice. Assessing the validity of spiritual beliefs when there is no religious practice is much more difficult. At least we know our instrument is reliable. Although a reliable instrument is not necessarily valid, an instrument that is unreliable is never valid.

All this measurement is taxing, so is it getting us any-

where? Well, there seems to be little empirical or theological basis to the claim that strong spiritual or religious beliefs (as distinct from the social support and health behaviors that arise from membership of a religious group) lead *directly* to better health. If they have any impact at all, it is more likely that they influence coping, happiness, acceptance, and endurance during serious illness. This may lead *indirectly* to better health outcomes. However, were it demonstrated that spirituality was good for your health, would we provide it as a treatment package? I should hope not. And were it to be bad for you, would that suggest we should advise people against it?

I believe what drives researchers in this field is not a question of utility; rather it is a fundamental curiosity about meaning and whether spirituality as a concept has any validity (whatever that means). If I am correct, it inevitably touches on what researchers themselves believe in. Science assumes (usually wrongly) that scientists are impartial, that they seek the truth whether or not it is comfortable. But in spiritual research, that impartiality is sometimes lacking. Health researchers who enter this field are often profoundly religious. However, they rarely declare it in their publications. Scientists who are not religious usually regard the whole enterprise at best with distaste and at worst with hostility.

My potential "conflict of interest," therefore, in research and in writing this article is as follows: I cannot accept metaphysical concepts of a God who requires that all people give the nod to a set of (usually arcane) beliefs before they can enter the kingdom. Nevertheless, I feel that the basic ethical stance of goodness and loss of ego that is encapsulated in the "golden rule" is a sign of what God is. I cannot agree with the view that this approach to life and meaning is merely one amongst many others (Vattimo 2004). Perhaps I am trying to find evidence that spirituality is good for our health, but I doubt it; as a cognitive behavior therapist, I am skeptical of the reliability or validity of my thoughts, beliefs and emotions.

What, then, is the consequence of religious bias? Data sets are sometimes dredged (with little sophistication) in order to find any association between spirituality and well-being. This was recognised at least 20 years ago (Levin & Vanderpool 1987), and fortunately there has been considerable progress in our approach to data. However, there remains a body of research whose claims are incredible. The kinds of study that come immediately to mind are randomized clinical trials of prayer in which patients admitted to hospital units are allocated to trial arms in which they either receive standardised hospital care or in addition to standard care are prayed for by various assortments of believers. These trials often report small clinical differences in favor of the groups for whom prayers were offered. One even purported to show that, since God stands outside of time, changes in outcome could be achieved *retrospectively*. Although published in earnest tone, it appeared in a Christmas edition of the *British Medical Journal*, a publication traditionally reserved for send-ups or articles of curiosity (Leibovici 2001). Good science is usually under-pinned by clear theory. If prayer "works," how does it work? Are such trials randomizing God? And why are the effects so small? I need not elaborate on the religious, epistemological or metaphysical pitfalls in such work; suffice to say they give research in this field a bad name.

So where are we heading? Despite reservations about poor research, I think that investigation into religion, spirituality and health is a serious subject worthy of serious funding. It provides a small counterweight to the drive to reductionism, especially in psychiatry and neurology, in which the activity of the brain is thought to be all, the self a useful illusion, and genes the key to existence. Spirituality may not be easy to define, but neither is depression, happiness, or any other human state. Functional brain imaging may tell us which areas of the brain are more active when we are depressed, happy or spiritual. It is unable to explain the vibrant world of our experience. To understand spirituality, we still need to grapple with the best phenomenological descriptions we can derive, and seek out what they mean and where they lead.

Researchers who enter this field are often profoundly religious. However, they rarely declare it

Man searches for meaning in every aspect of life. However, we should take care in assuming that spirituality is good for us. Bad things happen to good people. Instead of seeking simplistic linear associations between strong spiritual belief and good health, the focus should move

See Measurement and meaning *on page 10*

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Finding meaning in a child's violent death

By Lawrence VandeCreek

Chaplains provide ministry to parents whose children die violently — by murder, suicide or accident. This universally tragic event has many clinical and pastoral challenges. The article summarized here investigates whether and how parents find meaning in the death. The study of the meaning-making, meaning-finding process can inform pastoral care giving.

This article begins by reviewing theoretical perspectives concerning the search for meaning. They note that religious beliefs can have a major influence on the meaning-making process, claiming the death as "part of God's plan." Most chaplains have heard this expressed in their clinical work.

Most theoretical perspectives give attention primarily to the intrapersonal efforts to find meaning while neglecting interpersonal and social contexts of meaning-making. The authors adapt the theory that meaning-making occurs when persons make the death both comprehensible and significant. Meaning-as-comprehensible refers to "sense-making," creating a way to fit the tragic event into a broader life perspective. Meaning-as-significance refers to finding value in the event, producing a new appreciation of what really matters in life.

The authors comment on seven studies that support the assumption that the search for meaning is both common and essential. The purpose of their study was 1) to describe bereaved parents' process of finding meaning during the first five years following the violent death of a child, 2) to identify predictors of finding meaning, and 3) to describe differences among parents who found meaning and those who did not.

How did the authors conduct the study? They searched official death records for parents who met the following criteria: an unmarried deceased child between the ages of 12 and 28 years at the time of death by accident, homicide, or suicide, at least six but not more than 28 weeks previously. Among the families contacted (N = 329), 204 agreed to participate. Five years later 173 parents remained in the study, consisting of 115 mothers, 58 fathers, including 46 married couples. Parents provided information in small groups at four, seven, and 12 months, and by mail at two years and five years.

Parents responded to a single item: "How have you searched for meaning in your child's death as well as in your own life?" They also provided information concerning the cause of death (because previous research demonstrated that those who suffered homicidal loss coped more poorly), its possible preventability, self-esteem, use of religious coping, and attendance at a support group. They completed materials concerning their mental distress, symptoms of a post-traumatic stress disorder, acceptance of the child's death, marital satisfaction, and physical health status.

What were the results? The authors provide representative statements from parents that indicate their struggle. None of the parents found meaning-as-significance in the first four months after death. Only 12 percent reported finding meaning at the end of the first year. At the end of five years, 57 percent reported finding meaning while 43 percent reported no meaning.

What predicted finding meaning? The strongest predictor was the parent's attendance at support groups; those who attended were four times more likely to find meaning. The use of religious coping also predicted finding meaning; they were more than 1.5 times more likely to find meaning than those who did not use religious coping. Higher self-esteem scores also predicted finding meaning. Parents who believed that the death was preventable were less likely to find meaning. Those without meaning described significantly more mental distress, poorer physical health, and less marital satisfaction.

In closing, the authors compare their results to other studies, propose additional studies and suggest that the education of bereavement counselors, healthcare providers, and the public is crucial because "evidence is mounting that parents do not return to pre-bereavement states." These results suggest that chaplains should encourage support group attendance and give attention to the religious coping.

Reference: S. A. Murphy and L. C. Johnson. 2003. "Finding meaning in a child's violent death: A five-year prospective analysis of parents' personal narratives and empirical data." *Death Studies* 27: 381-404. Includes 42 references.

Lawrence VandeCreek, D.Min., BCC, is a retired APC chaplain living in Bozeman, MT.

Measurement and meaning

Continued from page 9

towards much more fundamental questions about whether belief is necessary at all, whether spirituality is an action rather than a belief, whether health may be neglected in a search for the "Other."

I am skeptical already about our Beliefs and Values Scale, or for that matter any other instrument purporting to measure spirituality. I am less than ever convinced that "belief" is the key. The great philosophical and religious thinkers of the so-called Axial Age 2,500 years ago considered that ethical action defined the religious man and paid no heed to the peculiarities of belief (Jaspers 1948). Can we start to measure openness, generosity and loss of ego? Probably much more difficult, but we'll see.

Michael King is Professor of Primary Care Psychiatry at Royal Free and University College Medical School in London, England.

Congratulations to our newly certified chaplains

The NACC congratulates the following chaplains who earned certification following their interviews this spring.

Rev. Bradley Baldwin, TOR, Hollidaysburg, PA
Ms. Jeanne Barone, Louisville, KY
Dr. Ruby Buffin, San Francisco, CA
Ms. Kathleen Burn, Cleveland, OH
Sr. Maryann Calabrese, CND, Bronx, NY
Mrs. JoAnn Chase, Junction City, WI
Mrs. Diane Clayton, Sheridan, IN
Sr. Francis Cordis Bernardo, SC, Convent Station, NJ
Ms. Maria McLain Cox, Fort Collins, CO
Mr. Mark Dickson, Charleston, SC
Mr. Henry Eichin, New Berlin, WI
Rev. Francis Ejimofor, Toledo, OH
Rev. Mike Ezeatu, Glenville, NY
Sr. Helen Farrell, SND, Chelmsford, MA
Rev. David Fick, Reading, PA
Rev. Robert Fields, Jefferson City, MO
Sr. Sebastiana Filip, CSFN, Chicago, IL
Ms. Maggie Finley, Seattle, WA
Ms. Kathy Haut, Chesterfield, VA
Mrs. Jan Heckroth, Waverly, IA
Rev. Bernardo Iniesta, Yuma, AZ
Sr. Rita Jarrell, OSU, Louisville, KY
Mrs. Margaret Jones, Garden Ridge, TX
Miss Sally Koester, Cincinnati, OH
Mr. William J. McNeeley, Knoxville, TN
Mr. Robert Mundle, Sudbury, Ontario
Mrs. Patricia Paquette, Olathe, KS
Ms. Shannon Queenan, Vine Grove, KY
Ms. Pamela Regner, Redding, CA
Rev. Antony Savarimuthu, Bronx, NY
Mr. Kevin Sheehan, Austin, TX
Ms. Janice Stanton, Minneapolis, MN
Rev. Jean-Rene Talabo, OMI, San Antonio, TX
Rev. Chrysanthus Udoh, Atwater, CA
Ms. Wendy Wilson, Redding, CA
Rev. Roger Yaworski S.J., Maywood, IL
Rev. Louis Yaya, Kingston, NY

Before

By Deborah Cooper

Sometimes
beginning to burn

a log in the fire will sing,
remembering the birds.

A brown bowl
holding three tangerines

holds too, the memory of
the hands that shaped it

and holds the cool,
still silence
of the earth.

Each tangerine
repeats the image
of the sun.

The shadow
that the rocking chair
releases

dances on the wall
like a tree,
answering the wind.

In the dark
we slip, with the breath,
out of our sleeping bodies

into all we knew before.

Deborah Cooper, NACC Cert., is a chaplain emerita in Duluth, MN.

Volunteers' tasks form bonds with elderly

By Lori Curtiss

Soon after Marianne Zoltowski became Coordinator of Spiritual Care at Schuyler Ridge Residential Health Care in Clifton Park, NY, she came upon a resident dying alone. In the following months, she realized that the problem was not an isolated one.

"Residents died alone because family members were unable to be at their side because of old age, sickness, child care responsibilities, employment duties, or travel restraints," she said. "I was inspired to gather volunteers and work with the staff to care for the dying."

For the next two years, Marianne advocated for enhancement of spiritual palliative care while pioneering the grassroots development of Presence, a group of volunteers to journey with the center's residents. Through the dedication of its volunteers and Marianne's support, it has grown into an integrated support system for residents at Schuyler Ridge.

Presence builds relationships that provide support for residents and their families

Coming in to work one morning, she was told that a resident she had seen the evening before had died during the night. Although initially concerned, she was immediately put at ease by the reassuring words of those who had been with this resident. The patient had been in loving hands with the Presence group and Schuyler Ridge staff. Marianne affirms, "We are united in our mission and have experienced a cultural change."

The program was established to accompany residents in their final life experience — the dying process. However, Presence volunteers responded to other needs of the elderly. They initiated regular visits with residents, and volunteers began participating in the weekly Eucharist. They also assist in the interfaith Holy Week retreat, the Schuyler Ridge Christmas pageant, and the resident renewal of wedding vows celebration. They help wheelchair-bound elderly with transportation to activities within the facility. In this way, the Presence group builds relationships that provide emotional, psychological and spiritual support for residents and their families.

Each resident begins a relationship with a Presence volunteer upon entering the facility. The volunteer visits their residents regularly to develop trust and familiarity. The relationship is not necessarily limited to quiet talks only. Enjoying a milkshake together, reorganizing a closet, going outside to feed the birds, whatever the resident's request may be, brings increased opportunity to share time and companionship. Meeting the individual needs of each resident is paramount and further strengthens the bond. Each Presence volunteer helps residents to feel more supported, happier, and better fulfilled, and shares in the enjoyment and celebration of their lives.

New Presence volunteers attend a training seminar and receive materials to bring a deeper meaning and understanding of resident needs. Regular group meetings are held which further support their experiences and include discussions of suggested reading materials. E-mail updates are sent to each volunteer on a regular basis to report resident status as well as ongoing training and activities information. Volunteers are encouraged to consistently address both staff and Marianne with concerns and information.

Presence volunteers offer service for many reasons. My son, Geoffrey, and I came into Presence shortly after the death of our loved one. My grandmother, Amelia Parker, was an alert, proud and caring woman who had lived her 108 years with dignity, strength and much love for her family. The Presence group and Schuyler Ridge staff were a blessing to us all. My grandmother was joyfully welcomed into the residence and was always treated with respect, compassionate care, and appreciation for her life. Comfort and support were consistently offered to our family.

For us, joining Presence was a way to give back to a facility which offered their very best for my grandmother. It is also a way to move forward, while staying close. The privilege of giving comfort to those in need gives back so much more in return.

My son, age 15, shared a remarkable relationship with his great-grandmother which transcended generation, and he misses her very much. During a memorial service at Schuyler Ridge, he eulogized her with a summarization of essays he had written about her life. This experience then developed into interviewing the residents and writing essays about their lives. The residents greatly enjoyed telling their life stories to a young person who is so interested in them; sometimes they even recalled memories that they hadn't thought of for years, a bit of new history for their families to treasure. After completing a number of essays, Geoffrey has chosen to stay on with those he has gotten to know so well. Presence bonds do bring comfort and joy to both sides of each relationship.

Although many needs may be anticipated, Presence continues to change and grow based on the voice of the people it serves. Feedback from the residents and their families is of the utmost importance, and there is an ongoing communication between staff, volunteers, residents and their families to ascertain effectiveness in care and satisfaction.

The quality of end-of-life care is complicated to measure, and there are no means to statistically evaluate treatment results when death is the outcome. However, care is evaluated from the personal experiences of the residents, their family and friends, Presence volunteers, and Schuyler Ridge staff. Routine staff and volunteer surveys as well as resident and family assessments also collect information to evaluate care, symptom relief and satisfaction. Communication ensures that end-of-life wants, needs and wishes are understood, and it also empowers the families, allowing them the opportunity to share their feelings.

Presence at Schuyler Ridge, an idea born out of receptiveness to need, reflects and values the moment-to-moment

quality of our time, and the celebration of our lives, together. It adds dignity to the living and support for the dying, as we honor the choices of the 120 residents that we serve and the wishes of the families. In this process, the Presence volunteers have grown as well. They are a unique membership of highly trained, experienced people from varied walks of life, dedicated to the spiritual well being of the elderly here at Schuyler Ridge.

Lori Curtiss is a volunteer at Schuyler Ridge Residential Health Care in Clifton Park, NY.

Vision to continue senior-care discussion

Vision is planning a theme issue on the topic of care for the elderly for January 2007. We would like to invite our readers to submit reflections and articles for this special section in order to explore this important and growing segment of chaplaincy.

Possible issues to address include:

- What are the unique pastoral-care needs of older adults?
- Where and how are elders themselves creating community? How does ministry support or contribute to their efforts?
- How can senior communities reach out to and mix with other generations, rather than being segregated?
- How can we expect ministry to the elderly to change in coming years, as baby boomers age, more care moves out of the inpatient environment, and other trends develop?
- What has working with the elderly taught you about your own aging process?
- How does chaplaincy in long-term care differ from an acute-care setting? What are the perceptions/misperceptions about the former that your colleagues in hospital ministry should know about?

We hope that these ideas will suggest other possibilities to you, as well. Please submit articles or ideas for articles to dlewellen@nacc.org or write to David Lewellen, NACC, 3501 S. Lake Drive, Milwaukee, WI 53207-0473. The deadline is Nov. 15.

Support group brings reiki to facility

By Marianne Zoltowski

Among the offshoots of the Presence group at Schuyler Ridge has been an energy healing group. The group began early in 2003 with two practitioners volunteering their time weekly and attending to about six residents. But the numbers increased quickly. Today, the volunteers average from eight to ten members for any one session, and about 33 residents are receiving treatment. Because of the popularity of energy healing, they now meet twice a month for two to three hours.

Energy healing began with two gifted Presence members, Ann Safier, who is at the reiki Karjuna level, and Marilyn Williams, who is a reiki master, certified in healing touch. I was trained in reiki at that time and delighted in the gift of two other practitioners who were willing to volunteer. With the encouragement of the interdisciplinary team at Schuyler Ridge, we applied our skill on a number of residents, with positive results. As volunteers became aware of and observed the reiki treatment, more expressed interest in being trained as well. Reiki has made a palpable impact in the quality of life for many at Schuyler Ridge.

Reiki is an ancient form of healing. The word describes both energy and non-invasive healing techniques used to maintain health, by channeling this universal energy or life-force. Reiki energy comes through, not from, the practitioner. Our energy healing volunteer practitioners are trained in healing touch, reiki, and pranic healing.

Healing energy therapy is a non-invasive and proactive healing practice, offered to residents. It involves channeling of energy through the host to the recipient. Hands are gently placed on or slightly above the body to allow the energy to flow and be received where it is needed. This allows the resident to join in this healing process with the practitioner. Healing energy may be viewed as universal energy or energy from God, but most importantly it is energy given to help for the purpose of healing. Healing Energy therapy provides enormous comfort and feelings of peace to those involved while soothing the mind, body and soul.

At a discussion with the residents and family members, about five practitioners presented a brief summary and explanation of the training involved in becoming a reiki practitioner. Resident comments included the experience of "less pain," of a "release of emotions," and the surfacing of emotions such as gratitude, love and peace. Residents also have expressed such enthusiastic feedback as "I shake thinking about it," or "I trust in God and feel good afterwards." It has been documented that people undergoing reiki healing energy have seen their medication work better and recovered from surgery more quickly.

Once the regular sessions were up and running, the volunteer practitioners and I composed a brief survey to track the effect of energy healing on the participating residents. The residents were identified by first and last initials, unit of residence, sex, and communication abilities. The survey contained questions regarding level of pain before and after treatment. The results echoed the reports from elsewhere. Residents reported experiencing a significant reduction in pain. Any expression of pain was reported to the nurse manager on each resident's unit.

All residents who were surveyed said they would like to return to the Energy Healing program. The response indicated that our residents felt blessed by the healing energy program. As the result of our volunteers' generous giving of themselves and their time, 40 residents receive personal and loving energy, vital for healing and quality of life. The loving energy flows palpably throughout Schuyler Ridge.

Marianne Zoltowski, NACC Cert., Reiki Master, is a chaplain at Schuyler Ridge, Seton Health Care, Clifton Park, NY.

CD creates soothing bedside environment

Loom of Love; *Musical Director: Gary Plouff; produced by Strings of Compassion, PO Box 10905, Eugene, OR 97440-9904*

By Carey Landry

When my mother-in-law was dying in 1998, her ten children kept vigil throughout her final days. As they did so, instrumental music from my own "Gentle Sounds" played softly in the background. With all of her children around her bed, she gently breathed her last. The beautiful smile on her face reflected a deep sense of peace, and we were filled with gratitude and awe in this most sacred moment with her.

Without knowing it, I had just experienced a form of music-thanatology. Since then, I have come to know that trained music-thanatologists, through the use of harp and voice, offer a musical vigil at the bedside of those nearing the end of life. Just as David's harp playing is described as relieving King Saul of suffering in I Samuel 16:14-23, they offer "prescriptive" music which "eases physical, emotional and spiritual pain and creates an atmosphere of loving kindness, beauty and peace that supports the soul in transition" for both patients and their families.

The artists who created "Loom of Love" are trained music-thanatologists from the Pacific Northwest. They have created a stunningly beautiful recording. They are the first to tell you, in their liner notes, that "this recording is not intended to replace the music-thanatologist's vigil, yet it is lovingly offered to you with the same generous spirit that these musicians bring to the bedside."

For the many of us who do not have trained music-thanatologists on our staff, this recording is a welcome addition. Time and time again, I have seen how well music ministers to both patients and their families as a patient is dying. "Loom of Love" is an excellent balance of harp music and sung music, with the sung music accompanied by the harp. The order of the music seems to imitate the final journey, and I found myself being carried emotionally to the final songs of "Calling All Angels" and "Blessing of the Road." My own favorite in the collection is "The Shearin's No For You," an exquisite harp rendition of the traditional Scottish song which John Bell adapted for his song, "The Summons." The entire recording is soothing, comforting and deeply relaxing. You may even want to use it as a means of prayerful relaxation for yourself.

Some of the music will be familiar, especially the Chant to Catholics, but some of it will not be. It is important to note that for patients who are actively dying, "favorite" music, replete with layers of unknown and profound associations, memories and experiences, may be binding, rather than liberating and peace-giving. This certainly is not always the case, but it may be.

I highly recommend "Loom of Love." I believe your patients will be anointed with sound when they hear this recording, and the music will benefit them emotionally and spiritually. Your purchase will support Strings of Compassion and dedicated, compassionate caregivers who offer spiritual and emotional comfort to patients and their families through music.

Carey Landry, NACC Cert., is a chaplain at St. Vincent-Carmel and Seton Specialty Hospital in Carmel, IN.

ITE training

Interview Team Educators Cathy Connolly (standing) and Sharon Mason confer during ITE training in Milwaukee in July. The ITEs offer training and support to the NACC's volunteer interviewers before they meet with candidates for certification.

Friar-physician seeks to link spirit, healthcare

The Rebirth of the Clinic: *An Introduction to Spirituality in Health Care*
By Daniel P. Sulmasy, O.F.M., M.D.; Georgetown University Press; Washington, D.C.; 2006; $26.95

By Colette Hanlon

For those of us who have had the pleasure of hearing Dr. Dan Sulmasy speak, some of the material in this book will not be new. However, he has gathered his material together in three parts to provide medical practitioners with a reflective basis for seeing the integral nature of spirituality and healthcare. In Part I, Sulmasy explores the nature of illness and that of healing from an historical perspective. He argues that the taking of oaths is the last spiritual sign in modern medicine, and he offers ways to revitalize the meaning of physicians' oaths.

In Part II he discusses the empirical studies about spirituality and identifies his serious reservations about their limitations. Instead, he proposes a bio-psychosocial-spiritual model and encourages all healthcare professionals to attend to the spiritual needs of patients as a moral obligation. Part III focuses on some spiritual questions that often arise at the end of life, offering cogent reflections on the play "Wit." (As a person who saw the movie version — and often uses it in teaching end-of-life ethics — I found some disagreement with his perception of Susie, the nurse, who was, for me, the most humane and Christ-like person in the film. But perhaps the live play is very different.)

Sulmasy makes no apology for his perspective as a Roman Catholic and a Franciscan friar, as well as a physician. He exhibits a refreshing openness in his willingness to share both moments of success and times when he experienced failure and the reality of medical mistakes. Yet he draws insight and wisdom from all these experiences and from the patients, families, interdisciplinary staff, and physicians with whom he has practiced. Many of his stories are profoundly moving and give flesh to the heavy philosophical bent of some chapters of the book.

He gives both a boost and a challenge to pastoral care when addressing how spirituality should be seen in a healthcare setting. Sulmasy suggests three models: The Doctor-Priest Model, the Parallel Track Model; and the Collaborative Model. He recommends the latter, in which interdisciplinary colleagues work together, communicating clearly — verbally and in writing — about what would be best for a particular patient. He states that this will require sustained, systematic, interdisciplinary reflection.

I especially appreciated his inclusion of poetry, woven throughout, to capture the profound mystery of the human person in the face of suffering. His goal in writing this book is to remind the reader that to be a healer, one must first be a person — a spiritual being — since healthcare is a spiritual discipline.

Sr. Colette Hanlon, S.C., M.E.D., M.A., NACC Cert., is Director of Pastoral Care and Patient Relations at Hospital of Saint Raphael, New Haven, CT.

Song written for NACC available in print

A song familiar to many chaplains from NACC gatherings is now available in print.

"O Jesus, Healer of Wounded Souls," which composer Peter Rubalcava wrote specifically for the NACC's 2001 symposium on the Anointing of the Sick, has recently been published by Oregon Catholic Press.

Rubalcava wrote the piece at the invitation of Rev. Joseph Driscoll, who was then the NACC's executive director. It has been played and sung at many association events since it debuted. "People used it, and people asked for it," he said. It had been stuck in a backlog for publication at Oregon Catholic Press, but this year "my number came up, I guess."

The song consists of a refrain and four verses. Rubalcava wrote the words himself, based on concepts from the liturgy for the sacrament. The tune, he said, came to him while he was driving to work. Tunes often pop into his head, but "if I remember it, that's a good sign."

"Chaplains came to know it and asked for it," he said. "I'm happy that it's available for people to use, even folks who aren't chaplains. People appreciate the theme and having something specific for the anointing of the sick."

For information on ordering the sheet music to "O Jesus, Healer of Wounded Souls," visit www.ocp.org or call 1-800-LITURGY.

Prayer Shawl

for Chaplain Linda Piotrowski

By Becky Evans

These cold winter mornings
before the house warms up,
I rise thankless for another day
of aches and pain, put on my robe
and slippers, whip the long blue
comfort shawl over my shoulder
and shuffle grumbly into the kitchen
to make coffee. Out the window
I notice a blanket of new snow
has covered the ground.

Cupping my steaming mug, I sit and
sip, and drink in metaphors, think:
shelter, blankets, thick comforters,
and people I don't know who have
none. Light, warm, soft, luxurious,
my prayer shawl, a chaplain's gift, knit
by a caring stranger's prayerful hands,
hands that soothe untold human hurts,
wraps me snugly, like an embrace,
this morning's blessing.

Becky Evans, the former editor of Vision, received a prayer shawl following a hospitalization. For more information about the Prayer Shawl Ministry, see the July 2004 edition of Vision (available online at www.nacc.org).

In Memoriam

Please remember in your prayers:

Mr. John Caulfield, who died June 24 in Apopka, FL. He served as the third President of the National Association of Catholic Chaplains, from 1968 to 1969. After helping the association through its early years, he moved on, although he rejoined the NACC briefly as a supervisor in the 1980s. His wife, Rev. Marie Caulfield, is an affiliate member.

Edwin D. Poulsom, who died in March at age 77 in Mercer Island, WA. After a career as a hospital pathologist, he retired from medicine and joined the NACC in 1992. He took affiliate status in 1994.

What do you think?

In response to our question in June about addressing cultural diversity in your institutions, we offer the following:

From Nancy Schweers, CHRISTUS Santa Rosa, San Antonio, TX

Cultural diversity is in the very roots of CHRISTUS Santa Rosa City Centre. Over 100 years ago, our founders emigrated from France to minister to the Anglo, German, Mexican, and native people of San Antonio. The hospital is located in the very heart of the rich multiculturalism of our city.

A beautiful wall hanging in the CPE classroom tells of the wide variety of cultures represented by the interns themselves: Nigeria, Haiti, Germany, Congo, and Mexico, to name a few. The experience of patient visits and staff interaction is enhanced by instruction in Pastoral Spanish and participation in local cultural events such as Fiesta San Jacinto and Good Friday Pageant.

Chaplains are Canadian, Mexican-American, Filipino, European-American. We celebrate *Dia de los Muertos* and Our Lady of Guadalupe with enthusiasm. The Education Department offers presentations on the tradition of the traditional Mexican healers called *curanderos*. Most literature is in Spanish and English. We have become sensitive to the values of *la familia* in visiting norms and decision-making. Most recently, growing awareness of immigration issues has sharpened attention to the unique needs of families separated by the Rio Grande and the emerging sense of empowerment of Hispanic Americans. Come see us. *Bienvendos.*

Our next question to consider: **How can chaplains help in downsizing situations?** Have you been through a time when your employer laid people off? What spiritual resources could you offer to the workers who were let go?

Please send answers of 200 words or less by Oct. 9 to dlewellen@nacc.org, or mail them to David Lewellen, NACC, 3501 S. Lake Dr., Milwaukee, WI 53207-0473.

Positions Available

DIRECTOR OF CPE

Boston, MA - The Caritas Christi CPE program extends across three locations in Caritas Christi's six-hospital system (second largest in New England), and consistently seeks to respond to the training needs of area ministers. Shifts in health care have prompted creative changes in each of three component sites in terms of outreach and new developments in programming. Each site offers CPE units in response to a variety of students' scheduling needs. The CPE Director exercises responsibility in keeping with the mission and vision of the Caritas Christi system, in collaboration with the Senior Vice President of Mission & Organizational Development, with the CPE supervisors in the component sites, spiritual care directors, and the Professional Consultation/Advisory Committee. Confidential point of contact: leaders@caritaschristi.org - Steve Baraban, Director of Executive Recruitment.

CHAPLAIN OF ENRICHMENT MINISTRIES

Kirkland, WA – Our Chaplain promotes fullness of life for persons with disabilities by providing community-based pastoral care leadership with adults with physical and/or intellectual disabilities. The Chaplain provides a compassionate, respectful pastoral presence, attentive listening, sees persons from a "capacity" perspective and is able to engage with persons without seeking to "fix" them. Through one-on-one pastoral care, small group facilitation and retreats, the Chaplain nurtures personal and spiritual growth and assists persons in building meaningful relationships within the church/community. Our nonprofit, ecumenical, Christian-based organization is located in Kirkland, WA. Contact (425) 828-1431 or bridge@bridgemin.org for a job description.

STAFF CHAPLAIN

Trumbull, CT – St. Joseph's Manor, a 297-bed long-term care facility, is seeking a full-time certified Catholic chaplain to join our spiritual care team. Responsibilities will include providing pastoral support to residents, families, and staff, computerized charting of residents' spiritual health and well-being, participating in resident care planning meetings, and assisting with liturgical and sacramental services. Position requires ecclesiastical endorsement, certification with NACC, and a minimum of one year's experience in pastoral ministry in a health-care environment. Winner of Circle of Life Award for innovation in end-of-life care, we offer a competitive salary and excellent benefits. Please fax, send, or email your resume, with salary requirements, to: St. Joseph's Manor, 6448 Main St., Trumbull, CT 06611, fax (203) 268-3394, humanresources@stjosephsmanor.org. Visit our website: www.stjosephsmanor.org

STAFF CATHOLIC PRIEST

St. Louis, MO – Full-time position with established integrated Pastoral Care program for Christian Hospital, a 463 bed acute care adult hospital. CH Pastoral Care is a person-centered, discipline-based, outcome-oriented service. CH is accredited by ACPE to offer all CPE programming and is a part of the St. Louis Cluster, ACPE. The department provides sacramental and supportive ministries; regular and Holy Day Mass and other worship opportunities for Roman Catholic patients, their families, hospital staff and physicians; coordinates, facilitates and supports the ministry of the department's eucharistic ministers, sacristans, and deacons; and coordinates ministry of on-call priests for patients, families and hospital staff. Qualified applicants must be ordained and in good standing. Previous health care experience and training preferred. We offer a competitive salary and benefits package. Send resume to Chaplain Jill Walter-Penn, Director, Pastoral Care Department, Christian Hospital, 11133 Dunn Road, St. Louis, MO 63136; (314) 653-5612; jwp5407@bjc.org; or Patty Kallal, Recruiter, Human Resources, Christian Hospital, 11133 Dunn Road, St. Louis, MO 63136; (314) 653-5639. You can also apply online at www.christianhospital.org.

PRIEST CHAPLAIN

Indianapolis, IN – Clarian Health Partners Inc. is seeking a full-time Roman Catholic priest chaplain to serve the spiritual and sacramental needs of our Roman Catholic patients, loved ones and staff as a member of our large and well-established Chaplaincy and Pastoral Education Department. This position primarily serves an 800-bed tertiary care hospital that is part of a three-hospital healthcare system located in downtown Indianapolis. Qualifications include master's degree in theology, pastoral ministry, divinity or religious studies; ordination and ecclesiastical endorsement; minimum of 4 units of CPE; professional certification complete or in process with APC or NACC. Competitive salary and benefits. Apply online at www.clarian.org/clarianjobs.

PRIEST CHAPLAIN

Washington, DC – Georgetown University Hospital has an immediate opening for a priest chaplain. This position provides for pastoral care to patients, patients' families, and staff of Georgetown University Hospital. The position provides for the administration of Roman Catholic sacraments and other worship services. The position will provide for support to the department's educational activities and activities in support of the hospital's Jesuit and Catholic identity. Interested candidates contact Brian J. Conley, S.J., Director Mission and Pastoral Care, Georgetown University Hospital – Main 1, 3800 Reservoir Road NW, Washington DC 20007; phone (202) 444-3030 or e-mail conleyb@gunet.georgetown.edu.

CHAPLAINS

Seattle, WA – Providence Senior & Community Services has exciting opportunities for chaplains in the Greater Seattle area. Opportunities are available in our hospice, long-term care and adult day health divisions — full time, part time, and on call. Chaplains provide pastoral counseling and guidance to residents, family members and facility staff; religious services as requested; and assist residents, families and staff with a variety of spiritual issues including end-of-life issues. Requirements: Master's degree in theology, pastoral ministry, or related field; completion of accredited NACC or CPE program and current certification by NACC or comparable accrediting authority; minimum 1 year clinical pastoral education including orientation to health care practices; minimum 2 years pastoral ministry experience with demonstrated interfaith experience; basic proficiency with computer software (MS Office). To apply or for more information, please contact Kris Williams, Sr. Recruiting Consultant, at kris.williams@providence.org or apply online at

Positions Available

www.providence.org/careers. At Providence Health & Services, we take care of our employees. We offer competitive salaries, an excellent variety of benefits, and outstanding opportunities to enhance and advance your career. Our core values of respect, compassion, justice, excellence and stewardship are reflected within all working relationships by demonstrating teamwork, dedication and service excellence.

▼ PASTORAL CARE DIRECTOR

Edgewood, KY – Excellent opportunity to join our management team! This position requires a master's in divinity, religious education or counseling, NACC or APC certification, 3 CPE units, 2 years hospital pastoral care as well as solid management experience, knowledge and acceptance of the Ethical and Religious Directives for Catholic Healthcare Services, as well as ministering to various faith traditions. Advanced CPE preferred. St. Elizabeth Medical Center, located just minutes from downtown Cincinnati, provides nationally recognized health care and has been serving the needs of Northern Kentucky since 1861. Resumes can be submitted in confidence by faxing to (859) 301-5178 or mailing directly to St. Elizabeth Medical Center, 20 Medical Village Drive, Suite 271, Edgewood, KY 41017. www.stelizabeth.com EOE: M/F/D/V

▼ PRIEST CHAPLAIN

Austin, TX – Discover a family of hospitals devoted to your career. No matter what your expertise or specialty, everyone throughout our family plays a part in our mission of care. From growth opportunities to professional development, discover the difference and the rewards of achieving with a hospital system that's dedicated to serving all people. Minimum Qualifications: Bachelor's degree required. Master's degree in theology from accredited seminary. Ordination as a Roman Catholic priest required. In good standing and ecclesiastical endorsement from Bishop of the Diocese of Austin required. Current certification or eligibility for certification within two years of employment as Board Certified Chaplain required. Four units of Clinical Pastoral Education training in accredited center. Previous experience in pastoral care ministry required. Prefer bilingual (Spanish and English). Our expansive network includes eight hospitals, four of which are Magnet-designated, with a total of 22 facilities. Explore opportunities with the Seton family of hospitals in and around Austin – one of Texas' most incredible cities. For more information and to apply online visit: www.seton.net/careers. EOE

▼ DIRECTOR OF SPIRITUAL CARE

Zanesville, OH – Located in beautiful southeastern Ohio, Genesis Healthcare is a 500-plus-bed, two-campus facility serving patients from an 11-county area. Among its premier services are a rapidly growing cardiothoracic surgery program, a dedicated inpatient cancer unit affiliated with the Arthur G. James Center Hospital and Richard J. Solove Research Center, and a Level II NICU. The mission of Spiritual Care is to promote holistic health in collaboration with other Genesis staff by providing emotional and spiritual support to patients, families, staff and the local community. The Director will supervise the provision of spiritual services according to the standards of the Spiritual Care Department, the APC and the NACC. The Director is required to work with personnel of all religious faiths and support cultural diversity in the workplace. Crisis intervention, resolving ethical issues, and implementation of a comprehensive program of spiritual care are key components of this position. Qualified candidates must possess a master of divinity, theology, or pastoral ministry degree, plus four units of CPE. Three to five years management experience in the healthcare environment is required, preferably in pastoral care program development and implementation. Ordination or commission to function in a ministry of pastoral care by appropriate religious authority is required, in addition to certification in the APC and/or the NACC. Qualified candidates please send resume to: Karen Eyberger, Employment Manager; Genesis HealthCare System Attn: Human Resources; 2951 Maple Ave., Zanesville, OH 43701; e-mail: keyberger@genesishcs.org; fax (740) 454-4529; phone (740) 450-6124; website: www.genesishcs.org

▼ VICE PRESIDENT, MISSION EFFECTIVENESS

Portland, ME – Mercy Hospital seeks a VP Mission Effectiveness. We seek an effective leader to promote and integrate our mission and values throughout Mercy Health System of Maine. The position provides administrative leadership to mission-related departments and serves as a liaison to the sponsoring Sisters of Mercy community and other religious and community organizations. A graduate degree in theology or related area is required. Knowledge of Catholic healthcare tradition and social teachings. A minimum of five (5) years leadership experience, preferably at an executive level. Proven ability to foster community relationships and to work collaboratively to guide projects to successful completion. To apply online, please go to www.mercyhospital.org.

▼ DIRECTOR OF PASTORAL CARE

Cedar Rapids, IA – Mercy Medical Center, located in Eastern Iowa, is a 353-bed private hospital and state-of-the-art Level II trauma center with a caring attitude toward employees, patients and their families. In keeping with the mission, vision and values of Mercy Medical Center, we are seeking a Director for our Pastoral Care Department. In this compassionate role, you will use your leadership and communication talents to assume responsibility for efficiently and effectively managing and directing the department, while also promoting empathy, respect and ethical decision-making. To achieve your intra-departmental initiatives, you will work collaboratively with physicians, hospital employees, volunteers and clergy persons to support quality care to patients and their families. Our ideal candidate will be a practicing Roman Catholic with strong knowledge of Ethical and Religious Directives for Catholic Health Care Services, as well as a bachelor's degree in a related field. You should have at least five years of experience in health care pastoral ministry, two years of which in a leadership capacity, and certification by the NACC, ACPE or APC. Experience the enviable quality of life, low cost of living and work/life balance you can only find in Cedar Rapids, Iowa. We are located just 25 miles from the University of Iowa and equidistant from Chicago, Minneapolis, St. Louis and Kansas City. We offer a competitive salary and excellent benefits package. Please send/fax your resume to: Human Resources, Mercy Medical Center, 701 10th St. SE, Cedar Rapids,

IA, 52403. Ph: 319-369-4699. Fax: 319-369-4530. Email: empcoord@mercycare.org. EOE. www.mercycare.org

▼ DIRECTOR, PASTORAL CARE

Mineola, NY – To head a department at Winthrop University Hospital on Long Island, NY as a staff member of The HealthCare Chaplaincy. The Director will have the opportunity to continue building an existing pastoral care department, which currently has two staff chaplains and participates in one of the country's preeminent pastoral care and training organizations. Winthrop is a very well regarded 600-bed community hospital with a Level I trauma center and a full range of medical specialties (www.winthrop.org). Qualifications: ACPE, APC, NACC, or NAJC certified, high energy with a well-developed sense of the role of professional chaplaincy, excellent clinical skills, and an ability to handle all aspects of pastoral care administration. Send resumes to: The Rev. George Handzo, Associate Vice President, Strategic Development, The HealthCare Chaplaincy, 307 E. 60th St., New York, N.Y. 10022 (ghandzo@healthcarechaplaincy.org)

▼ CATHOLIC STAFF CHAPLAIN

Indianapolis, IN – Community Health Network is one of the largest health care providers in Indiana and a leader in providing compassionate, quality health care services. Community Hospital East seeks a full-time Catholic chaplain to provide a comprehensive interfaith program to meet the spiritual and pastoral care needs of patients and their families; provide consultation and support for hospital employees, medical staff, and visiting clergy; provide overall supervision of the Eucharistic Lay Minister program; facilitate the chaplaincy services provided to Catholic patients by visiting priests; and maintain regular contact with local Catholic clergy. Qualified candidates will have a bachelor's degree with some postgraduate training in pastoral care and/or counseling, be in good standing with their order, have successfully completed four units of clinical pastoral education, be certified by or a member of the National Association of Catholic Chaplains, and be in good standing with the Catholic Church. At least three years' experience in a parish setting or equivalent is preferred. Interested candidates should visit eCommunity.com/employment for more information and to apply online. EOE.

▼ PRIEST CHAPLAIN

LONG BEACH, CA – St. Mary Medical Center, a 500-bed teaching hospital and trauma center associated with UCLA, has an exciting opportunity for a certified Catholic priest in good standing to be a part of our pastoral care services team. SMMC has a vibrant tradition of service to a diverse community in an urban Southern California setting. Desired gifts include: good collegial skills, an interdisciplinary approach to care, fluency in Spanish, comfortable in multi-cultural settings, and a desire for progressive growth in healthcare ministry. As a member of Catholic Healthcare West, we offer competitive professional compensation and excellent benefits. We would invite you explore the possibility; you'd be glad you did. Please apply <https://chw.recruitmax.com/ENG/candidates/default.cfm?szCategory=jobprofile&szOrderID=22662>

▼ DIRECTOR OF SPIRITUAL CARE

San Pedro, CA – Little Company of Mary Service Area, a member of Providence Health and Services, is composed of two acute facilities, three sub-acute facilities, and other health services in South Bay. We provide holistic health care in a mission- and core-value-based Catholic health care ministry. Based at our southern hospital, the Director leads the Spiritual Care Department team. The position requires a graduate degree in theology. Required certification in the NACC or APC. Two years chaplaincy service in an acute setting and excellent pastoral skills, along with demonstrated administrative, organizational, and management skills for three years are necessary. Interested applicants can email: cindy.mizuno@providence.org or fax: (310) 543-5897

▼ MANAGER of CPE

Corpus Christi, TX – "Our Lord Jesus Christ, suffering in the persons of a multitude of sick and infirm of every kind, seeks relief at your hands." This request, written by Bishop Claude Dubuis to the founding sisters over 135 years ago, continues to be the foundation of our ministry today. CHRISTUS Spohn Health System is seeking an innovative Clinical Pastoral Education Supervisor to provide leadership for the CPE Center. Our health system consists of six hospitals, outpatient clinics and other health services. The Spiritual Care Department includes chaplains and volunteers from many faith traditions, and our Clinical Pastoral Education program was established over thirty years ago. Qualifications: Master of Divinity degree or equivalent, supervisory certification through ACPE, endorsement by faith group, and chaplaincy certification by the NACC, APC, or NAJC. The ideal candidate will have 5 years experience as a CPE supervisor and 2 years administering a CPE program.
Competencies required for this position are: Knowledge of the standards and practices of ACPE and proven abilities in successfully administering a CPE program; skills in organizing, writing and presenting reports, including CPE student evaluations and ACPE reports; facility in establishing effective working relationships with health system employees, volunteers and physicians, community clergy, and seminary representatives; ability to organize and present a variety of educational programs; ability to provide effective pastoral/spiritual care and provide mentorship to students in this area; ability to work as a member of the interdisciplinary team, provide professional consultation and documentation regarding patients' spiritual needs and plan of care. Corpus Christi is located on the Gulf of Mexico about 150 miles from San Antonio and 200 miles from Houston. It is a growing city, but still small enough to be easy to get around, with a population in the county of approximately 330,000. Being a tourist destination lends a relaxed feeling to the community, and we enjoy an abundance of sun and gentle sea breezes. Interested applicants can see more about our health system on the website at http://www.christusspohn.org. For more information, please contact Tim Samet by phone at (361) 881-3135 or email tim.samet@christushealth.org.

Positions Wanted

NACC-certification-eligible chaplain seeks full-time work as a staff chaplain, preferably in the NJ, PA, or Baltimore, MD area, beginning in October. Prefer a hospital or hospice facility. Please contact: Brenda E. Rowe, RSM, 1645 Highway 22 West, Watchung, NJ 07069; rsmbrowe@aol.com or browe6195@yahoo.com

Board of Directors

Calendar

October

7-8	Chaplain certification interviews in Portland, OR, Milwaukee, St. Louis, and Boston
9	Copy deadline, November-December *Vision*
22-28	Pastoral Care Week

November

2-5	National Certification Committee meeting, Milwaukee
4	Supervisor certification interviews, Milwaukee
9-10	Board of Directors meeting, Milwaukee
13-16	USCCB meeting, Baltimore, MD
14	NACC Episcopal Advisory Council meeting, Baltimore, MD
15	Copy deadline, January *Vision*
23	Thanksgiving; national office closed
24	National office closed

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