Nurse assistant sees dignity in suffering

By Amy Chabot

“Helen” is a nursing home resident with whom I used to spend my afternoons. Helen was unable to speak clearly or communicate her needs effectively because she suffered from dementia. While I was working with her, she would become agitated because she couldn’t verbally express her needs. At first I felt lost; I couldn’t relate to Helen’s suffering and I did not even know where to begin to try to communicate with her. Yet every day, for two months, I would sit with her and come up with new ways of keeping her occupied.

Helen would have good days, when she could clearly form sentences such as “I like that” or “That’s terrible.” Taking advantage of these moments, I would ask her questions about what she needed or wanted to do. When her children came to visit, they told me that Helen was an artist whose paintings had been displayed at a well-known museum. This information helped me to see her as a whole person, rather than “the woman with Alzheimer’s.”

I took Helen to different activities and found that she was more awake at musical events. One time I even danced with her at a polka concert. She sat in her wheelchair, and I stood in front of her, holding her hands and moving her arms to the beat of the music. I danced and smiled while she smiled back, her eyes glowing, and she even sang along as best as she could. After that, I discovered that if she appeared scared or agitated, all I had to do was sing to her and she quieted down, feeling secure. We began to build a relationship. And through that relationship, I began to see this dying woman in a new light. I saw that she suffered in silence and with dignity, a charisma that demanded respect.

The suffering of long-term care residents is silent not because they refuse to voice their pain; they do. It is silent because their lives are slowly slipping away and they’ve become dependent upon others for their ever-basic needs. Living in a culture that sees dependency as a weakness, nursing home residents have embraced that weakness, however reluctantly, and their dignity shines forth.

Nursing home residents come to depend upon a certified nursing assistant as a confidant, consoler and companion. This has offered me many unexpected opportunities for growing and reflecting in my own life. I am a CNA, 25 years old and preparing for graduate school, with a career goal of chaplaincy. My job entails helping residents with their most basic physical needs. Often, however, they are experiencing much spiritual agony as well, and I am surprised by how much of my job involves ministerial skills. For example, on a daily basis, I calm confused and/or anxious residents, giving them the gift of presence. Before I enter a resident’s room, I pray that I might bring the consolation of Jesus’ peaceful presence to this resident. The

See Nurse’s assistant on page 6
Letters

Offer NACC a sacrifice beyond dues increase

Editor:

Many thanks to our interim director, Rev. Thomas Landry, Board Chair Karen Pugliese, members of the Board of Directors of NACC, and NACC office staff. I look to NACC for leadership, advocacy and professional training. You never fail to deliver. The recent issues of Vision are filled with exciting and hopeful information about your diligent work on behalf of our organization.

I opened Fr. Tom’s letter of October 26, 2006 with some trepidation. I had been anticipating an increase in our dues. I knew it had been some time since dues had increased. While I dreaded it, I knew from my daily living expenses that an increase was long overdue.

I was delightfully surprised to see that the increase in dues is so small. To increase only $10 a year is incredible. Don’t get me wrong! I’m not asking for a higher increase. I’m just amazed that NACC’s many activities and initiatives along with daily operations can be accomplished on such a tight budget.

I’ve prayed and meditated on the challenges facing us as an organization and the challenges in ministry that I experience on a daily basis. I reflected on the personal sacrifices made by so many Board and Committee members to do the work of NACC.

In prayer I asked myself what I sacrifice on behalf of NACC. I realized that I sacrifice very little. I cast about for something that I could do, if only as a symbolic act. I thought about how blessed I am in my life and my ministry.

A light dawned. At least once a week I buy myself a $1 soda at the hospital cafeteria. That’s $52 a year. I decided then and there to write a check to NACC for $52. I’ll sacrifice that soda once a week as a sign of my commitment and gratitude to NACC, Fr. Tom, the board and committee members.

How about it, fellow chaplains? Just think of what NACC might accomplish if each one of us sacrificed a little something to show our director, board and outside funders that we are committed to our organization!

Linda F. Pietrowski, MTS, NACC Cert.
Dartmouth-Hitchcock Medical Center
Lebanon, NH

No reason why chaplains can’t bill

Editor:

In regard to billing (September 2006 Vision), both sides of this discussion have valid points. I have no problem with billing for my services. I come from the medical world (21 years as a physician assistant) and am accustomed to having my services billed, either under my own name or the name of my supervising physician. As a PA, I provided as much spiritual care to my patients as I could without overstepping my boundaries. Now I have the joy of providing spiritual care all day without the risk of being questioned!

I see no reason why pastoral care services could not be billed in a similar fashion as a healthcare provider, that is, according to time and complexity. Mr. Bowman and Rev. Broccolo comment that “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?” The same is true for any healthcare provider. They also “minister” to family members and staff, as well as patients/residents. Some time is expected to be “free” — for example, the corridor consultation or phone calls. But otherwise, there are codes for various levels of time spent in patient care. New codes are developed as needed for new procedures, lab tests, diagnostic studies, etc. Codes can be developed for spiritual care as well.

I know there are many underpaid chaplains out there. I count myself among them. If we bill for our services, the facilities that graciously pay us “what they can” will be able to pay us what we are worth.

Pat Gavula
Norridgewock, ME

Book review was overly critical

Editor:

In reading Rabbi David Zucker’s comments about the Handbook for Chaplains by Mary Toole in the October issue of Vision, it appears he is overly critical. While I understand his expertise comes from his Jewish background, he writes, “What is true for me can be true for participants of other cited religions.” It does not seem fair to lump every religion presented in the handbook into a negative category.

As a chaplain intern at Mercy Hospital on Long Island, I have found Mary Toole’s Handbook an excellent resource of significant beliefs, birth, diet, sickness, dying/death, prayers, etc. for various religions. Ms. Toole does not claim this is an entire word on each religion, but provides sufficient introductory information for each religion in a concise format. The particular printed prayers provide a starting point of sincerity and application to a patient’s specific needs.

Rabbi Zucker states, “An educated, professional, experienced chaplain can offer comfort through spontaneous prayers that are custom-made in the moment for each patient/resident.” Yes, this is true. However, what experienced chaplain would not want to have the prayer “When a child dies” (taken from the Orthodox section) to refer to when called to be with a grieving patient?

Caroline Cella
Mercy Hospital
Rockville Centre, NY
New life for NACC proceeds in new year

By Rev. Thomas G. Landry
Interim Executive Director

S
o much that is so new! As we prepare this month’s Vision, we are steeped in the newness of life for the NACC that is calling us into 2007.

We have told you of our search for a new home for the NACC’s national office. Now we can show you a photograph of the exterior of our new home in Milwaukee. This office building at 5007 S. Howell Avenue is literally across the street from General Mitchell Airport. We are blocks away from an access ramp to Interstate 43/94, if you are driving to see us. And to make the options complete, we are only blocks from Amtrak! We will have more photos available at the annual conference in Portland to show you the interior layout once it has been refurbished for our use!

The spirit of the Lord God is upon me, because the Lord has anointed me; be has sent me to bring good news to the oppressed,

to bind up the brokenhearted,
to proclaim liberty to captives,
and release to prisoners;
to proclaim a year of the Lord’s favor.

Isaiah’s words announce both a mandate and a cause of celebration. Each is rooted in the goodness and mercy of God.

Our ministry to God’s people, and even more to a world still bereft of the knowledge of God, is meant to be both celebration and service. Everything, as ground into dust as the world might cause it to be, is meant to be renewed and given the new life of God’s grace and mercy. We are meant to be the instruments by which this miracle occurs.

Many of our members and some of our external stakeholders have committed to sharing in this call to new life by taking part in our Vision and Action Initiative, guided by the Reid Group. Others have taken a leadership role in bringing together the several spiritual care organizations into The Spiritual Care Collaborative. I was privileged to take part in my first meeting of the

National Association of Catholic Chaplains Episcopal Advisory Council, during the USCCB meeting in Baltimore in November. (Please see article on p. 5.)

I have been privileged to represent our members at annual meetings or conferences around the country since beginning my ministry as Interim Executive Director, and I feel increasingly comfortable as the itinerary for 2007 takes shape. I am especially excited to anticipate our NACC gathering in Portland, OR, in March! Twice I have served on the national planning committee for NACC annual conferences (2002 and 2005). It will be a true privilege and joy to experience our gathering in 2007 as your Interim Executive Director.

Why does this opportunity give me life?

In part because we haven’t had the chance to ask all our questions of God, or of each other, yet. I still have hope, even though all of the answers we have given or heard still don’t capture the mystery! As I said in my letter to you last fall, we must reinvest ourselves in the mysteries we behold, enabling each among us to do our part, to raise our voice in a way that lifts us all. We can only do this over time, for it is in the long term that we experience salvation history.

In part because of the way so many of you, my colleagues and peers, have welcomed and encouraged me since the first weeks of June 2006, when my appointment was announced. You have offered me feedback and guidance in response to my efforts to share my thoughts and dreams with you. You have kept me honest by being honest with me.
Vision, board activity both move ahead

By Karen Pugliese
Chair, NACC Board of Directors

My last two Vision articles focused on two of the larger initiatives NACC is involved with, namely the Spiritual Care Collaborative and the Vision and Action Initiative. This month, I’d like to give you a sense of involvement of our members in the Vision and Action Initiative and share a few exciting new ideas and projects the Board is spearheading and will implement relatively quickly.

Vision & Action Initiative

Seven women and seven men, including Fr. Tom Landry and myself, comprise the Planning Committee, which meets monthly. Sr. Barbara Brumleve, SSND, Ph.D., and Sr. Norma Gutierrez, MCDP, represent the Board of Directors on the Committee. An additional five women and men participate in the two planning retreats, and 47 members participated in the six focus groups. All in all, 132 invitations were extended, taking demographic diversity into consideration. Participants represent a balance of ordained and lay members, certified chaplains and CPE supervisors, ministry settings, geographic locations, age and experience. John Reid and Maureen Gallagher, our consultants from The Reid Group, meet weekly with Fr. Landry, NACC Administrative Assistant Cindy Bridges, and myself to guide and direct the work. They are theologically grounded, share generously from their deep personal spirituality, and skillfully lead with wisdom, insight, creativity, and humor.

Board of Directors

In October, the Board participated in an online self-evaluation process led by Patrick Bolton, Chair of the Governance Committee. Bridget Deegan-Krause, Vice-Chair of the Executive and Governance Committees, presented the Board with a statistical analysis of the evaluation at our November meeting. Maureen Gallagher spent several powerfully productive hours with us processing the results, harvesting learnings, and creating a manageable six-month action plan. In governance issues, we plan to study the current structure of Board, officers, committees, executive director and staff; and establish clear criteria and processes for Board succession planning, elections, expectations, recruitment, orientation, education and evaluation processes. We will also clarify Board roles and responsibilities, including committee assignments, and revise and update the executive director evaluation process.

At the staff level, we will address the staff policy and personnel manual along with current position descriptions, and establish a flow chart of roles and responsibilities.

In concert with our visioning activity, we are reviewing the scope of Board activity, authority and responsibility. This will be a major project, with several task forces to accomplish the work. Ann Hurst and Theresa V. Edmonson, former Board members with governance experience, will serve as advisors for this assignment.

Fr. Tom Landry and I agree that two key issues repeatedly thread through correspondence and conversations with our members: the desire for enhanced communication opportunities with colleagues, and local NACC-sponsored occasions for continuing education. In addition, the six focus groups consistently said that members miss opportunities afforded them in the old regional structure to connect locally. Sr. Barbara Brumleve suggested we employ a simple strategy similar our APC colleagues’.

representative from each state could forward news and information such as articles of interest; online chats and blogs; opportunities to serve in an NACC office, committee or task force; informal gatherings; and audio and video conferences. Obvious side effects would be community building and opportunities for participation in education and research.

Sr. Barbara also challenged us to consider controversial but critical questions around productivity measures for spiritual care. She suggested that NACC convene representatives from major Catholic hospital groups, including senior executive leaders of performance management and mission as well as chaplains and CPE supervisors, to address the issue. The Board agreed to initiate the project, linking the Common Standards with chaplains’ productivity in providing direct and indirect patient care services.

The Board also approved Sr. Barbara’s suggestion to authorize a correspondence campaign to seminaries and judicatories introducing our organization and inviting them to consider the benefits of our accredited CPE programs for their constituents.

We promise to keep you informed of our progress in implementing these ideas. Each of these tasks individually may seem small and limited, but each one leverages and positions our organization for the future.

The activities I have described in this brief update feel very Advent-like. We await the gift of New Life with joyful anticipation, but also with intentional preparation for the birthing process. We are midwives of a ministry both vulnerable and resilient; we are inspired and sustained by our faith and trust in the One who calls us to be instruments of healing and peace for one another and our world.

New life

Continued from page 3

as we search out the Wisdom of God, an experience of binding up the brokenhearted.

In part because I trust that God still desires for us a mantle of praise rather than a faint spirit. I trust that the ruin sowed by human limitations and failings is the arena in which God will work through us to raise up and rebuild. I believe that the future we share includes the question, “Who shall anoint?” but it continues in light of the prior and more important question: “What shall we do, whom God has anointed?”
Bishops’ council offers support to NACC

By Rev. Tom Landry
Interim Executive Director

People are making their way in and out of elevators, up and down escalators, and asking where receptions are being held. It could be the NACC annual conference in a large city somewhere in America, but it is not. This is the semiannual meeting of the United States Conference of Catholic Bishops, and we are in Baltimore. This is the body that charters our work as an association and approves our standards and processes of certification for professional chaplains and CPE supervisors.

The bishops met in Baltimore in November, instead of Washington, to help celebrate the rededication of the Baltimore Basilica, which served as the cathedral of the “premier see” of the Church in the United States in the earliest days of our existence as a nation.

Within the busy schedule of this meeting, bishops representing USCCB regions of the American Church gathered with me and with Bishop Dale Melczek of Gary, IN, our NACC Episcopal Liaison, to discuss and assist in the work of the NACC. Bishops familiar with our work welcomed bishops who joined us for the first time as members of the NACC Episcopal Advisory Council. We were pleased to welcome to the breakfast meeting as new Council members Bishops Mitchell Rozanski of Baltimore, John Wester of San Francisco, and Michael Warfel of Juneau, AK.

Our discussion touched upon changes at the NACC, such as our move to new quarters, the current transition in leadership, and the more open-ended processes of discernment and planning that are taking place in the Vision and Action Initiative. Bishops expressed great interest in the intersection of NACC standards and policies with requirements either in place or being established at the diocesan level for lay ecclesial ministers’ formation.

Several of the bishops expressed deep gratitude for the ministry of our certified professional chaplains who minister in their local church communities. They expressed a desire to explore the opportunities to recruit, train and certify additional, competent ministers to meet the needs of their people.

As our time together concluded, several of our Advisors asked for the opportunity to concretely support and contribute to the work of our Association. I assured them that we would welcome them to our conferences and educational gatherings to be scheduled around the country in the coming year. We will seek their input into our discernment and planning processes as well.

Are there particular questions you would like to address to the members of our Episcopal Advisory Council? Please send your questions to me or to David Lewellen, and as possible we will invite them to offer their answers and insights in Vision.

Congratulations to newly certified chaplains

The NACC congratulates the following chaplains who have earned certification following their interviews last fall:

- Rev. Augustine Abraham, West Haven, CT
- Ms. Denise Anderson, Portland, OR
- Sr. Anne Arabome, SSS, Henderson, NV
- Ms. Joan Bartman, Appleton, WI
- Mrs. Carole Butler, Littleton, MA
- Mr. Enrique Contreras y Martinez, Houston, TX
- Ms. Nancy Cook, South Bend, IN
- Mr. Michael Doyle, Evanston, IL
- Sr. Paulette Ducharme, OSU, Waterville, ME
- Deacon William Eckert, Tacoma, WA
- Mr. William Ferguson, San Diego, CA
- Rev. Elias Rinaldo Gamboriko, AJ, Sioux Falls, SD
- Sr. Josefa Ha, LHC, Gardena, CA
- Rev. Kevin Ikpah, Blue Springs, MO
- Sr. Nancy Jurecki, OP, Henderson, NV
- Rev. Tuan Le, SJ, Weston, MA
- Sr. Barbara Link, FSPA, Milwaukee, WI
- Mrs. Anita Lorbiecki, Milwaukee, WI
- Sr. Mary Morton, SSCM, Champaign, IL
- Rev. Francis Njau, Portland, OR
- Mrs. Judith Novak, Cudahy, WI
- Ms. Erin O’Donnell, Brighton, MA
- Rev. Charles Okoye, Hackensack, NJ
- Sr. Anita Lapeyre, RSCJ, ceremonially hands over leadership of the NACC’s Certification Commission to Rev. Jack Crabb, SJ. Effective this year, Rev. Crabb will chair the commission.

- Bro. Gerald Pacielo, OFM, Wilmington, DE
- Ms. Jennifer Paquette, Cypress, TX
- Mr. David Rapp, University Place, WA
- Sr. Gladys Reisenauer, SSND, Bismarck, ND
- Sr. Brenda Rowe, RSM, Wilton, CT
- Rev. Henry Schoenfield, Seattle, WA
- Mr. Mark Thomas, Bend, OR
- Rev. Marcellinus Uwandu, Evansville, IN
- Rev. Matthew Williams, Baltimore, MD
After Henry died in my arms, I was forced to confront questions that I normally put off. He was here one minute, gone the next; where did he go? Normally put off, he was dying and had told the hospital staff that he wanted to return to the nursing home, a familiar place. That spoke volumes to me about the sense of community we had created at the nursing home, a place of silent suffering.

After Henry died in my arms, I was forced to confront questions that I normally put off. He was here one minute, gone the next; where did he go? Normally put off, he was dying and had told the hospital staff that he wanted to return to the nursing home, a familiar place. That spoke volumes to me about the sense of community we had created at the nursing home, a place of silent suffering.

Although I had already experienced the deaths of Martha and Cheryl, among others, nothing prepared me for witnessing Henry’s last breath. Henry was returning from a visit to the hospital and needed help getting to his room. When I offered my assistance, he was experiencing shortness of breath and couldn’t even hold himself upright for very long. I wrapped my arms around Henry to hold him as we pushed his chair through the building. But then he went limp in my arms. The reaction of the nurse told me what I had already suspected — Henry had died. Shocked and overwhelmed, but not wanting to create a scene, we continued to his room, where he was pronounced dead. I later learned that in his condition, Henry should never have been released from the hospital. But he realized he was dying and had told the hospital staff that he wanted to return to the nursing home, a familiar place. That spoke volumes to me about the sense of community we had created at the nursing home, a place of silent suffering.

After Henry died in my arms, I was forced to confront questions that I normally put off. He was here one minute, gone the next; where did he go? What did Henry’s death mean for him, for me, and for others? I was unable to function and beside myself with the mystery of it all, so I went to the chaplain’s office and cried. Our society tells us that crying is a weakness, but chaplains know the strength found in tears. I was fortunate that our chaplain could communicate to me exactly that.

While death never gets easier to witness, it has caused me to re-evaluate my priorities. Now I spend time reflecting on the ways I minister to Jesus through my job. I thank God for my residents and co-workers as I pray that he gives us grace and courage for another day. I call my family every week and visit them every month. After wanting to play guitar all my life, I finally bought one and am teaching myself to play it. And I recently attended a workshop on end-of-life issues which affirmed my desire to become a chaplain. The workshop helped me to work through my questions and to accept my struggles with death as normal.

During my prayer time, I burned incense for Henry. Lighting incense has become my ritual for dealing with death. The visual aid of rising smoke helps me to feel the hurt and to give it to God. Whether through words of generosity or incomprehensible language, through prayer, as with Martha, or the desire to die in familiar arms, like Henry, each resident suffered in silence and died with dignity. Each one allowed me to see the true worth of their lives, up to the last breath. When I light incense for those who have died, I honor their worth and dignity, and I thank God for their lives.
New JCAHO goals relate to long-term care

By Richard M. Leliaert

While I was still working as in spiritual care in a large metropolitan hospital, I agreed to serve on the Long Term Care Professional Technical Advisory Committee of the Joint Commission (JCAHO). I attended my first meeting in Chicago last March, and I was pleased be seated next to the then-Chair of the committee, Marianna Grachek. It was kind of a privileged view of the proceedings, so to speak, and showed her respect for chaplaincy.

While some of the LTC deliberations may not be directly relevant to the concerns of chaplains, virtually every deliberation has some bearing on the ministry of chaplaincy in its professional context — especially when they are later enacted into JCAHO standards. For instance, when standards pertaining to contracted services were discussed, long-term care facilities might consider contracted services for the spiritual needs of patients, especially as a cost-cutting measure.

Contracted services came under the purview of my system’s Organizational Ethics and Business Practices Committee, which I chaired at the time. I would encourage chaplains to extend themselves to develop or serve on organizational ethics committees as well as clinical ethics committees. Skilled nursing or long-term care facilities often come under scrutiny for abuse or other violations, and the ethical issues surrounding patient rights and dignity as well as patient safety certainly affect chaplains and their ministry.

Mandatory influenza vaccinations have also been addressed in new JCAHO standards, effective January 1, 2007. This new requirement for healthcare workers is an infection-control standard and applies to long-term care facilities, among others. While vaccination of healthcare providers is the most effective measure for preventing healthcare associated transmission of influenza, only 35% of healthcare workers are vaccinated each year. Influenza causes approximately 36,000 deaths and more than 200,000 hospitalizations annually in the United States.

Some discussion was given to credentialing; it was noted that there are no formal requirements for graduate medical education participants in long-term care. This might call us as chaplains to consider or review certification in specialized ministries. Is our current overall certification process adequate for such specialized ministries as LTC and mental health? See below regarding JCAHO’s attention to its Disease-Specific Care certification program.

Much of the attention in LTC from JCAHO turns on the additions/changes to the 2007 National Patient Safety Goals (NPSGs), as well as related requirements for each of its accreditation programs and its Disease-Specific Care certification program. Accredited organizations are now required to define and communicate the means for patients and their families to report safety concerns, and to encourage them to do so. The requirement (first applied to home care, laboratory, assisted living, and disease-specific care programs in 2006) is the central expectation of one new goal: Encourage patients’ active involvement in their own care as a patient safety strategy.

Furthermore, a new requirement stipulates that behavioral healthcare organizations, as well as psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals, identify patients at risk for suicide. This is part of the NPSG: “The organization identifies safety risks inherent in its patient populations.” This certainly affects chaplains in our ministry to patients who share with us their feelings of depression or loss of meaning/purpose in life, or suicide ideation.

The NPSG stipulating that “a complete list of current medications be provided to the patient on discharge from care” is carefully applied to LTC as well as a host of other specialties. (For more on the NPSGs, contact Rick Croteau, rcroteau@jcaho.org.)

Furthermore, a revised organ procurement and donation standard includes a requirement for hospitals to develop criteria for donation after cardiac death. (For more information, contact Brenda White, bwhite@jcaho.org.)

The main NPSGs addressed are as follows (note that each goal stipulates the need to develop a protocol or procedure to realize the goal):

- Insure the accuracy of patient identification (especially before surgery). This seems obvious, but ID problems have arisen with female Shi’ite Muslim patients who wear veils over most of their face.
- Improve the effectiveness among caregivers, including standardizing a list of abbreviations, acronyms, etc. that are not to be used.
- Improve the safety of using medications. Spanish-speaking chaplains can cite the tragedy of the woman who thought taking medications once a day meant taking 11 pills (once is 11 in Spanish), resulting in her death.
- Reduce the risk of healthcare-associated infections, especially through handwashing.
- Accurately and completely reconcile medications across the continuum of care.
- Reduce the risk of resident harm resulting from falls.
- Reduce the risk of influenza and pneumococcal disease in older institutionalized adults.
- Encourage residents’ active involvement in their own care as a safety strategy.
- Define and communicate the means for residents and their families to report concerns about safety and encourage them to do so.
- Prevent health care-associated pressure ulcers (decubitus ulcers).

Rev. Richard M. Leliaert, Ph.D., NACC Cert., is pastor of St. Robert Bellarmine Parish in Redford, MI.
Flood brings LTC community closer together

By Judith Talvacchia

The ambulances lined up on White Street, followed by the immediate feeling of panic; the line of employees waiting — and wanting — to get into the building to help; the water everywhere — inside and out — even gushing out of the elevators.

My colleague Lucy Ticknor used these words during a Mass of Healing after the flood last May that forced Mary Immaculate Nursing/Restorative Center to evacuate 244 frail elders from our facility in Lawrence, MA. We felt secure that the six-foot-high berms surrounding the building would keep the spring rains swelling the Spicket River in the parking lot and away from the basement. In 150 years on the same site, we had never had water in the building. But on the morning of May 16, 2006, one of the berms was breached, and water came pouring in.

What followed can only be described as both tragic and miraculous. The building was inundated with water, filling the basement and rising three feet into the first floor. But every resident was safely evacuated — not a single death, not a single injury. Their rooms, on the second, third and fourth floors, were not damaged at all. The dining rooms, laundry, kitchen and office areas — all on the first floor — were destroyed. Incredibly, there was no structural damage, the elevators were repairable, and everything else was replaceable. Work began immediately on cleanup and repair.

The residents were transferred to 58 different facilities throughout eastern Massachusetts. Our management and board of directors decided to keep all employees (over 300) on the payroll until repairs were complete. This was an extraordinary commitment and gratefully received by the staff. The spiritual care chaplains — director Lucy Ticknor, Martha Byron, and I — spent a summer like no other. We divided up the facilities where our residents had been placed geographically, and we maintained contact with them all summer.

Like St. Paul and the first itinerant missionaries, we traveled the countryside so our residents would see a familiar face. We felt that the presence on the part of those who are severely compromised. Hopefully, my love and care communicate to them at some level that God is still a loving, caring presence in their lives.

1. Pastoral presence on a day-to-day basis has a much greater impact than I ever imagined. As I visited residents in many different facilities, I was struck at how much my visits meant to them. They might not remember my name, but they recognized me and what I represented immediately. “Come here. I know you!” “This is my lucky day to see you again.” “Is it time to go to Mass?” “You always bring me communion.” Even those with advanced dementia seemed to recognize me. Their faces would change when I greeted them or they would kiss my hand. I realized that loving, caring relationships built up over time do have an effect, even if there is rarely an external reaction to that presence on the part of those who are severely compromised. Hopefully, my love and care communicate to them at some level that God is still a loving, caring presence in their lives.

2. The practices of faith are deeply held and remembered, even by elders who are well into dementia. I always brought communion with me when I visited residents, and it was like giving them gold. Many cried when I brought out the pyx. They received with great devotion. Often, other Catholic residents asked for communion. As one dear lady told me when I offered her the body of Christ, “I love him and I love his mother.” Those who didn’t remember communion or who weren’t Catholic were very much comforted by prayer. “That’s nice, I like that” were some of the comments I received after sharing prayer. Families were comforted too in knowing that their loved ones were able to pray and receive communion on a regular basis.

When we returned to the facility, many residents told me how much they missed Mass, communion, pastoral care, and “God talk.” One resident told me very dramatically, “I never even heard the word ‘God’ where I was, not even in a curse!” As soon as they were back, residents wanted to know how much they missed Mass, communion, pastoral care, and “God talk.” One resident told me very dramatically, “I never even heard the word ‘God’ where I was, not even in a curse!” As soon as they were back, residents wanted to know
when we would have Mass. I arranged for a priest to come a
week after we returned. We would celebrate Mass in the
dining room on a table, if necessary. Our altar, ambo and
credence table had all been water-damaged, but our
maintenance crew made sure they were sanded and
refinished in time for that first Mass! They wanted the
residents to have an authentic church experience. Many
tears of joy flowed at that first Mass.

3. **God puts us where we need to be.** I felt terrible that I was
not at the facility on the day of the flood to support my
colleagues. But when I went up to the facility the following
day, I began to realize that there was a benefit in not having
been there. The staff needed someone who was not
traumatized by the events of the previous day to help them
process all of the grief and fear that they were holding in
behind their incredibly professional behavior. A number of
staff burst into tears when they saw me. Over the course of
the summer, many unburdened themselves over specific
feelings and incidents that they were having a hard time
letting go of. We chaplains put together a Mass of Healing
for the staff in order to have an opportunity to share our
grief in prayer. The staff bore a unique burden after the
flood, what I call “the burden of awareness.” They knew just
how serious the situation was, what could have happened
and what might still happen. They were aware of residents
and families who were not coping well. In a sense, they
knew too much, and the knowledge took its toll. We
chaplains were able to support each other and the rest of the
staff, to help each other carry the burden of awareness until
we were all back under one roof.

4. **All of the lessons of CPE concerning trust and letting go
came back to help me.** There were residents with whom I had
a close relationship that I did not see all summer. There
were residents who died during the summer whose last days
I couldn’t share, whose funerals I couldn’t attend. There
were family members I could not reach. There were
residents I could not comfort, residents whom I had to
watch helplessly as they went into decline. I was forced to
rely on God, to trust that God would take care of all the
needs I could not satisfy, including my own. I learned to
find peace at the end of a day when I had traveled many
miles and only seen a fraction of the people I wanted to see.
I had to remember that I was the instrument; that God was
doing the healing, the sustaining. I had to go to sleep
knowing I had done my best for the residents, families and
staff no matter how inadequate my efforts felt. Gradually, I
was able to trust more deeply that God would bring good
out of this tragedy. I was even able to let go of the outcome
and trust that whether we got back into the building or not,
God would provide for all of us. Now that we are back
together again, my gratitude is overflowing. I feel like my
trust in God deepened over the summer in ways that will
sustain me far into the future.

Tragedy can bring out the worst in people or the best. In
the case of Mary Immaculate, there was much more that
was inspiring than disappointing. Everyone
was united in a common goal — to get the
facility up and running and to support
residents, families and staff until that goal was
accomplished. Lucy Ticknor summed up the
wonderful spirit that emerged after the flood in
the closing words of her reflection. “One
phrase from the opening hymn has been going
through my mind: ‘All I longed for I have
found by the water.’ On May 16, by the water,
we did find the one thing we all long for — we
found our best selves and we found each other
— in ways we never had before. We found the care,
compassion and love which will bind us together forever,
and enable us to go forward with strength and
determination.”

Judith Talvacchia, NACC Cert., is a staff chaplain at Mary
Immaculate Nursing/Restorative Center in Lawrence, MA.

**In Memoriam**

**Please remember in your prayers:**

**Deacon Albert Bergeron**, who died Sept. 17 at age 84. Following a career in public relations, advertising, and journalism, he was ordained a deacon in 1987 and worked as a chaplain at hospitals in Rochester, NY. He was certified in 1988 and took emeritus status in 1992.
Preventative spiritual care helps long-term patients

By Carla Black

Recently, healthcare trends have focused on prevention. We fill out forms regarding our current health, lifestyle and family history to help the doctor stay ahead of illnesses that can be predicted, such as heart disease and diabetes. An obvious component of prevention is to stop doing harmful things. But the more subtle component is reinforcement and encouragement to continue to do the things that contribute to our good health.

As lay ecclesial healthcare ministers, we now recognize predictors of spiritual dis-ease as well as indicators of spiritual health, thanks to the work of talented researchers and practitioners as well as the supervisors who taught us so well. Because of this body of knowledge we have the opportunity, as Kenneth Pargament wrote, for “expanding the time to help.”

Expanding the time to help means addressing potential problems before they arise; I call what I do “preventative spiritual care.” In The Psychology of Religion and Coping, Pargament states, “Traditionally, religious ministry has been more closely associated with healing the sick and suffering than with prevention. But there is nothing about religion per se that restricts it to helping after the fact. On the contrary, religious resources and preventative methods of coping represent a potentially powerful form of assistance to people before they encounter trouble or before small problems become big problems.” I believe this principle applies not only to religion specifically, but to a broad range of chaplaincy interventions as well.

In my ministry at St. Mary Healthcare Center in Lafayette, IN, a skilled and long-term care facility, I carry out spiritual assessments to identify physical, intellectual and spiritual or character strengths. The preventative aspect of long-term spiritual care is helping residents to build on the foundation of earlier spiritual experience, wisdom and strength in order to face what is probably the most spiritually significant phase of their lives on earth, life’s final completion.

Cut off from their homes and without a strong connection to their foundational spiritual strengths, the elderly may find themselves adrift in the present and without hope for their future. But a spiritual assessment can renew their sense of connection and prevent ineffective coping.

Rather than focus on an immediate need, as I more often did in the acute care setting, I look for the foundational bedrock of faith and the strengths that have sustained residents throughout their lives. I guide the residents in identifying how the Divine has been active in their lives, creating the expectation that God will continue to be with them in the current situation.

While listening to residents describe their spiritual journeys, chaplains can gather indicators which Paul W. Pruyser describes as “guidelines for pastoral diagnosis” in his book The Minister as Diagnostician. Unfolding a spiritual legacy will reveal various descriptions of awareness of the holy, providence, faith, grace or gratefulness, repentance, communion, and sense of vocation. Whether these variables are solid or shaky tells me much about the residents’ spiritual base.

Because my initial interview is a “cold” visit for the resident, I start by explaining my reason for being there. I often see a look of concern or puzzlement on their faces, and I want to put it to rest immediately. (That look always brings to my mind the memory of being hospitalized when I was 19 for surgery to remove a mass that was suspected to be cancer. A man in a dark suit walked in and introduced himself as a chaplain, making me certain that death was near! I was greatly relieved when he explained the routine nature of his visit.)

As the resident tells me about their life, their faith and religious practices (or lack thereof), I listen for their personal relationships. Is there a strong sense of community in the connections of family and friends or neighbors, or is the resident alienated or lonely? Having satisfying relationships with others is a very important indicator of the ability to make supportive relationships with staff and other residents in our community. If those relationships are not present, then prevention of alienation and isolation in our community becomes part of our care plan. I’m also aware of how the residents are relating to me. Are they making eye contact, smiling, open and direct? Do they choose not to have a visit at all, or quickly decline?

Another basic essential to assess is the resident’s faith. In assessing faith, however, I am not looking for religious practice only. Two important indicators are: does the resident talk with God, and does the resident have a positive engagement with life? When a new resident tells me without prompting that they pray “all the time” or “every day,” I know that we have the best tool possible to use to keep them spiritually healthy during their stay with us. Then I look for their ability to take on a challenge, which I find in descriptions of things such as...
accomplishments, travel, and passion for some cause or activity. “Tell me what has really made you happy in your life,” is a question that will help us to find some similar experience in this new home, rather than just staying afloat in tepid waters waiting for the end.

My next step is to plan ways with the residents how best to draw on their spiritual strengths in this new setting. Occasionally, doing the spiritual assessment in itself may provide an adequate grounding for the resident. But for most, some spiritual and religious needs are identified for follow-up. Are they seeking worship opportunities and sacraments, mediation with family members, prayer, scripture, time to sit on the front porch with someone and talk about their life? Maybe all they need today is something as simple as turning the wheelchair so that they can see the birds at the feeder outside the window. Or maybe what is needed is discussion about something the resident has carried as a burden of shame for decades.

What is important, no matter what the plan, is the principle of prevention. To know what is working and to ask how we can keep it working are important considerations. For the elderly, the ability to recover from any setback, whether physical, intellectual, emotional, social, or spiritual is diminished. Therefore, making certain that spiritual health is maintained and strengthened becomes the goal for the long-term care chaplain.

We know that moving into a long-term care community means leaving the familiar surroundings of a home that was more than just a shelter. Our homes become self-defining. In them we keep those material things that help us to know and remember the events of our lives and the people with whom we have shared those events. We fill them with items that have meaning to us alone. We build our home environments on our memories and we inhabit them with dreams for the future.

When older adults leave their homes and move to a long-term care community, they face the challenge of integration, of honoring what has been, what is, and what lies ahead. But constructive responding becomes more complicated without some of the tools that they used previously. Adjusting to new environments is never easy, no matter what life phase a person is experiencing. Adjusting to a new situation is a “crisis event” in that it presents both possibility and danger.

Most of us working in long-term care have known persons who after moving into our community became withdrawn, bitter, hopeless, and angry with God. The music within them went off-key. Their relationships suffered along with their ability and desire to pray or to carry out previous religious practices. The spiritual foundation that they had relied on during their lives had been eroded by an inability to find meaning or to see God working in their new situation. It is the privilege of the long-term healthcare chaplain to help prevent this erosion from occurring.

People often need the assistance of others in times of crises. The chaplain’s assistance is significant as both pathfinder and journey companion. In our ministry, we enter the spiritual dwelling places of others by asking them to tell the story of their lives. Telling the story is part of moving toward the end of life with the peace of knowing that one’s unique, personal, divinely sustained life contained rich beauty and deep meaning. Certified chaplains’ training and formation uniquely enables them to find the harmonies, to recognize and articulate what has been spiritually and religiously significant to the resident. And most importantly, to be a caring pastoral presence that reflects the Divine presence.

Chaplains offer a relational element to obtaining a spiritual assessment. Checking answers to questions on a form would never substitute. The relationship becomes one in which residents can be encouraged to follow the spiritual threads linking their past, present and future. In honoring what has been without judgment and what will be without prescription, with trust in God’s good plans for all of God’s beloved children, the chaplain is the embodiment of hope and promise.

In my experience, people in the wisdom years of life receive renewed confidence in the present from reflection on how God blessed them in many ways in the past, especially during difficulties. Asking residents to tell about how religious practices and prayer were helpful in the past suggests to them how they can be used in the present situation to keep their spirits healthy. This process of exploration employs our training as we encourage spiritual reflection. Reflection on the meaning of it all is what we learned best during our clinical pastoral education and what we most importantly bring to the elderly as they prepare for the sacred relinquishing of it all to The One Which Is All.

The chaplain in long-term care prevents spiritual distress by building on the residents’ connections with a Wisdom beyond what either we or they possess. We begin with the initial assessment as we listen to and reflect on God’s presence in the history of their one, unique life. Through reflection planning, and follow-up, we build hope and prevent despair in the expectation that the Divine will continue to uphold our residents as they move into an unknown future.

Carla Black, NACC Cert., is a chaplain at St. Mary Healthcare Center in Lafayette, IN.
Team approach integrates all of elderly’s needs

By Michele Le Doux Sakurai

Jeff had been an established musician, and he had lived by his own rules. In his late 60s he suffered a debilitating stroke that affected one side and his speech, and he became full of rage. I remember introducing myself to him, and his response was to swear and stomp out of the room.

Jeff was my introduction to a unique concept of managing the needs of the frail elderly in the community rather than in a nursing home setting. PACE (Program of All-Inclusive Care for the Elderly) sought to address all participants’ medical needs at the day site. This includes a geriatric physician, nurses, physical and occupational therapists, nutritionist, social worker, recreational therapist, as well as specialists in dentistry, optometry, podiatry, audiology, speech therapy, and in some cases, complementary therapies such as reiki therapy and acupuncture. The one discipline that it did not include was spiritual care, but through the Providence Health System, this was integrated through the use of chaplains from Providence Portland Medical Center.

The care team struggled with Jeff’s demands to be left alone, but also sought a way to break through his anger. One day as I finished a communion service, Jeff, who had been sitting and listening outside the door, called to me. He pointed to himself and then to me, “You … me … the same.”

“How are we the same, Jeff?” I queried. Struggling though broken phrases and lost words, he was able to communicate that he and I shared the same alma mater. How he had learned this remains a mystery, but it was a turning point for both of us. He then began to invite me into conversation, but it took literally months to piece together Jeff’s life; he could not speak full sentences.

Over time we found that Jeff’s sources of grief and loss stemmed from more than the loss of his music, but his estrangement from his children, his church, and his friends. The team was amazing; through morning reports and quarterly patient assessments, they actively sought to reconnect Jeff with meaning in his life. Through gentle encouragement, the team reintroduced Jeff to his clarinet, and they investigated old friendships that Jeff was interested in re-enlivening.

Jeff was doing an incredible amount of internal work, rebuilding his life while confronting enormous deficits. One day he called me over; he was very intense and said to me, “One, two, three, four, five, six, seven,” while counting on his fingers. I called over one of the nurses who happened to be a Sister of Providence. She asked what he wanted, and again he began to count. She said, “Jeff, you want seven.” He nodded. She asked, “Are you talking about the sacraments? Are you Catholic? Do you need a priest?” He nodded and sighed; he had been understood.

This team paradigm began in San Francisco in the mid-1970s with the On-Lok Program, which focused on the health needs of the elderly in the Chinese, Philippine, and Italian communities. In 1986, this model expanded, and ten additional organizations replicated On-Lok’s services and funding. By 1990, the validity of this program had been established and PACE received Medicare and Medicaid waivers to operate.

I was privileged to participate in this program in its early stages. In 1991 Providence Health Systems was piloting the On-Lok program and had 68 participants, of whom Jeff was one. The majority of the participants came to the day program site from home; for participants who could no longer manage at home, alternative housing was available.

In 1991, this program was innovative and its success relied on intense team collaboration, for it was the team working together that responded to each participant’s health care needs. The PACE program continues to require that participants be 55 or older and have multiple medical conditions. It is now 15 years later, and I sat down with Sr. Maureen Niedermeyer, OSB, who has worked several years with the Providence PACE program known as ElderPlace.

Q: In 1991, ElderPlace was a single site with fewer than 75 participants. What does it look like now?
A: We now have over 800 participants at five sites. Two of these sites have assisted living units. For the day programs, participants come in from their homes or foster care one to five times each week, depending on their needs. There are three chaplains (2.8 FTE) covering the ElderPlace program, and it is a huge challenge.

Q: How do you manage the spiritual care for this many participants?
A: We handle the services and formal assessments and rely on other team members to let us know as needs arrive. I am not the only spiritual caregiver; it’s part of the team and what we all do.

Q: What is it that you see yourself doing, as a chaplain, in this environment?
A: First, it is a privilege to be involved with people at the vulnerable time of their lives. We have to accommodate what is there. We offer warmth, listening, and unconditional love, especially to those who suffer dementia.
January 2007 Vision

Dying woman receives kindness in palliative care

By Joan Owens

Lora grabbed hold of my heart from the time I began my ministry as a chaplain at The Terrace. At the time she resided in assisted living. She opened her heart and her frustration to me, sharing her mischief, humor, and great faith. I loved this, since she also received my mischief, humor, and faith. Though 40 years my senior, she walked with me as a “soul sister” for the next seven years. And as with all true ministries, we were mutually blessed.

Lora had been living in our facility for nearly 11 years, gradually advancing with dementia. Approaching her 95th birthday, she still had not fully accepted the need to be with us, still held hostage emotionally with thoughts of her children “putting me here,” still thinking she would have been fine at home. Her four children who “put her here” visited several times a week. In order to help bring Lora inner peace and acceptance, counseling and spiritual direction were offered her. But because of her dementia, the benefits were often lost.

Over the years, I spent considerable time with one daughter, who was scrupulous about her mother’s care and end-of-life issues, which we often discussed in order to help her prepare for her mother’s death. She was never comfortable with the Living Will which Lora completed in her younger years, especially the clause about no artificial food and hydration. She viewed it as a form of euthanasia. Yet she wanted her mother to die peacefully, preferably in her sleep, so as not to have to deal with any of these issues. Luckily, Lora’s son was her healthcare power of attorney and respected the wishes of his mother.

All along, Lora expressed readiness for her own death and would often question, “What am I good for now?” while wondering why God wouldn’t take her home. Months before her death, Lora moved under the umbrella of palliative care, which gave me a clear understanding of the course of care she would receive when her end of life approached. I felt assured the nursing staff would recognize and respond to her physical, emotional, and spiritual needs and those of the family. Many of our nursing staff and interdisciplinary staff had already attended the ANGEL (Advancing and Nurturing Education Goals Embracing People with Life-limiting Illnesses) Program offered through Catholic Healthcare Partners.

In her last months, she suffered great anxiety at times, crying out, but usually calming when a staff member spent a few minutes with her. Lora received the services of our gentle and kind holistic therapist who spends one afternoon a week with our palliative care residents, offering aromatherapy, massage and healing touch, as well as spiritual support from the therapist.

A week before her death, Lora and her daughter joined me in the dining room at lunch time, a typical date for them. Lora looked very lethargic, not interested in eating, not breathing regularly, not showing her usual spunk. I thought that Lora could be actively dying, so I suggested, without urgency so as not to alarm her daughter, that we return to her room and have the nurse check her. Because of the strong sense of teamwork in our facility, I knew my request for this nursing need would be met with respect. The nurse was wonderfully calm and compassionate,

Q: When I had been at ElderPlace, about 80% of the participants suffered from some form of dementia. How is it now?

A: It is a higher percentage than that. One of the biggest challenges is visiting someone who has advanced dementia. Sometimes they aren’t able to respond; have you really met their needs? It takes a lot of faith when you aren’t sure if what you have done is truly helpful. Yet, if you have given them a time of presence and love … for that moment you have been a blessing, and they have been a blessing for you. I guess it’s learning that we don’t have to be verbal to serve. Just to sit beside them, that is a gift.

Q: What has been the most valuable part of your ministry?

A: Learning from these wonderful people. It is such sacred space. I am constantly amazed at how they have had to learn to let go, and they do this gracefully. They find a way to be peaceful as they move through the losses.

Q: Finally, if you had to summarize what it is that makes ElderPlace so special, what would you offer?

A: As a team our goal is to let people make choices and this affirms their dignity. When we honor them by respecting them in this way, we are saying, “you are special.” And they are.

Michele Le Doux Sakurai, D.Min., NACC Cert., is a chaplain at Providence/St. Vincent Medical Center in Portland, OR.
Elderly residents share their lives in story circles

By Rev. Robert Fitzgerald, SJ

For ten years, I ministered among the elderly with story groups. Before our weekly afternoon session, someone from assisted living would help wheel down to the blue room those who needed help, and we would form a story circle. One resident would pick five jokes from an anthology and warm us up for telling stories on a seasonal theme like Halloween, Thanksgiving, or Christmas.

To start, we would spin a stick. The person the stick pointed to would tell a story while holding the story stick. When he was finished, he would spin the stick again to choose the next storyteller. At the end of our story hour I would type the stories for posterity into a one-page newspaper called The Party Line.

A friend who also worked with story circles told me how one of his wise story circle members explained how important stories are to the elderly community: “If only they understood how important this being heard is, I can take living in a nursing home. It’s really all right with a positive attitude. My daughter has her hands full, three kids and a job. She visits regularly. Don’t you see? It is a precious thing to us. It’s our life we want to give. You’d think people would understand what it means to us, to give our lives in a story. Most of what goes on here is people listening to each other’s stories. People who work here think this is like bingo, just filling time.”

Recently, my own graduate training to be elderly came from my memory and walking problems from normal pressure hydrocephalus, which is too much fluid on nerve centers in my brain. Everything now takes longer to do. I retired from ministry on Nov. 12, 2005, to continue storytelling full-time.

Rev. Robert Fitzgerald, S.J., NACC Cert., retired from Creighton University Medical Center, where he ministered as a chaplain.
By Susan Gore Zahra

It was the first time I had seen George’s eyes. On previous visits he had been hunched forward in his wheelchair. That day he was in bed, propped on pillows so that he could look at me. His eyes were the deep brown of buckeyes, sparkling with life from the flat mask that Parkinson’s disease had sculpted into his face.

“Why don’t you pull up a chair and sit down?”

That was the second sentence George ever spoke to me. The first came about four months earlier. I had met George on one of my first solo visits as a hospice chaplain, armed with listening skills to engage in life review and pocket versions of the New Testament, Psalms, and Catholic prayers to make profound theological connections. After realizing that life review was going to be very tedious with George responding only yes or no, I asked if he would like me to read scripture or pray with him. He twisted his head to peek out with one eye, responding, “That isn’t the way I was brought up.”

My entire pastoral care repertoire was shot down in one visit.

Eventually, I learned that George liked baseball, shoulder rubs, and scooting his wheelchair around the nursing home on his own power. Our visits became a ritual of my delivering a monologue on the weather, ending with a comment about how long it was until spring and baseball season. Then I would rub George’s hunched shoulders for a few minutes before he scooted down the hall. I dutifully noted “Provided caring presence” in his chart, but did not see what my actions had to do with the care of George’s spirit.

That was why George’s invitation to pull up a chair and sit down came as a welcome surprise. Within minutes George’s responses to my comments about the weather diminished to one or two words, then whispers of yes or no. All too soon he only stared out the window. I turned my chair to look out the window with him, wondering what to do next.

“That’s two school buses.” George spoke slowly, halting between words.

I was puzzled by what George was saying. Then I saw a school bus pass on the interstate highway outside the window.

It took several moments, but George finally said, “That’s three.”

“Sure enough.” I breathed slowly and deliberately, trying to rein in my racing mind to George’s pace.

Another bus passed. It was even longer before George whispered, “There’s four.”

I nodded. “It must be time for school to let out.”

A pair of buses passed side by side. Not wanting to rush ahead of George, I took in a couple of breaths before counting, “That’s five and six.”

Buses continued to race by, and I continued to measure my breathing and counting just in case George regained the energy to speak again. The parade slowed to a trickle and finally ended. I thanked George for inviting me into his view of the world.

George didn’t speak, but twisted his mouth into a crooked, bare-toothed and utterly radiant smile.

Be still and know that I am God.

Counting school buses was a jewel among the gritty visits with George that followed. I tried to engage him in meaningful conversation again, but if he couldn’t respond with yes or no, he scooted away. I tried to persuade George to lie down for a rest, hoping that would free him to speak, but he always refused. Each visit his shoulders seemed more hunched, his speech softer.

It wasn’t long before George stopped trying to speak. When spring came, we sometimes added a few minutes of watching baseball to the ritual. Baseball and silence.

One day George curled forward until he toppled out of his wheelchair, so we got him a geri-chair with a tray. He could no longer scoot up and down the hall but didn’t seem to mind. Sometimes he nodded when I asked if he would like me to push his chair closer to the window. Usually we sat next to each other in silence.

I saw the changes and knew George was coming closer to death. There were so many things I wished I could ask him. What did he believe would happen when he died? Where did he see hope? Did he believe God exists? What about unfinished business?

Before we counted school buses, I didn’t realize that I might have gotten answers to those questions if only I had taken a moment to breathe between questions. After he returned to his nonverbal world, I didn’t know how to put the questions into yes or no form.

Be still.

George’s geri-chair is reclined and he is propped on his side, twisted into a question mark waiting for an answer. He speaks to me for the last time.

“I’m scared.”

“Yeah. It’s hard — not knowing what comes next.”
In a small long-term care setting, community is an outstanding reality that is clearly visible. For 22 years, I have experienced the joys and challenges of being part of such a wonderful ministry. Particularly difficult for me was the time my co-director was seriously ill and dying over a 9-month period. For a short part of that time, he was a resident in the same long-term care facility he pastored.

Monsignor Daniel J. Foley and I had ministered together for almost 15 years in this same setting, and through his illness and death I was grieving not only the loss of my colleague, but also the loss of my wonderful friend. Since we were co-directors of pastoral care in a 141-bed facility, I had to face my own grief as well as try to listen to the feelings of staff, residents, volunteers, friends, and family who loved him deeply. This was a very complex experience for me. How do I minister to others in their grief when I could hardly contain my own? Not easily; not well, sometimes.

More than ever, I had to lean more heavily on my pastoral volunteers to minister to the residents; own my vulnerability at the staff meetings so that others would be aware of what I was able to do and unable to do; share my mourning in the privacy of my office with trusted co-workers; and tell friends and family when I was unable to be for them what it seemed they needed. Needless to say, I spoke the words “I’m sorry” more than I usually do because of the all-too-frequent conflict of needs I was encountering.

Personally, I was grateful to my religious community, Sisters of the Holy Family of Nazareth, family and friends who supported me so preciously and faithfully. In a special way, too, I am thankful to my administrator, who not only showed much understanding, but also kept reminding me that she was only a phone call away whenever I needed her support. Also, the comforting letter I received from our NACC executive director made real the face of our organization.

Because of so many gifts given to me throughout these past years, I am able to know the daily presence of my friend, Dan, keeping an ever-watchful eye on me. This eternal presence reminds me of what he had written on a small paper that fell out of one of his prayer books: “Love always finds new ways to keep loving.”

Sr. Frances Smalkowski, CSFN, NACC Cert., is director of pastoral care at Pope John Paul II Rehabilitation and Nursing Center in Danbury, CT.

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.

Respecting silence

Continued from page 15

George nods.
“Are you afraid this will go on forever?”
He nods again.
“No, George, not forever. We will try to keep you comfortable. And you’re not alone here. May I stay with you for a while?”

George inches his hand toward me. I take his hand in mine and try to match my breathing to his. Soon we breathe together.

There are no more baseball games to watch.
There are no more school buses to count.
There is only Now.
Be . . .

Susan Gore Zahra is a chaplain at Bethesda Hospice Care in St. Louis, MO.
Four plenary speakers to address 2007 conference

The 2007 Conference Committee is pleased to announce the four plenary speakers who will bring the theme of “Bridges to Peace, Paths to Transformation” to fruition during the conference. Our talented and diverse speakers will address the conference’s critical questions and issues when we gather in two months in Portland, Oregon.

**Gina Hens-Piazza, Ph.D.**
Saturday, March 17, 2007
Critical Question and Issue: Prophetic — How do we speak the truth in a world in need of healing? When do we speak? When do we listen?

Dr. Gina Hens-Piazza is Professor of Biblical Studies at Jesuit School of Theology in Berkeley, CA. She received her B.A. from Canisius College, M.A. from Vanderbilt University, and Ph.D. from Union Theological Seminary. Dr. Hens-Piazza’s teaching and writing on the Hebrew Bible, the biblical prophets, and cultural, literary and feminist studies have led her to assist parishes and RCIA directors in developing Bible study programs. At the Jesuit School, she also teaches courses such as Reading and Praying the Bible in the Parish, the Old Testament as Literature in Culture, and Hebrew Language. Dr. Hens-Piazza frequently lectures at national Bible institutes, including Georgetown, College Misericordia, LA Catholic Bible Institute and the Sacred Heart Bible Institute. She serves on the editorial board for Catholic Biblical Quarterly and is the author of *Nameless, Blameless, and Without Shame: Two Cannibal Mothers Before a King* (Liturgical Press, 2003), *The New Historicism* (Fortress Press, 2002), and *Of Methods, Monarchs, and Meanings: A Sociohistorical Approach to Exegesis* (Mercer University Press, 1996).

**Sr. Brid Long, SSL**
Monday, March 19, 2007
Critical Question and Issue: Personal — How do we transform ourselves personally through Scripture?

Sr. Brid Long, SSL, is the Regional Leader of the Sisters of St. Louis in Woodland Hills, California. She received her S.T.D. from Gregorian University in Rome in spirituality theology. For several years, prior to being in religious community leadership, she was Associate Professor of Theology and Chair of the Pastoral Studies Department at the Washington Theological Union and also taught in the Theology Department of the Catholic University of America. Sr. Brid has published in the area of theology of ministry and has served as co-editor of the journal *New Theology Review*. She has a particular interest in the development of lay ministry, and has facilitated numerous conversations between bishops and theologians on the topic for the USCCB Subcommittee on Lay Ministry.

**Tom Stella, M.A., S.T.M.**
Tuesday, March 20, 2007
Critical Question and Issue: Professional — What do we need to do as a professional to experience transformation?

Tom Stella lives in Colorado Springs, where he is the co-founder and director of Soul Link Inc., a nonprofit that offers spiritual seekers opportunities to form community. Tom is a hospice chaplain, spiritual director, speaker, and retreat facilitator. He leads workshops for healthcare and for other professionals that focus on spirituality in the workplace. Tom is the author of two books, *A Faith Worth Believing: Finding New Life Beyond the Rules of Religion* (2005) and *The God Instinct: Heeding Your Heart’s Unrest* (2001). He holds graduate degrees from the University of Notre Dame (theology), the University of Michigan (counseling), and the Jesuit School of Theology in Berkeley (spirituality). At the NACC national conference in Columbus last year, Mr. Stella presented a workshop on “A Gospel-Based Reflection on the Chaplain as Shaman, Servant, and Mystic.”

**Rev. Mark R. Bandsuch, SJ**
Sunday, March 18, 2007
Critical Question and Issue: Organizational — How do we transform organizations in the context of Catholic Social Teaching?

Fr. Mark Bandsuch, SJ, is Assistant Professor of Marketing and Business Law at Loyola Marymount University in California. He received his B.S. from Miami University of Ohio, J.D. from Cleveland State University and his M.Div. from Jesuit School of Theology at Berkeley. Fr. Bandsuch served as a hospital chaplain in Cleveland and worked with the Jesuit Refugee Service in assessing immigrants in prisons in the Bay Area in California, where he also served as a prison chaplain. His most recent work, written with Gerald F. Cavanagh, SJ, is entitled “Integrating Spirituality into the Workplace: Theory and Practice” in the *Journal of Management, Spirituality and Religion*. Additionally, Fr. Bandsuch authored “Virtue as a Benchmark for Spirituality in Business” with Fr. Cavanagh in the *Journal of Business Ethics* (2002).
By Camelia Hanemann

One August afternoon in 1973 as I packed for our family trip to California to meet my parents and go to Disneyland with them, a call came from a community hospital — my mom had had a heart attack. About an hour later, I heard the devastated voice of my dad telling me that Mom had died. In the rush to get to California, I was comforted by my husband but feared for my dad, not realizing that God’s love for us would translate into the loving care he would receive from the hospital personnel. When we finally arrived at 2 a.m., the physician who had cared for my mom at 2 p.m. was sitting with my dad in the lobby of the hospital — the first of many miracles of love that surrounded a very pain-filled time for me and my family. Each miracle we encountered brought a deeper revelation of peace. We basked in the warm glow of God’s love and presence. With peace came the ability to be transformed from paralyzing grief into joyful celebration of a life well lived.

Perhaps the greatest miracle was that as those who were transformed, we could become people who could accompany others through devastating sorrow. I was reminded during that time of Jesus saying, “Where two or three are gathered in my name, I will be.” I later came to realize that during the experiences surrounding my mom’s death, a seed was planted that led to my career in chaplaincy.

Like that time in 1973, this past year has been one of transition — this time from active chaplaincy into retirement — that has caused me to stop and reflect on what has been and what is yet to come. Life is full of transitions, some more poignant than others, but the relationships we build along the way are the difference between simply moving from one state to another and a truly transformative time. We find the gift of love in so many unexpected places and cannot help being changed by it.

When I worked in chemical dependency, we called these unexpected experiences of love “God shots,” perhaps the very epitome of “where two or three are gathered.” “God shots” were a never-ending source of amazement for me, as I observed God using the tiniest opening in a person’s armored attitude of “I don’t need anyone or anything else in my life to succeed” to shower them with unexpected and unasked-for unconditional love that led to recovery. In the course of my career as both chaplain and mission leader, I often found that those I was called to minister to, ministered to me. Their deep expressions of love and their ability to accompany family members or friends through very difficult times were always examples of what it meant to be the human face and hands of God.

I particularly remember two deaths I was privileged to attend. The first was a gentlemen brought in through the ED who was actively dying. His family gathered around his bed and asked if they could pray the rosary with him. This form of prayer was obviously standard practice in their family, but this ordinary act took on extraordinary meaning as each of his adult children took their turn in leading a decade of the rosary. One of the daughters had great difficulty trying to speak through her tears; her siblings waited with patience for her to find her voice, and when that did not seem to be coming, her mother moved to her side and together they led the fifth glorious mystery. I remember thinking how powerful their example of prayer and faith was, and hoped that I could someday be that same kind of example for someone else. It was even more powerful when we all realized that their father had died during the recitation of that rosary — they had literally prayed him through his final journey home.

Several years later, an emergency nurse told me how important it was to the staff to have me present during a code. When I inquired why, since I didn’t see myself as doing much before the family arrived, she replied, “It’s like you show up and hold the room, bringing peace into chaos.” I realized then that like the family above, the ordinary act of praying for all those involved in the code changed the dynamic of what was taking place — where two or three are gathered.

The other death was a woman who at our first meeting was not critically ill. She was listed as Catholic, so I went prepared to give her communion. But she refused, saying something about not needing a priest. I told her we didn’t need a priest since I had come prepared. As I watched huge tears began to flow down her face, she looked at me and said, “You mean YOU can give me communion?” When I replied, “Yes,” she looked at me and said, “I never thought I’d live long enough to be ministered to by a woman in the Catholic Church.” She then received communion — and two days later was in the ICU dying. Her family was also one that taught everyone who encountered them the meaning of love and relationship. They played her favorite TV shows, just in case she could hear them; they promised her they would make sure Dad learned how to use her washer and dryer; they sprinkled lavender around her because they knew she would want to smell good for God.

Each of these loving acts brought home to the whole staff how important it is to be involved in good relationships. We were transformed by this family from mere bystanders into active participants in the very sacred moments leading to this patient’s death. We matured as a team of caregivers who would forever hold each death as sacred, offering the same kind of tender care to all who were dying, but
Wisconsin Chaplaincy Association

gathers for fellowship, renewal

The annual conference of Wisconsin Chaplaincy Association last fall gave me the privilege to experience fellowship among chaplains from a variety of faith backgrounds and ministry settings. I was especially moved to hear of the changing landscape of chaplaincy in prisons. Sr. Susan Van Baalen and Bruce Fenner from the Federal Bureau of Prisons discussed legal developments pertaining to religious freedom in prison settings, and social changes within the prison population. More than ever, I admire and pray for these men and women who bring to others the light of faith in their ministry.

At a breakout session for the NACC family, we had lively discussion around vision and planning, the changing pools of candidates for our ministry, and efforts to bring programming back to more localized settings. The Wisconsin Chaplaincy Association offers a model of multi-faith collaboration worthy of study and emulation. It also provides a forum for fellowship and continuing education which the NACC will be wise to remember as we plan localized offerings in the future! My hat is off to Fr. Gene Pocernich and other members of the Chaplaincy Board for their fine work!

In 2005, the Wisconsin Chaplaincy Commission transformed itself into a freestanding, nonprofit interfaith entity, known now as the Wisconsin Chaplaincy Association, with a mission to advocate for the funding, selection and placement of qualified chaplains; provide a communication network among chaplains, clergy, parish nurses, institutions, and faith groups; and educate chaplains via conferences and workshops to support their professional needs in ministry. The work is organized by an active volunteer board of directors and a part-time executive director, who is the only paid staff person.

There is something special about the Wisconsin Chaplains each fall, both from the education in a retreat-like atmosphere and the opportunities to meet and connect with chaplains from around the state. I come away feeling refreshed and renewed for my work in chaplaincy.

This year, I especially appreciated the opportunity to learn from others in pastoral care leadership about ways they track their work and evaluate the chaplains who work for them. It was an additional gift to meet Tom Landry, and to hear his enthusiastic support of our work. Some years, I have walked along the shores of Green Lake and shivered as the snowflakes fell. Most years, I have enjoyed the beauty of the lake with autumn color in the trees around it. I have gained in education and relationships. The Wisconsin Chaplains’ Conference is truly a time to be enriched in body, mind and spirit.

Cam Hanemann, NACC Cert., is retired from Providence Milwaukie Hospital in Milwaukie, OR, where she was Director of Mission Integration and Spiritual Care.
Sulmasy offers rewarding look at spirit and healthcare

**A Balm for Gilead: Meditations on Spirituality and the Healing Arts.**


By John Gillman

“Is there no balm in Gilead? Is there no physician there? Why then has the health of my poor people not been restored?” (Jeremiah 8:22)

The well known African-American spiritual, “There is a balm in Gilead,” affirms that the “sin-sick soul” can indeed be healed. When that balm is absent, however, the health of the poor has little chance of being restored, a sad truth enunciated long ago by Jeremiah. This painful reality is relived each day by the medically underserved whose lives cry out with the prophet’s question: “Is there no physician there?”

Daniel Sulmasy, a Franciscan friar and a physician, addresses not the lack of doctors but the poverty of spirituality among the profession. The author of The Rebirth of the Clinic (2006), he pulls no punches in his diagnosis of “the spiritual malaise” of physicians, nurses and other healthcare providers. His judgment is severe: “Like the prodigal son, we physicians, as a profession, have squandered our common patrimony on dissolute living for several generations.” His diagnosis sounds terminal: “We are dying from spiritual starvation.” Little comfort here for his colleagues — unless they heed the wakeup call.

After addressing the relationship between spirituality and morality in clinical practice, Sulmasy writes an exhortation in letter form to “A Young Intern” with this guidance: “All the good that you will do will come … in the obedience of faith, to be used by God’s love … [and to] just serve Christ’s truth.” In the following chapter he offers three ways of understanding healing from a Catholic perspective, namely “as the restoration of right relationships, as encounter with Christ, and as witness to Christ.”

Several chapters make explicit use of biblical themes and passages. He offers meditations, sometimes homiletic in tone, on the prodigal son (renamed “The Prodigal Profession”), the man born blind, and the beatitudes. In other chapters he reflects on the blood of Christ, the Temple of the Holy Spirit, dying in Christian hope, and the communion of saints. Often the author’s perspective comes through the lens of his Franciscan spirituality.

Although healthcare professionals from the Catholic tradition will feel most at home with the expressions of spirituality presented, other persons of faith (particularly Christians) interested in exploring how their faith commitment impacts their clinical practice may also find much here that is challenging and inspirational.

As a reader, I would like to have seen more attention given to social justice issues as they impact healthcare. Also, the inspirational character of the book would be enhanced with more vignettes of physicians whose beliefs and spirituality are integrated into their medical practice. And finally, a broader lay readership would benefit from an explanation of some of the more technical terminology that is used. These comments notwithstanding, the prophetic character of this book makes it a fruitful, potentially transformative experience.

John Gillman, Ph.D., is an NACC and ACPE supervisor at VITAS Innovative Hospice Care in San Diego, CA.

**News Briefs**

**Half unit of CPE offered**

Dartmouth Hitchcock Medical Center in Lebanon, NH is offering a half-unit program of CPE for CPE alumni. The 240-hour program will provide 60 hours of group and individual supervision in three three-day sessions over the course of the summer, along with 180 hours of practicum at DHMC or in the student’s parish.

The program is aimed at the continuing education needs of persons who have completed at least one unit of CPE at any accredited institution and are now active in ministry. It will be held at LaSalette Retreat Center in Enfield, NH, which features beautiful grounds for walking, a lovely chapel for meditation and worship, and proximity to hiking trails and canoeing/kayaking spots.

**Web site designed for Catholics with disabilities**

A new Web site seeks to increase awareness and inclusion of people with disabilities in the church.

The site, www.catholicdisabilityteachings.com, is run by Dennis McNulty, director of Catholic Charities Disability Services in the Diocese of Cleveland. It provides information on the church’s teachings about how people with disabilities can have fuller access to the sacraments, including links to statements from the Vatican and U.S. bishops, and inspirational prayers and reflections.
CPE RESIDENCY

Rochester, MN – Mayo Clinic CPE residency positions beginning August 23, 2007 through August 20, 2008 for Resident I applicants. Residents are offered a broad array of clinical opportunities, which include medical and surgical subspecialties, diverse intensive care unit ministries, organ transplantation, a children’s hospital, a psychiatric hospital and a regional trauma center. Two different hospital campuses and three different certified supervisors make this a uniquely powerful learning environment. Mayo Clinic health and dental benefits available to residents at a reasonable rate. The resident stipend is $26,200 for 12 months, four consecutive quarters of CPE. For program information, e-mail cpeprogram@mayo.edu, or write Mayo Clinic CPE, 201 West Center Street, Rochester, MN 55902; phone (507) 266-7275; fax (507) 266-7882; website www.mayo.edu

CHAPLAIN

Bellingham, WA – PeaceHealth-St. Joseph Hospital, a 253-bed medical center located in beautiful Bellingham, WA, is seeking a chaplain to join our Ecumenical Spiritual Care Team. As a PeaceHealth hospital, we take seriously our responsibility to our community “to care on the healing mission of Jesus Christ” and to consciously live our core values of “Respect for individual dignity and worth, Stewardship, Social Justice, and Collaboration.” The successful candidate will be at home with our Mission and Values and have the following: Demonstrated compassion, respect and caring to patients, families, visitors; provides personal, spiritual, religious support to patients, families, hospital staff; degree in theology, pastoral ministry, related field; minimum 4 units CPE; certified by NACC; holistic lifestyle; commitment to own faith and practice of theological reflection; maturity, wisdom, sense of humor and good judgment; interfaith and multi-cultural understanding and sensitivity; resilience, flexibility, adaptability; ability to communicate effectively verbally and in writing; ability to manage confidential information. Apply online at www.PeaceHealth.org. Email: JMcAuley@PeaceHealth.org. EOE

VPM MISSION SERVICES

Omaha, NE – Alegent Health seeks a Vice President Mission Services to provide leadership in promoting and integrating mission, vision and core values throughout the organization. Alegent Health has a mission of treating the whole person – body, mind and spirit. Reporting to the CEO, the VP Mission Services is a member of the senior leadership team and actively participates in the policy development, strategic planning and budget activities. Alegent Health is a nonprofit, progressively managed healthcare organization serving Nebraska and western Iowa with eight hospitals, over 8,000 employees and 1,200 medical staff. Operating profitably with gross revenues of $1.9 billion, the system founded in 1996 is sponsored by Catholic Health Initiatives and the Evangelical Lutheran Church of America, Nebraska Synod. The VP Mission Services provides strategic and operational leadership for the integration of the mission of being faithful to the healing ministry of Jesus Christ and values of Alegent Health into the strategic direction, operational management and daily life of the organization. The Vice President of Mission Services will play a lead role in ensuring mission integrity in the programs, policies, structures, strategies and decisions throughout Alegent Health. Some programs that report to the VP Mission Services include the Center for Healing Ministry, the Ethics Center, Direct Spiritual Care, Language Access, Ministry Education, CPE, and the Community Benefit Trust. Today, this person has direct supervision over a team of 70. The successful candidate must

be an articulate and passionate spokesperson, have a track record of successfully translating mission into the culture of an organization, have demonstrated skills in managing group dynamics and influencing others. Other qualifications include a bachelor’s degree with a master’s degree in related field preferred, at least five years experience in a management position ideally in healthcare; previous experience in mission service or mission effectiveness leadership is preferred. If you would like to learn more about this opportunity, please contact Karen Otto or Janet Oppenheimer at: AlegentVPMission@wittkieffer.com; Fax: (630) 990-1382.

VICE PRESIDENT OF MISSION INTEGRATION

Towson, MD – Let your spirituality touch an entire organization. St. Joseph is seeking a Vice President of Mission Integration to help shape the culture of the medical center. Our ideal candidate will be grounded in the core values of reverence, integrity, compassion and excellence. The position is responsible for collaboration with others in the development of new ministries to promote healthy communities; facilitating the integration of mission, ethics and spirituality; and assisting with advancing advocacy agenda at the national, state and local levels. The incumbent will provide direction and leadership along with a variety of other functions to fulfill St. Joseph’s mission. A master’s in theology and/or pastoral studies with knowledge of healthcare ethics is required. Candidates of the Catholic faith with three years’ experience preferred. This candidate must be conversant with Catholicism, have a demonstrated familiarity with a diversity of spiritualities, and possess the knowledge and ability to work effectively within the framework of the Catholic Church. Knowledge of healthcare ethics with particular emphasis on the Ethical and Religious Directives for Healthcare Services is imperative. For consideration fax cover letter and resume to Vice President, Human Resources at (410) 337-1489 or apply online. St. Joseph Medical Center, 7601 Osler Drive, Towson, MD 21204; Apply online at www.stjosephjobs.org. The mission of Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities. An equal opportunity employer. Drug-free and smoke-free environment.

CHAPLAIN

Austin, TX – The Seton HealthCare Network is the leading provider of healthcare services in Central Texas, serving an 11-county population of 1.4 million. The network includes five urban acute care hospitals, two rural hospitals, and a mental health hospital. The chaplain seeks to make God’s redemptive love and healing present to the sick and suffering among our patients and their families, as well as the hospital staff. Ministers to the sacramental, spiritual/religious, and the emotional needs in the various crisis situations as they arise. Contributes to the care of the whole person and communicates this value to other members of the healing profession. Maintains equipment (clinical/technical) and age-specific competencies as well as promotes the mission, philosophy, vision and values of the Daughters of Charity. As a chaplain with the Cancer Care Team, you would be part of a multidisciplinary team whose goal is to meet the holistic needs of cancer patients entrusted to our care. Our patient population is very diverse and our team often

January 2007 Vision
Positions Available

cares for the most at-risk and vulnerable. The Cancer Care Team chaplain must speak fluent Spanish and have a minimum of two years experience postgraduate work as a chaplain. Also preferred would be experience with cancer patients as well as end of life experience and ministry. Please contact mfaulks@seton.net and complete an online application www.seton.net for employment consideration. EOE

▼ CLINICAL STAFF CHAPLAIN

Salina, KS – Salina Regional Health Center is expanding and will be adding a clinical staff chaplain to the Mission Effectiveness department. Education requirements include a master of divinity or master of theology from an accredited school, ecclesiastical endorsement, one year of hospital chaplaincy, board certification eligibility by APC, NACC, or JCA with a minimum of four units of CPE and three years of congregational experience. Chaplain responsibilities include providing professional, spiritual care for patients utilizing spiritual assessment, diagnosis, planning, intervention, and evaluation in keeping with the health center mission. The successful candidate will also provide care education to chaplain staff, clergy, student interns, and local organizations. Salina Regional Health Center offers excellent benefits, competitive salary, administrative support, and career enhancement opportunities. Apply now at www.srhc.com.

▼ DIRECTOR OF PASTORAL CARE

New Haven, CT – As the Hospital of Saint Raphael begins its second century of caring, we are committed to continuing our strong tradition of providing high quality pastoral care services. We were the first Catholic hospital to establish a pastoral care department and to embrace the CPE model of training. We provide an excellent training program which is fully integrated into the department. The highly qualified interfaith permanent staff members act as mentors and support to the Manager of the CPE program and work collaboratively with the Director. We are looking for a dynamic, experienced leader to join our staff and support the growth and development of the hospital’s mission, since its founding by the Sisters of Charity of Saint Elizabeth in 1907. We are an inner-city academic health center of 511 beds and many outpatient services where spiritual care of patients, their loved ones, and staff is highly valued and supported. A master’s degree in related field as well as certification by the National Association of Catholic Chaplains is required. Five years of experience in a pastoral care environment with proven supervisory experience required. Professional compensation and excellent benefits are offered by the Saint Raphael Healthcare System. Please send a letter of application and a full resume to Peggy Dilinger, Human Resources Department, Hospital of Saint Raphael, 1450 Chapel Street, New Haven, CT 06511, or email to: lcortes@srhs.org.

▼ VICE PRESIDENT, MISSION SERVICES

Illinois – Our client, a large Midwest health system, is searching for a VP of Mission Services for their long-term care division. This high profile executive position requires experience as part of a senior management team, graduate degree in pastoral studies, theology, ethics or healthcare administration and 3-5 years of mission experience. Reports to the CEO and manages a team of directors. Must have experience in developing church relationships including coordinating service offerings with the local Catholic parishes and bishops. A detailed understanding and belief in the Roman Catholic doctrine, including the Ethical and Religious Directives for Catholic Healthcare Services, is required. The Vice President will participate and actively chair the mission integration committee of the Board of Directors as well as various important community task forces. If you are interested in discussing this opportunity please call Anna Inglett, President Putnam Healthcare Services at 888-551-6996 or ainglett@johnputnam.com

▼ DIRECTOR OF CHAPLAINCY SERVICES

South Dakota – If you have at least three years of experience as a chaplain, NACC certification, some supervisory experience, and you are ready to be a Director, this might be for you. Our client is searching for a director for their 200-bed facility. Hospital is part of a health network of 100 locations across several northern states. If you are interested in learning more about this opportunity please contact Anna Inglett, President, Putnam Healthcare Services at 888-551-6996 or ainglett@johnputnam.com

▼ PASTORAL EDUCATION COORDINATOR

Sacramento, CA – Sutter Medical Center in is seeking a certified CPE supervisor. The supervisor will join the Spiritual Care Services team in working collaboratively with the Director of Spiritual Care/ACPE Supervisor and three board certified chaplains. The supervisor will take primary responsibility for training and development, including CPE students and SMCS staff. The supervisor will develop, manage and supervise all CPE programs. Sutter Medical Center, Sacramento is the foundation of Sutter Health, Northern California’s largest health network. The downtown Sacramento medical center is comprised of several facilities that include Sutter General Hospital, Sutter Memorial Hospital, and Sutter Center for Psychiatry. The supervisor must have the ability to work well as a team member with other top-level health care professionals. Qualifications include, but not limited to a master of divinity degree (or equivalent), supervisor certification with ACPE or NACC, and hospital ministry experience. Please apply at www.checksutterfirst.org. For additional information contact Rev. Lisa Nordlander, Director of Spiritual Care Services, (916) 454-2222 x79120, nordlal@sutterhealth.org.

▼ CHAPLAIN EDUCATOR

Iowa City, IA – University of Iowa Hospitals and Clinics - Chaplain Educator - Program Associate I full-time, to provide spiritual care for patients and their families, to plan, supervise and evaluate CPE interns, and to coordinate and supervise volunteer chaplain associate activities. A Master of Divinity degree is required, as is completion of supervisory clinical pastoral education in an accredited program. Certification as a supervisor from the Association for Clinical Pastoral Education is required. Six months to one year of chaplaincy experience is required, preferably in a health care setting. One to three years of chaplaincy experience is highly desirable. Excellent written and verbal communication skills are required, as is proficiency in computer software applications. Competitive salary, fringe benefits. Women and minorities are encouraged to apply. Interested persons should apply at http://jobs.uiowa.edu, requisition 53269. For additional information, please contact Linda Liedtke at linda-liedtke@uiowa.edu, or telephone (319) 356-7119. Credentials subject to verification. The University of Iowa is an affirmative action and equal opportunity employer.

▼ CHAPLAIN

Cheyenne, WY – Cheyenne Regional Medical Center has an opening for a part-time chaplain. This position participates in the department on-call schedule in rotation with other chaplains. The chaplain provides spiritual and emotional care and support
MANAGER, MISSION LEADERSHIP
Anchorage, AK — Works with residents, staff, management, physicians, volunteers and community at Providence Extended Care Center in furthering the understanding of the mission of the Providence Health & Services and the integration of the core values into the life and programs of the facility. This includes assuring that the mission and values are reflected in all policies and programs. Articulates and interprets the meaning of spiritual care in the context of health and illness, and advocates for its effective inclusion in all health care provided by Providence Extended Care Center. Networks and collaborates with appropriate local faith communities in order to assure that continuity of spiritual care and opportunities for prayer and worship occur throughout the health/illness cycle. Participates in the PHSA Mission Council. Requirements: academic degree, master’s level, in theology, pastoral ministry or related field; five years of successful experience in mission and/or spiritual care services; certification by NACC and/or APC. All of the beauty and adventure of Alaska awaits you. From hiking to skiing snow-capped mountains, fishing in wild streams to exploring the open wilderness, Alaska offers a spectacular way of life. If you’re looking for a rewarding career in a beautiful setting, consider Anchorage and Providence Extended Care Center your destination. We offer a generous benefits package along with relocation assistance. Please complete an online application at www.providence.org/alaska/jobs.htm or call (800) 478-9940 for more information. Providence Health & Services is an equal opportunity employer.

ROMAN CATHOLIC PRIEST CHAPLAIN
Rochester, MN — Mayo Clinic is seeking a Roman Catholic priest to serve as a full-time Chaplain, ministering to the needs of patients, families and employees at Mayo Clinic. Responsibilities may include: Work cooperatively with other members of the Chaplain Services Department to provide a total program of pastoral care for unit and on-call coverage; assist in liturgical, ritual, and sacramental ministry; support and participate in staff continuing education programs; assist in orientation of new personnel to the department; document patient care activities in the medical record as well as the departmental record. Qualifications: An advanced theological degree from an accredited seminary with a minimum of four units of accredited Clinical Pastoral Education; ordination and endorsement for service as a chaplain by a religious superior or local ordinary; certification from the Association of Professional Chaplains or the National Association of Catholic Chaplains. Preferred candidates will have a minimum of three years of parish or general hospital chaplain experience. Mayo Clinic, recently named one of Fortune magazine’s “Top 100 Employers,” offers an excellent salary and benefits package. To apply, please visit www.mayoclinic.org/jobs-rst/, referencing job posting # 12085. Contact: Anita Dvorak, Mayo Clinic Human Resources; Phone: 507-266-0134; e-mail: dvorak.anita@mayo.edu

SVP, MISSION AND MINISTRY
Denver, CO — Centura Health is a faith-based, not-for-profit health care organization formed by Catholic Health Initiatives and Adventist Health System. Located in beautiful Colorado, on average we enjoy over 300 days of sunshine per year. Our system encompasses 12 hospitals, eight senior living facilities, and Centura Health at Home—home care, hospice, infusion, home medical equipment and oxygen services. This position serves as a member of the senior management team promoting the understanding and integration of Catholic philosophy, values and mission. This position will also enhance the faith dimension of ministry in the areas of mission effectiveness, pastoral services, ethics, advocacy and new ministries; and design methods for establishing a Centura culture that promotes both the spiritual and social values encompassed within the mission. Requirements include bachelor’s degree, master’s is preferred. Equivalent work and/or theology experience will be considered. Candidate must have 10 plus years of experience in an organization or institution promoting the sponsor’s mission, values and philosophy. Relocation assistance will be available. Learn more about Centura Health, visit our web site: www.centura.org. If you have questions, please contact Michael Freemyer at michael.freemyer@centura.org.

RELIIGIOUS SERVICES SPECIALIST
Florence, AZ — Jesuit Refugee Service/USA (JRS/USA) is looking to fill a religious services specialist position at the US Department of Homeland Security Service Processing Center. The incumbent provides counseling, spiritual direction, support and pastoral care to non-citizen immigration detainees in accordance with current federal regulations. Applicants must have earned a bachelor’s degree from an accredited college in social work, counseling, pastoral work or other appropriate discipline. Formal ministerial preparation in a congregational or specialized ministry setting is desired. The ecclesiastical group of all candidates will provide an ecclesiastical endorsement. Spanish speaking language skills are required for this position. Please send your resume via e-mail to Armando Borja, Director for Management and Programs, at aborja@jesuit.org. Compensation range upper 30’s per annum plus excellent health benefits and vacation leave. JRS/USA is an equal opportunity employer.

Positions Wanted

NACC full member and certification-eligible chaplain and CPSP certified pastoral counselor and clinical chaplain seeks a full-time position as a Catholic priest staff chaplain in any part of the United States, beginning from January 2007. Please contact: Rev. Charles U. Okorougo, e-mail: charlesokorougo@hotmail.com

Catholic priest and NACC board certified chaplain seeks a short-term (10-12 months) chaplain position with hospital or hospice within Milwaukee, WI area, starting immediately. Contact Rev. John Vanney Muweesi, 1735 N. Hi Mount Blvd, Milwaukee, WI 53208, tel. (414) 258-1735 or (414) 258-2708, e-mail: weekembe@hotmail.com
Board of Directors

CHAIR
Karen Pugliese
Chaplain
Central DuPage Hospital
Winfield, IL
karen_pugliese@cdh.org

VICE CHAIR
Bridget Deegan-Krause
Ferndale, MI
krausebd@udmercy.edu

SECRETARY
Paul Marceau
Vice president, Mission Services and Ethics
Trinity Health
Novi, MI
marceaup@trinity-health.org

TREASURER
Sr. Geraldine Hoyler, CSC
Notre Dame, IN
ghoyler@cscsisters.org

EPISCOPAL LIAISON
Most Rev. Dale Melczek, DD
Bishop of Gary
Merrillville, IN

INTERIM EXECUTIVE DIRECTOR
Rev. Thomas G. Landry
National Association of Catholic Chaplains
Milwaukee, WI
tlandry@nacc.org

Patrick H. Bolton
Director of Pastoral Care
Mercy Medical Center
Daphne, AL
patrickb@sa-mercymedical.org

Alan Bowman
Director of Spiritual Development
Catholic Health Initiatives
Denver, CO

Sr. Barbara Brumleve, SSND
CPE Supervisor
Alegent Health Care
Omaha, NE
bbrumleve@alegent.org

Sr. Norma Gutierrez, MCDP
Chaplain
St. Mary Medical Center
Apple Valley, CA
norma.gutierrez@stjoe.org

Sr. Mary Eileen Wilhelm, RSM
President Emeritus
Mercy Medical
Daphne, AL
smew@sa-mercymedical.org

Calendar

February
1 Chaplain certification materials due at NACC office
1-3 ACPE Racial, Ethnic and Multicultural conference, Indianapolis, IN
7-10 CAPPE conference, Niagara Falls, ON
11 World Day of the Sick
21 Ash Wednesday
26 Copy deadline, April Vision

March
15-18 Certification Commission meeting, Portland, OR
16-17 Board of Directors meeting, Portland, OR
17-20 NACC annual conference, Portland, OR
17 Supervisor certification interviews, Portland, OR

The National Association of Catholic Chaplains

5007 S. Howell Avenue Suite 120
Milwaukee, WI 53207-6159

Address Service Requested

Nonprofit org
U.S. Postage Paid
Milwaukee, WI
Permit no. 4872