

A journey with Eric:

Reaching out with cultures, subcultures in mind

By **Linda F. Piotrowski, MTS, BCC,**
and **Donna Soltura, MSW**

Eric is a 44-year-old gay man of Hispanic descent, who is originally from New York City. He has been diagnosed as HIV-positive for 18 years. His partner died seven years ago, of a non-HIV related cancer. Eric is acutely grieving this loss. He is an active alcoholic. He has been seen by physicians and nurse practitioners at this institution for six years and has been encouraged to see a counselor regarding both grief and substance abuse several times throughout those years. He always declines this advice.

Eric's mother died of alcohol abuse several years ago. His sister is a cocaine addict. He is very close to his sister's daughters, who live locally. Eric disclosed his sexuality to his father and brothers 19 years ago. They beat him so badly that he had to be hospitalized. A year later he discovered and disclosed his HIV-positive status to his family. His brothers again beat him. No hospitalization occurred as a result of this beating.

Eric lives in a moderately urban area of Vermont (by Vermont standards). He is a waiter but has been unable to work for the last three weeks due to uncontrolled pain.

Donna Soltura (article co-author) and Paula Caron, palliative care nurse practitioner, are about to meet Eric Ramirez (not the patient's real name) in the Outpatient Clinic. His infectious disease physician referred him to them for his uncontrolled pain.



Palliative care is a relatively new specialty. The focus is on helping people live well in the face of physical and personal challenges, on the quality of one's life. At Dartmouth-Hitchcock Medical Center in

Lebanon, NH, the Palliative Care Service addresses the physical, emotional, social and spiritual needs of seriously ill patients and their families. The clinical team was originally made up of physicians and nurse practitioners. Under the leadership of Ira Byock, palliative care physician and author, the team has expanded to include a chaplain/ spiritual care coordinator (Linda Piotrowski, article co-

author), a social worker/continuing care manager (Donna, article co-author), a network development director, a volunteer manager and a corps of No One Alone volunteers.

Initially, Linda and Donna carried both inpatients and outpatients in their individual daily caseloads. Over several months they learned that it was both inefficient and ineffective to try to be everywhere at once. They determined that Linda would assess inpatients for psycho-social-spiritual needs and Donna would do the same for outpatients. This involved educating each other on the finer points of needs assessment from their similar, yet different, professional perspectives. This method of skilled needs assessment and follow-up referral to the appropriate discipline (social work vs. chaplaincy) enhances the service's commitment to being an interdisciplinary team, rather than a

When meeting someone from another culture or spirituality it is important to reflect upon these three questions: What does my faith have to do with this situation? How do I invite the other to share? How do I create a sense of hospitality?



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NACC making shifts to increase value to members

By David Lichter, D. Min.
Executive Director

The first shift is with the association's staff: *from* perceiving themselves or allowing themselves to be perceived as the ones who know best the members and their needs *to* developing their capacity for a "new kind of listening" to the members — not through questions and answers but by relating with them in co-developing ideas and solutions for their professional needs.

Some of you might be familiar with the phrase "value analysis." It is used in very diverse industries to describe a method of examining and determining the "value" of something, whether it is a service line, a process, a system, or a machine. In 1947, Lawrence D. Miles, while working for General Electric (GE), created this systemic approach that revolutionized GE's productivity and costs. One of Mr. Miles' famous remarks was: "Value analysis is a system for use when better than normal results are needed." Its aim is to increase the value of whatever it analyzes. The equation goes like this: value equals how well something functions divided by its cost. So it is not just equated with cost. To know how well a service functions is critical to the equation. Through this process we learn a service's or tool's "value proposition." Many healthcare entities have developed systems of value analysis to examine most areas of their services to their customers. Let me reflect a little about both the NACC and chaplaincy through the perspective of their "value proposition."

Sometimes it's helpful to get a little outside perspective to reflect on such a question. In the Spring 2007 edition of *The Journal of Association Leadership*, the article by Anna Caraveli, "Building the Future on Member Value: Co-development as a Key to Customer Relationships in the 21st Century," emphasized that the future of associations rests in moving from productive-intensive to relationship-intensive strategies. She mentions five shifts that must take place to build the value proposition of associations.

The first shift is with the association's staff: *from* perceiving themselves or allowing themselves to be perceived as the ones who know best the members and their needs *to* developing their capacity for a "new kind of listening" to the members — not through questions and answers but by relating with them in co-developing ideas and solutions for their professional needs. Member engagement in their association's value proposition is key. How is NACC doing here? During this past year NACC staff have tried to begin re-establishing some approaches to the new listening, but we have a long way to go, and need to listen to you for better ways.

The second shift is *from* relying on lists of benefits being offered and delivered (more is

better), and mistaking them for a member value proposition, *to* focusing on one or two areas that are critical to the practice of the profession, and all other services are directed to this (these) targeted area(s). What are the one or two areas of NACC? The NACC mission and strategic plan did name driver goals that I discussed in past columns — promoting/advancing the profession of spiritual care drives member support, and all the other goals.

The third shift is to move *from* trying year to year to figure out a budget *to* developing a business model that best leverages its competitive advantage. This business model requires *first of all* defining the base, "What is the knowledge base and area of expertise that only you can provide?" For some associations it is the networking among their members and the collaborative activities that spawns, for another association it might be the research and advice/resources it offers. What is it for NACC? What is it that only NACC can provide? *Then* you create the value, where success is judged by learning outcomes and customer experience, not the number of benefits. This service model relies on a life-long engagement of a member rather than a one-time engagement (at certification). It answers questions such as, "how has the association contributed to my development at various life stages?" Or, "what competencies and relationships have been developed through being a member that have made a difference to my professional growth and success?" How is NACC doing here? Many of you have shared with each other the long-term value of being an NACC member and how important NACC colleagues have been to your professional life. Yet, we have a way to go here also.

The fourth shift is *from* relying mainly on outside experts and formal research to know the needs of members *to* developing strategies for continuous informal conversations among members and peers through local gatherings, chat rooms, e-mail exchanges, conference calls, blogs, etc., both for member enrichment and for continuous learning on how best to serve members. They call it "dynamic, contextual knowledge" that helps associations appreciate the changing needs of members over a lifetime, what knowledge is most needed, how it is applied at work, how to best provide to one another ongoing training and professional development. How is NACC here? Again, I think we are beginning to take steps toward this transition. While we have not relied much on outside expertise, we certainly have a need to improve the ways we engage you in co-developing what you most need.

The final shift is *from* assessing strategic goals only in terms of member growth, *to* creating and adopting value-based measures of evaluating an association's progress. Certainly member retention and development is of highest priority, yet how do we assess the lifetime value of being a member? How do we convert a member from a low-value to a high-value assessment? How do we learn from members how they benefit from being a member? Some associations might also use a

vision

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

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Embrace the journey, transitions and all

**By Karen Pugliese, M.A.
NACC Board Chair**

In a previous column I mentioned that David Lichter and I share our reflections with one another before going to print. After reading his draft for this edition of *Vision*, I re-wrote my column! His discussion of Anna Caraveli's "five shifts" captured my imagination. Her observations provided me with a new articulation of my personal hopes and dreams for a desired future for NACC. And David's reflections generated the following thoughts and challenges related to "the five critical transitions."

I've also shared with you in this column my deep appreciation for the five stained glass windows in my hospital chapel representing the elements of Creation and the notion of Transition. Intricately woven with symbolism, they wrap around the sacred space, embracing all who enter. The Transition Windows, designed to reflect the artistic integrity of design from one theme to another as well as the state of transition itself, are an abstract presentation of life's journey. In their nuances of season and light I envision NACC's progress in navigating the five shifts that relationship-intensive organizations utilize in their value analysis.

1. In thinking about the shift toward "a new kind of listening" between members and staff I am struck by the notion of collaborative idea generation and problem solving. The Vision and Action Initiative served as a catalyst for enhancing this way of being in relationship. The process restored elements of grass roots involvement our members missed. NACC Now, state representatives, and the new task forces focused on strategic priorities, etc., are all strengthening our "value proposition." *Vision's* Editorial Advisory Panel is an excellent example of staff and members in meaningful dialogue and creative exchange.

2. Discussing the second shift,

David challenges us to reframe our perspective related to benefits. Might we dare to imagine that "less is more?" Friends of mine chose for the theme of their wedding liturgy the image of "two individual candles transforming the darkness with fire. And yet, as the two flames unite to form one, they ascend even higher." Do we dare to advocate for our profession by creatively maximizing our strengths and assets in the sharing of resources? Can we eliminate duplication of services in greater alliances with our strategic partners without fear of diminishment, loss of boundaries or compromising our uniqueness?

3. Perhaps the third shift is the most challenging for us. Competency in leveraging our competitive advantage is not a practice standard for our profession! (Not yet.) And yet, it seems to me that the key to the Secret Garden of Competitive Advantage lies in story telling. And that is not only a competency, but also a core value at the heart of our ministry. Daily we hear again the ancient stories of Sacred Scripture and discern anew their meaning for our lives and the lives of those we accompany on their spiritual journeys. In our dreams and desires for NACC, are we underestimating the significance of defining our knowledge base and areas of expertise in order to build a compelling and viable business model to benefit those serving as well

Do we dare to advocate for our profession by creatively maximizing our strengths and assets in the sharing of resources? Can we eliminate duplication of services in greater alliances with our strategic partners without fear of diminishment, loss of boundaries or compromising our uniqueness?

See *Journey* on page 5.

Certification interviews planned, renewal of certification process outlined

Q. Where will fall 2008 certification interviews take place?

A. We are especially grateful to the number of institutions who give in-kind donations to allow their sites for our certification interviews scheduled for Saturday/Sunday, Oct. 4-5, 2008, for our 70 applicants. Interviews will be held at:

1. St. Joseph Hospital (Orange, CA)
2. Caritas St. Elizabeth Medical Center (Brighton, MA)
3. NACC National Office (Milwaukee, WI)
4. Providence St. Vincent's Medical Center (Portland, OR)
5. St. Joseph Medical Center (Towson, MD)
6. De Paul Hospital (Bridgeton, MO)

2008 - Renewal of Certification Applications

Renewal reminder letters were mailed to those members due to renew their certification by Dec. 31, 2008.

Thank you to members who submitted 2008 Renewal of Certification Applications early. These renewal materials were reviewed at our recent Certification Commission meeting, which was held in July 2008 (Milwaukee, WI). Notification letters and new certificates were to be mailed, via U.S. Postal Service, the week of Aug. 18, 2008.

For those still working on Renewal of Certification Application and materials, please note items received ***by Oct. 10, 2008**, will be reviewed at the upcoming Certification Commission meeting, which begins Oct. 30, 2008, (Milwaukee, WI) with notification mailed by Dec. 2, 2008.

Renewal of Certification Applications received after **Oct. 10, 2008**, will be reviewed at the Jan. 30, 2009, meeting (Orlando, FL) with notification mailed out by March 3, 2009.

*Please Note: For those members requiring notification prior to Dec. 31, 2008, it will be necessary to submit your Renewal Application and materials in time to be reviewed at our last Commission meeting of the year (October 2008). Although you have until Dec. 31, 2008, to complete the process, we urge you not to wait until November or December unless you are OK with waiting until March 2009 for your notification letter.

2008 Renewal of Certification Materials

Please be sure to visit www.nacc.org / CERTIFICATION /

Renewal of Certification to print your renewal of certification materials:

- ▼ Standards,
- ▼ Renewal Process Guide,
- ▼ Renewal Application,
- ▼ Education Report Forms, and
- ▼ 2008 Peer Review Form.

The old-outdated blue-cards, Recertification Process Report, are no longer acceptable. To avoid having materials refused/returned-to-sender, please be sure you are using the updated/required forms (listed above).

Logging your Continuing Education Hours

When logging Continuing Education Hours (CEHs), please be sure to use a separate Education Report Form for each year. So, you will have a total of five (5) Education Report Forms to submit with your application/materials. If you have an abundance of CEHs to record, then please use the Education Report Form (longer version), which will allow more entries.

How do I Find a Peer Reviewer?

To select a Peer Reviewer (an active certified NACC member) to complete your one (1) hour peer review session, please visit www.nacc.org / MEMBERSHIP / Members-only Pages / On-line Member Directory / Enter your Username (your Member #) / Enter your Password (your last name in lowercase letters) / U.S. State Index / And click on the state's abbreviation to view a list of Members in your area. (Must also see the Peer Review Process located in your Renewal Process Guide.)

2008 Renewal of Certification Fee

The 2008 Fee for Renewal of Certification is \$135, made payable to the NACC.

Renewal Contact Person

If you have any questions or concerns regarding the renewal process, please contact Rose Mary Blanco-Alvarado, Certification Specialist, at the NACC National Office, (414) 483-4898.

Value

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criterion such as benefitting the broader community to evaluate their benefits. What measures should NACC use to evaluate its progress as an association? I am anxious to hear from you, as members, about which measures we might use to evaluate long-term member value.

In the past months I have had several conversations with vice presidents of mission integration, and other healthcare executives to learn more about how they perceive the value of chaplaincy and the value of the NACC. Most intuitively know chaplaincy's value and have heard stories of the positive, healing

influence of our profession. Yet they are also challenged in the financially tough service environment to find a reliable and consistent way to do a reputable "value analysis" of the chaplaincy profession. How well does this service function? How do you measure it? They look to NACC to help advance the national initiatives to answer these questions. These are not questions of the value analysis of NACC but of chaplaincy. I look forward to reflecting on this topic in my November-December column.

In the meantime, I look forward to hearing from you regarding your reactions to this column and how NACC measures up in terms of the five critical transitions I mentioned. Please contact me at dlichter@nacc.org.

God Bless

Journey

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as those being served?

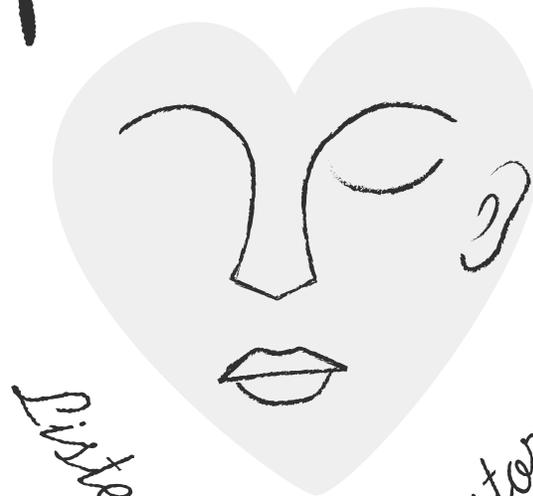
4. Once again I gratefully acknowledge and applaud members who have participated in and are currently involved in the ongoing Vision and Action work, focus groups, task forces, panels, committees, commissions, certification, professional gatherings, state representation, etc. The “dynamic, contextual knowledge” generated by these activities is invaluable. Unlike some organizations, we tend to rely less on outside experts and formal research. The fourth shift invites us to own our tendencies toward insular thinking and isolationist practices. Awareness of these inclinations offers opportunities to stand on shifting sands, holding in creative tension and delicate balance the internal and external resources for enrichment and continuous learning.

5. The fifth shift has to do with assessment – another of our core competencies. How do we adapt and apply our clinical pastoral skills in evaluating and treating spiritual distress in patients, clients, caregivers and co-workers to the health and well-being of our association? For me, an essential element in assessment is evidence of

readiness for transformative change. How do we continually discern the changing meaning and purpose of professional affiliations? In September of 2006 our consultants, The Reid Group, summarized feedback from a series of telephone focus groups with members. Our learnings indicated a need to evaluate NACC’s most appropriate and effective commitments and relationships in order to benefit our members and our profession. We need to hone our analysis skills and “sharpen the saw,” as Steven Covey would say, to prune away that which no longer serves us well, thus inviting new life and new growth.

In closing, I return to the place I began — the hospital chapel. Our hope and prayer in designing the chapel was that all who visit would find comfort and healing, and experience

*Listening
Presence*



Listen, hear the story.

*Pastoral Care Week
2008*

God’s presence in special ways. The wood, copper, stones and plants in the entryway represent Earth, where one is grounded, centered. The Wind Window depicts the spirit of God hovering over chaos and disease, restoring goodness and wholeness to our lives. The Water Window represents abundance, cleansing and rebirth. The image of Fire, which embodies the very essence of spirituality, also suggests the comforting vision of a warm fire shared with companions on life’s journey, the perpetual flame lighting their way. My hope and prayer for us, blessed by a call to the profession of spiritual care and membership in an association that embraces reflection, action and analysis, is that we will be ever grateful for all that has been, and always ready to embrace the journey that lies before us.



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Diversity

Continued from page 1

multidisciplinary team, and benefits patients by providing them with a better educated clinician doing evaluations.

In the Outpatient Clinic, the medical clinician (MD or nurse practitioner) is teamed with the social worker for new patient evaluations. The inpatient medical team (attending MD, nurse practitioner, fellow and, often, an intern, resident or fourth-year medical student) meets patients as a group during rounds. Linda meets patients separately, often in the afternoon, when this academic teaching center is free of “white coats” filling patient rooms, and she has more effective, uninterrupted privacy to introduce herself and get to know patients and their families. In both settings sensitivity to multicultural and spiritual values, beliefs and expectations must be present from the first visit with patients if they and their families are to be served in a way that is comforting and meaningful to them.

How does one ensure that Eric’s cultural and spiritual beliefs are taken into consideration? First, terms need defining. Most broadly stated, “culture” is the sum total of a way of living. It involves the values, beliefs, standards and language of a people. It influences thinking patterns, communication style and what they consider “normal” behavior. It guides decisions and creates expectations.

In end-of-life care, culture determines how one finds meaning out of illness, suffering and dying. It explains cause and effect. In healthcare, it defines the role of “healers” in both physical and spiritual realms.

The world is growing smaller; separate cultures live in closer proximity to each other than years ago. The blending of people and cultures creates an uncertainty in assumptions and expectations on the part of both the consumer and the provider of services. Consumers may feel unheard, disrespected, isolated and vulnerable. Providers may lack knowledge of multiple cultures, act as if there are no differences in beliefs and values, be too hurried to notice or problem-solve cultural and spiritual dilemmas, or lack confidence in their ability to negotiate the exploration of cultures new to them.

Providers treating a diverse population need to consider age, ethnicity, history of substance abuse, spiritual beliefs and rituals, economic status, sexual orientation, national origin, differing abilities, history of mental illness, gender, language, etc. To understand how culture impacts one’s experience in healthcare systems, it’s critical to be aware of varied beliefs about how information is shared (who tells/asks who what?); decision-making (Is autonomy assumed as a primary goal or is it perceived as isolating?); the use of life-prolonging technology; what “healing” means

and who it involves (What is the patient-provider relationship?); what “suffering” means; and which beliefs surround the discussion and documentation of advance directives or code status (and whether talking about them is perceived as beneficial or harmful).

▼ ▼ ▼

Donna and Paula enter the exam room. It is 11 a.m. Eric is lying on his back on the examination table. The room smells strongly of alcohol. Eric has a friendly and engaging personality. He smiles readily, but there is wariness in his eyes.

Paula introduces herself and Donna, each shaking hands with Eric as he sits up on the table. Smiling, Paula invites Eric to join them in the chairs (“We won’t be poking you today unless you want us to.”) and all sit together, chairs pulled to a comfortable circle rather than in the formal arrangement of providers on one side, patient on the other. Paula asks Eric if he knows why his physician has asked him to meet with them today and he replies, “I thought it was about controlling my pain, but why are we meeting in the Cancer

Center? Do you know something I don’t know?” Paula reassures him that she knows of no cancer diagnosis and explains that their clinic space is located in the Cancer Center so it is the usual place for meeting. She apologizes for not informing him prior to coming. She and Donna acknowledge that that must have been stressful for him to worry about that when he arrived and as he sat alone in the waiting area.

Paula asks Eric if he knows what palliative care is. He does not. She explains what the Palliative Care Service team at Dartmouth-Hitchcock does and who is on the team. Then she begins her assessment, starting with inquiries about physical symptoms (there were medication changes that could be helpful to him), moving to “How are you doing emotionally with all of this?” and on to “Where do you gain your strength from? What feeds your spirit and gives you comfort?” Donna participates by asking questions that might further develop an understanding on any of their parts, reflecting back (for clarification) on what Eric was telling them and straightforwardly addressing the pervasive smell of alcohol in the room (Paula has no sense of smell so was unaware of it until Donna asked about it.).

“Eric, there’s a strong smell of alcohol here. I read your chart and I know you’ve had a long struggle



In the realms of culture and diversity, there is no definitive level of competency. It’s possible to learn generalities about various cultures, nationalities, religions and spiritual perspectives, but each person makes each category uniquely his or her own. No person is the same as another. In the realm of the multicultural, your competency is your openness to learning and your awareness and celebration of difference.

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Diversity

Continued from page 7

with drinking. Can you tell me about it?" Eric openly talks about his drinking. He states he is in the habit of getting home from work at 1 a.m. and having two strong drinks before going to bed and then "I have a cocktail or two late in the morning before going back to work. I had one at lunch today before coming in for my appointments." He says alcohol helps him sleep at night. "When I try to go to sleep my mind just won't shut down. I just think about how much I miss Steve. Even after all these years I just cry and cry. I have to have two or three cocktails or I won't sleep." He acknowledges his dependency on alcohol and his acute grief over Steve's death. Donna offers to help him find a good alcohol treatment program and he declines. "I don't really think I can stop right now. Not while I'm having so much pain from my shingles."

Paula leaves the room to take care of the prescriptions they talked about earlier. Donna begins to talk to Eric about loss, focusing on the cultural implications of his life. Eric is Hispanic (Consider the issue of his sexuality in the Hispanic culture, which sometimes includes a strong dose of machismo. In Eric's particular case, this may be linked to the beatings he experienced and estrangement from his father and brothers.); his mother died from acute alcoholism (Consider the culture of alcoholism — the alcohol itself becomes an ever-present member of the family, consider the loss of a mother at her death, the loss of a "normal" mother-figure during her life), he is gay (Consider the loss of friends and surrogate family to AIDS, the loss of a sense of safety in intimacy, the loss of a gay community due to living in rural Vermont, the loss of faith in a loving God), he is HIV-positive (Consider the loss of a sense of future, the loss of health, the loss of being able to be open about his health status for fear of reprisal), and he is without his life-partner (Consider the loss of his love, the loss of his expected caregiver [Eric was HIV-positive when he met Steve. Steve was diagnosed with cancer later.] and the loss of Steve's family after Steve died).

Donna names the losses, compassionately, but as completely as she understands them to be. It is a long, long list. She says, "Eric, you're trying to dull the emotional pain of all of these losses with alcohol. But it's not working for you. It's a band-aid over a wound that needs air to heal. You'll never stop loving or missing Steve, but as long as you get high every night, your pain will never lessen. You'll rip the scab off and tear the wound open again every single day because you haven't truly faced it. You have had more losses in your life, on so many levels, than most people have ever had. But you've got strength, too. You're here, you're alive and that means you have a chance to heal this pain. Won't you consider letting people help you? I promise you we'll be here with you, and we'll do all we can to help you heal."

Eric sobs. He says that no one has ever truly understood his grief before. He believes in God but he can't bring himself to pray to him. He loves Steve and feels so guilty about secretly being angry with him for dying first.

Figure 1.

LEARN Model of Cross-Cultural Guidelines for Health Practitioners

LISTEN with sympathy and understanding to the patient's perception of the problem

EXPLAIN your perception of the problem

ACKNOWLEDGE and discuss the differences and similarities

RECOMMEND treatment

NEGOTIATE agreement

Berlin E.A., Fowkes W.C. Teaching framework for cross-cultural care: Application in Family Practice. West J Med. 1983;139(6):934-938.

Paula returns and Donna reviews what she and Eric had talked about. Eric agrees to think about having Donna help him find a gay-sensitive psychotherapist. He declines the offer to have Linda meet with him to talk about his feelings about God. Paula gives him the Palliative Care Services 24-hour phone numbers and encourages him to call with any questions or concerns that he faces.



Throughout the visit with Donna and Paula the dynamic in the room had been one of thoughtfulness, a sincere desire to understand what Eric was saying and feeling and an unhurried yet direct communication about his medical history, his personal history and his current concerns. Eric felt accepted and cared about. He allowed himself to open up and trust that there was help for him and, maybe, that he deserved it

It wasn't that several providers had not heard Eric's grief and sympathized, nor that they had not offered reasonable options to help him, and certainly not that they hadn't cared. They'd cared and tried for years. They saw an active alcoholic whose partner had died. It was that they had not been sensitized to the cultural and spiritual considerations that need to be examined if they were to meet people where **they are** instead of where **the providers were**.

Communication is an important area to consider when addressing these cultural and spiritual considerations. Berlin and Fowkes (1983) developed the LEARN Model of Cross-Cultural Guidelines for Health Practitioners. It is most simply stated as follows: Listen, Explain, Acknowledge, Recommend, Negotiate. (figure 1). Another resource is Kleinman's Explanatory Model, which gives clear-cut questions to ask when attempting to understand cultural issues in work with patients (figure 2).

Several months after successfully completing alcohol treatment, Eric relapses. He could not work because of his declining physical

health; he was in danger of losing his home. He could not afford a private psychotherapist and did not feel emotionally safe in a non-gay specific AA group. His physical pain increased with his alcohol use, he isolated himself, missed appointments and did not consistently take his medication. He felt hopeless.... He calls Donna, stating that he feels suicidal. He is considering jumping from a bridge in a place where he had often felt happy walking his dog. He contracts with Donna to stay safe while she arranges for his admission to the psychiatric unit at the medical center. Later that evening his niece brings him in for admission. The next morning Donna goes to see him. He agrees to see Linda. But he is clear, even in his demoralized state, that he does not want to talk to God.

At morning rounds, Eric appears on the inpatient list. Because outpatients and inpatients are discussed at each morning meeting, Linda is familiar with Eric's case. When Donna makes a referral for a spiritual care visit, Linda is eager to meet him. After morning rounds, Donna and Linda determine that it would be best for them to go together to meet Eric. After reviewing Eric's medical record, they go to the psychiatric unit. They find Eric in his room, still in bed although it is nearly 10 a.m. Lying there with his eyes closed, he appears younger than his 44 years. Eric's vulnerability is almost tangible. Donna greets Eric. He opens his eyes to look at her. He appears a bit surprised to see that someone is with her. Donna introduces Linda, who tells Eric that it is a pleasure to meet him and asks permission to sit down. Eric closes his eyes. Donna inquires about how he is feeling. He recounts recent events and his feelings around them. He says he is no longer feeling suicidal, but instead "very depressed." His speech is slow. He chooses his words carefully.

Donna asks if he would like to speak with Linda privately. Eric tells her to stay. Linda begins to talk to him about his deep feelings of despair and asks if he, in any way, finds a source of comfort in any type of a relationship with God. He explains that he believes in God but does not believe that God loves him since he is all alone, has disappointed everyone in his family, has lost his beloved and his family, is unable to work and soon won't have any place to live. Linda agrees with him that it is hard to sense God's presence in our lives when everything in life is going wrong and we feel abandoned. She asks if he has anything at all in his life that he can love and who can love him back. At this, he begins to talk about his dog. He is worried about his dog and hopes that a neighbor is looking after him while Eric is hospitalized. Linda suggests that perhaps this is a place to begin. He has a dog who loves him unconditionally and a neighbor who is willing to help, at least a bit.

He nods and is silent. The three sit in the silence. Much to the surprise of Linda and Donna, Eric opens his eyes and asks if Linda will pray for him. She asks if she might hold his hand and asks what he would like to pray for. He begins to cry, saying, "You know what to say. You say it." In her prayer, Linda gathers Eric's concerns and asks God to bless him with the knowledge that God loves him and is with him in this awful time. Linda prays for courage for Eric and a return to interest in life. She prays that God

Figure 2.

Kleinman's Explanatory Model

- What do you call your problem?
- What name does it have?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you?
- How does it work?
- How severe is it?
- Will it have a short or long course?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- Is there anyone else with the same problem?
- What have you done so far to treat your illness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?
- Who else can help you?

Kleinman A. Explanatory Models in Healthcare Relationships, National Council for International Health: Health of the Family, Washington, D.C. 1974: 159-172.



will give him eyes to see those around him who are willing to befriend him and help him on his journey. She prays that he will know himself as loved and worthy of being loved. She prays that he might have joy in life again.

Throughout the prayer Eric cries. When it ends he comments on the beauty of the prayer and how it makes him feel a little bit hopeful that God might still be part of his life. Linda asks if there is anything else he might like to talk about.

He says that for now he'd like to rest. Linda and Donna leave with promises to see him the next day.



Linda was aware of Eric's background and his culture. This enabled her to fashion a prayer that would address his needs within the context of his beliefs and his life experiences. In subsequent visits this made it possible to draw more information from Eric about his family and his experiences as a gay man living in rural Vermont as well as how this influenced his thinking about his relationship to God, belonging to a faith community, his faith and prayer.

For chaplains, the key to remaining aware of diversity and cultural issues is being attentive to the community in which they minister while remaining aware of the complexity of culture and subcultures. Those who work in healthcare fields need only think of healthcare with its culture and layers of subcultures each with their own customs, language, and hierarchies. That said, it is important to remember that we are

Diversity

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talking in cultural generalizations. The key is to be sensitive to cultural values, beliefs and practices while understanding that each person is an individual with experiences that influence their particular perspectives.



The film, "Gone Baby Gone," begins with scenes of the Dorchester section of Boston, MA, perhaps the most racially and culturally diverse area of the city. You hear the voice of the main character: "I always believed it was the things that you don't choose that makes you who you are. Your city. Your neighborhood. Your family. People here take pride in those things like it was something they'd accomplished. The bodies around their souls, the cities wrapped around those.

"I lived on this block my whole life. Most of these people have. When it is your job to find people who are missing, it helps to know where they started. I find the people who started in the cracks, and then fell through. This city can be hard. When I was young I asked my priest how you could get to heaven and still protect yourself from all the evil in the world. He told me what God said to his children: 'You are sheep among wolves. Be wise as serpents yet innocent as doves.'"

The film's main character, Patrick Kenzie, a private investigator, attempts to locate a missing child. He assumes that having grown up in the neighborhood gives him special insight into the motivations of the people most likely to be involved in the child's disappearance. He neglects to take into account the various cultures and subcultures at work in this neighborhood that he believes he knows so well. He forgets that individuals make up the neighborhood. He forgets the truth of his own words and the visuals that introduced the diversity existing within the seeming uniformity of his neighborhood.

It is a great temptation to make the assumption that because someone has the same color skin, shares your gender or marital state, speaks your language, belongs to the same faith community, shops at the same grocery store that he or she is the same. No two individuals regardless of their locale are the same.

Many of the spiritual assessment tools currently in use do not explicitly address the cultural dimension of care. However, users, with some degree of sensitivity, can remain aware of this limitation. For example, Paul Pruyser's spiritual dimensions tool addresses: awareness of the Holy or God, acceptance of God's grace and love, repentance and openness to change, a faithful and open attitude toward life, a sense of providence, involvement in a religious community, flexibility and commitment to living with ethical values. Yet, even this tool may have cultural bias. Pruyser was a Christian psychologist, who brought that background and belief system to his work.



(Pruyser P.W. "The Minister as Diagnostician." Philadelphia: Westminster Press, 1976.)

George Fitchett's 7 by 7 model for spiritual assessment is more inclusive and multidimensional. It is also more complex. It reviews seven dimensions of the person (medical, psychological, psychosocial, family systems, ethnic and cultural, societal and spiritual). Additionally, it asks us to consider seven spiritual dimensions. Note: Fitchett's book is published by a Christian publishing company. (Fitchett G. "Assessing Spiritual Needs: A Guide for Caregivers." Ohio: Academic Renewal Press, 2002)

Chaplains cannot be effective in ministry if they do not remain aware of their journey as cultural and spiritual people. The journey of ministry with another begins with self-awareness. Everything builds on this. Each individual must develop and remain aware of his or her own personal cultural and spiritual profile. It is what helps to define each chaplain and his or her ministry.

When meeting someone from another culture or spirituality, it is important to reflect upon these three questions: What does my faith have to do with this situation? How do I invite the other to share? How do I create a sense of hospitality? Henri Nouwen defines this for us:

"Hospitality . . . means primarily the creation of a free space where the stranger can enter and become a friend instead of an enemy." (Nouwen, H. "Reaching Out." Minneapolis Zondervan, 1998.)

"Spiritual care is discovering, reverencing and tending to the spirit of another person," once commented Fr. Joseph Driscoll, former NACC executive director. If you sit by the bed of one who thinks and prays and believes differently than you, what comforts you may not comfort him or her. What do you do? Do you approach with an attitude of reverence? Are you able to let down your guard? Can you allow yourself to move into the unknown? Are you able to say, "I don't know how it is to be Muslim or Jewish or gay or ... Please help me to learn. How do you celebrate this part of yourself? How does it make you who you are?" (A valuable Cultural and Spiritual Sensitivity Resource written by Sue Wintz, BCC, and Earl Cooper, BCC, can be accessed and downloaded from the website of the Association of Professional Chaplains, www.professionalchaplains.org -- Go to Professional Resources -- Reading Room -- Learning Module: Cultural and Spiritual Sensitivity.)

In the realms of culture and diversity, there is no definitive level of competency. It's possible to learn generalities about various cultures, nationalities, religions and spiritual perspectives, but each person makes each category uniquely his or her own. No person is the same as another. In the realm of the multicultural, your competency is your openness to learning and your awareness and celebration of difference.

At Palliative Care Service/Norris Cotton Cancer Center, Dartmouth-Hitchcock Medical Center, in Lebanon, NH, Linda F. Plotrowski, spiritual care coordinator/chaplain, works together with Donna Soltura, social work continuing care manager.

Q&A with Peter M. Ruta, STL, PhD, BCC

Know there are universals, but respect the individual

By Laurie Hansen Cardona
Vision editor

After Vision's Editorial Advisory Panel members decided that the theme of this issue of Vision would be "Ministering to a Diverse Population," they thought it would be helpful to get the view of a chaplain who originally hailed from another country. Chaplains from other nations who work here often minister to people who speak a different language than their first language and who grew up in a culture different than their own. NACC member Peter M. Ruta agreed to a Q&A session for Vision.

—Laurie Hansen Cardona Peter M. Ruta



Peter M. Ruta

properly understood in order to get quality spiritual care. I have to recognize my limitations. In our organization, I have these options: make a referral to a fellow chaplain who understands the language better (e.g. for Spanish- and German-speaking patients, etc.), we have an emergency list of spiritual care providers in the community who can be contacted if needed and we have a phone system that facilitates a three-way conversation with an interpreter. The

philosophical underpinning is that language is an essential ingredient in providing quality spiritual care.

Q. How important is offering a listening presence to your ministry?

A. Active and supportive listening presence is paramount, letting the patients "lead the dance" and being with patients where they are in the moment rather than doing things to them.

Q. Can you relate a story of your work with a patient in which you felt you crossed cultural boundaries and helped an individual despite cultural differences?

A. In my culture, men hugging women in public is not culturally correct. I have come into situations, especially in trauma situations, when a female is grieving for a loved one and the obvious and appropriate way to support that woman or girl is to give her a hug even without saying anything. The times when I had the audacity to cross that cultural boundary, almost always that intervention was appreciated and comforting to those involved. That is confirmed by statements such as: "Thank you, Chaplain, I needed that hug or to hold onto you without letting you go until I felt better."

Q. How do your faith and your Catholicism help you to cross cultural boundaries in dealing with patients?

A. Being grounded in Catholic theology, while acknowledging the individuality of each person's cultural background, I can utilize universals of the Catholic spiritual care of ministry to the sick, e.g. give patients access to anointing of the sick, viaticum, prayers of the dying etc., and be free to minister to all irrespective of cultural differences.

Q. What advice would you offer chaplains ministering to people from your native country?

A. Assume that, in general, the spiritual needs of the sick are more similar than different. Next, be aware that the role of chaplain versus pastor is not as well understood and, hence, the need for a good brief introduction to the role of chaplain. A prayer or offering to pray will be expected of a chaplain's visit. Finally, cultural respect and openness are appreciated traits of a pastoral care encounter.

Q. Please share a little about your background.

A. Originally I came from Tanzania, East Africa. I arrived in the USA for the first time on Sept. 13, 1981. Today I am manager of chaplaincy services at Froedtert Hospital, in Milwaukee, WI.

Q. What are the greatest challenges involved in ministering to patients who come from a culture different than your own?

A. The greatest challenge is "cultural literacy limitations," which may stand in the way of correct interpretation of the experiences of the patient and lead to misuse of humor or wrong assumptions about core values of the patient.

Q. What tips do you have for other chaplains ministering to a diverse population?

A. Assume a non-knowing attitude and be willing to respect the cultural values of the patient and learn from him or her; be cautious in the use of humor as what may be humorous in my culture, may not be so in the patient's culture; be careful in the use of "self" by not yielding to the temptation of being carried away by talking about yourself and your culture even if a patient is very curious about you and your culture; remind myself that "respectful listening presence" is the best approach to ministry; although the individuality of each patient must be taken into account, it is important to remember that there are also universals in ministry due to the universality of the human condition and spiritual needs.

Q. What are the greatest blessings you have found in ministering to patients who come from a culture different than your own?

A. Blessings of being welcome into their intimate lives, being trusted with confidential information about their condition and accepting your ministerial role even if you come from a cultural background different from their own.

Q. What do you do when language issues arise in your ministry, for example, you don't speak the language of the patient to whom you are ministering or your level of fluency in the language prevents you from communicating in the manner in which you would like?

A. When language issues arise because of different linguistic background, I remind myself that a patient has a right to be



'Robert' rediscovers Native heritage in hospital

By Ed Horvat, MA, BCC

"Robert," in his early 30s, is recently diagnosed with a rare form of cancer that spreads quickly and will take his life. He is given months to live.

Robert is tall and thin with long black hair. I think he also may have had tattoos. He has a 1-month-old daughter with his girlfriend. His girlfriend has a 6-year-old son from a

prior relationship to whom Robert is very close. Robert works full time in the hospitality industry and also has a part-time job. Robert has been complaining about back pain for about four months, and is passed around in the healthcare arena. It was assumed that he was complaining about pain as a way to get narcotics. A further work-up at our hospital identifies the problem/prognosis, and Robert is angry. That is how I got the referral.

Robert is receptive to my involvement, though somewhat suspicious of my role. I introduce myself and give him an overview of the Pastoral and Spiritual Care Department. I validate his feelings of anger, and help him express them, giving him "permission" to own his feelings. Part of this anger is complicated by anticipatory grief. During the discussion, I learn that he is originally from the Southwest.

He is Apache, and feels isolated from his culture and traditions. He expresses regret about falling away from the customs of his culture/spirituality/ethnicity. His life has been moving so fast, that these things were placed on the back burner. I assure him that many people of his age are so involved with work, a young family and other obligations, that their spirituality is not given priority. I did not want him to feel alone in this because developmentally, this should be a consideration. I let him know that we had Native American spiritual care providers as

part of the Pastoral and Spiritual Care Department, and I offered to introduce him if he would like. I let him know that all of my consultants were from Eastern Woodland tribes, and apologized that none were Apache. His mouth dropped open. He said, "I thought hospitals only had Protestants or Catholics pushing their wares. Did you say that I could meet with an Indian?"

During his months of hospitalizations, he met several of our Native American providers. He began assembling a medicine bag. He wanted a piece of coal for it because it

was native to West Virginia and that is where he has been living and loving. He was rediscovering his spirituality and was encouraged to do so by most staff. At one point, one of our staff saw him assembling his medicine bag and said, "Oh, you think that is going to help you?" Robert was able to let that remark roll off of his back because of the support he was given by most staff to cope with this crisis in his own way.

Robert was married in the hospital. His girlfriend was Christian, so one of our volunteer chaplains and one of our Native spiritual care providers performed the ceremony. I remained involved in Robert's care, but the spiritual care he was provided was definitely shared, and the Native providers were the most important element. I remember sitting with Robert through several panic attacks, and once held his head as he threw up blood. He also asked me questions about Christ and my beliefs. At one point he said, "Maybe I'll see him there." Regarding complementary modalities, a special tea was brewed for

Robert. The provider wanted Robert's physicians to be aware of the ingredients due to the possibility of interaction with medications.

We also made arrangements for Robert's room to be cleansed with the burning of sage, and special permission was obtained from Security and Infection Control to bring a wolf (his spirit guide) into Robert's room. I was the go-between in these instances and documented his spiritual care in the medical record.

We arranged for Robert to be videotaped holding his daughter, telling her that he loved her, passing on his heritage. We arranged for a paternity test to prove his fatherhood so that his daughter would be able to claim native heritage and any future advantage that may hold for her. This was done at the suggestion of our Native providers. I also worked closely with Robert's girlfriend/wife, the 6-year-old, and Robert's family. My pastoral relationship with Robert was terminated when he was discharged from the hospital and went home with hospice. Our Native providers continued their involvement in the home setting and later conducted his funeral service, which I was invited to attend.

Robert took a new name while here, letting go of his "Anglo-American" name. He became a new man. I saw a strong life force in him. His Native American memorial service was beautiful, meaningful, and devoid of Judeo-Christian influences and Scripture. Storytelling and oral traditions were used during the service. God was there.

RIP

Ed Horvat is coordinator of pastoral and spiritual care at Monongalia General Hospital in Morgantown, WV.

I let him know that all of my consultants were from Eastern Woodland tribes, and apologized that none were Apache. His mouth dropped open. He said, "I thought hospitals only had Protestants or Catholics pushing their wares. Did you say that I could meet with an Indian?"



In Boise: On lessons learned from the stranger

By Michele Le Doux Sakurai, D.Min., BCC

There are times in our lives that we become acutely aware of the guidance of Providence, and we realize that events are not coincidental. Such an event occurred for me a year ago when I mentioned to a manager that I was unimpressed with most cultural assessments I had seen. Within a day I was invited to work with nurses in maternity; they wanted to better serve the refugee community but did not know how. This launched me into a world of service that was unfamiliar and humbling; a world that confronted my assumptions and called me to a new level of accountability as a Catholic working in healthcare.

“They can never go home.” This is how the manager for our Family Center defined refugees. “They can never go home;” it has taken me a year to begin to understand what this means for our refugees. In Boise, ID, we have more than 4,000 refugees and this number is projected to increase by at least 900 by the end of this year. Many come from war-torn countries, have been traumatized, separated from family members and their communities, and brought to a land that bears no resemblance to the land or culture they know. They are given Medicaid and other support for eight months and then are expected to work, support themselves and their families, and to pay back the cost of their flight to the United States. The learning curve is steep and intense.

I started working with the staff through focus groups. What did they see as barriers to serving this community? “They don’t eat or they don’t eat enough.” Nurses concurred, and one added, “I use the interpreter to help with the menus, but there is so much plate waste. I would like to order something that they would like to eat.” As a result, we developed a picture menu. The staff loved it; it saved them time at the bedside and the patients were eating more of their meals. The refugees loved it; it gave them a sense of control in a setting where, due to language barriers, control was hard to find.

The menu success sent me deeper into the refugee experience. The Family Center manager invited me to help her develop a refugee clinic for pregnant women and new moms. Again I used focus groups and I asked what women wanted in their care. Many of the issues were pragmatic. “How do I get to the hospital when I am due

to deliver?” (Hospital staff were concerned that the refugees use 911 to get to the hospital. What I found was that these patients had no transportation and no money for a taxi. Because of the limits of Medicaid assistance for transportation, we are now exploring the option of having a voucher provided “for time of delivery only.”) Other questions included, “How do I use a stove and the dishwasher?” “When I walk, is it OK to carry my baby or must I always have her in her car seat?” Of course there are the cultural questions such as, “Why doesn’t Medicaid pay for circumcision? No uncircumcised man can get a wife.”

Perhaps for the refugees the most compelling issues focus on their human rights: Women spoke of how important it is for them to understand what was happening, and to be given choice. “They (doctors/staff) don’t always tell us what they are doing; in Africa, they first educate us, answer our questions, and then take us into the clinic for the check-up.” When asked what would be helpful, refugee women said they wanted a class on how to understand doctors.

Religion is very important to many refugees. They are of both Christian and Muslim traditions, and the refugees take their faith very seriously. On more than one occasion, a refugee family declined participating in a focus group because it conflicted with church, a day of fasting, or some other religious commitment, and we rescheduled to meet their needs.

“You shall treat the stranger who sojourns with you as the native among you, and you shall love him/(her) as yourself...” (Lev. 19-34). This passage speaks to both a responsibility of service and a gift we receive when we are present to the needs of others. The refugees I have met are warm, welcoming, laugh easily and seem open to each moment as it comes. They remind me that abundance does not lie in earthly measure, but is an attitude – it is about gratitude.

Michele Le Doux Sakurai, who resides in Boise, ID, is director of mission services for Saint Alphonsus Regional Medical Center and mission fellow for Trinity Health.



“They can never go home.” This is how the manager for our Family Center defined refugees. “They can never go home;” it has taken me a year to begin to understand what this means for our refugees.



'Stay with me. Listen to me. Care for me.'

By Fr. Brad Baldwin, T.O.R., BCC

I have been a hospital chaplain for seven years, and the headline above truly summarizes the essence of my ministry. Dr. Kenneth Doka, a professor of gerontology, in a recent presentation articulated the three most important needs of the dying patient as those listed in the headline of this article. Personally, I believe that they also describe what we chaplains are called to remember, as we persevere in our vocation. Patients need us to stay with them, listen to them, and care for them. A patient named Ralph challenged me in these three areas.

He had been suffering with bone cancer and severe diabetes, which had caused him to become weak and lose parts of both legs. Eventually, he and his family decided to discontinue treatment, asking that only comfort measures be carried out. In the time leading up to his death, his seven children, 16 grandchildren, and five great grandchildren, along with his two brothers and several friends gathered around Ralph. His wife had died some years earlier. Even with all of this support and love, there were moments when Ralph would ask for only me. These moments were usually early in the morning or late in the evening, after everyone had left for the day, and he was alone. He would ask me to stay with him, and help him process what was taking place in his mind and in his heart.

For example, he would say: "I can't grieve this illness with my family, and cry or be angry. They want me to be strong; but, I'm really frightened." He would ask me to visit him, because he knew that I would give him permission to cry, scream, hit his pillow, or simply talk about what was going on inside of him. He asked for my opinion on how he was dealing with everything and wanted to be reassured that he was not losing his mind. Most of all, he wanted to be himself, and not feel the need to put on a happy face.

Often, Ralph would make statements such as: "I need someone who will allow me to get angry at God" or "Nobody hears my anxiety and pain." "I just wish all of this would end." These statements were disturbing to his family, so he would refrain from saying them. But, with the chaplain listening, he felt comfortable sharing his feelings. After he expressed his anger for several minutes, he would often cry for an even longer period of

time, leading him to emotional and spiritual healing. When we are comfortable with our identity as chaplains, we can allow patients the freedom to be themselves, to feel better, and become more comfortable with us. "I'm so glad you're here, Father," Ralph would say, "because you're the only one who will listen to me. I get tired of talking, and no one hears me. But, you hear me, and for that reason, I'm less afraid and more at peace." The good chaplain listens without agenda or expectations, and accepts people where they are, and not where the chaplain believes they should be.

The final need is to "care for me." In one sense, Ralph was being cared for 12 hours a day, with family and friends by his side. But, in another sense, what Ralph really desired was the care of a chaplain. When he would finish speaking about his family, particularly the ones who would have the greatest difficulty with his death, he would then say: "Father, I need to pray." I'd ask if there were special intentions he wanted to pray for, and he would tell me. Then, we would pray together, and I would invite him to add his own spontaneous prayers. What heartfelt prayers he would share for his family, and his hopes for entering everlasting life. Through prayer, Ralph found comfort and peace, and the ability to have closure with his family.

One month later, Ralph passed away in his sleep, surrounded by family and friends. Two weeks before his death, he asked me to help plan his funeral liturgy. I was touched by how peaceful he was, in planning his service. He chose the readings, the music, and the family members that would participate. He also wrote his eulogy, which centered on the primary experiences of his life and death, his love for his family, and how he wanted people to remember him.

How honored I felt, when I was asked to preside at his funeral. I read his eulogy, and then spoke of my journey with him in these last 30 days. Afterward, his oldest son said to me: "Our family never realized how much Dad had shared with you." I said that from the very first day, we just seemed comfortable with each other, and I then told him what an honor it was to walk part of this journey with his father. In my heart, I knew it was much more, for I had remained faithful to my vocation as chaplain. I stayed with him, listened to him, and cared for him. My fellow chaplains, may we strive to be faithful each day, in continuing this good work that God has begun in each of us.

Father Brad Baldwin has been a priest chaplain for the Altoona Regional Health System since August 2001. He resides in Hollidaysburg, PA.

He asked for my opinion on how he was dealing with everything and wanted to be reassured that he was not losing his mind. Most of all, he wanted to be himself, and not feel the need to put on a happy face.

NACC keeps her up-to-date on standards



Name: Virginia Yeager, CSJ

Work: Vice President

Mission/Director Pastoral Care/CPE Supervisor at Saint Francis Hospital, Charleston, WV

NACC member since: 1988

Volunteer service: My volunteer involvement has been limited over the past six years

due to serious illness as well as being part time on my congregation's leadership team for 10 years. I volunteer on two Boards: The SSJ Charitable Fund and the SSJ Health and Wellness Foundation. I volunteered on the Spirituality at End of Life Task Force for the state of West Virginia. My volunteer work with NACC over the years has included regional chair of certification, National Certification Commission and Grievance Committee

Book on your nightstand: "The Last Lecture," by Randy Pausch and Jeffrey Zaslow

Favorite spiritual resource: Nature

Favorite fun self-care activity: Golf, bike riding and reading

Favorite movie: "Miss Congeniality"

Favorite retreat spot: St. Joseph Center, Wheeling, WV

Why did you become a chaplain?: I took a summer unit of CPE and wanted to continue the formative process. This led to my becoming a chaplain and then a CPE supervisor.



What do you get from NACC?: NACC has provided me with a way to stay current professionally with what is happening in the wider arena of spiritual care and CPE education. It provides networking with friends and colleagues as well as with other professionals in the field.

Why do you stay in the NACC?: For the same reasons as above. In addition, being in the only Catholic CPE center in the state, it helps me keep abreast of any changes in standards. NACC also helps me become aware of best practices in providing spiritual care for our patients and families.

Why do/did you volunteer?: I volunteer because I want to contribute my gifts to organizations that have given so much to me. I also volunteer because of wanting to join with other people in promoting the good of others. It also provides me with peer support.

What volunteer activity has been most rewarding?: Serving on the board of the Health and Wellness Foundation provided me an opportunity to learn about the healthcare needs of children in our rural communities. I am inspired by the commitment and dedication of people in small rural communities trying to make a difference in the lives of their children with very little help from state or local monies.

What have you learned from volunteering?: Volunteering is hard work, and a commitment of time that is only enjoyable when you believe in the purpose or mission of the activity, are willing to collaborate and function as part of a team, and are willing to think beyond your own self interests.

En garde

May Sabbath Knights rule with valor

By Rod Accardi, D.Min., BCC

I have regularly been inflicted with the Sunday Night Blues, or should I say blahs. As the sun sets on another Sabbath, that unsettling feeling settles into my bones. In looking back over the weekend, I get regretful for not completing all the tasks I had expected to accomplish. In looking ahead to another workweek, I get overwhelmed at the prospect of piled up work that awaits me. How quickly the Sabbath Spirit can fade.

August marks the twilight of another summer season. Oh, I know that summer does not end until mid-September, just like I know in my head that January begins a new year. But my psyche is still on academic time, and when my senses are surrounded by back-to-school sales, it signals the end of summer. Deep in my bones August feels like an extended Sunday night, with all the regrets for the summer tasks left undone and the overwhelming expectations for the coming year.

During a recent bout with the Sunday night Blues, I was called into the hospital on two separate occasions. The 9 p.m. call led me to the Emergency Department, and then up to the

ICU to be with the children and spouse of a critically ill man. The 2 a.m. call brought me to the palliative care unit to be with 20-some family members of a dying elderly woman. In both of these situations, time stood still. There was no past or future, only the present moment. Being present with family members at such a sacred time brought us all into the presence of the Holy One. When past regrets and future expectations are suspended, we could hear the voice of God whispering in our ears, "I am here now. I am ... here ... now."

What can we do to preserve the Sabbath Spirit in our lives? Imagine the knights of old who were guardians of all that was sacred and true. Remember their highly developed discipline and august valor! May we be Sabbath Knights, guardians of the Spirit that dwells within us. With discipline and valor, may we increase our capacity to become more fully present to our deepest selves and to one another in the present moment. Long live the Sabbath Knights!

Rod Accardi is director of spiritual care resources and volunteer services at Central DuPage Hospital in Winfield, IL.

Book Reviews

Pause. Practice. Honor the hours.

Seven Sacred Pauses – Living Mindfully Through the Hours of the Day. By Macrina Wiederkehr; foreword by Paula D'Arcy. Sorin Books, Notre Dame, IN, 2008. Hardcover, 203 pp., \$18.95.

By **Bruce Aguilar, BCC**

“**P**ause.” “Practice.” These two words seem to capture the spirit of this small friendly book by Macrina Wiederkehr, OSB. Wiederkehr has lived the “monastic life” more than 40 years, currently living with her Benedictine community at the St. Scholastica Monastery in Arkansas. As the book’s title suggests, Wiederkehr leads us through seven sacred pauses or “hours,” with one chapter devoted to each. Her book is written in an accessible language and format and promises to be an encouraging spiritual guide. While the pauses are the *what* of the book, the *how* of its message is practice — in order to “honor the hours.”

As to the pauses, Wiederkehr outlines seven, which correspond to the seven historical Hours of Divine Office: The Night Watch (traditionally Matins or Vigils), The Awakening Hour (Lauds or Morning Prayer), The Blessing Hour (Terce – or the Third Hour of the Day), The Hour of Illumination (Sext – the sixth hour), The Wisdom Hour (None – the ninth hour), The Twilight Hour (Vespers or

Evensong), and finally The Great Silence (Compline or Night Prayer). Each chapter begins with reflections on these “seven invitations to mindfulness” and a brief prayer guide for that hour, along with some poems and brief antiphons to carry. (A companion CD, not received by this reviewer, contains the music for the prayer times — with songs written by Wiederkehr). Like the interior reality of our breath, the turning of our planet’s changing light and darkness is a natural call to prayer.

Another theme that recurs throughout this book is the importance of practicing mindfulness, as some adaptation may be required to benefit from the prayer schedule. In the chapter on the Twilight Hour, traditionally the end of the monastic work day, Wiederkehr writes, “For many of you in the workaday world this may be the end of our day job, but more than likely a myriad of other little jobs await you: transporting children to various places, caring for elderly parents ... picking up groceries, preparing meals ... thus each of you will have to find your own Vespers path.” This reviewer benefited from a timely vacation — even by a lake and near the woods — all conditions described by Wiederkehr as ideal for beginning to practice these pauses.

A nice touch for chaplains — and others on the payroll — is the recurring monastic appreciation of work (balanced with prayer and leisure). Wiederkehr extols work as “continuing the work of creation” when approached mindfully. This view stands as a refreshing contrast to the stereotype of the after-lunch comments one hears, “Well, back to the salt mines.”

Bruce Aguilar is a chaplain at Youville Hospital and Rehabilitation Center in Cambridge, MA.

“Finally I hope you will dare grief, ‘Take your best shot!’ In your time of loss, give your grief its voice. Remember your griefprint will be as individual as your thumbprint. Listen to your heart. Allow grief to teach you its lessons.”

— Harold Ivan Smith
Introduction, “ABCs of Healthy Grieving”

Book helps on journey of grief

ABCs of Healthy Grieving: A Companion for Everyday Coping. By Harold Ivan Smith, D. Min. Ave Marie Press, Notre Dame, IN, 2007, Paperback, 176 pp., \$12.95

By **Marilyn Williams, BCC**

This book, written as a companion for persons on the journey of grief, is the outcome of Shawnee Mission Medical Center’s efforts to provide extended bereavement care to the families of patients. Designed for use over a period of time, the book is a series of 72 one- or two-page reflections organized by letters of the alphabet. Titles include, for example, “Befriend the silence,” “Expect some people to be insensitive,” and “Symbolize your grief.” Each reflection begins with a quote and ends with an “I can ...” statement such as “I can find — or make — a safe place to grieve.”

The reflection topics or themes acknowledge that the loss and grief of a loved one impacts our total being — mind, body, and spirit. Consequently themes are varied as “Exercise,” “Get a physical,” “Know your limitations,” “Never apologize for

crying,” and “Tell God what is on your mind.” Also, some reflections offer practical advice such as “Do the paperwork and ask for help,” and “Update your estate plan” while others address the process of grief, such as “Recognize anniversary grief.”

Although this book does not especially offer the chaplain new information, it would be an excellent resource for chaplains or others working with grievers or facilitating grief support groups. For example, I could envision using one of the reflections as a vehicle for opening up discussion at a support group session. Indeed I can see why Dr. Smith noted in his introduction that the ideas and their applications included in the book are those he has presented at workshops along with insights he and his colleagues have gained from working with grievers.

Dr. Smith is a member of the American Academy of Bereavement and is on the board of the Association for Death Education and Counseling. He also teaches at Saint Luke’s Hospital in Kansas City, MO.

Marilyn Williams is chaplain at Memorial Health Care System, Catholic Health Initiatives, in Chattanooga, TN.

When there is no chaplain:

Promoting the spiritual health of older nursing home residents

By **Meredith Wallace Ph.D., APRN,**
and **Everol Ennis, RN, MSNc**

Spirituality is an important dimension in the lives of older adults. In fact, spiritual dimensions are included in most quality of life assessments. Quality of life indicators usually include physical, psychological, social and spiritual aspects of both function and well-being (Muldoon, Barger, Flory and Manuck, 1998). Multiple aspects of life, including health and care environments, impact an individual's spirituality, social support and psychological stress. Among older adults, spirituality is integral to health and wellness. MacKinlay (1992) provides a definition of spiritual integrity that underscores the importance of this dimension among older adults and the need to assist older adults with this important aspect of care.

Spiritual integrity is "a state where an individual shows by their life and example and attitudes, a sense of peace with themselves and others, and development of wholeness of being. The search for meaning and degree of transcendence is evident (p. 292)."

Research focusing on spirituality among older adults has consistently shown that improved coping and physical health were found in those who regularly participate in religious or spiritual practices. Moreover, MacKinlay (2005) reports that "psychosocial and faith development continues into old age" (p. 214). In a small study of older women, spirituality was shown to have a positive impact on views of death and dying at the end of life (Knestrack and Lohri-Posey, 2005). The purpose of this paper is to describe the impact of spirituality on the health and quality of life of older adults residing in nursing homes, where often there are no chaplains employed, and discuss ways in which, when no chaplain is present, healthcare providers may help older adults to fulfill their spiritual needs.

How important is spiritual health?

Much attention is paid to the physical health needs of older adults in nursing homes. In fact, the majority of the care provided to nursing home residents is centered on administering medications, ensuring adequate levels of nutrition and hydration, assessing and managing physical diseases and preventing infections and negative consequences of illnesses. Given this substantial emphasis on the physical health needs of older adults, many may question whether it is necessary or even appropriate for nurses to assess and explore residents' spiritual health needs.

While there has been limited literature on the role of spiritual health in the lives of older adult nursing home residents, the available literature has consistently supported the link between spiritual and physical health. In fact, Cotton,

Levine, Fitzpatrick, Dold and Targg (1999) found that among 268 chronically ill older adults, religious coping was significantly related to health outcomes. In a 1999 study of more than 1,300 cancer patients, researchers found spiritual well-being affected quality of life as much as emotional and physical well-being (Eldridge, 2007). Moreover, Potter and Zauszniewski (2000) found that heightened spirituality was significantly related to a positive perception of health in their sample of 47 older adults with rheumatoid arthritis. Callaghan (2006) also found that older adults who participated in spiritual health practices had greater self-concepts. While more evidence is needed to support the relationship between spiritual health and other dimensions of quality of life, existing evidence provides a call to action for healthcare providers.

Whose job is it to improve spiritual health?

Even if agreement can be reached regarding the importance of spiritual health among older adults, healthcare facilities are left with the

question – whose job is it to promote spiritual health?

Many nursing homes do not employ chaplains and, as a result, meeting the spiritual needs of patients falls to the nursing home staff or to the occasional assistance of clergy and staff at nearby churches.

Substantial spiritual health needs require an interdisciplinary approach and a more consistent presence. Thus, at nursing homes, the role of promoting spiritual health often lies with the 24-hour nursing staff.

Despite the need to promote spiritual health in nursing homes, nurses are often poorly equipped to manage the spiritual health needs of older adults. A study by Lowry and Conco (2002) found that in their sample of 40 older adults, participants believed that health care professionals could facilitate meeting spiritual health needs. Yet, spirituality is underdeveloped in nursing and medical education programs and not consistently integrated into undergraduate nursing curricula (Lemmer, 2002). Thus, nurses lack the knowledge and skills to promote spiritual health (Callister, Bond, Matsumuro and Mangum, 2004). Given the rising elderly population, enhancing nurses' skill set to meet the spiritual needs of older patients is increasingly necessary. Ross (1994) outlined the following conceptual framework as the requisite knowledge bases needed to meet the patients' spiritual needs: assessment -- nurse must know what the patients' spiritual

Despite the need to promote spiritual health in nursing homes, nurses are often poorly equipped to manage the spiritual health needs of older adults.



No Chaplain

Continued from page 17

needs are and how they can be recognized; planning and implementation — nurse must know what might be appropriate interventions for meeting these needs; evaluation — nurse must know what factors would indicate that the needs had been met. Roff and Parker (2003) suggested that specialized education or training for professionals could help enhance their own spiritual resources, enabling them to provide better health care.

In a recent analysis by Wallace and O'Shea (2007) aimed at investigating perceptions of spirituality and spiritual care among 26 older nursing home residents at the end of life, two independent samples reported moderately high views of spirituality and spiritual health. The samples indicated several interventions that nurses could use to support spirituality, including arranging visits with religious personnel, showing kindness and respect, spending time listening to residents (presence), and encouraging time with music and nature.

What interventions can be taken to promote spiritual health?

So what can nurses do to promote the spiritual health of nursing home residents? The research literature has revealed that nursing home residents rarely have been asked this question. In fact, the study conducted by Wallace and O'Shea (2007) is one of the only ones that begin to shed light on this topic. This study reveals a number of possibilities that may be helpful in promoting spiritual health and spiritual integrity among nursing home residents.

Facilitating meetings with religious personnel or services

Residents have reported that nurses may facilitate spiritual health by respecting their need for formal religious practices and making arrangements for residents to meet with clergy or attend religious services. In some faith-based facilities in which an onsite chapel or synagogue is present, and chaplains or clergy are part of the staff, this may be easily arranged. Nurses can schedule services into residents' plan of care, or contact clergy to schedule regular visits. In non-faith based facilities, more effort is required. Relationships between nurses and clergy should be developed in order to facilitate the scheduling of visits. This is challenging for nurses, who already keep tight schedules, often providing care to 15 or 30 residents per shift. However, simple introductions of clergy to nurses and engagement in relationships may help to facilitate future calls or scheduled visits.

Showing kindness

Residents have also reported that simply showing kindness and respect are ways in which spiritual health may be facilitated in long-term care. In this day and age, when healthcare is overscheduled, kindness seems to be a dying gesture. However, the Bible tells us the following about kindness: "Go and learn

what this means," said Jesus, "I desire Kindness, not sacrifice" (Matthew 9:13). "What does the Lord desire: that you do justice, love kindness, and walk humbly with Him." (Micah 6:8). "The earth is full of the kindness of the Lord" (Psalm 33).

Consequently, small acts of kindness shown by staff to patients in the form of extra consideration of requests, a simple smile or touch, a small gift or a sign of understanding will represent a spiritual gesture and may facilitate spiritual health in nursing home residents. In fact, Sr. M. Peter Lillian DiMaria, O.Carm., in an article on person-centered care states that efficiency is no substitute for care "kinder than kindness itself." She calls upon nurses to provide kindness above all to nursing home residents and questions the competing needs on nurses' time that prevent opportunities for kindness and respect. She challenges the medical model in which nursing home care is provided, charging that it treats the illness at the expense of the person.

Presence

Residents have consistently reported that they would really just like nurses to be with them. Spending time listening to residents and having a nursing presence can go a long way toward ending the loneliness of long-term care residence and may play a role in the promotion of spiritual health and spiritual

integrity. Duis-Nittsche (2002) conducted a qualitative study of seven patients and nurses and, based on the findings, reported that "nursing presence" is more important than any technical care that nurses provide. Themes from the research included knowing and supporting the patient; accessibility and responding to the patient's needs, attitudes and beliefs; bonding with the patient;

influencing others and relationships; and healing. Simply sitting on the edge of a resident's bed for five minutes while he or she talks or reminisces may influence a person's health. Watching a sporting event with another resident or just checking on the score is a way in which a presence can be maintained with the resident.

Facilitating relationships with others

Because of nurses' busy schedules, it is often necessary to call upon others to help meet residents' needs. Supporting residents' relationships with family and friends by having them dressed and ready for visits or moving them to a common area or another's room may help the older adult to feel engaged and spiritually healthy. Often limited mobility and difficulty in managing a wheelchair or walker facilitate social isolation. However, with nursing assistance, resident relationships may be enhanced. In the case of cognitive impairment, a focused activity may also enhance the relationship. For example, residents could be paired together to work on a puzzle or other task.

Helping to forgive

Supporting the need to forgive and be forgiven are important components of spiritual health and integrity for older adults (MacKinlay, 2005). Wallace and O'Shea affirmed this in their



study in which residents reported that nurses could facilitate forgiveness as a means to promote spiritual health. In MacKinlay's study of nurses in six nursing homes "facilitating reconciliation with family members" was cited frequently as a positive way to foster residents' spiritual health.

Facilitating forgiveness is a difficult and complex task and like other aspects of spiritual care, involves an interdisciplinary approach. Nurses may make a substantial contribution to facilitating forgiveness by identifying the need to forgive and be forgiven through routine assessments and discussions with older adult nursing home residents. Further discussion regarding these issues is appropriate, and family meetings may be facilitated. Moreover, nurses may make referrals to other members of the interdisciplinary team, such as clergy, social workers and psychologists, to facilitate extended discussions and family meetings as necessary.

Encouraging spiritual environments

Older adults also have reported that fostering a spiritual environment is a way in which nurses may facilitate spiritual health and integrity. This can be accomplished by simply dimming the lights and quieting the environment to facilitate rest, relaxation and meditation — simple interventions that are often forgotten in a busy workplace. Playing spiritual or inspirational music may also help older adults to improve connections with a higher power. In addition, nurses may address patients' spiritual needs by facilitating joyful interactions that involve laughter. In a 2007 study of 100 hospice patients, every patient listed laughter as a spiritual need (Eldridge, 2007). Connecting older adults with gifts of nature, such as walks outside while plants and trees are in bloom or when a fresh snow has fallen may also better spiritual health.

Conclusion

Spirituality is "that which lies at the core of each person's being, an essential dimension which brings meaning to life" (MacKinlay, 1992). For older nursing home residents, spirituality is an important part of their being and contributes significantly to health and quality of life. Nurses individually and as part of interdisciplinary healthcare teams can play an important role in promoting the spiritual health of older adults through arranging visits with religious personnel, showing kindness and respect, providing a listening presence and offering access to music and nature. As the U.S. population continues to age, the need to promote the spiritual health of older adults will become increasingly important. Nurses properly educated to address the spiritual health of patients will facilitate this process. Further research directed toward the most effective spiritual interventions will contribute greatly to improved spiritual health.

Meredith Wallace is associate professor at Yale University, School of Nursing, in New Haven, CT, where Everol Ennis is a primary care nursing student.

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Nurses individually and as part of interdisciplinary health care teams can play an important role in promoting the spiritual health of older adults through arranging visits with religious personnel, showing kindness and respect, providing a listening presence and offering access to music and nature.

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.

Dennis Eldridge
(Kathy's husband)
Milwaukee, WI
Cancer treatment

Teddi Tomsic
Shelton, CT
Major surgery

Fr. Mike Burns, SDS
Milwaukee, WI
Eye surgery

Sr. Mary Anna Euring, OP
West Islip, NY
Bout with Non-Hodgkin's
lymphoma

Sr. Hilda Mallet, MH
Lafayette, LA
Cancer radiation treatments
that followed chemotherapy

Sr. Albertine Kramer, CSC
South Bend, IN
Recovering from extensive
surgery; in rehabilitation

Sr. Paula Jacobs, SSM
Oshkosh, WI
Terminal cancer

Sr. Joyce Troyer, CSC
South Bend, IN
Recovering from surgery

Positions Available

Beginning in January 2009, Positions Available and CPE Residency ads will run only on the NACC website, not in *Vision*. We have found that the fastest and most expedient way to learn about position openings and to apply for them is through the website, www.nacc.org.

▼ FULL-TIME CPE EDUCATOR

Tacoma, WA – The Franciscan Health System seeks an ACPE Associate or CPE Supervisor who will function under the Manager of CPE, conducting programs and providing some spiritual care, collaborating with the spiritual care staff of 21 FTE (including 9 in FHS Hospice), assisting with quality assurance, participating on the Professional Consultation Committee, and working for re-accreditation by the ACPE and USCCB-CCA due in 2009. Puget Sound is a beautiful place to live, and this five-hospital health care system, one of the flagships of Catholic Health Initiatives, is flourishing financially and organizationally. Apply online at www.fhshealth.org or contact Gordon J. Hilsman, 253-426-6735 gordonhilsman@fhshealth.org.

▼ CHAPLAIN

Camarillo, CA – Elder Care Alliance is a nonprofit organization committed to serving and enriching the physical, emotional, and spiritual well-being of older adults through a network of professional, faith-centered care communities and services. AlmaVia of Camarillo, a 78-unit Elder Care Alliance assisted living and dementia care retirement community in Southern California, is seeking a Chaplain to provide, coordinate and evaluate activities related to the spiritual life and well-being of our residents, including liturgical and pastoral care needs. To qualify, you should have clinical pastoral education or equivalent. We prefer a Master of Divinity or related degree and a minimum of two years of experience in providing services to older adults. This is a part-time position with benefits, 24 hours/week. For consideration, please email your resume to camjobs0041@eldercarealliance.org or fax it to 805-388-2665. EOE

▼ CHAPLAIN - ROMAN CATHOLIC PRIEST

Camden, NJ – Our Lady of Lourdes Medical Center, a

Share your ideas

Themes for upcoming issues of *Vision* will include:

- ▼ On a chaplain's bookshelf
- ▼ Reaching out to the immigrant

If you have article ideas or thoughts of persons to interview, contact Laurie Hansen Cardona, *Vision* editor, at lcardona@nacc.org. Thank you!

teaching healthcare facility sponsored by the Franciscan Sisters of Allegany, New York, is pleased to carry on the tradition that the Sisters began when they built this hospital more than 50 years ago. We are seeking a Roman Catholic Priest with NACC or ACPE Certification or eligibility within one year to join our Pastoral Care Department. Must have ecclesiastical endorsement. Healthcare experience preferred. Duties will include assessment of the spiritual needs of a diverse population and the provision of support to patients, families and staff members. This includes the sacramental ministry for Catholic patients. Emphasis is placed on an interdisciplinary team approach and enhancing the spirituality of the organization. In-house and on-call coverage is required. Excellent pastoral ministry skills are a must! Our Lady of Lourdes is conveniently located in South Jersey just minutes away from Philadelphia. New York City and Baltimore are about a 2-hour ride. We offer a comprehensive wage and benefit package, including comprehensive healthcare, income protection plans, and time off. Learn more or apply online at: www.lourdescareers.org Member of Catholic Health East, Sponsored by the Franciscan Sisters of Allegany, NY. Diversity lights our way. EOE/M/F/D/V

▼ CPE RESIDENCY

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Extended Program (\$500/\$700 tuition depending on clinical placement) each provide one unit of CPE upon completion of the unit and are designed for clergy, laypersons, ministers, and seminary students. Completion of one of these units qualifies you to apply to the Residency program. Scott & White's Residency Program (no tuition) provides 3 units of CPE in a calendar year and offers a competitive stipend and benefits. (Additional fees determined according to specific program). Send applications to: Krista Jones, Scott & White Hospital, 2401 So. 31st St., Temple, TX 76508; website: <http://pastoralcare.sw.org>, fax: 254-724-9007, phone: 254-724-1181, or email KRJONES@swmail.sw.org. \$25 application fee required for all applications. Scott & White is the largest multi-specialty academic medical center in Texas, with more than 600 physicians and research scientists caring for patients at the Scott & White Memorial Hospital & Clinic in Temple and 22 regional clinics networked throughout Central Texas. Scott & White is listed among the Thomson 100 Top Hospitals in America* for four consecutive years. Scott & White is An Equal Opportunity Employer/Tobacco-Free Environment. *2008 Thomson 100 Top Hospitals@

▼ DIRECTOR OF PASTORAL CARE

Augusta, ME — MaineGeneral Medical Center in Augusta, Maine, is looking for a full-time Director of Pastoral Care. Position is responsible for administrating the Department of Pastoral Care and providing pastoral care services to patients, families, Medical Center employees and medical staff. Will plan, organize, and direct departmental activities. Develops and recommends departmental operating and capital budget requests. Will implement and monitor budget. Serves as consultant and educator in matters related to pastoral care. Provides for specific needs of individual faiths by fostering an ecumenical approach to pastoral care. Maintains department statistics and participates in medical center performance improvement. Administers the HEART Fund employee assistance program. Master's degree in Theological education and/or meets educational standard for professional certification. Minimum of three years' applicable experience. MaineGeneral Medical Center is the leading healthcare provider in the Kennebec Valley and the third largest healthcare system in Maine. Our mission is to enhance, every day, the health of the people of Kennebec Valley. Visit www.maine-general.org for a complete list of current openings, detailed job descriptions, and to apply with our Online Application System. Call 207-872-4497 with any questions or for more information.

▼ CHAPLAINS, PART-TIME AND FULL-TIME

Frankfort, IN and Elwood, IN — We seek compassionate, knowledgeable individuals to provide for the spiritual needs of our patients, families and associates at St. Vincent Frankfort Hospital in Frankfort, IN, and St. Vincent Mercy Hospital, in Elwood, IN. We have both full-time and part-time positions available (Job #27890). Guided by our mission and core values, we provide exceptional care to our patients. Become part of the St. Vincent team, where your actions will make a difference. In this critical role, you'll be responsible for:

- ▼ Providing for the spiritual needs of patients, families and associates
- ▼ Offering a safe haven for others and helping them on their

journey

- ▼ Assisting patients in coping with their current health situations
- ▼ Inviting others to explore a deeper sense of self-discovery
- ▼ Helping to shape a spiritual environment that embodies our Mission
- ▼ Collaborating with nurses and physicians to support ethical decision-making
To qualify, you must have:
 - ▼ Master's degree in Divinity, Theology, Religious Studies, Pastoral Ministry or Spirituality
 - ▼ Minimum of four units in Clinical Pastoral Education
 - ▼ Certification from the National Association of Catholic Chaplains or the Association of Professional Chaplains
 - ▼ Ecclesiastical endorsement is required
 - ▼ Knowledge of pastoral theology, ecclesiology, spiritual and sacramental practices within the Roman Catholic Church and other traditions
 - ▼ Roman Catholic preferred
- ▼ We offer an attractive salary and benefits package. To learn more about us and to apply online, please visit jobs.stvincent.org. Please be sure to indicate the job number of the position you are applying for. EOE

▼ SUPERVISOR, CPE PROGRAM

Charleston, SC — Roper Saint Francis Healthcare seeks a third supervisor to join our CPE program. Accredited at Levels I – II and Supervisory education. Seeking Full or Associate ACPE Supervisor; will consider Candidates whose papers have passed. Certification by National Association of Catholic Chaplains; this will be seen as an added advantage. Roper Saint Francis Healthcare is a not for profit healthcare organization anchored by two acute care hospitals, Roper Hospital and Bon Secours St. Francis Hospital, with a third hospital opening in the fall of 2010. It is Charleston's largest private, nongovernmental employer with more than 3,800 employees. The CPE program, established in 1992, is an integral element of Roper Saint Francis Healthcare. Charleston, a beautifully preserved city with a rich architectural and cultural heritage, is renowned for its gracious hospitality, elegant homes and beautiful gardens. It has a thriving arts and culture scene, and offers numerous recreational opportunities. Ninety miles of sandy beaches and an average annual temperature of 65 degrees make Charleston a delightful place to live. Salary commensurate with level of certification and experience. For further information, consult our website or make inquires to Chaplain Robert Morris, 843.402.1124 or Robert.Morris@RSFH.com

▼ CHAPLAINS

Seattle, WA — Providence Hospice of Seattle, the first Hospice service in the Northwest, has two full-time opportunities for experienced Hospice Chaplains. Chaplains work within a multi-disciplinary hospice team to provide pastoral/spiritual care to hospice patients in their homes. The function of the position actively incorporates the Mission and Vision of Providence Health System. The Core Values of RESPECT, COMPASSION, JUSTICE, EXCELLENCE AND STEWARDSHIP are reflected within all working relationships by demonstrating teamwork, dedication and service excellence. Must have a Master's Degree in divinity, theology, pastoral ministry, or equivalent, be board certified by one of the professional bodies recognizing the Common Standards of Professional Chaplaincy, and have a minimum

Positions Available

of 1,600 hours of clinical pastoral education including orientation to health care practices. Minimum two years of pastoral ministry experience with demonstrated interfaith experience. For more information and to apply, please go to the following link: https://recruiter.kenexa.com/providence/cc/CCJobDetailAction.ss?command=CCViewDetail&ccid=bupJEdUjTs%3D&job_REQUISITION_NUMBER=35401

▼ CHAPLAIN

Springfield, OH — Springfield Regional Medical Center is currently seeking a Chaplain. Assists the Senior Director, Spiritual Care Chaplaincy, in assessing and addressing the emotional and spiritual needs of patients and families in the context of medical care, illness, suffering and loss. Accountable for spiritual/emotional support for patients/families in crisis, and in critical care units, with emphasis intensive care, Palliative Care, and end of life care. Coordinates, schedules and oversees contract staff services. Qualifications: Experience in an acute care setting with focus on Intensive Care (e.g. staff chaplain, pastoral counselor, CPE resident). Certification: APC, NACC, or CHP. Minimum: Bachelor's degree. Desired: Master's level theological degree. For more information or to apply, please contact: Jennifer Borden, HR Generalist, Springfield Regional Medical Center - Fountain Campus Affiliate Of Community Mercy Health Partners, 1343 N. Fountain Blvd., Springfield, Ohio 45504, Telephone: 937-342-5449; Fax: 937-390-5079; jennifer.borden@health-partners.org; www.community-mercy.org; Equal Employment Opportunity.

▼ CATHOLIC PRIEST

South Bend, IN — Trinity Senior Living Communities (TSLC) is seeking a Catholic Priest for our senior housing community, Sanctuary At St. Paul's, located in South Bend, IN. By following the Sanctuary Model™ for senior care, we honor the sacredness of every resident and the holiness of our work through uncompromising standards and services. We encourage fellowship and independence while serving seniors and their families with dignity and respect. We are a multi-resident facility offering a full continuum of care including independent apartments, assisted living, nursing care and Alzheimer's community to our elders. We are offering a 20-hour per-week position for a Priest with a desire to minister while enjoying semi-retirement. Room and board is negotiable. If you are looking for a ministry in a community serving a variety of elders, Sanctuary at St. Paul's has the opportunity for you. Interested candidates should contact: Will Braniff, Sanctuary At St. Paul's, 574-299-2340.

▼ STAFF CHAPLAIN

Spokane, WA — Sacred Heart Medical Center, a 623-bed Level II Trauma Center, invites you to apply for our Chaplain position. Within our collaborative Chaplaincy department, you will utilize your insights, expertise and creativity to provide spiritual support to patients, family and staff in many different settings. Here you are a valued member of a multi-disciplinary team and will enjoy opportunities for collegiality and professional development. Qualifications include board

certification with NACC or APC (or attain certification within 18 months of hire), master's degree in theology or related field, minimum of 4 units Clinical Pastoral Education, ecclesiastical endorsement. Experience in an acute care/trauma setting preferred. Part time position (32 hours) consisting of two evening shifts and two night shifts each week. We offer a comprehensive wage and benefit package. If interested, please apply at www.shmc.org or send resume to: Debbie Ozust, Employment Specialist, Fax: (509) 474-4496, E-mail: ozustd@shmc.org EOE

▼ CPE RESIDENCY

LaCrosse, WI — Gundersen Lutheran Health System has 2 positions available beginning at the end of August 2008 for a 3 unit, 12-month residency. The total tuition for the 3 units is \$500.00. Applications for residency beginning August 2009 are also welcome. We offer health insurance, tuition scholarships and other benefits. Resident I \$26,000, II \$27,000. Extended Unit September 26, 2008 – February 27, 2009. GLHS is a Level II Trauma Center, a 325-bed comprehensive hospital and clinic nestled in the scenic bluffs along the Mississippi River Valley with a reasonable cost of living. In this year-long program, we offer 6-month rotations in our hospital, hospice program and at Hillview Health Care Center. Minimum of one CPE unit required for residency. Visit our Web Page at www.gundluth.org/web/ptcare/pastoral.nsf No application fee is required. Apply to: Laura Kaufmann, Manager of CPE, Gundersen Lutheran Health System, 1900 South Avenue – Mail Stop H01-022, La Crosse, WI 54601-9980; 608-775-3620, 1-800-362-9567, ext 53620; FAX 608-775-3557; E-mail ljkaufma@gundluth.org; www.gundluth.org

▼ ROMAN CATHOLIC PRIEST

Paterson, NJ — Our vision for tomorrow makes healing more rewarding today. What could you accomplish with broader practice options, mission-driven care, and nurturing colleagues behind you? Choose a career with our multi-site health care system and find out. For over 100 years, we've been a source of high quality and community responsive care — delivered with compassion, strong values, and the highest professional standards. In this significant role, you will assess the spiritual needs of a diverse population within our hospital and nursing home, as well as provide support to all patients, residents, families and staff members. In addition, you will emphasize an interdisciplinary team approach, and help enhance the spirituality of the entire organization. To qualify, you must have NACC or ACPE Certification, or eligibility to join our Pastoral Care Department within one year. Ecclesiastical endorsement and excellent pastoral ministry skills are a must. In-house and on-call coverage will be required. Healthcare experience preferred. We offer a competitive salary and comprehensive benefits package. For immediate consideration, please fax 973.754.4511, email careers@sjhmc.org, or send your resume to: St. Joseph's Regional Medical Center, HR Dept-VC, 703 Main Street, Paterson, NJ 07503. EOE M/F/D/V Faith, Care and Medicine...Working Together at ST. JOSEPH'S HEALTHCARE SYSTEM: St. Joseph's Regional Medical Center, St. Joseph's Children's Hospital, St. Joseph's Wayne Hospital, St. Vincent's Nursing Home, Visiting Health Services of New Jersey, Inc., A Ministry of the Sisters of Charity of Saint Elizabeth www.stjosephshealth.org

▼ DIRECTOR OF PASTORAL CARE

Richmond, VA — The Bon Secours Richmond Health System, comprised of four acute care hospitals, seeks a Director of Pastoral Care. Primary responsibilities: Plans, organizes and directs the provision of pastoral care services throughout Bon Secours Richmond Health System. Manages and leads the operations of a multi-site, diverse team of chaplains. Creates and coordinates the elements of a spiritual support infrastructure across disparate organizational boundaries. Develops and maintains new initiatives that support the spiritual needs of patients, families, staff and communities served. Masters in Divinity or Theology and CPE (4 units) with national Board Certification required. Supervisory experience of CPE students a plus. Previous administrative experience in Catholic healthcare required. Visit www.bonsecours.com for more info and to submit application/resume.

▼ CHAPLAINS

Kalamazoo, MI — Borgess Medical Center is seeking to fill a regular part-time and a full-time Chaplain position. Requirements include a Master's Degree in Theology and 4 units of Clinical Pastoral Education (CPE), eligibility for board certification or board-certified with the Association of Professional Chaplains (APC) or the National Association of Catholic Chaplains (NACC), twelve months related work experience and advanced interpersonal skills to effectively support patients, visitors and hospital employees during times of crisis. For more information and to apply online, please visit www.careers.borgess.com.

▼ PRIEST CHAPLAIN

Darby, PA — Mercy Fitzgerald Hospital, a member of Mercy Health System, has an employment opportunity for a Priest Chaplain who will further Mercy Health System's mission toward quality health care and holistic healing by striving to meet the spiritual and emotional needs of patients, families and staff. This individual will cover 24-hour shifts on Mondays and Tuesdays. However, we can afford to be flexible with the days for the right person! After 9 p.m., the chaplain is free to relax and sleep in the provided room and living space. The chaplain will be adequately reimbursed in addition to receiving meals and reading materials at no cost, as well as Health Insurance at the same rate as provided for employees. Coverage is available to allow for staff vacations. CPE certified chaplain preferred. Ordination required. Please send resume to rmartin5@mercyhealth.org or apply online at www.mercyhealth.org/employment.

▼ PRIEST CHAPLAIN

Hollywood, CA — As a faith-based organization, QueensCare strives to provide, directly and with others, accessible healthcare for uninsured and low-income individuals and families residing in Los Angeles. We are a Public Charity with various divisions serving the healthcare needs of our community. Our Pastoral Care Department ministers primarily within Hollywood Presbyterian Medical Center, a 470-bed facility providing a full range of medical services. We have culturally, linguistically and religiously diverse patients, families and staff whom we serve. This diversity is reflected in our Chaplains. QueensCare is currently seeking an additional Priest Chaplain to join our professional team of Chaplains. A priest should have, or

be able to obtain, ecclesiastical endorsement from the LA Archdiocese. CPE training and ability in Spanish are highly preferred. Please send cover letter and resume to: Liz Hoang, HR Director, 1300 North Vermont Avenue, Suite 502, Los Angeles, CA 90027; Email: LHoang@queenscare.org Fax: 323-660-0359; Website: www.queenscare.org

▼ CHAPLAIN/SPIRITUAL CARE COORDINATOR

Dubuque, IA — Come grow with us! Heartland Hospice has an exciting part-time opportunity for a Chaplain/Spiritual Care Coordinator to join our established, growing hospice agency supporting Dubuque IA, and surrounding counties. We are seeking a chaplain to provide spiritual care to patients, families and staff as part of a collaborative interdisciplinary team that provides the highest quality end-of-life care. The successful candidate will have previous hospice experience. Qualifications include: M. Div. or MA in Theology or Pastoral Ministry, minimum of four units of Clinical Pastoral Education, and certification by APC or NACC or other pastoral care cognate group, or the ability to be certified within one year of hire. Must have ecclesiastical endorsement. If you are compassionate and want to utilize your chaplain skills in a way that will personally touch your patients, call today. At Heartland Hospice, our commitment to our patients is what inspires us to give the best care possible. We invite you to become a part of our established and growing agency. Interested candidates please contact Kristin at kueptow@hcr-manorcare.com 877-245-0789 (phone), 888-819-6612 (fax) or apply online at www.hcr-manorcare.com. People. Strength. Commitment.

▼ CPE SUPERVISOR

San Antonio, TX — CHRISTUS Santa Rosa's CPE program recently received its USCC NACC reaccreditation. The Clinical Pastoral Education Supervisor is responsible for planning, conducting and evaluating the CPE units. Will supervise the CPE interns as well as recruit for prospective future CPE candidates. Directs activities of the Professional Consultation Committee and promotes the program within San Antonio, TX, community. To qualify, you must have a Master's of Divinity or equivalent and have CPE supervisory training from accredited NACC or ACPE center. Interested candidates should e-mail their resumes to: md.davis@christushealth.org

▼ PART-TIME CHAPLAIN

Seattle and Tacoma, WA — Experienced and trained Roman Deacon Chaplain in good standing with the Seattle Archdiocese for a part time / per-diem chaplaincy position in the greater Seattle/Tacoma area. Hold M.S. and D.D. through Triune University. Held positions as Regional Director and floor chaplain for five Catholic entities. Contact Deacon Richard Olsen at Dickeydonk1@aol.com.

Position Wanted

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Bonnie.Burnett@christushealth.org

Calendar

September

- 19-20 Chaplain Gathering,
Portland, OR
- 25-26 North Central Prairie Chaplains
Gathering, Alexandria, MN

October

- 4-5 Certification Interviews
- 9-10 NACC Board of Directors
Meeting, Milwaukee, WI
- 10 Chaplains Association of Ohio
gathering, Findlay, OH
- 20-26 Pastoral Care Week; Theme:
"PASTORAL CARE:
Listening Presence"
- 26-28 Wisconsin Chaplaincy
Association, Green Lake, WI
- 30-31 Certification Commission
Meeting, Milwaukee, WI
- 31 Chaplain Gathering,
Colorado Springs, CO



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