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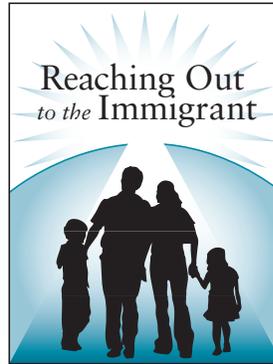
Serving the vulnerable in tough economic times

*Hospital develops process in attempt
to assist the undocumented cancer patient*

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

“Catholic healthcare cannot
be everything to
everybody.”

This statement did not come as a complete surprise, but I was a bit taken aback by it. The ethicist who spoke was trying to put into perspective how the economic times impact how we, in Catholic healthcare, must find balance in how we serve. Finding a balance between stewardship and care needs is a sober reality if Catholic healthcare is to survive the challenges of increased numbers of uninsured patients, lower reimbursement, and growing unemployment. What does social justice and care for the



poor and underserved mean in light of these trends?

This was the question put to my own hospital six months ago as it was confronted with non-emergent care for undocumented immigrant patients. A patient from an Eastern European country, seen as an outpatient, was identified

with a late stage cancer needing both surgery and chemotherapy. What was evident is that this woman, without insurance or

— See [Uninsured](#) on page 9

The strength of this process lies in its transparency. All parties share responsibility for stewardship, and the patients receive care that meets community standards and is ethically justifiable.

Chaplaincy on the border

*Immigrants in need
of translation, empathy, advocacy*

By **Laurie Hansen Cardona**
Vision editor

When Sister Esther Rodriguez, OP, encounters new immigrants who have crossed the border from Mexico and elsewhere, “the first thing that comes to my mind is Jesus, Mary and Joseph when they were immigrants in Egypt, their struggles during their travels, their persecution by Herod, and how they were far away from home, family and friends.”

“I see the financial hardship, no jobs and no insurance,” continued Sister Rodriguez. “I listen to immigrants share their financial and legal status concerns.

I hear their sad stories of how others take advantage of them, exploiting them with hard work and miserable pay. I encourage them and I make referrals to support groups to find legal aid to help them.”

Sister Esther, an immigrant herself who is a hospital chaplain in Brownsville, TX, said that during four years of ministry on only a few occasions has she learned about immigrants found on the

— See [Immigrants](#) on page 8

“I listen to immigrants share their financial and legal status concerns. I hear their sad stories of how others take advantage of them, exploiting them with hard work and miserable pay.”

— Sister Esther Rodriguez

Collective impact of NACC is life-giving, powerful

Sr. Barbara Brumleve, SSND, Ph.D.
NACC Board Chair

We can justly consider that the future of humanity lies in the hands of those who are strong enough to provide coming generations with reasons for living and hoping. “Gaudium et Spes,” chapter 2, section 31.

My yellowing copy of Abbot’s “Documents of Vatican II” is well-worn and underlined, its margins filled with notes. But one sentence in the 794-page book stands out because it is boxed in red, with three exclamation marks in the margin: the above sentence.

More than 40 years ago the fire of that sentence gave hope and courage to me as a 28-year old woman religious graduate student. And it continues to speak to me today as your new chair of the NACC Board.

In my mind’s eye I look out over the nearly 2,800 of us, who day in and day out speak to life and hope -- at the bedside of the dying, in the prison cell, in the uncertainty of acute rehab, with the chronically ill, in the soup kitchen and parish, in the group and individual work of CPE, in administrative offices and board rooms. Yes, we are a smaller number than we once were, but what is the power of 2,800 dedicated women and men? Yes, many of us are older and no longer have the energy we had in our 40s, but don’t we also have greater wisdom and experience than we did then?

We begin a new year in our world where there is heightened anticipation of a new U.S. president, a deepening world recession that is affecting our families and institutions, a world torn by conflicts in the Middle East and parts of Africa and Asia, our planet threatened by us humans. We wonder not only how our immediate families and communities will fare, but also what kind of world we are leaving to our grandchildren and their children. Our world needs strong people who can give our present generation and future generations

reasons for living and hoping.

And in NACC we are blessed with many of those people: first of all, all of us who are members. Let us take a moment to visualize our collective impact among God’s people. Let us visualize our diversity. Let us reflect on the contributions of Board Chair Karen Pugliese and Executive Director David Lichter. They are strong, courageous, visionary ministers of the Gospel who have and will continue to give us in NACC reasons for living

and hoping. Thank you, Karen and David, and all our former leaders. Let us reflect on those who currently serve NACC on commissions, committees, and task forces, as state liaisons, as board members, Episcopal liaisons, as national staff, as financial supporters, as friends committed to NACC’s mission. Let us turn our attention to our newly and recently certified chaplains and supervisors, those in the certification process, those in CPE, and those in graduate ministry programs. Let us reflect also on our members who are ill. You have ministered to others in suffering and diminishment; thank you for continuing to minister to us though your lives. Together, and with God’s grace, we are providing coming generations with reasons for living and hoping. How do we visualize that? What will further that reality? What are the impulses of the Spirit that we experience in our hearts?

Let us broaden our circle of reflection to include our nearly 7,000 brothers and sisters in ACPE, APC, AAPC, CAPPE, and NAJC. Together we are the Spiritual Care Collaborative (SCC), some 10,000 of us. I know that travel budgets have been cut and that money is tight, but I hope that many of us will be able to attend the SCC summit conference this month in Orlando. There we will learn and talk and celebrate with each other and will welcome our new board-certified chaplains of NACC and APC, together with our newly certified ACPE supervisors.

Whether or not we are able to attend the summit, we all have at least three opportunities to collaborate with our sisters and brothers in the other organizations: (1) by completing the survey we received about the SCC; (2) by visiting the SCC website and bookmarking it (and NACC’s website) in our favorites for easy return; and (3) by planning events together and working together locally and on state levels.

Your NACC board members, whether elected or appointed, take seriously our responsibility to serve you and NACC as a whole. We oversee the services that NACC provides. We look outward to other people and groups who share our vision and mission; and we work with them. We scan the horizon for movements and trends that will impact our members and the NACC. We monitor the implementation of NACC’s strategic plan within a changing environment. We look ahead and seek to create and support those structures that our members and the organization need. In a word, we try to both listen to you and to maintain a 10,000-foot and 10-year perspective.

As your new board chair, I commit myself to daily prayer for each of you and ask for your prayers for all of us on the board. The fire that burned in my heart 43 years ago when I first read “The Church in the Modern World” still burns there. I look forward to working with you.

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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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Ambitious goals met; new ones ahead

By David Lichter, D. Min.

Executive Director

While you will be reading this column in early 2009, I am writing it on the First Sunday of Advent 2008. So I wish you two "Happy New Years!"

The second reading for this First Sunday of Advent was I Corinthians 1:3-9. As I listened to it proclaimed this weekend, it captured my prayer of gratitude for you, as members of NACC and ministers of Christ's healing, and my prayer for you for 2009.

Brothers and sisters, grace to you and peace from God our Father and the Lord Jesus Christ. I give thanks to my God always on your account for the grace of God bestowed on you in Christ Jesus, that in him you were enriched in every way, with all discourse and all knowledge, as the testimony to Christ was confirmed among you, so that you are not lacking in any spiritual gift as you wait for the revelation of our Lord Jesus Christ. He will keep you firm to the end, irreprouchable on the day of our Lord Jesus Christ. God is faithful, and by him you were called to fellowship with his Son, Jesus Christ our Lord.

As we conclude 2008, I give thanks for the significant steps that have been taken in NACC in 2008 to promote the ministry of spiritual care and to renew the opportunities for NACC members to gather with one another and with others involved in the chaplaincy ministry. Let me highlight three of these steps.

First of all, the goal of the NACC/CHA Pastoral Care Summit in October 2007 was to create collaboration among health systems to promote spiritual care. Four task forces (metrics, care services, recruitment, and education/credentialing) committed themselves to continue the efforts of the summit by collaborating through conference calls to create useful

deliverables that would benefit healthcare systems and other entities in their work with chaplains. The metric task force developed patient and associate satisfaction questions and continues to work on the metrics goal, as you will see by the professional development column in this *Vision* issue. The care services task force developed and tested the fundamental responsibilities/expectations of a certified chaplain. The recruitment task force helped prepare many tools for our member use that can be found under the "Consider Chaplaincy" on our NACC website. The education/credentialing task force developed a very helpful document that compares the revised NACC Standards to the core course requirements for a master's in a theological discipline to be an aid for heads of graduate theology programs as they are invited to introduce graduate students to chaplaincy as a career. The work of these task forces continues. We are so appreciative of those involved in them.

Secondly, we wanted to get better data on the spiritual care ministry to make available to healthcare leaders and NACC members. We partnered with the Catholic Health Association (CHA) and the Spiritual Care Collaborative (SCC) to provide members and others with two survey studies: with CHA on status of pastoral/spiritual care within Catholic Health settings, and with SCC on the 2008 Compensation Study.

Thirdly, in fall 2007 we set an ambitious goal, almost like a dream, to have a local chaplain gathering in every region of the country, as well as to find more ways to connect

We are committed to expand the ways for members to access more educational offerings and resources and to network with each other.

See **Goals** on page 5.

NACC enters new season of expectation

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

When you read this article, remnants of holiday wrapping paper will have been discarded or put away for next year; Christmas gifts will have been given, returned, exchanged, and gratefully worn or used. As I write this final column as chair of your NACC Board of Directors, it is the First Sunday in Advent. I am wrapped in reflection on the meaning of Advent this year, not only for me personally, but for us as a ministry of the church and a professional association.

As an association we are entering a new season of expectation and anticipation. We will begin the New Year co-sponsoring a groundbreaking Spiritual Care Collaborative (SCC) Summit in Orlando. During the conference, the SCC Steering Committee will meet together to discuss and discern our understanding of the implications of the responses to the SCC Survey. Feedback from the professional spiritual and pastoral care cognate membership groups will provide us with critical information. This data is essential to effectively advocate for the health and vitality of our profession and consciously chart a course to guide our strategic planning for the future. I am deeply grateful for this unique venture undertaken in collaboration with the HealthCare Chaplaincy. In this season of wonder and awe, I ponder a few mysteries of my own. What will we learn? What actions will our learnings compel us to take? For now, I am enveloped in a cloud of unknowing regarding much of what the future holds for us.

Here are some things I do know. During the conference we will honor newly certified chaplains and CPE supervisors. We will celebrate the service so many of you generously offer us on the board, commissions, committees, panels, task forces, certification teams, as ITE's, state reps, and as formal and informal advisors and coaches. We will honor many of our significant external partnerships — with the USCCB and CHA, as well as Catholic Health Systems, religious communities, ministry formation and academic programs and associations.

I am confident that David will clearly and articulately review our Strategic Plan and report progress on the accomplishment of our goals. We will review the work of the NACC-CHA Summit task forces. New and exciting improvements in the governance function of NACC will be announced. We will welcome Rev. Baaju Izuchi to the Board

of Directors, and I will relinquish my responsibilities as board chair to the capable hands of Sr. Barbara Brumleve.

As SCC cognate partners, I know we will all revel in the diversity of events, learning experiences, and worship opportunities afforded us. As Catholic chaplains, members of NACC, APC, AAPC and ACPE, we will continue to celebrate that which makes us unique — symbolized and consummated in our liturgies.

And I know that unfailingly the Seasons of our Liturgical Year will continue to offer us abundant graces and blessings. Advent reminds us that we dwell spiritually, physically and psychologically both in joyful anticipation and in clouds of unknowing. Advent surprises us with New Life in unexpected places and unusual circumstances. Advent gives us opportunities for deeper integration of the virtue of Hope.

I know that while your board members believe we have prepared the way for effective and efficient succession planning, for meaningful opportunities to grow and exercise leadership skills, and for active participation in the work of our association, we can only hope for vibrant and vigorous members who will be involved, aware and highly competent. I believe we must prepare to be “prophets of a future not our own,” to become as wise as the Magi in reading the signs of our time. I know we need to be ever-wiser stewards of limited and diminishing resources. Some of these resources are obvious, and strategies to share and work with others to maximize financial, programmatic, technological, material and even human resources, may be necessary but nevertheless demanding to implement. Even more challenging is to allow ourselves to be led where we would not naturally or instinctively go to respond to a call to the desert experience.

Yesterday I read an ancient parable retold recently by Judy Fortune, R.S.M., in “Advent Musings,” the Mercy Center at Madison (CT) Newsletter. It seems “some Westerners hired a few native guides to help them travel through the Kalahari Desert. Not being used to moving at the pace their employers were expecting, the guides suddenly sat down to rest, and no amount of persuasion could induce them to continue the journey until they were ready. The reason for this much needed rest, they explained, was that they had to wait for their souls to catch up.”

Each liturgical season extends its own invitation to wait for our souls to catch up. We wait, not in a passive lack of engagement in the work of preparation for what is only yet embryonically present in our lives and in the life of our association. Rather we wait engaged in reflective preparation for birthing the un-anticipated and the unknown, and for Epiphany Strangers and Guests in our lives and the life of our association. We wait with quiet confidence in the One who is All-Knowing.

I know we need to be ever-wiser stewards of limited and diminishing resources. Some of these resources are obvious, and strategies to share and work with others to maximize financial, programmatic, technological, material and even human resources, may be necessary but nevertheless demanding to implement.

Goals

Continued from page 3

members to each other. The *NACC Now* has become a valuable tool of communication and networking among members. Some type of local event occurred in every region thanks to so many of you who came forth to help plan and execute these events, and to the many partner associations who often collaborated with us to make them happen. Let's keep them going!

As we look to 2009, let me highlight three steps that, I believe, will help improve the value of NACC to you, as members, and will reinforce our efforts to advocate for the spiritual care ministry.

First of all, while the local gatherings need to continue to grow, we are committed to expand the ways for members to access more educational offerings and resources and to network with each other. I am committed to focus on three ways this year.

▼ We are committed to improve our NACC website resources, a task which we have begun. My dream is that the NACC website becomes the default setting on your computer because you find it valuable to constantly be looking for helpful resources, including new educational programs available throughout the country. When you go there, you will find dedicated space enabling you to communicate with and learn from other NACC members working in specialized settings.

▼ We are committed to develop a series of audio conferences with content that aligns with the revised NACC standards, and to better publicize existing audio conferences that already are offered by diverse healthcare systems. These audio conferences will be good opportunities for chaplains, either alone or in groups, to gain CEH's for their professional development. These aim to help certified chaplains to improve their professional competencies, be better prepared for their renewal of certification, and learn skills to position themselves for future spiritual care leadership opportunities.

▼ We are committed to help you network better with other NACC members working in your special area of ministry whether that area is hospice, nursing home, palliative care, mental health, pastoral care leadership, or others. These networking opportunities will hopefully be supports for you and opportunities for more professional development.

Secondly, we are committed to continue to collaborate with strategic partners to advance the spiritual care ministry together. I am committed right now to focus on three ways to do that this year.

▼ The NACC is very committed to further our SCC collaboration. As you know, Karen Pugliese serves as secretary and I serve as chair of the SCC Steering Committee. You were already invited to complete a survey that we hope will provide important data to help the SCC Steering Committee set its priorities for the coming years. The SCC 2009 Summit late this month provides us the setting to gather as colleagues, celebrate our common ministry, and look forward together. We anticipate nearly 2,000 participants for this Summit.

▼ We will continue to work closely with Catholic Health Association as we plan to share more information from the 2008 Pastoral Care Survey, identify ways to better position spiritual care within systems, and advance and promote the work from the Pastoral Care Summit task forces that continue.

▼ We plan to collaborate more closely with theological institutions with three goals in mind: help them to better understand and promote chaplaincy as a ministry career, work with them to develop more healthcare/chaplaincy ministry graduate programs, and partner with them and local chaplain groups for CEH offerings. I have been invited to attend the Association of Graduate Programs in Ministry (AGPIM) annual meeting and will be given an opportunity to speak with the group as another step toward improving our collaborative efforts.

Thirdly, we, as the NACC national staff, are committed to continue to improve our services to you as members. While there will always be exceptions, we take great pride in being able to answer your questions, refer you to helpful resources, connect you with the right expertise, and assist you in networking with each other. We want to work very closely this year with our NACC state liaisons to help you connect with us, communicate with one another, and provide the administrative support needed to make sure you are able to coordinate local and regional activities. We are undergoing some reorganization to help us meet these goals. I will share more of that with you as the year continues.

I look forward to 2009 with you. Blessings on your ministries!

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Family, respect, trust seen key in ministry to Latinos

By Norma Gutierrez, MCDP, BCC

Family, respect, personal relationship, trust and spirit – these are key words to keep in mind when ministering as chaplains to the growing U.S. Hispanic population.

Today, Hispanics are found in every state of the United States. Hispanics are in all of our places of ministry. In the Los Angeles area alone, Latinos hail from 40 different countries. Some have lived in this nation for five generations, while others are recent immigrants. There are Hispanic immigrants who have lived in the United States more than 20 years and are still here “illegally.”

We have Hispanics who speak only Spanish, others who speak only English, those who speak both English and Spanish, and still others for whom a Mayan, Inca or Aztec dialect is their native tongue. We have Hispanics who are every shade of skin color. In my own family of 12, I have four brothers and sisters who are fair skinned, freckled, with red hair; four of us with “medium” skin color; and four of us who were so dark that when they were little they were not allowed into community swimming pools because some saw them as “black.”

Since so many variations exist, it may be unwise to generalize about Latinos. There will always be individual variations, and unstated rules may impact the way in which Hispanics *perceive, seek and receive* services.

Despite the many differences, I would contend that a good starting place for any discussion of Hispanic culture is with *La Familia*—the Family. Hispanic families traditionally emphasize interdependence over dependence. Therefore, family members are likely to be involved in the treatment and decision-making process for a patient. Including family members in the consultation is often critical to the patient and may contribute to a patient’s ability to adhere to the recommended treatment. Family does not only include parents and siblings but grandparents, uncles, cousins, close friends, godparents (*padrinos*), and *comadres*,

mothers of godchildren. Hispanic extended families and the important role they play for the patient may run counter to certain institutional rules, such as hospital policies that limit a patient’s visitors to two at a time.

For those with families still in their native country, friends, co-workers, and people who live in the same complex become family and may be involved in decision-making. Thus at times our ICU waiting rooms are filled with “family members” of a patient who is not biologically connected to them. Birthing

waiting rooms are filled with first, second and third cousins, or women who say, “We are like sisters” and have come to witness the most holy moment of new life.

At times, because of a language barrier, some Latino patients have someone who has been in this country longer or knows English better speak for them regarding health issues. So, involve family members, allow them to participate in a consultation and pay attention to the matriarch or patriarch of the family. Keeping eyes open and paying attention to family dynamics will help increase sensitivity to the needs of Hispanics.

Health providers, by virtue of their healing abilities, education and training, are afforded a high level of *Respeto* (Respect). As a general rule, Hispanics tend to look forward to what their healthcare providers have to say and value the direction and service. Older Hispanics expect respect from younger men and women, both family members and healthcare providers. Be mindful of elders when an acculturated child is the spokesperson and acknowledge them as the matriarch or patriarch.

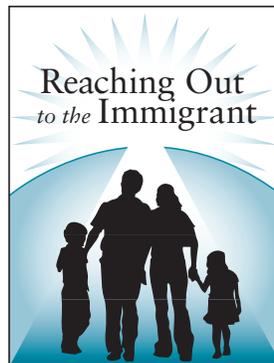
Respect is deep seated in most Hispanics. Many avoid disagreeing with or questioning their healthcare providers about the treatment they are receiving. One of the main reasons is that when we are in our most emotional, vulnerable state (which for many is sitting before a doctor with only a flimsy robe), we go back to our comfort zone, which for many Latinos includes speaking or wanting to hear our native tongue. As a chaplain, I have often asked, “What did you hear the doctor tell you?” and frequently the patients have heard only the first sentence — after that their minds went back to their native tongue and they could not understand the rest of the conversation.

A provider, even one with limited time scheduled for patient visits, might greet Señora Cruz with “Buenos Días, Doña Cruz, how are you doing today? How did your granddaughter’s quinceañera (15th birthday celebration) go?” Such a greeting implies *Personalismo* (Personal Relationship), conveying to the patient that the provider is interested in her as a person. Warm, friendly providers who take a sincere interest in the patient’s life are more likely to earn loyalty, respect and confidence, and patients are more likely to adhere to recommended treatment.

Where there is *Confianza* (Trust), Hispanics will value the time they spend talking with their healthcare providers and believe what they say. Then they will be willing to take wellness and risk-reduction advice to heart. Remember with *confianza* there is compliance. Many clinics and hospitals are using *promotoras* or community outreach workers to play a key role in establishing trust with a new provider.

Hispanics are naturally rooted in Mother Earth, thus are centered on the earth and most tend to view health from a synergistic point of view. This view is expressed as the continuum of body, mind and *Espíritu* (Spirit). End-of-life

At times our ICU waiting rooms are filled with “family members” of a patient who is not biologically connected to them. Birthing waiting rooms are filled with first, second and third cousins, or women who say, “We are like sisters” and have come to witness the most holy moment of new life.



Church argues that immigrants, too, have rights

Javier, 13, asked his mother, “What have we done that God is punishing us like this?” Javier referred to the recent deportation of his father. His father, Juan, and his mother, Luz, have lived in California for 14 years.

Luz works in the hospital where I work. She and her husband Juan often participated in community service by helping out in weekend education clinics throughout the city. Juan is a hard-working man, who worked building houses, was active in their church, and busy being father not only to Javier but also to 5-year-old Teresa, adopted as a baby.

This is the kind of separation story many of us chaplains hear frequently when we listen to the problems of immigrants among us. Luz told Javier, “*mi hijo*, God does not punish us. I believe God cries each night like we do, as he feels sad that we are separated. But *mihijo*, with God beside us and Our Lady of Guadalupe, we are going to make it through and soon we will be together again.”

The U.S. and Mexican bishops spoke out in 2003 with one voice about immigration in their landmark pastoral letter, titled “Strangers No Longer: Together on the Journey of Hope.” They wrote that people have the right “not to migrate, that is, they should be able to live freely in their countries of birth. However, when this is impossible, whether due to extreme poverty or persecution, the church says they have a

right to migrate, and nations have a duty to receive them.”

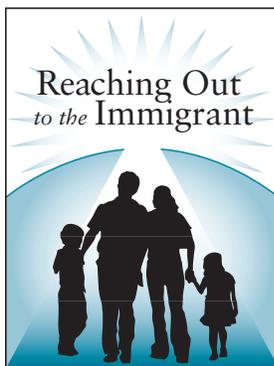
Donald Kerwin, executive director of the Catholic Legal Immigration Network Inc., a subsidiary of the United States Conference of Catholic Bishops, in 2006 wrote that the church “sees the current U.S. immigration system — while generous in many respects — as badly in need of reform.”

It has been particularly offended, Kerwin said, by

“hundreds of deaths along the U.S.-Mexico border; the growth of human smuggling rings, the disconnect between U.S. labor needs, trade policies and immigration admission levels; and decades-long delays in some family reunification categories. The church does not believe that criminal prosecution and deportation of unauthorized immigrants offer a viable, much less a humane, approach to the problem.”

As they continue to come to our doorsteps, sick and without insurance, how do we welcome and educate our immigrants? What steps do we take to educate them on diabetic or pre-natal care in their own barrios? How do we educate them and assist them to plan for their own future? How do we grade ourselves and our workplaces using the measure suggested by U.S. and Mexican bishops in their pastoral letter: “We judge ourselves as a community of faith by the way we treat the most vulnerable among us.”

— Norma Gutierrez



issues are natural comfort zones for Hispanics; what occasionally gets in the way is a lack of trust with providers. When counseled on the benefits of hospice, for example, the sound advice may be interpreted as “they do not want to offer us the best because we may not have the money to pay for the services.”

Hispanics may choose to use folk or traditional treatments before or concurrently with modern healthcare. Be sensitive to the role folk medicine plays, show tolerance and respect for it, and ask questions of the patients.

What follows is a questioning procedure, using the letters of the word ETHNIC, that healthcare workers may employ to help Latinos communicate their stories:

Explanation: What do you think may be the reason you have this problem? What do your friends, family and others say about your symptoms? Do you know anyone else who has had or who now has this kind of problem?

Treatment: What kinds of medicines or home remedies have you tried? Is there anything you eat or drink or do to stay healthy?

Healers: Have you sought advice from alternative healers or folk healers? If so, tell me about it.

Negotiate: Try to find options that will be mutually acceptable, incorporate their beliefs, do not contradict.

Intervention: Determine an alternative that may incorporate folk treatments, spirituality and healers, as well as other cultural

practices.

Collaboration: Work together with the patient, family members and other healthcare members, healers or community resources.

Finally, many Hispanics have come and continue to come to this country seeking education and economic opportunities denied them in their own countries of origin. Some may have endured terrorization by violent groups, imprisonment and torture, and may be suffering from psychological distress or post-traumatic stress disorder. Some may have faced hostile conditions in their homelands. They may be thankful for the opportunity to work but grieve the loss of their old life—a life some may never see again.

The greatest gift of Hispanics is that they live from their hearts. They are grounded to Mother Earth, thus their homelands are also at their emotional center. That is why churches are packed on the Feast of Our Lady of Guadalupe, as young men and women have their pictures taken as they place their roses at the feet of the Virgin. The aim is to express their devotion to the Lady, but also to obtain the photo to send home and show their families, “See, even though I am miles away we connect in this holy moment.” May we learn from Latinos to live from our hearts.

Norma Gutierrez is chaplain at St. Mary Medical Center in Long Beach, CA.

Immigrants

Continued from page 1

streets in very poor health. “They expired without any identification. The county took care of the burials.” Their tragic plights were exceptions, she said, because there is always a place and treatment for the seriously ill immigrant in the Rio Grande Valley.

Sister Esther and three other chaplains who work with new immigrants agreed to answer questions about their ministry for *Vision*. Their comments suggest that where uninsured immigrants locate within the United States and whether or not they can communicate well with healthcare workers may make a big difference in terms of the quality of healthcare they receive.

Isabelita Boquiren, a hospital chaplain in Nogales, AZ, said that most immigrants she has encountered in her work come

from Mexico, although there have been a few from Vietnam. “Most of the women who come need help in pregnancy (obstetrical and gynecological) services and some had come because of severe dehydration in the desert trying to cross the US-Mexico border, as do the men who are brought into the hospital by the (U.S.) Border Patrol.”

Ms. Boquiren said that lack of legal status complicates the matter of medical treatment for the seriously ill immigrant. “Sadly, some are literally left to die,” she commented.

A major challenge for the immigrant population she encounters in her chaplain ministry, she said, is the immigrants’ struggle with human rights, preserving their dignity as human beings.”

In her view, to advocate for immigrant patients, a chaplain needs to work in collaboration with others to create a healthcare system based on

the idea that everyone has a right to human dignity. “Each chaplain can also advocate to reject a health system that separates those who can pay for services from those who cannot pay,” she said.

“By law we are to give treatment for everyone,” noted Isidro Gallegos, coordinator for spiritual services for a Chicago hospital system. “However, the level of treatment may not be the same for those who do not speak for themselves.” he said. “There is no better advocate than yourself, but things get more complicated when the person is not even in the position to advocate for himself or herself.”

He finds that due to language difficulties, immigrants often don’t understand the procedures outlined by healthcare professionals, sometimes leading to “really bad consequences for the patient.” Similarly, too often medical personnel miss the target when responding to immigrant patients’ queries and concerns because they misunderstand the patients’ stories, he said.

Gallegos, who manages a department of nine chaplains, said he has been trying to find another Spanish-speaking chaplain for some time, “and they are as rare as water in the desert, while the patient population with this need continues to grow.”

Sister Rodriguez said part of her ministry involves listening to immigrants’ stories and struggles, providing empathetic presence and speaking their language, “making them feel that they are not alone.” She also helps the staff to translate basic health information for Spanish-speakers.

Gallegos said the major concern the documented (legal) immigrant faces is “if they are going to receive adequate treatment,” while the undocumented fear whether they will be treated with respect or not.

Chaplain Louise Landeta, of San Ysidro, CA, said, even when undocumented immigrants are physically well, a constant struggle for them is not knowing what will happen to them or when. “They are detained without a sentence.

They could be there (in detention) for a few weeks and deported, or for months. They never know. If they are appealing their cases, the time will be even longer — possibly years. It is the not knowing that is so stressful for them,” she said.

Ms. Landeta was head chaplain and coordinator of religious services for the Immigration and Customs Enforcement Detention Center in El Centro, located in California’s Imperial Valley about 125 miles east of San Diego, for two years before coming to San Diego as a hospice chaplain/case manager.

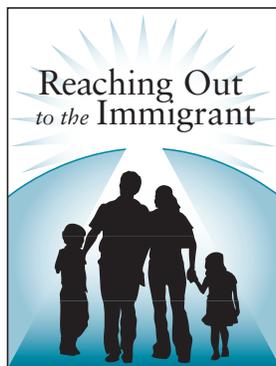
At El Centro, she served detainees from all over the world — not just Mexico but from several countries in Central America, South America, from the Middle East, from Russia, Ukraine, Israel and some western European nations. As a hospice chaplain in San Diego, she ministers primarily to immigrants from Mexico and Central America.

Those detained at El Centro “are allowed to contact relatives and friends by phone but if they don’t have any money to make the calls or if the relatives don’t have phone numbers, they are unable to let them know what is happening to them. Many of the detainees are quite poor,” she commented.

Ms. Landeta thinks changes in immigration law are needed. “I just wish others would realize how difficult life is in other countries and why the USA is so very attractive to people all over the world. Most of the immigrants come looking for a life with opportunity and freedom. Granted there are some who come for less than honorable purposes and those need to be weeded out and returned to their homelands swiftly,” she said.

“I understand that there must be limits upon how many immigrants this country can admit and absorb. I also understand that socioeconomic status must be a consideration (in terms of who the United States allows to immigrate). Yet I think current immigration standards in that regard contribute heavily to the numbers of people who cross illegally any way that they can. Perhaps ways could be found to strike a better balance for all,” she said.

Ms. Boquiren noted that she had learned through her ministry to immigrants that “to cross the desert in search for a



“Who would like to leave their family behind and end up in the hospital sometime in a different country with no support from those who love him or her?”

— Isidro Gallegos

Uninsured

Continued from page 1

financial resources, had waited until her pain was uncontrollable before she sought care. Oftentimes, this is the plight of the poor; if they could pay for healthcare, they could be diagnosed earlier with perhaps better outcomes. At this point, the cost of care for this woman was estimated to be in the tens of thousands of dollars; Mission Services was called and asked if there was a process that could be used to assess need and our response to that need?

We looked first for established models for decision-making and found a couple of examples. There are hospitals that provide a set amount of money each month for such care (and when the money runs out, so do the care options for those in need). There are also hospitals that set parameters for care and limit their service to these parameters. In more than one case an acute care hospital, not having the resources to cover long term needs, would work with the consulate for the patient to receive care in his/her home country. This resolution can become problematic when the patient or the family refuses to return home.

Early on it was recognized that there would be no easy answers. Called into conversation were key players: physicians, patient finance representatives, social workers, and mission services. Initially the problem seemed overwhelming; how could we manage a process that could address needs of all undocumented patients? We decided, that instead of addressing all diagnoses and treatments, we would look at the heart of the problem — where were we most challenged to meet these patients' needs? Our focus narrowed to cancer care in relation to chemotherapy, and from the ongoing dialogue, a process evolved. The steps identified include:

- ▼ Get the needed medical information: patient prognosis and benefit of treatment.
- ▼ Take into account financial considerations:
- ▼ Possible financial assistance, including drug company programs and less costly therapeutic options.
- ▼ Willingness of patient/family to cooperate with applications for assistance.

better life for one's self and family is an act of great sacrifice." Gallegos agreed. "Who would like to leave their family behind and end up in the hospital sometime in a different country with no support from those who love him or her?" he asked.

Ms. Boquiren would like others to realize that immigrants are human beings, too, "with basic needs just like everyone else ... and long to have the same basic human rights to shelter, food, health, and safety."

In her view, Catholic healthcare should take its lead from the healing ministry of Christ — "where none was sent away 'empty' and each one came as they were and were welcomed, the poor,

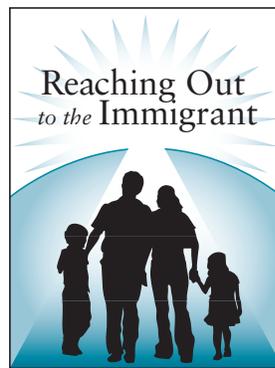
- ▼ Cost to hospital.
- ▼ Call together members of the ethics panel that meet to consider all factors and approve charity care.

The strength of this process lies in its transparency. All parties share responsibility for stewardship, and the patients receive care that meets community standards and is ethically justifiable. With the woman described above, we were able to identify a less expensive drug that is as efficacious as the proposed chemotherapy. Her pain is mitigated and her quality of life has been enhanced. In a second case, the patient had an excellent prognosis and was approved for charity care. In another case, the patient had intended to receive both surgery and chemotherapy, but when she weighed the burden vs. benefit for this treatment, she opted for hospice. We also had a case in which the patient refused to cooperate with applications for assistance; the ethics panel supported the hospital policy that requires cooperation prior to approval for charity care.

Perhaps the gift of this process comes in the form of awareness. Cases, such as these, are no longer revealed after care is given when the costs are set and it is too late to consider options. Now these cases are brought forward soon after diagnosis is made and, in doing so, team members have the opportunity to be creative, to be proactive in seeking resources, and in empowering the patient in the process.

The needs of the poor and underserved will grow over the next months to years. Hospitals continually will be challenged to serve with less, and Catholic healthcare must not lose sight of those most vulnerable. Chaplains can play an important role through their prophetic voice. Chaplains are trained to invite story, to demonstrate nonjudgmental presence, and to provide the needed space for dialogue and the hard questions. Whether they are involved in policy making, participate on ethics committees, or simply lift up the needs of individual patients, chaplains can model a Gospel response to the needs of undocumented patients. "A preferential option for the poor simply reminds us who we are: a people who, when we are honest and awake, would do anything to end one another's suffering." — *Jack Jezreel*

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.



the rich, the sick, and the well."

"We have a moral call to respond to the cries of the poor, the immigrants, the uninsured. As chaplains we have the opportunities to be sensitive in our ministry to bring about response and advocate for change," she said.

Mr. Gallegos commented that he recently sat in a deanery meeting at which the bishop shared that one of six upcoming pastoral targets for U.S. bishops is pastoral work with Latinos. "How can we translate this into healthcare?" asked Mr. Gallegos. He hopes that part of the plan will be to target Latinos who may wish to be trained as chaplains.

Q&A with Elaine Chan, MSW, M.Div.

By Laurie Hansen Cardona

Vision editor



Elaine Chan, a full-time chaplain for the past five years at Beth Israel Medical Center Kings Highway in Brooklyn, NY, ministers to people who hail from countries around the world. She has a B.A. degree in journalism, a master's in social work, and a master's of divinity. Before becoming a chaplain, she worked almost 20 years in community development on the

Lower East Side of Manhattan. NACC member Elaine Chan agreed to a Q&A session for Vision.

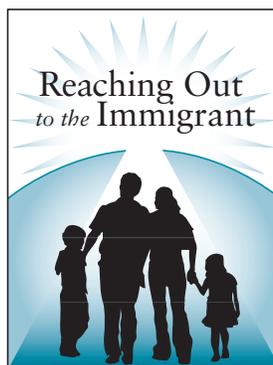
We may use Eastern medicine and speak of the yin and yang balance in referring to our health. Also while most may prefer to die at home, family members who are superstitious may not want the departed one's ghost in the house so prefer that their loved ones die in the hospital.

1. What brought you to chaplaincy, and what keeps you a chaplain?

Truth be told, God brought me to chaplaincy and God keeps me in this field. As a child I often thought about ministry, but being a religious sister was not to be. Then God made a way for me by introducing me to being a chaplain. God did it in a sneaky way. I was discerning a vocation as a religious sister and found myself pursuing seminary studies at New York Theological Seminary. While in seminary I was asked to do one unit of CPE, which became a seminal experience for me. I still remember some of the patients I worked with at Beth Israel. One was a retired nurse in early stages of Alzheimer's who shared a life experience with me that had haunted her for years. I felt privileged that she told me and am grateful that I was able to minister to her. About a year after graduating NYTS, Beth Israel had an opening for a full-time chaplain and I was hired.

The work is not easy. There are challenges to working with the chronically ill and dying. Also there are challenges to working in a non-Catholic setting. God listens to me complaining but then encourages me as I make my rounds. One colleague jokingly will ask me daily if I have saved a life. I may not have performed life-saving CPR or some other

medical intervention but often times I breathe new life spiritually into those thought too old, too sick or disinterested in the faith.



2. I know you work with a wide variety of patients at Beth Israel. Can you list the different nationalities?

I work with individuals of various or no professed faiths as well as many different nationalities. Roman Catholic patients are often of Italian, Irish and/or Polish descent as well as immigrant Catholics from various places, including Haiti, Puerto Rico, Dominican Republic, Trinidad, Jamaica, Cuba, Chile, Panama, Colombia, Mexico, China, Korea, Czechoslovakia, Lithuania, Italy, Ireland, Nigeria, etc.

3. How does your own ethnic background assist you?

I am a second-generation Chinese-American, and folks are sometimes surprised to learn that I am Catholic. They assume that I am Buddhist. Others are surprised that I am a chaplain, assuming that only priests can be chaplains.

These issues aside, my ethnic background makes me uniquely qualified to be a chaplain because, as an Asian, I grew up with many faiths. My grandparents are Buddhists and some of my other relatives are Protestant. I have an accepting attitude toward folks of different faiths. Generally speaking, patients and their loved ones feel comfortable speaking to me.

4. What kind of Chinese cultural issues have you been able to bring to the attention of others?

I have an understanding of my cultural background, but I am not a spokesperson since I realize that there are many different cultural practices and preferences. Generally speaking, the older population prefers hot water as opposed to ice-cold water, even during the summer time. The older and more traditional population prefers to have rice at meals whenever possible. We may use Eastern medicine and speak of the yin and yang balance in referring to our health. Also while most may prefer to die at home, family members who are superstitious may not want the departed one's ghost in the house so prefer that their loved ones die in the hospital.

5. Can you give an example of when you felt particularly blessed to minister to people of a culture different than your own?

A year ago I was making my rounds when a social worker referred me to a hospice patient. His wife was by the bedside and inquired about arrangements for her husband who was dying. I explained that once he dies the staff would notify the "hevra kaddisha," a volunteer burial society that is trained to prepare the body. As I was speaking to the wife I observed that the man's arm was tattooed with numbers, the markings of a Holocaust survivor. I commented on this, and his wife told me that he was the sole survivor of his family.

To be an instrument of healing:

How best to minister in 'thin places,' where life meets death

By Kathleen Hope Brown, D. Min., and David M. Orr

In Celtic spirituality we find the image of “thin places,” where the line between the human and the divine, earthly presence and God’s presence, the physical and spiritual worlds, almost disappears. In thin places, we are privileged to touch the holy, breathe the Spirit, and feel our hearts beat as one with nature and the universe. All of us have encountered places of great beauty and wonder that are thin places – majestic mountains capped with snow, the shore where earth and water meet the sky, the birth of a child. Such beauty is of God and leads us to God. Thin places are found on the edges of nature and existence. They bring us to our knees in awe and wonder before the mystery of God.

Then there are thin places where suffering and faith come together at the edge of life. Ministry to the sick is one such place, and the formation of those who minister there requires heightening their awareness of God’s presence where life meets death, where pain meets hope. That formation must integrate theology, prayer, and pastoral practice.

Theology

For surely I know the plans I have for you, says the Lord, plans for your welfare and not for harm, to give you a future with hope. Then when you call upon me and come and pray to me, I will hear you. (Jeremiah 29:11-13)

Where is God in the midst of suffering? What is our hope? If I am not cured, has God not heard my prayers? These are central theological questions that ministers confront in people who are sick and dying, families who suffer and grieve, and in their own hearts. Ministers to the sick must have reflected deeply on these questions if they are to bear authentically the Christian message of hope. Sometimes those stricken with illness believe that their suffering is punishment from God. Ministers must be able to witness gently, sometimes silently, becoming the reflection of God who is love itself.

Many people find it difficult to pray in the midst of suffering. They may feel angry with God and hesitate to

admit this. The Psalms give us language to lament suffering. Praying the psalms with the sick and dying can provide comfort to them and to their families and assurance that their pain can be brought to God in prayer.

Ministers also will do well to meditate deeply on the suffering of Jesus. When Jesus prayed in agony before he died, he said, “Father, if you are willing, take this cup away from me” (Luke 22:42). The answer to his prayer was not freedom from suffering, but the strength to bear it. On Calvary, it appeared as though the mission of Jesus was over and had ended in failure. The God of mercy, love and compassion whom Jesus had spent his life preaching seemed nowhere to be found. But on the cross, when Jesus cried, “My God, my God, why have you forsaken me?” (Matthew 27:46), he cried not into an empty void but to a Father he knew was there on the underside of suffering. The paschal mystery, with its suffering, death, and then resurrection for eternity, is our belief that suffering and death do not have the last word, that out of death comes new life. This message of hope that ministers bring requires deep prayer and meditation.

Prayer

Leaders of prayer will be icons of the community’s prayer before God only to the extent that they are in touch with the human need and longing for God that lie deep within their own and every human heart.

To lead prayer means to make one’s own life of prayer public. To lead prayer effectively, one must be a person of prayer. Though ministers to the sick usually do not think of themselves as leaders of prayer, their

Where is God in the midst of suffering? What is our hope? If I am not cured, has God not heard my prayers? These are the central theological questions that ministers confront in people who are sick and dying, families who suffer and grieve, and in their own hearts.

See [Healing](#) on page 15.

All the while the wife and I sat next to the bedside of the husband who had on an oxygen mask and was breathing heavily. Momentarily the wife observed that the husband was no longer breathing. I summoned the staff and they confirmed that he had died. I realized afterwards that he had heard me speaking about the “hevra kaddisha” and may have thought that this would be a good time to let go, since I would see to the care of his body and stay with his wife.

I stayed with the wife as she waited for her son to come. She was concerned that she might be keeping me from other duties. I told her my job was to stay with her. Presently the son arrived and he was grief stricken. He

asked to see his father. I waited with his mother while he did this and then said my good-bye and parted.

After they left I reflected on the death. The Jewish religion prescribes specific rituals for the care of the dead and burial. During the Holocaust it would have been unlikely that any of the patient’s family members were given a proper burial. I felt privileged to have had the opportunity to assist in a small way to make sure that this patient’s body was properly prepared. In my mind’s eye, I could see not only the “minyan” (a Jewish prayer group) praying for him at the cemetery but also the ancestors, all those who had gone before.

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.

Judy Novak
Cudahy, WI
Radiation treatment for
colorectal cancer

Teddi Tomsic
Shelton, CT
Major surgery

Sr. Rose Grabowski,
SSJ-TOSF
Arcadia, WI
Stomach surgery

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

Sr. Hilda Mallet, MHS
Lafayette, LA
Cancer radiation treatments
that followed chemo

Bro. Brian Boyle, CPPS
Chicago, IL
Broken foot

Sr. Paula Jacobs, SSM
Oshkosh, WI
Terminal cancer

Mary Pawicz
NACC Staff member
Milwaukee, WI
Recovering from heart surgery

Rev. Jim Radde, SJ
St. Paul, MN
Recovering from surgery

APC announces new board members

Schaumburg, IL – The APC has announced several elections and appointments to its board of directors.

Rev. Susan K. Wintz, M.Div., BCC, has been named president. Wintz is a staff chaplain at St. Joseph's Hospital and Medical Center in Phoenix, AZ, where she is the lead chaplain in the intensive care units of the Barrow Neurological Institute. A graduate of Dubuque Theological Seminary, Wintz is endorsed by the Presbyterian Church (USA) and has served on the APC Board of Directors since 2002.

Rev. David C. Johnson, D.Min., BCC, has been elected president-elect. Chaplain Johnson is the director of pastoral care and education at Cabell Huntington Hospital in Huntington, WV. He has served on the APC Board of Directors since 2002, is endorsed by the United Methodist Church and was APC board certified in 1994.

Rev. debbie husband, JD, M.Div., BCC, has been appointed secretary of the board. Chaplain husband is Clinical Specialist/Chaplain Supervisor at Orlando Health, serving ORMC and M.D. Anderson Cancer Center Orlando, in Orlando, FL. She became APC board certified in 2001 and is endorsed by the Presbyterian Church (USA).

Chaplain Kenneth Siess, D.Min., BCC, was elected board member and chair of the Commission on Professional Ethics. A

“retired” chaplain, he last served full time as director of chaplaincy and clinical pastoral education at University of Minnesota Hospital in Minneapolis, MN. He continues serving in various capacities as teacher and consultant. Chaplain Siess was certified in 1978 by the College of Chaplains and is endorsed by the Lutheran Church Missouri Synod.

Chaplain Harry Burns, M.A., BCC, was elected to the board of directors as a member at-large. A chaplain at The Presbyterian Hospital in Charlotte, NC, he became APC board certified in 2003 and is endorsed by the African Methodist Episcopal Church.

The Reverend James Gibbons, Th.M., BCC, has been appointed Transitional Executive Director of the association and joins the board as an ex-officio member. Chaplain Gibbons retired from Advocate Health Care in 2002 as vice president, mission and spiritual care. He has participated in the education of many chaplains and clinical pastoral education supervisors, and has taught at many Chicago area theological schools, including an 11-year appointment with the Divinity School of the University of Chicago. Gibbons has a master of theology degree from Perkins School of Theology, Southern Methodist University, and is ordained and endorsed by the United Methodist Church.

Book review

Author addresses difficult issues with humor, balance

Final Journeys: A Practical Guide for Bringing Care and Comfort at the End of Life. By Maggie Callanan. Bantam Dell, New York, 2008. Hardback, 350 pp, \$25.

By Colette Hanlon, S.C., BCC

Both experienced and new chaplains will find much in Maggie Callanan's latest book to make this a very worthwhile

read. The chapter titles themselves convey both the wisdom and the humor in her reflections. A sample follows: “Don't Tell Mom She's Dying. It'll Kill Her!,” “We're Not Giving Up! We Have Hope!,” “I'm Dying! Of course I'm in Pain!,” “When I Think of Granddad, I Feel Lonely in My Throat: How Children Grieve.”

The author speaks directly to many of the complex issues that face a terminal patient and his or her loved ones. Her hospice experience with a variety of patients provides her with a rich legacy to pass along.

I found the ways in which she addressed cultural differences especially insightful in this time of multicultural challenges for healthcare chaplains. She also explodes many

See [Book Review](#) on page 16.

Measuring the immeasurable?

An invitation to participate in a new spiritual care improvement project

By **Larry Ehren, M.Div., MBA, BCC,**
and **Rev. Dean V. Marek, BCC**

In the classic Rogers and Hammerstein musical “Sound of Music,” the mother abbess muses about her novice Maria, “How do you catch a cloud and pin it down?”

Similar musings can occur when asking: “How do you “pin down” quality in spiritual care? What data verify an effective chaplain intervention? How do we measure what chaplains do?”

Following a national summit of spiritual care leaders in 2007 hosted by the Catholic Health Association and the National Association of Catholic Chaplains, a number of task forces were created to further pursue the key questions raised at the summit.

One task force is focusing on metrics, hoping to collect and research the best measures for quality spiritual care, productivity, and accountability. Since the summit, the members of the task force drafted a standardized question for surveying patient satisfaction with the participation of a representative from Press Ganey. Then they turned to chaplain activity measures, reviewing several used by

various health systems with a view toward a standardized system of measurement. This endeavor has proved to be a daunting task because there are more models in current use than we know about.

So, the metrics task force is inviting you and your healthcare organization to describe your measurement tools, data collection processes, quality chaplain service indicators, etc. Your information will be added to our resource base to help advance the quality and effectiveness of spiritual care in healthcare.

We are looking for measures from all healthcare settings, community and academic medical centers, whether faith sponsored or not, whether non-profit or for-profit. We believe that this is a unique project that can add to the quality movement of spiritual care in the healthcare setting.

Please send your spiritual care measures and metrics to: Rev. Dean Marek, Department of Chaplain Services, Mayo Clinic, Rochester, MN. Email address is: marek.dean@mayo.edu

Larry Ehren is director of mission services at St. Jude Medical Center, St. Joseph Health System, in Fullerton, CA. Rev. Dean V. Marek is a chaplain in the Department of Chaplain Services at Mayo Clinic in Rochester, MN.



Please remember in your prayers:

Brother Richard Dube, CFA, provincial of the Immaculate Conception Province of the Congregation of Alexian Brothers, who died Oct. 12 at age 68.

Brother Dube, an NACC member, was elected to the Alexian Brothers' Provincial Council in 2001 and served on the council until June 2006, when he was elected as the 25th provincial of the Immaculate Conception Province. During his term as provincial, Brother Dube oversaw the Alexian Brothers' ministries in the United States, the Philippines and Hungary. Earlier he served as director of mission integration for Missouri and director of the Alexian Brothers community in St. Louis.

He was born March 25, 1940, in South Berwick, ME. The youngest of 10 children of Joseph and Roseanne Dube, Brother Dube served in the U.S. Navy for six years as a corpsman and received an honorable discharge in December 1964. Next he pursued a 25-year career as a professional musician, playing piano in clubs and various venues. He often volunteered at nursing homes, delighting residents with his musical talents.

After entering religious life, he continued this practice while serving as the director of spiritual wellness at Alexian



In Memoriam

Brothers Sherbrooke Village, an assisted-living and skilled-care residence in St. Louis. Brother Dube entered the Alexian Brothers Congregation as a postulant in November 1991. He made his first vows in July 1994 and his life vows in 1997. After becoming provincial, Brother Dube served as a trustee on many Alexian Brothers' boards and was chairman of the Board of Governors of Alexian Brothers Health System.

Brother Jim Classon, CFA, Alexian vicar provincial, said Brother Dube served as provincial “in a compassionate, dignified manner and enacted many initiatives that encompassed the charism of the Alexian Brothers.”

Brother Classon said his colleague “was attuned to changes and challenges, accepted them, and worked with them with determination, boldness and courage.

“He will be deeply missed. The lasting impact that Brother Richard has had on the many lives he touched is immeasurable,” he said. “We were truly blessed to have Brother Richard’s leadership, fellowship, and friendship.”



God's nourishment present in dying woman's living room

By John W. Carley

Some time ago, while visiting a Las Vegas Catholic church, I came across a three-dimensional sculpture of The Last Supper. And what struck me as strange and yet wonderful was, with the exception of Judas, all the apostles as they approached Jesus to have their feet washed were smiling.

Was it after Jesus said: "Do not let your hearts be troubled. You have faith in God: have faith in me" (John 14:1)? Was it the wine? Or was it their conversation? Or was it an inside story among friends. Perhaps Andrew said, "Remember the time...." and Phillip replied, "That's nothing. Remember the time Jesus..." And they all smiled because they were moved by those miraculous stories. Or perhaps they wanted to change the subject when Jesus said: "I have eagerly waited to eat this Passover with you before I suffer" (Luke 22:15). For me, this unique sculpture emphasizes that when there is genuine celebration, there is a flicker of joy in the midst of sorrow.

So, reflecting on my 15 years as a chaplain, I recalled one special visit with Anna, a 79-year-old dying woman. That visit reminded me that a person's last days can be a final gift to those he or she loves.

I had been referred to Anna, who had raised three children. They were ages 9, 6, and 4 at the time her husband abandoned her. One son died at 14. Anna recently expressed that she thought she would "go to hell because of past sins." Our hospice social worker, after consulting with Beth, Anna's daughter-in-law, suggested to Anna that she talk with a chaplain, and Anna agreed. Beth welcomed me and introduced me to Anna, who

lay in a hospital bed in her living room. She was very frail, terminally ill, assisted with oxygen, blankets pulled up to her neck covering her thin arms. Anna's hair was freshly combed, and as we greeted each other, I noticed her eyes were deep blue. Anna spoke in whispers as I leaned close to listen to her faint conversation. I asked Anna if she was comfortable sharing with me the unease she felt about her past. I also asked if she would like to receive Communion. No! Anna said. So many people had told her through the years that whatever she had done that had not turned out right was her fault. She seemed to interpret this as evidence of her sinfulness.

I explained that the Sacrament of The Sick she

received the week before included reconciliation, that is God's complete forgiveness of past sin. I asked if she remembered that when the priest anointed her, he had said, "May the Lord who frees you from sin save you and raise you up."

I prayed with her, "May the God of peace be with you, Anna, stilling your heart that hammers with fear, doubt, and confusion. And may the warm mantle of God's peace cover you who are troubled and anxious." And, "Dismiss all anxiety from your mind. Present your needs to God in every form of prayer and petitions full of gratitude. Then the peace of God, which transcends all understanding, will guard your heart and mind in Christ Jesus. Amen." (Philippians 4:6-7).

At this point Anna saw me struggling to get comfortable on the soft couch and asked me to come over to the other side of the bed where there was a chair. I took joy in her direction, a sign of her true self emerging, her ability to control even some small part of her life at this critical time. Beth then brought some medication and, when Anna was focused, I asked her to name her gifts. She shook her head dismissively. Then Beth and I assisted Anna in recalling specific instances over her 79 years that exhibited her generosity, her faithfulness, her courage and her spirit. "Seething," she repeated several times, and with patience we interpreted it as "soothing."

Anna then asked for her bed to be raised and we joined in a Communion service. We ended with Jeremiah (17:7-8): "Blessed is the woman who trusts in the Lord. Whose hope is the Lord. She is like a tree planted beside the water that stretches out its roots to the stream: It fears not the heat when it comes, Its leaves stay green. In the light of drought it shows no distress but still bears fruit. God cares for all the needs of those who follow him. Lord God of Hosts, happy is the woman who trusts in you."

As I began to say goodbye, Anna whispered to Beth, who laughed and told me that Anna enjoys champagne on occasion and she wanted to share some with me. Beth returned and as she poured champagne from the bottle, we toasted one another with clinking glasses and smiles. Quietly sipping champagne, I was reminded that Jesus poured out life itself and when we drink of his blood, we have life within us. As the hymn "Our Blessing Cup" goes: "Taste and see, taste and see the sweetness of the Lord, the goodness of the Lord." And "Look beyond the cup you drink, see his love poured out in blood."

I prayed with her, "May the God of peace be with you, Anna, stilling your heart that hammers with fear, doubt, and confusion. And may the warm mantle of God's peace cover you who are troubled and anxious."

So how does my experience with Anna and Beth shed light on how God communicates with us? Was more going on in Anna's living room than what tingled the palate? For if we truly believe in the Body of Christ, as we toast each other, it is Jesus saying, "Here I am for you Anna, Beth, and John, so that you might live!"

Years ago Fr. John Kavanagh, S.J., wrote in *America*, "It may be complex for modern minds to believe the proposition that God could be our food and drink. It is just as difficult to believe anything wonderful about ourselves, to

hope there is more to sustain us than bread and wine chewed, drunk and digested."

And yet, Anna's, Beth's, and my faith is just that — faith that there is more in Communion than what meets the eye. Faith that here in a hospice setting, we were beneficiaries of God's miraculous nourishment.

John W. Carley, a certified chaplain emeritus, has served in pastoral care in various capacities over the past 15 years. He is currently a volunteer with Sea Coast Hospice in Portsmouth, NH, where he co-facilitates bereavement groups.

Healing

Continued from page 11

role requires it. Whether to one person or a larger gathering, ministers to the sick are called to lead prayer as a double icon. The minister gives voice to the prayers of the community, gathering them and raising them to God. The minister also stands in the image of God for the community, giving expression to God's presence, compassion and love.

The rites and rituals of the church can be very comforting for those not able to find words with which to pray. Spontaneous prayer also has an important place in ministry to the sick. Leading prayers for the sick is more than saying prayers; it is inviting those gathered to pray. This is the challenge and the art of presiding at prayer. It entails showing pastoral care and concern, being sensitive to God's presence and the needs of those assembled.

Pastoral Practice

Since this ministry is to Jesus himself, as he assures us, I soon realized that I had to give of myself and never hurry... Each individual deserves the time he or she needs, no more and no less. We ... should measure time by our heart, not our watch.

Ministry is holding the heart and soul of another, and ministry to the sick is holding a heart and soul at an especially vulnerable moment. Pastoral maturity and skill are never so important as they are at these liminal points on a spiritual journey.

The minister needs to be unhurried, take the time to listen, invite the person who is sick to share his or her story, memories and fears. The human spirit can be lifted and freed simply by being in the presence of someone who cares enough to listen, to hold a hand, to affirm. That presence, far more than "doing" anything, is the healing touch that a minister can bring. Words of comfort must be offered with the utmost respect for what the person is feeling. Offering an "Easter" reflection to one who is still in the midst of "Good Friday" pain can seem to minimize or deny suffering. Silently, respectfully, and lovingly dwelling with individuals in their pain is a true gift of love.

The Gospel of John tells us that at the Last Supper, Jesus washed the disciples' feet. He touched and ministered to a dirty, smelly part of them. Luke's Gospel tells us that Jesus touched a leper (Luke 5:13). Jesus did not hesitate to reach out to people in ways that others might have found unpleasant or unacceptable. He looked past any physical unpleasantness to the image of God within. Ministers need to touch when possible and appropriate, because human touch so powerfully conveys love. Ministers to the sick need to reach out with tender, foot-washing love.

Conclusion

God's love is mediated to the world in and through human beings. Human words, presence, and touch are the language of God's compassion and care. Ministry to the sick is a privileged opportunity to share God's love at moments when people most need to feel it. One who ministers to the sick needs a deep and abiding conviction that God is present even in the midst of suffering. A warm, loving presence that conveys the very loving presence of God can make ministry to the sick a "thin place," where pain is met with hope, doubt is met with faith, and death is met with the promise of new life.

¹ Kathleen Hughes, *Lay Presiding: The Art of Leading Prayer*. American Essays in Liturgy, Edward Foley, ed. (Collegeville, MN: The Liturgical Press, 1988), 39.

² Fernando Poyatos, *I Was Sick and You Visited Me: A Spiritual Guide for Catholics in Hospital Ministry*. (New York: Paulist Press, 1999), 33.

Kathleen Hope Brown is director of formation for ministry at the Washington Theological Union, where she is an adjunct professor. She is the author of, "Lay Leaders of Worship: A Practical and Spiritual Guide" (Liturgical Press, 2004) and numerous articles on lay ministry and spirituality.

David M. Orr is a career senior executive with the U.S. Department of Justice. His avocation is poetry. He considers poetry to be prayer and an expression of the poet's own journey toward truth. He collaborates with Kathy Brown in writing, and in presenting workshops and retreats.

A longer version of this article was published in the February 2006 issue of Ministry and Liturgy.

This chaplain began as a caring nurse



Name: Brother Ed Smink, Ph.D. (ABD)

Work: I am vice president of mission and compliance for Dubuis Health System in Houston, TX, a division of CHRISTUS Health. I oversee mission, ethics, spirituality and chaplain services in 14 hospitals with 16 sites.

NACC member since: 1987

Volunteer service: I have served as an assistant regional director of NACC, on the planning committee for the joint committee of NACC and APC Albuquerque Assembly, on the NACC mission, vision, and values reorganization committee, and now I serve on the Care and Standards task force and the joint NACC/CHA task force.

Book on your nightstand: Joseph Campbell's "A Hero with a Thousand Faces."

Book you recommend most often: A book that I certainly would recommend for all chaplains is: "The Art of Theological Reflection," by Patricia O'Connell Killen and John De Beer.

Favorite spiritual resource: As I continue to work on my dissertation, I am drawn to understand more fully the fact that our work, accomplished along with our many co-workers, is a spiritual practice. This is one of the greatest spiritual insights that I am spending much time in understanding. Somehow, as I reflect in the work that I do as a chaplain and caregiver, I understand more fully the spiritual practice that we as healthcare providers are practicing. Our work is one of the corporeal works of mercy, and the danger in our dualistic culture is to separate work and spirituality. We cannot do this in healthcare as healing is a sacred art in which the divine is discovered.

Favorite fun self-care activity: One of my favorite

self-care activities is gardening. Thomas Merton used to say, we cannot pray until we get our hands in the soil. Flowers, trees, shrubs, vegetables are part of my Slovak farming tradition.

Favorite movie: I did a study of archetypes in the movie "Les Miserables" and enjoyed discovering the genius of Victor Hugo.

Favorite retreat spot: I have attended different men's retreats in the outdoors and have found them extremely helpful.

Personal mentor or role model: I have a great friend and a former boss that continues to inspire and coach me.

Famous/historic mentor or role model: When I read Thomas Merton, I feel at home and that he is a friend and mentor.

Why did you become a chaplain? My journey to chaplaincy began as a nurse at the bedside. I remember caring for a patient who was dying. He had no family. As I was washing

him, I noticed he was anxious. He could not speak. During the care, I spoke with him. He knew he was dying. I took his hand and asked him if he would like me to stay with him and asked if he would like me to say a prayer with him. Together we prayed the Our Father. He smiled and shortly afterwards died. No matter what I did as a nurse, I found myself spending more time with patients. Eventually, I became ordained and then certified.

What do you get from NACC? I love being with chaplains and sharing the stories that each of us has experienced. This is sacred work. These stories have transformed us and experiencing this reminds us how present God and grace are to each of us.

Why do you volunteer? I volunteer to assist NACC because, in reality, NACC is about us. NACC is about each chaplain, CPE supervisor, director or VP at the bedside, in the classroom or boardroom, advocating for the privilege of reminding all in healthcare of its sacred vocation.



Book Review

Continued from page 12

common myths about end-of-life experiences with common sense insights and suggestions. She speaks respectfully of how children can be assisted as they accompany loved ones on their final journeys and on the role of pets in the dying process.

Each chapter ends with a brief sentence summarizing the material. The section about truth telling refers to the "pink-hippopotamus-in-the-tutu-syndrome" and ends with this wisdom: "Silence does not spare or protect; it isolates and

causes loneliness." The appendices include material on advance directives, the Dying Person's Bill of Rights, the Hospice Medicare Benefit, and recommended readings and resources.

I can imagine using this wonderful book as a training tool for volunteers in hospitals, long-term care facilities, and hospices, as well as for individuals and families facing end-of-life issues. It provides a balanced and thorough view of so many concerns that people face on their final journeys. I highly recommend it.

Colette Hanlon is spiritual care coordinator at Providence Care Center of Lenox, MA, and chaplain at Berkshire Medical Center in Pittsfield, MA.

Late husband, St. Teresa are her role models



Name: Annette Castello

Work: I am life issues coordinator at Epiphany Cathedral parish, in Venice, FL.

I visit parishioners at home, in nursing homes and in assisted living facilities as well as coordinate a respite program and funeral planners. I am a Eucharistic minister to the homebound

and to nursing home residents. I also assist in workshops on grief, bereavement and ethical decision-making.

Volunteer service: After completing a training session with Jim Yeager at St. Joseph's Hospital in Tampa, FL, in 1993, I began volunteering as a certification interviewer. Over the years I have met and worked with numerous interviewers and looked forward to being involved in this special ministry. I have also met wonderful, compassionate chaplains who have gone through the certification process. When I meet them, they often ask me if I remember their interviews. I must confess I usually do not, but it is always a joy to see how they have developed and grown in the ministry and in NACC. Three years ago I became an interview team educator. This role also gives me the opportunity to interact with numerous certification interviewers as well as other team educators. Over the years we have grown into a cohesive group and have seen numerous improvements implemented in the certification process.

Book on your nightstand: At the present time I am reading "The Transformation of Desire," by Diarmuid O'Murchu and "Quest for the Living God," by Elizabeth A. Johnson. The first book allows me to expand my vision and look at the world from a different perspective and gives me much food for thought and prayer. I also love to get a woman's perspective on our loving and living God as provided by Elizabeth Johnson.

Book you recommend most often: Recently I have been involved in facilitating prayer groups on contemplative dialogue. The writer used is Thomas Merton, who I began reading at 18, so I have recommended a number of Merton's books depending on the focus of interest. This has given me much joy over the past year and a half.

Favorite spiritual resource: Nature especially at the seashore and the mountains. These places calm me down, give me focus, and allow me to listen to God.

Favorite fun self-care activity: I have a monthly massage from a licensed massage therapist.

Favorite movie: "The Secret Life of Bees"

Favorite retreat spot: Genesis Farm in Blairstown, NJ, located in northern New Jersey near the Delaware Water Gap.

Personal mentor or role model: Jack Wilcox, my late husband, who not only gave me love but showed me that love is

unconditional. Something that has remained with me was his belief in always going back to someone and keeping the lines of communication open no matter how many times that person may have alienated or hurt you.

Famous/historic mentor or role model: St. Teresa of

Avila, Doctor of the Church, a strong women who listened to the voice of God in the depths of her soul and shared that vision with the church and the world of her time. This is someone who gives me the courage to speak the truth in love when the occasion arises.

Why did you become a chaplain? A good friend, Sr. Helen Hayes, former NACC executive director, encouraged me to pursue chaplaincy. I did an extended CPE Unit at St. Joseph's Hospital in Ann Arbor, MI, and in the fall of 1987 did a residency at Harper Hospital in Detroit, MI. I was then hired on staff at Harper Hospital, ministering mainly to cancer and HIV/AIDS patients and their families. It was a

ministry I loved. I especially loved listening to people's stories and their journey with God through life and death. After moving to Florida in 1991, I was without a chaplain's position for almost a year and a half. One day I prayed (really I threatened God!) "Lord, if you want me to stay in this ministry, you need to find me a job." Within a month's time I was at St. Joseph's Hospital in Tampa, FL, where I remained for 12 years.

What do you get from NACC? Over the years, I have met and become friends with many wonderful people in NACC. It is the depth of the sharing that I treasure. You may not have seen someone in the association for a long time and yet when you meet them again it is as if you had seen them yesterday.

Why do you stay in NACC? It is the level of professional sharing as well as seeing the growth and development of the organization to the level of professionalism there is today. I interact on a monthly basis with a chaplains' group in the area that includes NACC, NAJC and APC chaplains. This offers me the opportunity to relate and interact with others involved in chaplaincy in hospitals, hospices and parishes. It has been enriching, informative and life giving.

Why do you volunteer? I find it mutually enriching as well as the opportunity to share and receive gifts and insight. I love to meet others in NACC and to see what they are doing in their ministry and learn from them.

What volunteer activity has been most rewarding?

Serving as a certification interviewer. This has enabled me to work with experienced and gifted interviewers and future chaplains.

What have you learned from volunteering? NACC has many caring, compassionate and gifted people in the organization. It is a privilege to be part of NACC.



Questions chaplains may wish to consider prior to research

By **Mary E. Johnson, M.A.,**
and **Katherine M. Piderman, Ph. D.**

Introduction

Accredited seminaries and schools of theology usually do not require courses in research methods or statistics. Similarly, only a small number of clinical pastoral education programs provide research preparation. As a result, most chaplains are not trained researchers. Typically their opportunities for research involve collaboration with researchers from other disciplines.

The invitation to join a multidisciplinary research effort is important to consider. Acceptance provides an opportunity to join a team, to engage in the development, implementation, and interpretation of research while bringing to these stages our unique perspectives and experiences as chaplains. As the work is translated into practice, the people in our care can potentially benefit. However, as attractive as these invitations are, there are some questions to consider in making a wise and reasonable response.

Is this research study a project in which you absolutely want to be involved?

Research demands time, commitment, and perseverance. It is essential that you understand the central research question and aims the study is designed to address.

Are you comfortable with them? Do you feel a sense of passion about this particular area of research?

Inherent in the research question and aims are hypotheses. These hypotheses will be tested as this research question is explored. Does your experience and review of the research literature support these hypotheses? Does testing these particular hypotheses appear to have potential

application and benefit to the spiritual care of persons?

If your responses are affirmative, it is a good sign that you may want to proceed.

Does the research design make sense to you?

You should have a basic understanding of the research design and it should make sense to you in your role as a pastoral or theological co-investigator. It's important to be attentive to anything inherent in the study that is vexing to you, as your questions and concerns may actually help improve the design.

Spirituality and/or religion are complex and multidimensional terms. Have these or related terms been adequately defined? Many research instruments are available to use in the investigations of a spiritual or religious nature. Will

the instruments chosen effectively measure spirituality as defined in this study?

Statistical methods are beyond the expertise of most chaplains. Have statisticians been involved in the design of the study and will they carry out the analysis? Are they known to be patient with questions and timely with their answers?

Who makes up the research team?

Who is the principal investigator? The leader of the research team is the principal investigator (P.I.). Is the P.I. someone with whom you have a professional relationship? Do you know the P.I.'s research track record in terms of research leadership and project completion? Is the P.I. someone whose leadership you respect and who is respectful of you?

Who else is on the research team? Sometimes professional researchers, especially those who are not clinically based, do not have a clear idea of what chaplains do. It is important to note, when evaluating the research team, what other disciplines are involved and the scope of their contribution.

Are there other multidisciplinary colleagues who, in your opinion, should be involved in the research?

If the research team is well-rounded, you will be better positioned to function within the scope of your expertise as a chaplain.

What is your role in the research project?

It is important to clarify the scope of your experience and skills with the P.I. early on in your collaboration. Why have you been asked to be a part of this research study? Will you have an active role in the actual research study, i.e. providing a spiritual intervention?

Chaplains providing spiritual interventions in the context of a research study is a good news-bad news story. The good news is that the spiritual intervention is being provided by a spiritual professional. The bad news is that, in the name of standardization, the actual spiritual intervention may or may not resemble the real work of ministry. For example, what if you were directed by the research protocol to respond to a research participant only in a particular, pre-scripted way instead of responding in a pastoral way? It is important to understand what you are being asked to do and to consider whether the request is relevant and professionally sustainable. You are the best judge of what you can and cannot do.

How much of your time will the project require?

Completion of a research study involves numerous steps: 1) identification of the research question, 2) protocol development, 3) procurement of funding, 4) approval by the Institutional Review Board, 5) recruitment of research participants, 6) implementation of the intervention and/or research assessments, and 7) analysis and interpretation of the data. What is the projected time-line for each step? How much of your time will be required? How will this impact your day to day responsibilities? What portion of your time will be funded by a grant or other source?

Will you be expected to do something with the data

Sometimes professional researchers, especially those who are not clinically based, do not have a clear idea of what chaplains do. It is important to note, when evaluating the research team, what other disciplines are involved and the scope of their contribution.



generated by the research study?

Because you are a member of the research team you will likely have a role in the development of manuscripts that share the results of the research. What is the scope of your responsibility in manuscript development? Will you be expected to generate text or will you be a reviewer of others' writing? What gifts can you bring to manuscript development?

If the research study has a clear spiritual/religious component you may have opportunities to present your work at meetings and conferences in our discipline. Does the P.I. have an expectation that you make presentations at professional meetings or conferences? Are you willing to do this?

Do you have the support of your department/institutional leadership?

Many times institutional leadership considers involvement in research and its presentation as a burden vs. benefit enterprise. Does your department leadership understand the commitment you are being asked to make and support this commitment? Can you explain how this project will impact your day-to-day activities but also the eventual benefits realized by the people in our care?

Conclusion

No one has the final answers to all of these questions when they begin a project, but they are good to review and to keep in mind, if you choose to accept an invitation to become involved in research. There will be challenges along the way but if your responses are clear in your mind or can be clarified in times of confusion or conflict, things can flow smoothly. Involvement in research is a marvelous experience for chaplains with much potential to bear fruit in our work. Thoughtful preparation and continued reflection when necessary can help to pave the way to a fulfilling experience and successful harvest.

Mary E. Johnson is coordinator of education in the Mayo Clinic Department of Chaplain Services and assistant professor of oncology in the Mayo Clinic College of Medicine in Rochester, MN. Katherine M. Piderman is coordinator of research in the Mayo Clinic Department of Chaplain Service and assistant professor of psychiatry in the Mayo Clinic College of Medicine in Rochester, MN.

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A sample of research by the authors

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Many times institutional leadership considers involvement in research and its presentation as a burden vs. benefit enterprise. Does your department leadership understand the commitment you are being asked to make and support this commitment?

Find Positions Available on web

Please find Positions Available and CPE Residency ads on the NACC website, www.nacc.org.

We have found that the fastest and most expedient way to learn about position openings and to apply for them is through the website. You also may refer to NACC Now, the e-mailed newsletter, for updates on position openings. Thank you!

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Calendar

January

- 29-30 American Red Cross Spiritual Care Response Team Training, Orlando, FL
- 31 NACC Board of Directors Meeting, Orlando, FL
- 31 NACC Certification Meeting, Orlando, FL

February

- 1 NACC Board of Directors Meeting, Orlando, FL
- 1 NACC Certification Meeting, Orlando, FL
- 1-4 Summit '09, Spiritual Care Collaborative, Orlando, FL
- 2 Articles due for March-April *Vision*
- 11 World Day of the Sick
- 15 Postmark deadline for support materials for Oct. 3-4 certification interviews
- 25 Ash Wednesday; first day of Lent

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