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Ethics conversations may help lower nurses' moral distress

By **Paul R. Helft, MD,**
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Chaplains frequently serve multiple roles in healthcare institutions, including participating in clinical ethics functions and providing emotional and spiritual support to other employees.¹ In some hospitals, especially smaller facilities, the chaplain may be the only professional with in-depth ethics knowledge and one of the few with training useful in care of staff. Thus, initiatives where both ethical issues and staff care are engaged are of particular interest and priority for chaplains. This article describes such an initiative that chaplains in partnership with other professionals could consider replicating.

Because of their close proximity and extended exposure to patients, nurses often gain early insight into futility of care.² Many factors conspire to limit nurses' opportunity to take time to reflect on the burden they bear being ever present in providing care to patients, particularly in

ethically challenging situations. Moral distress is a feeling that occurs when one believes that she or he knows the correct thing to do, but is unable to pursue the right course of action. Moral distress among nurses is a

growing problem that has been linked to poor performance, to burnout and indeed to nurses leaving jobs and leaving the profession altogether.³⁻⁹ Given the current critical shortage of bedside nurses and the growing projected future shortage, we must make reducing nurses' moral distress a priority if we hope to meet the growing demand for trained nurses.¹⁰ Hospital chaplains are frequently consulted by their nursing colleagues in response to moral distress, and the support they provide in this area is an integral part of hospital team-based care.

Because nurses are more likely to

Chaplains who wish to participate in leadership of these conversations should develop competencies in ethical assessment and group facilitation and deepen competencies in interpersonal engagement.

See [Ethics](#) on page 6

Keynoters to include Joncas, Byock, Copeland and González

By **Robert Barnes, BCC**

Among the highlights of any major conference are the keynote speakers, who serve to both focus and inspire participants around the themes of the conference. Such will also be the case at next year's NACC national conference March 20-23, 2010, in St.

Paul, MN. The four conference keynote speakers will each address different aspects of the conference theme, "Winds of Change, Spirit of Promise."

Speaking to "Individual Change and Promise" is Fr. Jan Michael Joncas. Rev. Joncas, a priest of the Archdiocese of St. Paul and Minneapolis, is most widely known



See [Keynoters](#) on page 5

Let's use renewed energy to address our challenges

**By David Lichter, D. Min.
Executive Director**

We had a very good September NACC Board of Directors meeting. You will read in Barbara Brumleve's column the strategic plan priorities identified for the next 12 months. I greatly appreciated the board members' exchange and guidance. We have work to do and challenges to meet, but it's "we" and not "I." I praise God for all of you. I know the future of chaplaincy is in good hands, yours. As mentioned in my previous executive director column, we do have much to celebrate and be proud of regarding our strategic plan implementation. We are inspired and encouraged by the "new life" so many members have experienced over the past couple years. Let's use the renewed energy from these connections and take on together the challenges the board has identified for the next year of our plan implementation. We embrace together the health of the profession of chaplaincy and our ministry in the name of the church.

In this column, let me highlight three items that are important for you to know.

Healthcare Reform and NACC

Over the past months, I have shared with you through *NACC Now* news of a variety of events and writings from diverse religious and professional body sources, such as the excellent September 2009 summary of healthcare issues by Healthcare Chaplaincy's CEO, Walter Smith, S.J. (<http://www.healthcarechaplaincy.org/#hcr>), Faithful Reform in Healthcare's efforts to educate on the healthcare reform

proposed bills based on a set of shared religious values (<http://www.faithfulreform.org>), and the coalition of religious organizations and associations that helped plan the June 24 Washington, D.C. Interfaith Service for Healthcare Reform. My purpose in doing so was to alert you to other faith initiatives and to encourage member involvement in the healthcare reform debate. Many fine resources have been developed and shared with us.

However, we, as a Catholic association, have been very intentional in seeking the expertise and guidance from the advocacy staff of the Catholic Health Association USA (CHA) when making decisions as to how and where we would publicly endorse a group or statement with our association name or logo. For instance, given the very diverse organizations (some with whom we cannot be in agreement) that are public partners in Faithful Reform in Healthcare, the NACC could not be a public partner in that organization, although most of its values correspond closely

to those of CHA. Our guiding values are those of CHA (<http://www.chausa.org/Pub/MainNav/Advocacy/0708advocagenda.htm>). Its section on Ethical Integrity and Social Justice begins with, "The values guiding our advocacy flow from the Church's teachings about the dignity of the human person and the sanctity of human life from conception to natural death." Even though all our members do not work in Catholic healthcare settings, CHA's values and advocacy efforts embody our Catholic teaching. They are our advocacy arm on healthcare issues. I am very grateful to the CHA advocacy staff members, particularly, Jeff Tieman. They labor on our behalf, but not in our place. Each of us must still make our voices heard. Is that happening?

Building Awareness of the Ministry

Barbara Brumleve noted the Board's priority of getting new members. Amen, to this need! I want to emphasize here that we realize that getting new members is not a guarantee of NACC's solvency; rather, it is imperative in order to maintain a Catholic presence in our ministry settings after we have retired. It's above all continuing the healing ministry of Jesus in the name of the church. New members bring new life to the association and, most importantly, they bring solace to the sick, hope to the confused, and meaning to those in mourning. New members are about the new life in Christ on which each of us has staked the mystery and meaning of our ministry. So please help us build awareness of our ministry so that others can discern this call.

One way we build awareness of chaplaincy is by reaching out to graduate ministry programs. We encourage those considering chaplaincy to join NACC as part of their discernment process. We have a new chaplaincy ministry video and a brochure that many of you have commented are very well done and valuable. The video is available for purchase for a small fee, but you can also access it on our NACC website by clicking on "Consider Chaplaincy" (<http://www.nacc.org/about/default.asp>). Some members are giving presentations in parishes or to other groups to encourage newcomers to the ministry and to join the NACC. We encourage all of you to consider doing this! In *NACC Now* #52, August 31, 2009, we shared with members NACC Board Certified Chaplain Blair Holtey's article on his strategy, approach, and content for giving a parish presentation on chaplaincy as a vocation. Please read his story as a way to consider promoting the ministry. Go to www.nacc.org/resources/e-news/holtey_recruit_talk.asp.

Yes, current concerns about job stability and security make some of us question the appropriateness of encouraging others to a ministry where jobs have diminished. However, we know, given the age of our membership, that we will need qualified, certified chaplains.

I want to emphasize here that we realize that getting new members is not a guarantee of NACC's solvency; rather, it is imperative in order to maintain a Catholic presence in our ministry settings after we have retired.

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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Get in on NACC's elevator talk

**By Sr. Barbara Brumleve,
SSND, Ph. D.
Board Chair**

When the Board of Directors met this fall, a major part of the agenda was identifying priorities for 2009-2010. What is the 20% of our NACC activities that should get 80% of time and energy from the executive director, staff and board? After considering 2.5 years' implementation of Vision and Action (the five-year strategic plan) and the reflections of the executive director, board members, and Vision and Action participants, the board identified five priorities for NACC in the next 12 months.

First is the current and future financial health of NACC. You are probably not surprised, because in our homes and ministry settings we have all taken long looks at income and expenses. The NACC is no different. Our largest sources of income are membership fees, certification and renewal of certification fees, and CPE unit registrations.

We don't want to keep raising those. We continue to study how we can reduce expenses. For example, if you are receiving *Vision* electronically you are contributing to expense reduction. If you do not currently have an e-mail address on file with NACC, you could help reduce NACC expenses by getting and sending your e-mail address. (Your action would also speed your communications from the NACC.)

Second priority is to increase the number of NACC members in all categories. The NACC is a membership organization, so renewal of membership is critical to the organization. Each of the past five years, the NACC has lost approximately 150 members, mostly through retirement. How can you

participate in this priority? Re-read the categories of membership available on the NACC website.

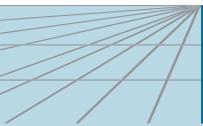
Whom can you invite to become a member? Colleagues? Persons enrolled in ministry formation programs or schools of theology? Parish nurses? Stephen Ministers? Share the new NACC video or brochure. Share NACC Now and some of the resources on the NACC website. Remember the phrase used by some of our brothers and sisters: Each one reach one.

Third priority is to further develop the NACC's relationship with the Catholic Church. Through the action of Bishop Calvo, our episcopal liaison, the NACC Episcopal Advisory Council now has a representative from each of the country's regions. In early November David Lichter will be meeting with the Episcopal Advisory Council. David is also taking the leadership with several other church-related matters that will serve the membership.

The last two priorities are more process-related, how we want NACC to function. The first process priority is to work collaboratively with other related organizations. The focus in this priority is on collaboration: to support other organizations; to work together and thereby strengthen the collective impact, and to avoid duplication. Topping the list of

Re-read the categories of membership available on the NACC website. Whom can you invite to become a member? Colleagues? Persons enrolled in ministry formation programs or schools of theology? Parish nurses? Stephen Ministers?

See Elevator Talk on page 4.



On Leadership

“The plethora of contemporary writing and research on leadership is quite consoling. We can learn much from the new insights on leadership, some coming from unlikely sources. For example, Margaret Wheatley, in “Leadership, The New Science,” applies findings of science, namely quantum mechanics, chaos, and fractal theory, to the ambiguity and the complexity of situations which leaders face. Overwhelming amounts of unrelated information produce chaos; however, the relationship of all this information creates a new synergistic energy out of the chaos. Quantum physics posits that relationships, not things, are the basic building blocks of matter. Physicists have discovered that chaos always conforms to a boundary within which information interacts as the primal, creative force. Systems fall apart by design so they can renew themselves according to an invisible organizing purpose. The disequilibrium of chaos creates new possibilities for evolutionary growth. God truly does hover over the chaos!”

— *Andrée Fries, CPPS, “Transformative Leadership: Key to Viability”*

(This quotation corner focusing on leadership is included in *Vision* upon the recommendation of the Pastoral Care Summit Care Services Task Force.)

Elevator Talk

Continued from page 3

related organizations would be the Spiritual Care Collaborative (SCC) with its member organizations (AAPC, APC, ACPE, CAPPE, and NAJC) and Catholic Health Association (CHA). In addition, NACC has existing partnerships with a number of organizations and common interests with others.

The second process-related priority is to move the leadership of NACC activities wherever possible to groups/states/areas of the country or to individuals. This priority is about subsidiarity and delegation. It’s also about freeing up the executive director and national staff to focus on tasks that they need to do. The priority builds on the current involvement of many NACC members in various activities. The process implements the Whitehead four-step model of leadership: do the task yourself, find someone else to work with you on the task, let the other person take the lead on the task but help him or her, and have the other person take leadership of the task.

The five priorities indicated above are NACC’s “elevator talk” that any one of us can give between two (or at least three) floors. How can you contribute to each priority? What feedback and ideas do you have for implementing these five?

Challenges

Continued from page 2

What a shame and tragedy if we have not done what we could to ensure that someone as qualified, even better qualified, than us will be ready to work with us and take our places! We are committed to continue to work to strengthen the professional attractiveness of this ministry (a recognized profession alongside other professions with commensurate compensation, etc.) through our collaborative work with our SCC colleagues. In turn, please be committed to confidently tell your ministry story. As Barbara Brumleve counseled in her article, “Each one reach one!”

Our NACC Annual Appeal

Last fall, NACC set a goal for the Annual Appeal, \$35,000. I was anxious given the state of the economy. I wondered, “The many financial and work stresses our members experience will make such a goal unreachable.” However, as of Oct.1, we reached our goal! More importantly, we have had a remarkable increase in the number of people giving over the past two years! In 2007, 240 gave; in 2008, 324 donated, and

as of Oct. 1, 449 have given! THANK YOU! This tremendous increase in the number of members giving is the biggest “gift” to the NACC. Each and every gift has been a blessing to us.

As I stressed in the request letters, your gifts this year provide us the ability to support more and more education offerings at low costs so greater numbers of members can access programs. Also the higher percentage of members donating signals to anyone not a member who is thinking about supporting the NACC that our members believe in what we are doing. I did receive some letters and e-mails from members who let me know about their inability to give or their disturbance in being asked again. Our hearts go out to all members who are experiencing financial constraints. And for those who were upset with my asking again, I am sorry. I did it for the NACC and its future. I will ask again on your behalf. If you would like to make your first or second gift before the end of the year, we welcome it. I also will ask the NACC Board of Directors to use any gifts received in October through December as scholarship money for our 2010 National Conference March 20-23. We will be good stewards. I promise.

Please let me know your thoughts and comments.

Keynoters

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as a composer of liturgical music and the author of "On Eagles' Wings." He currently serves as an associate professor at the University of St. Thomas in St. Paul, MN, where he teaches courses in Catholic culture and liturgy. In addition to his teaching, Rev. Joncas has spoken and written extensively on spirituality, liturgy, culture and justice.

His life story took an unexpected turn during Holy Week of 2003 when he was suddenly struck down by Guillain-Barré Syndrome. Coming close to death he spent months in the hospital and then outpatient rehabilitation recovering the use of his arms and legs. Rev. Joncas said later that this experience opened his eyes to the experiences of the sick, as well as his dependence on God and others. "I think I have a deeper appreciation for what it means to live "on the other side" of death.... I now live with a profound sense of just how deeply I'm loved, both by God and by my family and friends, and I really believe now that that love conquers death." After his recovery, Rev. Joncas experienced a new surge of musical creativity that gave birth to his CD titled "In the Sight of the Angels."

Those present at the 2008 NACC Conference in Indianapolis undoubtedly remember the unplanned "keynote address" Ira Byock, M.D., gave as part of the ceremony when he received the Outstanding Colleague Award. In his acceptance address he spoke passionately of the importance of spiritual care and urged chaplains to never ask permission for our ministry. In Minneapolis, Dr. Byock will speak to "Professional Change and Promise."

Dr. Byock is director of palliative medicine at Dartmouth-Hitchcock Medical Center in Lebanon, NH, and a professor at Dartmouth Medical School. He has been involved in hospice and palliative care for many years, and has written and lectured widely on these subjects. Among books he has written are "Dying Well: Peace and Possibilities at the End of Life" (1997), "A Few Months to Live: Different Paths to Life's End" (co-authored with Jana Staton and Roger Shuy, 2001), and "The Four Things That Matter Most: A Book about Living" (2004).

Asked about his experience with chaplains and his view of their place on the medical team, Dr. Byock pointed to the work of Chaplain Linda Piotrowski on his palliative care team. "She truly sees herself as a clinician. She is as involved in the care of the patients as much as anyone on the team."

M. Shawn Copeland, Ph.D., is an associate professor at Boston College, where she teaches in the areas of political

theology as well as African and African-derived religious and cultural experience and African-American intellectual history. Ms. Copeland is especially interested in Christian social praxis: how are we as Christians responding to the needs of our time? She will speak in St. Paul on the subject of "Ecclesial Change and Promise."

Ms. Copeland, who counts many chaplains among her friends and colleagues, said she has learned much from them. "One thing that has always struck me about chaplains is that they operate continuously in the midst of change.... Among the challenges they face is how to interpret the cultural context while maintaining the connection with continuity, both within our culture and the church."

Sr. María Elena González, RSM, will speak to the final topic of "Global Change and Promise." She has the distinction of having been the first woman president of the Mexican American Cultural Center — a national Catholic center in Texas — to being one of the first women to be named as diocesan chancellor. In November 2007, the United States Conference of Catholic Bishops honored her with the Archbishop Patrick F. Flores Award Medal for

Leadership in Hispanic Ministry. She served as a consultant to the U.S. bishops' Committee for Hispanic Affairs from 1994-2002; was a member of the bishops' Subcommittee for the National Encuentro 2000, and was named to the U.S. Census Bureau Race and Ethnicity Committee for the 2000 Census.

Sister González always has considered herself an educator at heart, devoted to the empowerment of the poor and oppressed. Throughout the United States and abroad, Sister González is known for her presentations on culture and its impact on power and communication. About the importance of understanding the role of cultural awareness, she said, "Each of us carries within us a cultural iceberg. We are only aware of the tip. The things underneath only come out under stress."

Sister González received her bachelor of arts degree in education from Webster University in St. Louis, MO, and her master's in theology from St. Mary's University in San Antonio, TX. She holds certificates of theological studies from the Institute of Spirituality and Worship, Jesuit School of Theology, Berkeley, CA, a certificate on spiritual direction from Mercy Center in Burlingame, CA, and a certificate in spiritual direction from the Hesychia Program at the Redemptorist Center in Tucson, AZ.

We are pleased to have such a powerful line-up of keynote speakers to set the stage for our workshops, prayer, and conversations with each other. I hope you will make the trip to St. Paul, where I think you will find that the warmth of the people more than makes up for the spring temperatures outside.

Robert Barnes is staff chaplain at St. Mary's Medical Center in Duluth, MN.





Ethics

Continued from page 1

utilize resources that are unit based,¹¹⁻¹³ staff of the Charles Warren Fairbanks Center for Medical Ethics at Clarian Health created a new program in 2005 known as Unit Based Ethics Conversations (UBECs) in response to an identified need for meaningful conversation among staff nurses about the ethical issues they face in routine clinical practice that are felt to contribute to moral distress. The mission of UBECs is to create an environment with morally open space

where reflective dialogue and sharing experiential narratives are encouraged. To date, our group has facilitated more than 200 such UBECs on more than 20 different clinical units. Here we report our initial experiences with the development of the program and describe what we have learned to date about the impact of these discussions.

Techniques of facilitation

The goal of the UBEC program has been to encourage open and honest conversation about the ethical issues bedside nursing staff face in the ordinary course of caring for patients. Conversations are organized without a specific agenda and with no didactic goals. Facilitators begin each UBEC with a prompting statement such as "Does anyone have a case he/she would like to discuss?" or "Have any ethical issues arisen since the last time we met?" In some sessions, participants have agreed ahead of time on the case to present for discussion. In others, a specific case is mentioned; frequently, several participants have cared for the patient involved in the case. In some sessions, issues that affect the unit's practice across cases serve as the basis for the conversation.

Facilitators use standard techniques of group facilitation including active and reflective listening and validation of feelings.¹⁴ Frequently, participants find it difficult to articulate the exact nature of the problem at the heart of

nurses' distress, so facilitators may use focused questions to probe carefully for the essential aspects of the problem. Not uncommonly, we have found that it requires extensive probing and exploration to help participants uncover and put into words the issues that actually underlie their distress.

During the meetings, we find it useful and instructive to summarize the issues under discussion using ethical terms for the issues that appear most important or troubling. For example, "It sounds like you were in conflict between your ethical obligation to act in the best interests of your patient and your professional duty to follow orders." We have found that once participating staff members feel comfortable in

this group environment and trust they are safe to speak their minds around the facilitators, there is free exchange of feelings, emotions, information, and insight. In rare instances, a case has led a staff member to become flooded with emotions and express reluctance to continue participation in UBECs. In such cases, our practice is to enlist the individualized support of the distressed employee's unit manager to ensure the individual receives adequate support and follow up.

Chaplains will readily recognize the skills required to facilitate these sessions. The skills are moderate to advanced listening and counseling skills applied within a group setting. Most certified chaplains, therefore, already possess the requisite skills. An additional requirement that a chaplain may or may not meet is moderate to advanced clinical ethics knowledge and practice.¹⁵ We believe that attending to both the emotional and ethical dimensions of nursing practice constitutes the effective synergy that addresses stress and increases awareness.

Stimulating discussion

The facilitators have found several techniques to be useful in stimulating productive conversation and reflection among the nursing staff participants.

1. **Clarifying details.** Assuring that the "whole story" is presented is an important aspect of all ethics case analysis. It is common that several participants are only partially informed about the details of the case under discussion and that such partial understandings contribute in important ways to feelings of distress and, in some cases, to judgments that do not follow logically from a deeper understanding of the facts.
2. **"Pushing" participants.** Gently "pushing" participants to reflect out loud and articulate the central ethical issues of each case under discussion leads to productive discussion.
3. **"Polling."** Stopping a case discussion at a controversial point and going around the room to poll participants for their opinions invites participants to consider on which side of an issue they find themselves at that moment and stimulates participation from all individuals present. The "answers" allow the group members to identify variations in an individual nurse's approach and learn from each other.
4. **Reflective and supportive statements.** Careful listening fosters an atmosphere of trust and mutual respect. Listening attentively to what a participant is saying and then reflectively summarizing the meaning of the comment back to the speaker demonstrates interest and respect. When there are disagreements among members over strongly held positions, we find it helpful to acknowledge that disagreements in conclusions can ethically derive from valid and deeply held beliefs.
5. **Resist answers and solutions.** One of the important lessons we have learned in facilitating UBECs over

Chaplains can advocate for unit based ethics conversations even when the chaplain is not a leader. Chaplains are often in positions to speak to hospital leadership about the needs of nurses and other professionals.

the past four years is that, as in all clinical ethics, we rarely find a tidy “answer” or a completely acceptable resolution to a given ethically-charged situation. So, more frequently than not, we end the UBECs not with “the right answer,” but with the sense that the conversation has “worked” because it led to clarity about the issues underlying the participants’ distress.

- 6 **Best practices.** The facilitators intentionally invite discussion of strategies for handling difficult situations. This technique of exploring what the participating nurses believe to be best practices in difficult situations leads to highly productive interactions in which novice and expert nurses share approaches and debate the merits of each approach.

Program evaluation

We conducted a formal evaluation of the UBEC program in early 2009. The evaluation included a survey of individuals who worked on nursing units that host UBECs and focus group discussions with individuals from those units who had actually attended a UBEC. Based on survey responses and attendance records from the UBECs, we estimate that at least 10% of nurses on each of these units have attended a UBEC. We had a 25% response rate to the surveys. All but three (2%) of respondents indicated they felt it was somewhat (30%) or very (68%) important to have an opportunity to discuss ethical issues encountered in clinical practice. The most often identified reasons for attending a UBEC were to participate in open discussion, voice concerns or to participate in a discussion of a particular patient. Some attendees expressed a desire to gain a better understanding of the issues and find answers to specific questions. Respondents who attended UBECs were 1.5 times more likely to have requested a formal ethics consultation in the past when compared to respondents who had not attended UBECs.

Survey Responses

Overall, the survey responses were positive. Eighty-eight percent of attendees who responded to this survey stated UBECs provided a safe environment to discuss morally troubling issues that arise during patient care. Eighty-six percent of attendees stated the UBEC helped them to address ethical issues they faced in their clinical practice, and 67% stated they felt better able to manage ethically challenging situations after attending UBECs. Four broad topics were typical elements of discussion at the UBEC: issues related to

informed consent, non-beneficial treatment, communication challenges, and tensions between nurses and physicians.

We believe UBECs may be an important step in the continued development of moral agency of participants by empowering them to take action as advocates for their patients even during ethically challenging situations and by providing an ongoing forum for engaging problems with the help of trained facilitators. We plan to take the lessons we have learned and will learn through more systematic evaluation and create a “train the trainer” program for UBEC facilitators so that the program can be exported and implemented by others.

We have learned several important lessons so far from this novel program.

1. Bedside nurses are hungry for opportunities to process the ethical challenges that affect their daily lives and are generally grateful that others recognize that their work includes substantial ethical dimensions.
2. Common ethical experiences cross cut units and practice areas of nursing: e.g. the problem of non-beneficial treatments, issues surrounding communication about difficult information, staking out territory as a patient advocate in a hierarchical system. There are no easy solutions to any of these problems, but the opportunity to share experiences and learn from others is valuable.
3. Training or deep experience in ethics on the part of the facilitator seems to be a vital component of successful

leadership of UBECs with bedside nursing staff. Many of the issues that cause nurses frustration are not, specifically, ethical issues but the facilitator’s acumen in helping participants to recognize and, indeed, to name and analyze those that are ethical issues is an important component of the program’s impact.

Opportunities for chaplains

Our experience suggests that unit based ethics conversations constitute an effective intervention for addressing the moral distress of bedside caregivers. Chaplains who wish to participate in leadership of these conversations should develop competencies in ethical assessment and group facilitation and deepen competencies in interpersonal engagement. In addition, chaplains should bring their awareness of the specific culture of the hospital and the more general culture of the community to bear since “the way things are” likely shapes – and may be the root cause of – the experienced distress.



The logo for 'ethics at work' features the word 'ethics' in a blue, lowercase, sans-serif font. The letter 'i' in 'ethics' is replaced by a white cross symbol. Below 'ethics' is the phrase 'at work' in a smaller, grey, lowercase, sans-serif font. The entire logo is set against a white background within a light blue rectangular frame.

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Ethics committee strong despite center's change from diocesan to for-profit

By Sr. Frances Smalkowski, CSFN, BCC

The Catholic identity of the Pope John Paul II Care and Rehabilitation Center in Danbury, CT, remains intact despite the sale of the healthcare center twice in two years after being diocesan for 23 years.

Strong connections with the Bridgeport Diocese have helped the center's Ethics Committee, which I have chaired or co-chaired since it was begun 23 years ago, to maintain its Catholic focus.

It was 25 years ago when our long-term healthcare center, now with a 141-bed capacity, admitted its first resident — Sept. 21, 1984, to be exact. As a matter of fact, I was the admitting nurse.

About a year later, I began my ministry in the pastoral care department, started an expanded CPE program, and became a certified chaplain. Once things got somewhat organized, in January 1986, our first administrator called a meeting of our first ethics committee. I served as its first chairperson and subsequently as that or co-chair. It was and still is a real joy for me participating in the committee. Meetings were and still are held quarterly for one hour. Also, of course, there were and continue to be emergency consultation meetings held as requested.

The most difficult part for me through these years has been the facilitation of ethical policy formation. Each policy went through a rigorous round of being generated and tweaked, which was no small undertaking. It involved the input of all committee members; department heads and other staff; the bishop who gave final approval (I worked with three); and the board of directors. By the way, all these policies were reviewed each year and revised as needed.

The most exciting life-giving part for me, and I feel probably for most of our members, was and is that of the case presentations — current, prospective or retrospective. Perhaps a fair indicator of how compelling was this aspect is that

three of the original committee members still participate.

The constituency of the committee has been essentially the same throughout the years. These include: administrator, attorney, director of pastoral care, priest chaplain, director of nursing, director of social services, medical director, board member and ethicist. Membership was and is appointed and approved annually by the bishop.

As time went on, the major issues discussed generally revolved around end-of-life decisions and those surrounding the concerns of assisted suicide. Of late, as can be expected, we have had to be more involved in situations related to persons in a persistent vegetative state. That each be provided with hydration and nutrition if there is not a terminal diagnosis needs to be regularly overseen by our committee. This necessitates the ongoing

review of advance directives on admission and otherwise; updating the education of all committee members in their understanding of medical conditions such as end-stage Alzheimer's disease vs. early stage, and keeping abreast of the "Ethical and Religious Directives for Catholic Health Care Services" as they

get revised.

On Nov. 20, 2006, our Bishop William E. Lori, S.T.D., notified the people of the Diocese of Bridgeport that there was a need to sell our three diocesan nursing homes. These three buildings were sold to a for-profit corporation that within the year was again sold to another for-profit corporation. In his own words, he reassured that: "for each facility we continue to have beautiful chapels in which to worship and have daily Mass and excellent pastoral care teams to share the faith with all the residents...." Furthermore, he stated that in this sale, "I did so with the bedrock condition that we would continue to have Catholic ethics and pastoral care as the foundation of life in each facility. To that end, we constructed the enclosed Catholic covenant, which continues no matter who actually owns the buildings and the business as long as there are residents. We retain possession of the land as stated in the sale documents...."

Was this a difficult transition? "Definitely" is an understatement from my perspective. However, the weight of this experience was lightened by the gracious assistance of an interim director of pastoral care who was a direct connection with the diocesan Catholic Center. Numerous transitions of administrators and staff further complicated the process as one might expect.

On Sept. 14, 2009, at our quarterly ethics committee meeting we experienced something akin to a "spa" ethics

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The most difficult part for me through these years has been the facilitation of ethical policy formation. Each policy went through a rigorous round of being generated and tweaked, which was no small undertaking. It involved the input of all committee members; department heads and other staff; the bishop who gave final approval (I worked with three); and the board of directors.

Ethics

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In those institutions where chaplains are expected to be a source of moral authority and ethical wisdom, participation as a leader in a unit based ethics conversation may require a reshaping of staff (and chaplain) expectations. Leaders in such conversations must be able to bracket the “oughts” that accrue to their position sufficiently that participants can explore a variety of possible answers to situations that seldom admit to clear answers. In addition, UBEC leaders must be able to hear and see critical problems without compulsion to become “fixers.” Issues for follow-up may be clear to a UBEC leader, yet great care must be exercised in that follow-up.

Finally, chaplains can advocate for unit based ethics conversations even when the chaplain is not a leader. Chaplains are often in positions to speak to hospital leadership about the needs of nurses and other professionals.

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meeting. (I read an article about 20 years ago that mentioned the concept of taking a “spa” in counseling, and having it mean sort of looking back at the gains made in a real “feeling good” kind of way. I thought that our last ethics meeting lent itself to doing that.) The simple celebration consisted of looking back on the fact that we are now basically on “the same page” we were before the transitions. This means that there is a mutual understanding of our current Catholic medical ethics requirements; that there is clarity about what is needed for all to know when a resident is in end-stage of life, and that there is ongoing communication about residents’ conditions and when there is a need for ethics discussions before there are complicating factors.

At present, our diocesan ethics committee, comprising

representatives from all three nursing homes, that is, directors of pastoral care, their priest chaplains and ethics consultants, has been meeting regularly with the bishop and other diocesan personnel. In the past, members met to discuss and work through the transitioning challenges that could arise and affect the Catholic Covenant. Their current role has been to complete the “Ethics Committee and Pastoral Care Department Policies and Procedures Manual.” It is near completion, and after meetings with corporate members, this manual will serve as a basis for new admissions’ information as well for mandatory in-service education on the computer corporate university. For me it is all very exciting!

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

Chaplain's role on ethics committee respected by peers

By Gary Weisbrich

At Avera McKennan, a 500-bed hospital with a 16-bed hospice cottage and a 110-bed behavioral health center in Sioux Falls, SD, where I am a chaplain, my impact on the hospital ethics committee is taken seriously and highly regarded. In turn, the work of our ethics committee has had a major impact on our hospital and with our staff.

This is my seventh year as a chaplain, and I am now going on my third year as a member of our hospital ethics committee. I recall my first meeting and how enthusiastic I was and yet anxious at the same time. I received great advice once from a priest friend: "Listen, learn about your new role and listen some more...."

Learn from those around you and you will gain confidence, it is what naturally follows."

A few months on the ethics committee and I started to feel more at ease and met some wonderful people, dedicated and genuinely concerned about the welfare of others and the hospital.

When I began, our ethics committee focused on some very important questions: What does it mean to be an ethics committee and what are our goals? What are some objectives to reaching those goals? This was a very helpful starting point. Our committee would also critique case studies in order to improve our critical thinking and to help collaborate as a team. I realized quickly that my input as a chaplain was taken very seriously and highly regarded. I have a unique role as a chaplain because I am on the front lines everyday, listening to the patients, families and the medical staff. As a chaplain, I cover all units in the hospital and have a good feel

for what is going on.

Our committee receives consults from physicians, primary care providers, nurses, chaplains, social workers as well as patients and families. We call these consults "special ethics committees" that are sometimes scheduled on very short notice in order to meet the need before a particular intervention or procedure is done. I realized very quickly that we are not there to make a decision one way or the other in regard to a situation, rather, we are there to provide our best professional advice and counsel. We collaborate and work as a team.

Our committee deals with a variety of ethical issues including some of the controversial issues such as nutrition and hydration. However, we also provide guidance to the medical staff in order to help them deal with patients and families faced with difficult choices. We also provide a place for physicians to bring cases that are difficult for them as well as consults from nurses that are experiencing so-called moral distress.

I will give some general examples of the issues our committee has dealt with the past three years.

- ▼ A physician has concern continuing chemotherapy treatments for a mother who was recently diagnosed with an aggressive leukemia and the positive test for pregnancy did not occur until after the first round of chemo.

- ▼ A young pediatric trauma patient will not survive; the family decides for comfort care but their child continues to survive more than three weeks. Are we doing the right or best thing for the baby and family?

- ▼ A patient is concerned that if he or she is given too much medication (sedation) for pain that he or she will not be following the church's guidelines and will not experience redemptive suffering.

- ▼ A patient visiting from outside the country is ventilator dependent, but stable. What are our resources and responsibility to help return the patient to his/her home country to be with his/her family, even though there is far less medical technology to treat the person effectively in that home country.

- ▼ An undocumented resident comes in for an acute attack, then the test shows that there is an aggressive illness, potentially terminal without treatment. However, the undocumented resident will be deported back to his/her country. What is our moral responsibility?

- ▼ A patient and his or her family want a procedure that several doctors have said will not be of any value to the patient.

- ▼ A doctor wants another procedure that in the eyes of the nurses will cause more burden and not offer any more medical hope of recovery.

- ▼ A young woman finds out that the baby she is carrying has a life threatening illness (Trisomy 18 and or Potter's syndrome) and that the baby is considered to not be "compatible with life." Our pediatrician consults our committee for guidance.

- ▼ A patient is depressed and does not want to eat. He has no family or relatives but was assessed and is competent.

These are just a few, cases that we have had and obviously there is much more information than what I just listed; however, I think that it shows the uniqueness of each situation and that each case needs to be looked at individually. "The Ethical and Religious Directives for Catholic Health Care Services" (ERDs) are more pastoral than I ever realized. They give the medical staff as well as the family and patient peace of mind when dealing with these important concrete concerns. Further, they provide our committee with a consistent and authentic framework when dealing with tough ethical situations.

I believe that our ethics committee is influential inside and throughout our hospital system. I have seen with my own eyes the relief that a physician had when we deliberated and offered

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I have a unique role as a chaplain because I am on the front lines everyday, listening to the patients, families and the medical staff. As a chaplain, I cover all units in the hospital and have a good feel for what is going on.

Chaplains well-equipped to join in ethics forums

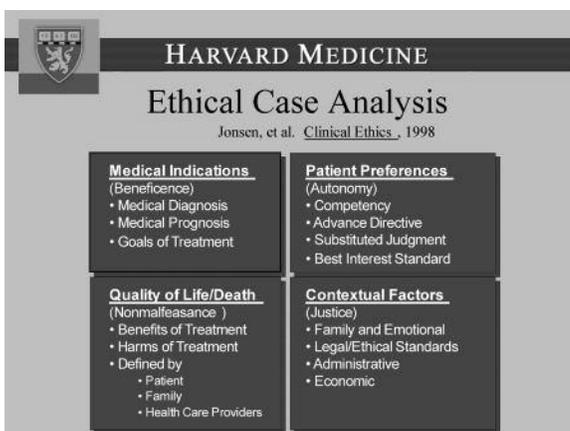
Case of Catholic monk illustrates weight of wishes of healthcare proxy

By Georgia Gojmerac-Leiner, BCC

The presence of a board certified chaplain is vital on an ethics panel, committee, or a consultation team within the healthcare setting, given that culture, religion and spirituality play key roles in a person's life. When we consider the formation of a chaplain, we see the rigors of training in the areas of process and interpersonal skills, listening presence, compassion and self-awareness. Nonjudgmental attitudes and openness to belief systems, patience, and being responsive to the other in supportive ways are the ingredients of the chaplain formation. When a chaplain analyzes a verbatim she or he has written, for instance, she pans not only for the gold of theology and spirituality but also looks at the sociological or life-circumstances of the person and the psychological, emotional, spiritual and ethical dimensions of the case. The chaplain also analyzes her or his own self in relation to the case. The chaplain is trained to be aware of personal history and of the assumptions, feelings and prejudices that may be brought to the situation. Also, chaplains, as most people, do not like conflicts so this is another area where they may be helpful.

Given this extensive and deep training of a chaplain in self-knowledge and respect for the other, she or he is well equipped to come to the table of ethics forums of any type. The best practices of a chaplain's training through the CPE (Clinical Pastoral Education) model should also include the teaching of ethical assessment skills. In our society, the core ethical values are autonomy, beneficence, non-maleficance and justice. Martha Jurchak, RN, PhD, director of the Ethics Service at the Brigham and Women's Hospital in Boston, framed these core values well in her slide presentation at an Ethics Conference at the Newton-Wellesley Hospital in November 2008. (See Figure 1.)

Figure 1



A familiarity with these basic principles outlined in Figure 1 is needed to determine whether there is an ethical conflict or dilemma present in particular cases we may encounter. As Catholic chaplains we may also ask ourselves how these societal or asecular core ethical values line up with the "Ethical and Religious Directives for Catholic Health Care Services."

Value for value, autonomy lines up well with Directive 59, which states, "The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching." Examples of contrariness to Catholic teaching would be assisted suicide, euthanasia and abortion.

The values of beneficence or the benefit of treatment to the person and non-maleficance or "do no harm," line up well with the Directives 56 and 57, which outline the "moral obligation to use ordinary or proportionate means of preserving (one's) life," (56) and that a "person may forgo extraordinary or disproportionate means of preserving life." (57). "Justice" is seen as caring for the person appropriately as defined by the Directives. Not only the sick person but family and society must be taken into consideration in Directive 57, which addresses a situation in which an illness places "excessive burden, or impose[s] excessive expense on the family or the community." The task of defining what is meant by "excessive burden" and "excessive expense" is beyond the scope of this article. However, one example may be a futile care situation in which medical science has done all it can for a person and yet a family member insists on ongoing aggressive treatment. While medical and technological treatments no longer make sense, prayer and support are never ending. The directives do not direct us to offer false hope or to pray for a miracle. Though miracles do happen, they happen beyond our comprehension. When God's will is invoked we must compassionately and professionally guide a person to

When a chaplain analyzes a verbatim she or he has written, for instance, she pans not only for the gold of theology and spirituality but also looks at the sociological or life-circumstances of the person and the psychological, emotional, spiritual and ethical dimensions of the case.

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reflect on whether the person's will is aligned with God's will.

The "Ethical and Religious Directives for Catholic Health Care Services" guidelines go a long way to address concerns beyond the core ethical values used by the secular or societal ethics services. They eloquently address the importance of treating a person's pain in Directive 61. The case which is presented below will illustrate a dilemma dealing with analgesia, or a state of not feeling pain, when health proxies disagree with caregivers. This case was brought to the Emerson Hospital Ethics Committee by its chair, David Green, MD. The case originated at a local nursing home where a religious brother was being cared for. First, a brief description of the Hospital's Ethics Committee.

The Ethics Committee at Emerson Hospital is composed of physicians, nurses, an administrator, a chaplain, a social worker and a representative from the community who is also a member of the hospital board. The Ethics Rounds meets weekly, except for in the summer, and it is open to every employee at the hospital and clergy from the community. The makeup of the attendees may vary from week to week, but members of the core committee are always present. All members of the ethics committee have a role in discussing this case as it covers many disciplines. The chair, Dr. Green, has seen to it that members receive the necessary education in order to qualify to serve on the committee. Members are required to regularly attend the hospital's critical care rounds and be active participants in discussions of cases. Dr. Green provides educational reading materials from

professional journals which are read and discussed by the committee members and guest attendees. Many members also attend ethics workshops presentations. The chaplain is an active participant in the committee and her role is admirably respected by the chair. The chaplain is routinely invited to serve on small ethics consultation teams and participates in the documentation of case consultations. The chaplain sees her role as similar to those of others, who need to have skills in ethical assessment, discussion, recommendations, and so on. The core competencies and knowledge required for ethics consultations as outlined by Ms. Jurchak are in Figures 2 & 3.

No matter how skillful and wise the recommendations of an ethics consult may be, the patient or his or her healthcare proxy have to be on board with the recommendations before they can be implemented.

Figure 2

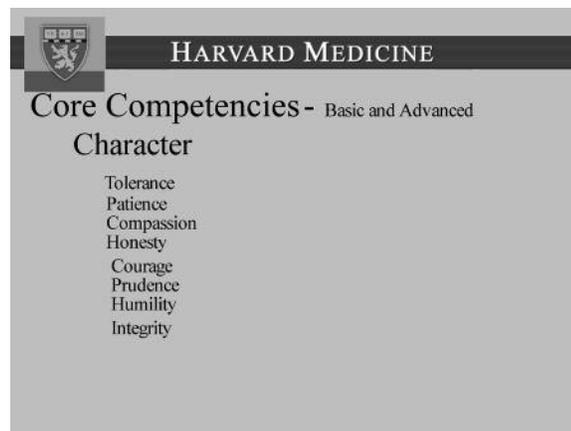
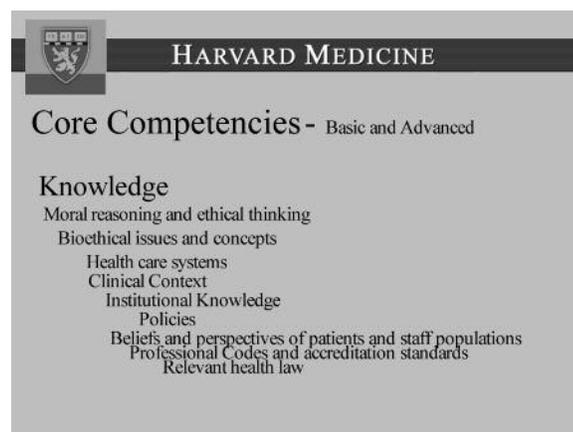


Figure 3



Although it is true that in many respects the role of the chaplain overlaps with that of the other members of the interdisciplinary teams, she is likely to be the only one who carries the "Religious Directives" in her pocket. Her advanced degree in theology, pastoral theology, spirituality and related fields of social sciences and training in the clinical settings make her especially prepared to be attuned to listening for and identifying religious, spiritual and cultural dimensions of the human person. Just as the physician is the most qualified in medical diagnosis the chaplain is qualified to make the spiritual/ cultural diagnosis. The chaplain's role in making recommendations for treatment is, as everyone else's, solely advisory.

The case of a Catholic monk

What follows is the case presentation quoted exactly as presented to the Ethics Committee except that the names of persons and institutions and exact dates have been further de-identified.

The resident was an 81-year-old Catholic monk who was admitted to (a nursing facility from a Boston rehab). He suffered a stroke ... while traveling in New Orleans. He was in the hospital and rehab there (for a number of months) until he transferred to the Boston rehab. His diagnosis included: intracerebral hemorrhage, peg tube, HTN, afib, pacemaker, depression and dementia.

Resident was born in Boston, MA. He had one brother and one sister. He attended (a local prestigious university) and had a degree in music. He worked as an engineer for the state for 25 years. He had been a Catholic monk for 25 years. He was never married and had no children. While his family was involved, the fathers at the Abbey were his HCP (health care proxies) and responsible for all medical decisions. He was described by those who knew him as a very active person; he loved music and loved the outdoors.

When he was first admitted he was alert, oriented x3, confused at times. He was receiving nutrition through a peg tube as well as eating some orally. His functional ability was very limited from the stroke. He worked with physical therapy, occupational therapy and speech therapy. He made slow progress with small gains. He eventually was off the artificial nutrition but still remained dependent on staff for almost all aspects of his care. He was very depressed when he was first admitted and this did not improve during the course of his stay with us. He would make negative statements and often express a desire to die. He could not accept the limitations that the stroke had caused him, would express that he felt we had "given up on him" and that we had left him "high and dry" when he was not receiving therapy.

The fathers and brothers from the abbey were very supportive and involved. They really wanted to care for the resident at the abbey, as they had done for other brothers for many years of the other brothers. However, he required too much care for them and they were never able to take him home. When he was more stable they were able to take him to the abbey for short visits. Someone from the abbey visited daily.

The resident was fairly stable for the first nine months or so, although he was on and off the artificial feeding. He was hospitalized (a year later) with pneumonia and demonstrated a significant decline upon his return to our facility. He continued to be very depressed and would often request to die. His code status was still full code at that time. The team brought up the topic of code status and the possibility of hospice in a care plan meeting in May '05. The fathers seemed to listen about the issues with code status but were adamant that they did not want hospice. The abbot stated he felt people were put on hospice and left to die. He was concerned care would decline. Nothing that was said would change his opinion.

Since that first hospitalization in (the spring), the resident continued to have recurrent bouts with pneumonia

and his condition continued to decline. He eventually had to be back on 24-hour tube feeding and could not eat meals. His code status was eventually changed to DNR/DNH but he continued to be treated aggressively (IV abx, IV fluids) until he passed away in November '05.

The question posed by the staff who worked with the brother was, "How do you provide comfort if healthcare proxy disagrees with analgesic?" The monks felt that pain brings one closer to God.

Case Analysis

This is a case of a religious brother whose already complex medical situation is made more difficult by his clinical depression and dementia. It is possible that if he were not depressed he would not be asking to die. Due to dementia he no longer speaks for himself but others make decisions on his behalf. The perception of his caregivers is that "pain brings one closer to God." This may be true and we know that saints and martyrs welcomed suffering in order to identify more closely with God in the person of Jesus, who suffered and died for them. They welcomed the suffering out of gratitude for what Jesus did for them, declaring that no amount of their suffering could compare with the magnitude of what Jesus suffered for them. Saint Theresa of Lisieux, from as recently as the 19th century is an example of such a martyr/saint. "The Little Flower," as she is known, who died of tuberculosis at age 24, said,

This evening when you (Mother Agnes) told me I still had a month or so according to Dr. Cornière's opinion, I was absolutely amazed. It is so different from yesterday when he said that I should be anointed that very day! All this, however, leaves me in a deep tranquility. I do not desire to die more than to live; it is what He (God) does that I love. (St. Therese of Lisieux, Story of a Soul, ICS Publications, 1996, p 264)

It is clear from this that what makes one close to God is their faith in God, and aligning one's will with God's. But this is rational thinking and there is no indication that the sick brother or his HCP or healthcare proxy could think rationally. It was not clear that it was the sick brother's intention to grow closer to God through pain and depression. This is what the HCP thought and his wishes had to be upheld most likely because the caregivers respected the patient's autonomy through his healthcare proxy.

However, Directive 61 of the "Ethical and Religious Directives for Catholic Health Care Services" states that, "Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die." It is only in the case of the "Patients experiencing suffering that cannot be alleviated (that they) should be helped to appreciate the Christian understanding of redemptive suffering." This chaplain

Q&A with Larry Ehren, MDiv, MBA, BCC

By Laurie Hansen Cardona
Vision editor



Larry Ehren, director of mission services at St. Jude Medical Center in Fullerton, CA, part of St. Joseph Health System, is one of 50 Ethics ACES at St. Jude's. He has been involved in Catholic healthcare ministry for more than 15 years, most of those years as a certified chaplain.

Mr. Ehren has degrees from St. Louis University in philosophy and psychology, a master of divinity degree from Weston Jesuit School of Theology (now Boston College Graduate School of Theology and Ministry) and an MBA from Rockhurst University in Kansas City, MO.

He did his clinical training in chaplaincy at California Pacific Medical Center in San Francisco. Before embarking on a career in healthcare ministry, he worked 10 years on a bishop's staff focusing on ministry training and development. Previously, he was a member of the Jesuits for 12 years.

Mr. Ehren is currently a member of the NACC Metrics Task Force that developed out of the 2007 CHA-NACC Pastoral Care Summit. He agreed to share with *Vision* readers his experience as an Ethics ACE and talk about the innovative program.

Q How did the Ethics ACES first come to be at St. Joseph Health System?

A The Ethics ACE approach was developed by Kevin Murphy, Ph.D., who serves as the system ethicist of our health ministry. Kevin, who was a chaplain in Canada before going to graduate school to complete his doctorate in medical ethics, noticed that there was a need for front-line staff to be educated and empowered to notice and be an initial resource for medical ethical issues. The "ACE" acronym comes from a longer title – "Assisting Colleagues with Ethics." This approach began systemwide in 2004.

Q What do the Ethics ACES aim to do, and please describe the Ready Reference Grid used by the ACES?

A There are six purposes of the Ethics ACES:

First, to receive questions on their own clinical units or departments regarding medical ethics concerns. Second, to support colleagues experiencing moral distress arising from unresolved ethical issues. Third, to familiarize colleagues with learning resources available to clarify ethical concerns. And fourth is to help name the ethical issue at stake in accordance with the Ready Reference Grid.

This Ready Reference Grid is a unique grid developed by Johnny Cox, RN, Ph.D., an ethicist who worked previously with our system. Based on clinical experience it lists the most common medical ethics issues that occur in acute medical settings. It then links each issue to the relevant medical center policy, the relevant ERD, and the relevant state law that deals with this issue. It then

points to the main ethical issue involved (autonomy, beneficence, etc.). Suggested actions are then linked to the issue.

Continuing with the last two purposes of the ACES, fifth is to point to the next step in medical center protocols for resolving ethical concerns, and sixth, is to convey patterns of ethics concern to the local medical center's Ethics Resource Service/Committee – also called the Ethics Consultation Team.

Ethics ACES are told not to solve complex ethical dilemmas themselves or take over their colleagues' responsibility to take the next step in the protocol for resolving ethical issues.

Q What are the strengths of the program in your setting? What have been found to be the weaknesses in your setting?

A Ethics ACES varies in the 14 health ministries that make up our health system.

At St. Jude, we have more than 50 trained ACES. They are intensive care nurses, chaplains, clinical social workers and case managers. We have monthly continuing development education so that they may grow in their role. We recently added a medical ethics module to our electronic Incident Reporting System so that medical ethical situations could be easily reported and tracked. Those are the strengths. This is an innovative and creative development as a practical resource for clinical ethics.

As with all visionary development, there are weaknesses. Many of the nursing ACES are so busy with their primary clinical responsibilities that they cannot function in this capacity. As at all medical centers, some situations are not identified early on and develop more complexity, mainly due to communications issues. The electronic reporting system is not used consistently or frequently to document our ethical issues and help us to identify trends.

Q How do you see this approach developing in the St. Joseph Health System?

A When the approach varies in each of our local ministry settings, some general hopes would be:

- ▼ To train and use our electronic Incident Reporting System consistently. This would allow for a very effective medical ethics issue tracking that would be a wonderful resource to determine possible system improvements, unit education, etc. The vision, taken directly from Quality Improvement processes, would be to improve the system of addressing/resolving ethical dilemmas vs. getting bogged down in particular ethics cases.

- ▼ To continue to recruit, develop and support appropriate front-line staff that can serve as Ethics ACES.

- ▼ To explore more concretely how ACES could assist with the very real experience of moral distress that occurs with bedside professionals – especially in Intensive Care Units, where they are often asked to continue to give, in their eyes, non-beneficial or futile care.

Q How did chaplains come to be included among the Ethics ACES? Is it a good fit for chaplains?

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counsel. He was not left to make a critical decision alone. Each meeting begins with a prayer and supplication for guidance and direction as we discuss the situation. This gives me peace of mind knowing we do not go at it alone, either.

We conducted a survey this past year to get a feel for how our staff viewed the ethics committee. Questions that came back to us included: "What is an ethical situation?" "How do I bring it to the ethics committee?" "What will the doctor think if I, a nurse, ask for a consult on one of her patients?" "I had an ethics

course while in Nursing School, but never had a course that dealt specifically with the Ethical and Religious Directives." These honest and sincere questions are a reminder that we as a committee have work to do to provide continued education to our nursing staff and medical teams.

In a hospital this size, new medical staff enter daily and there is a need for ongoing information about the role of the ethics committee. A case that goes to the ethics committee is not a bad thing, where something went wrong; rather, it is a good thing. It means the system is working!

Gary Weisbrich is a chaplain at Avera McKennan Hospital and University Health Center in Sioux Falls, SD.

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author did not participate in the original ethics discussion of this case but, if there, would have cited the above Directive 61.

Some questions that remain are:

- ▼ Was the health care proxy convinced that his sick brother's pain could not be alleviated?
- ▼ Was he aware that it is religiously/ethically sanctioned to treat a person's pain?
- ▼ Was there evidence that the sick brother would want the pain even if it could be alleviated?
- ▼ Why did the brothers not follow the "pure" example of the martyrs, who did not want to die more than to live, and conversely, did not want to live more than die?
- ▼ Was it the caregivers' discomfort with their patient's crying in pain and wanting to die that was the problem?

Alex FM Cist, MD, chair of the Ethics Advisory Committee at the Spaulding Rehabilitation Hospital in Boston, MA, pointed out in her presentation on ethics at the Ethics Conference held at the Newton-Wellesley Hospital in November 2008 that, "there are psychological, emotional, social, spiritual, rational and irrational forces at work" in a person's mind in life and death decision-making. No matter how skillful and wise the recommendations of an ethics consult may be, the patient or his or her healthcare proxy have to be on board with the recommendations before they can be implemented. It can sometimes be a yearningly long and painful process for caregivers to witness a process of a person's dying, clearly without dignity, because those who have a role in their care cannot agree. Our prized autonomy is at a cost.

Georgia Gajmerac-Leiner is coordinator of pastoral care and chaplain at Emerson Hospital in Concord, MA. She is a student in the doctor of ministry program at Boston University School of Theology.

When I came to St. Jude two years ago, I was surprised to realize that the chaplain team was not involved in clinical ethics or advance healthcare planning. My experience was that chaplains were often key resources in these types of sensitive patient and family situations. Working with our Ethics Committee and the local coordinator of Ethics ACES, the entire chaplain team went through the training and began to participate in the monthly education/development sessions. There is little question in my mind that this is a good fit for chaplains, in combination with other front-line disciplines that interact with patients all the time.

Q How does your Ethics Committee interact with the Ethics ACES?

A The ACES are one of the primary sources for referrals and feedback to the Ethics Committee. ACES are accountable and supported by the committee.

Q Can you give an example of how an Ethics ACE is called into action?

A Recently we had a very sad and not uncommon situation in our Intensive Care Unit. An only adult son in his 50s was

convinced that his 95-year-old mother, despite a clearly declining clinical situation, wanted him to do everything to prevent her death. She had no Advance Healthcare Directive and had not expressed this desire to her longtime primary care physician. As the days passed, the chaplains supported him in a wide variety of ways during these difficult days. He brought in several faith healers and continued to express that he did not want to talk to any physicians. The situation was identified early by the chaplain, an Ethics ACE, on the unit and brought to the attention of the Ethics Resource team coordinator. Although several attempts were made to engage the son in this sensitive situation, he continued not to be open to reconsideration. Consistent support was given to the nursing, physician and other care staff who were clearly experiencing moral distress.

ACE is not a silver bullet to solve all medical ethics dilemmas. It does, however, serve as an excellent early notification system and bedside resource for moving through many ethical dilemmas without requiring a formal ethics consult. It has great potential and I encourage others to explore this approach.



Could it be that I have doubted?

By Michele Haasl Micklewright, BCC, HTP, D. Min.

Some time ago I listened to the Gospel story about Thomas doubting that Jesus had risen and how he came to believe only after actually placing his finger in the wound, after touching the wound. And I began to question why it was that Jesus returned with fresh wounds; why he didn't resurrect without wounds or at least with his wounds scarred over? How was it that Thomas could touch his wound; could place his finger in the wound? What was the significance of having these open wounds visible, tangible, touchable – inextricably bound together with the Resurrection? And what

was the significance of having to actually physically touch the wound to experience the Resurrection, to believe?

And how can one believe when one has not seen and not touched the wound?

From this reflection arose the following thoughts. I share these thoughts as a way of reflecting upon my spiritual journey, my movement toward trying to see connection; attempting to integrate and come to some understanding of how three distinct parts of my life as a pastoral minister might interrelate – my life in inner city Chicago; in a barrio in Venezuela; and in an urban hospital near Minneapolis. It is an attempt to reflect upon my own doubts and experiences of the Resurrection.

Could it be that I have doubted? I do not know.

But I do know that I have touched the wound,

As an elderly woman sits paralyzed, wheelchair bound in her one-room apartment, as mice scatter past my feet and roaches climb the walls.

And I have seen the Resurrection

As her neighbors cook her food on their hot plates and ensure that her heat is paid, her electricity on, and her letters written.

Could it be that I have doubted? I do not know.

But I have touched the wound

As a 16-year-old girl groans and moans and covers an infant casket with her body, her 6-month-old baby dead, too distant to find transportation to the hospital, too poor to pay the medical bills.

And I have seen the Resurrection

As family gather, as neighbors and friends and children surround the casket to sing the child to heaven; as all walk, arm-in-arm, a death march up the hill to the chapel.

Could it be that I have doubted? I do not know.

But I have placed my finger in the wound

As a young mother lies dying from a brain tumor; hair laid out and combed through, her body warm to touch, the family asking for prayers, “she is afraid to let her baby go...”

And I have witnessed the resurrection

As her family surround her, praying for her death, her journey; allowing her to go forth, “We will love and care for your little Emily, she will be okay, we promise. You may go, we love you so much, we will miss you.”

Could it be that I have doubted? I do not know.

Could it be that I doubted ... that the wound is bound to the Resurrection

that the Resurrection is bound to the wound

that the wound and the Resurrection are inextricably bound together?

(Could it be that I have doubted that there is hope in the midst of the wounds of life?)

And could it be that I have doubted that one must touch the wound to experience the Resurrection; that one must go through the wound to see the hope? I do not know.

But I do know one thing

that in my ministry ... I have touched the wound

and I have seen the Resurrection

and I believe.

Michele Micklewright, a member of the Association of Professional Chaplains, currently serves on the APC's Task Force to Develop Standards of Practice for Chaplains in Long-Term Care Settings. Michele volunteers as a spiritual director with City-House, a program that serves men and women who are in transition due to

homelessness, while she is completing a master's degree in creative writing from Hamline University in St. Paul, MN. She has worked as a chaplain for more than 20 years, serving in inner city community settings and in hospital, hospice and long-term care facilities.

Chaplaincy is his calling



Name: Patrick Bolton
Work: Board Certified Chaplain, Mercy Medical, Daphne, AL
NACC member since: 1996
Volunteer service: NACC Board of Directors, Renewal of Certification Peer Reviewer
Book on your nightstand:

"The Traveler's Gift: Seven Decisions that Determine Personal Success," by Andy Andrews

Book you recommend most often: "A Short History of Nearly Everything," by Bill Bryson

Favorite spiritual resource: Nature

Favorite fun self-care activity: Tennis

Favorite movie: WALL-E (and the other Pixar movies, thanks to my kids)

Favorite retreat spot: High Sierra Wilderness in Yosemite, CA

Personal mentor or role model: Marie-Therese Leveque — my grandmother

Famous/historic mentor or role model: Catherine McAuley

Why did you become a chaplain? During my first unit of CPE, I discovered how much I enjoy one-on-one ministry, which propelled me into the ministry of hospice and overall Catholic healthcare.

Why do you stay in the NACC? Chaplaincy is my calling, and I love what I do. The NACC helps so many make their dream come true of being a certified chaplain. I want to help make that continue to happen.

What volunteer activity has been most rewarding? One aspect of my role on the Board of Directors is to serve on the governance committee. I have come to appreciate the meticulous need for developing and fine tuning policies, procedures, and by-laws so that we can function with proficiency and integrity as well as be good stewards of the work entrusted to us.

What have you learned from volunteering? Volunteering is integral to living a happy life because it adds value to the lives of others.



Former teacher finds fulfillment

Name: Janet Biemann, RSM
Work: Director, Clinical Pastoral Education, Sisters Hospital, Buffalo, NY
NACC member since: 1981
Volunteer service: present member of Certification Commission; formerly member of Board of Directors; sat in on interview teams for chaplain certification and supervisor certification

Book on your nightstand: "Reclaiming Spirituality," by Diarmuid O'Murchú

Book you recommend most often: "Poverty of Spirit," by Johannes B. Metz

Favorite spiritual resource: Early morning meditation and readings of the day.

Favorite fun self-care activity: Reading, movies, traveling

Favorite movie: Gandhi

Favorite retreat spot: Jesuit Retreat House, Gloucester, MA

Personal mentor or role model: My father

Famous/historic mentor or role model: Joan Chittister, OSB

Why did you become a chaplain? I felt it was a good fit for me. I had been a teacher first, but I found chaplaincy much more fulfilling.

What do you get from NACC? I really appreciate the welcoming spirit of NACC. I have developed many friends over the years and feel we have grown together to become a wonderful organization.

Why do you stay in the NACC? I believe in the philosophy of NACC and have always felt at home here and appreciated for whatever I have contributed.

Why do you volunteer? I believe in the organization. I enjoy being a part of the various aspects of leadership in NACC and know I have grown because of it.

What volunteer activity has been most rewarding? I really enjoy being a part of the Certification Commission. It is wonderful to meet so many people who are so committed to developing chaplains and supervisors and in promoting spirituality in our healthcare organizations throughout the country.

Please remember in your prayers:

Raymond (Ray) John Kelleher, who died July 28 at Providence St Peters Hospital in Olympia, WA, from post-surgery complications. A member of the NACC, he was a chaplain at Franciscan Hospice in Tacoma at the time of his death.

He was born Dec. 10, 1952, in Chicago, IL, received a bachelor's degree from The Evergreen State College in Olympia and earned a Master's in Divinity degree from Seattle University.

He was a woodworker, prize-winning writer and a teacher, The Olympian newspaper reported.

Mr. Kelleher is survived by family members, Shannon Nelson-Deighan, stepsons Reed Nelson-Saunders, Caleb Saunders, David John Deighan (Molly) and Rick McKinnon.

In Memoriam

In Chicago, he is survived by his mother, Virginia Kelleher, aunt Mary Garrahan, sisters Mary Kelleher and Liz Repking (Ron) as well as brothers Pat, John (Rose), Matt (Kathy), Bill (Gail) and Bob (Pam) Kelleher. He will be sorely missed by many nieces and nephews in Chicago and Seattle as well as by extended family in Minnesota, Connecticut and New York. He was preceded in death by his wife, Kathy Jordan, stepson Ian McKinnon, father Raymond Kelleher, brother Danny and sister Julie.

How do I determine continuing education hours?

Q How many hours do I count for the various types of media? For example, does the length of a book determine its continuing education hours? Do audio books and video tapes/CDs count for the number of “running time” hours, or a particular number of hours per book/tape/CD?

A Let’s first look at how many hours are permitted for various forms of media education.

You can claim 25 total hours per year in any of the following combinations: books, articles, audio, and video. With regard to how do you account for those hours, well, that’s based on your own discretion. If it takes you 10 hours to read a book then count those 10 hours. If you’re a particularly fast reader and you read it in five hours, then put five hours. It comes down to your honest account of how much time you spent on a certain activity. Just be sure to include titles and authors. There is no minimum per item, just 25 hours total per year.

Q Do we get a letter when we are to renew our certification?

A Yes, you’ll receive a letter from the NACC national office, referencing your renewal and the materials needed. The letter will be sent to you in December preceding your year to renew. You won’t receive paper copies of the materials that you will need for renewal. Instead, those materials are available to you on the NACC website.



Q It is difficult sometimes for me to determine which category (theory of pastoral care, identity and conduct, pastoral, professional) to choose for a workshop I attended. It seems many of the workshops cover more than one area. Can we share the time, for example, for a two-hour workshop using one hour in pastoral and one hour in theory of pastoral care?

A You’re right. Sometimes it can be difficult to figure out which category to list for a particular activity, especially since so often the topics are interrelated. One way to determine how to classify an activity is to ask your self, “What did I learn from this?” or “What was the educational value of this activity?” If you felt that the article or experience helped you to deepen your understanding of your professional identity as a chaplain, then list it that way. If your theological understanding was enhanced, than classify it accordingly. Sometimes, an experience may enrich us in several ways. For example, after reading a book on ministry in an outpatient setting, you may not only have gained insights to improve your pastoral ministry but it also may have broadened your theological understanding of ministry. So, in situations such as that, you may divide the hours in a workshop or activity into more than one category.

Book Review

Concise guide clearly not for the seasoned CPE supervisor

Supervising a Ministry Student. By Ann M. Garrido. The Concise Guide Series (ed. by Kevin E. McKenna). Ave Maria Press, Notre Dame, IN, 2008. Paperback, 180 pp. \$17.95.

By John Gillman, Ph.D.

Ann Garrido, a teacher at Aquinas Institute of Theology in St. Louis and an active member of the Catholic Association for Theological Field Education, seems to have in mind the person new to the task rather than a seasoned supervisor in writing this concise guide for supervising field education.

In five chapters she summarizes relevant literature on the theme while adding reflections of her own. Each chapter concludes with helpful questions for reflection and discussion. I found particularly helpful the last chapter where she addresses the spirituality of the supervisor and names eight virtues gleaned from her conversations with experienced practitioners. She identifies wholeness, humility, courage, trust, curiosity and patience, reflection as a way of life, embracing “death,” and hope.

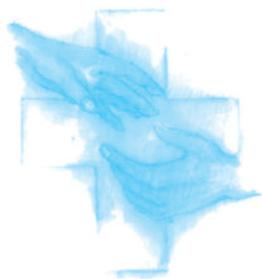
For me the last two qualities stand out. Ms. Garrido reminds us that “supervisors experience a death of the ego when they come to a new awareness of their own shortcomings and limitations.” And on hope she quotes a supervisor who reflects: “Working with students can refresh my spirit on days when I’m feeling jaded or cynical or have difficulty seeing the hand of God through the political aspects of church work.”

The five appendices include case studies, a self-assessment for supervisors and selections from church documents on ministry. I found it curious that most of the quoted passages on ministry pertain to the ordained (three documents, 10 pages of text) rather than lay ministry (one document, “Co-Workers in the Vineyard,” four pages). Greater balance would be achieved by also including key paragraphs from “Called and Gifted for the Third Millennium: Reflections of the US Bishops on the 30th Anniversary of the Decree on the Laity” (1995) and “Lay Ecclesial Ministry: The State of the Question” (U.S. Catholic Bishops, 1999).

Since supervisors of field education and CPE supervisors sometimes interact, I would like to have seen a discussion of how these two can best interface. How might they relate to each other professionally, and how might they collaborate in preparing ministers for the church? This resource will best serve those interested in or just beginning with the supervision of ministry students.

John Gillman is ACPE/NACC CPE supervisor at VITAS Innovative Healthcare in San Diego, CA.

World Day of the Sick ▼ February 11, 2010



Prayer Card Order Form

Item	Quantity *	Cost (each)	Total
▼ Card 1 – Prayer of the Caregiver		15¢	
▼ Card 2 – Prayer for Sick Persons		15¢	
▼ Set of both cards		25¢	

* A minimum of 15 cards must be ordered.

Grand Total _____
(Includes shipping & handling.)

Please enclose a check for the Grand Total, payable to the NACC.

Name _____

Title _____

Institution _____

Street address _____

City & state _____ Zip code _____

Phone number _____

The World Day of the Sick is sponsored by the Vatican's Pontifical Council for Health

Pastoral Care and has been celebrated since 1992 on the feast of Our Lady of Lourdes. This celebration is a reminder to pray for all those who are sick and to recognize and honor those who work in healthcare and those who serve as caregivers.

Over the last several years, the NACC has provided support materials for this celebration such as an ecumenical service, reflection notes and homily hints, prayer of the faithful, and so forth. These materials are available on the NACC website; go to www.nacc.org/resources/wds/default.asp.

For 2010, the National Association of Catholic Chaplains will offer two separate prayer cards for World Day of the Sick: Prayer for the Caregiver and Prayer for the Sick. On both cards, the prayer appears in English on one side of the card and in Spanish on the reverse.

Mail the check and order form to:
National Association of Catholic Chaplains
5007 S. Howell Ave. Suite 120
Milwaukee, WI 53207-6159
(414) 483-4898

For delivery by Feb. 11, orders must be received in the NACC office no later than Jan. 15, 2010. However, the prayer cards will continue to be available throughout the year. Orders will be shipped via U.S. Postal Service.

Books assist those who care for people with dementia

The Alzheimer's Advisor: A Caregiver's Guide to Dealing with the Tough Legal and Practical Issues. By Vaughn E. James. American Management Association, New York, 2009. Paperback, 320 pp., \$14.96., American Management Association, NY, NY.

By Judy Novak, M.Div., BCC

Dr. James takes his own family story of dealing with the ethical, legal, and moral complications of Alzheimer's and dementia as a prism and leads the reader through the legal issues that families must face at this time. This is not just about "power of attorney" situations, but also legal matters such as when Auntie gets the car keys and smashes up the local store. The law becomes more clear in Dr. James' hands.

This is a good book to have on hand to recommend and refer to when dealing with families who "just don't know what to do first." When the legal issues, especially between differing states and nations, leave one as if lost at sea, Dr. James helps the reader

Book Review

see the next step to take. Rooted as it is in personal experience, the book is human and immensely helpful to families and caregivers. It should be helpful to the entire interdisciplinary team as well.

Pray With Me Still: Rosary Meditations and Spiritual Support for Persons with Alzheimer's, Their Caregivers and Loved Ones. By 2006, Holy Cross Family Ministries. Ave Maria Press, Notre Dame, IN, 2006. Paperback, 64 pp., \$5.95.

I was touched by this little reflection on primal prayer, Alzheimer's, and caregiving through the life of the rosary. It is a nice read for a caregiver and would be helpful as well in your ministry with people with dementia.

Judy Novak is staff chaplain at Wheaton Franciscan Health Care in Racine, WI.

DVD Review

DVD on forgiveness a great resource for chaplain retreat, CPE seminar

Power of Forgiveness, produced and directed by Martin Doblmeier. Journey Films, Alexandria, VA, 2007. DVD, 78 min., \$18.71, available from www.firstrunfeatures.com

By John Gillman, Ph.D.

The need to forgive or to seek forgiveness emerges regularly in our work as chaplains. As we know, this theme is not just a spiritual concern of our patients and their family members, but on a personal level a matter that arises for us as caregivers from the often hidden recesses of our soul. Director Martin Doblmeier has produced an engaging film that deals with forgiveness drawing on both the traditions of faith communities and research from the world of science.

Featured in this documentary are Nobel laureate and Holocaust survivor Elie Wiesel, the Vietnamese Buddhist monk Thich Nhat Hanh, and the authors Thomas Moore, a therapist, and Marianne Williamson, a New Thought minister. A special addition is an address by Bishop Desmond Tutu, past chair of the Truth and Reconciliation Commission in South Africa, given at Washington's National Cathedral.

Witnesses and victims from Northern Ireland to Ground Zero, from the rural Amish community in Pennsylvania to the site of a murder of a Muslim in San Diego are interviewed. "To forgive and forget" does a tremendous disservice to the injustices and violence-inflicted pain that is often passed along from generation to generation. Instead, focus is on transforming the memory, letting go of its pain and traveling the road to peace by crossing "the bridge of forgiveness," as one Lebanese mother put it.

Speaking before the Bundestag in 2000, Elie Wiesel tells the German leadership that forgiveness is made possible when the evil is acknowledged and forgiveness is sought. Two weeks later for the first time a representative of the German government did just that before the Knesset in Israel.

In other areas, seeds of compassion have given rise to a Garden of Forgiveness in Beirut, and, though not without opposition, to a similar garden at Ground Zero. As one hurting family member put it, "If we don't show forgiveness, we are no better than the terrorist."

From the scientific perspective, multiple studies have shown that those who are able to let go of anger and extend forgiveness have lower blood pressure than those who harbor animosity. Forgiveness curricula are now being integrated in schools in Northern Ireland and courses on the same theme are common at the university level. Such is not required for the Amish, who with roots in the Anabaptist tradition have suffered tremendously, since they learn this from their families and from praying the Our Father daily.

The film concludes with a moving conversation between Azim Khamisa, whose 20-year-old son Tariq was shot and killed while delivering pizzas in San Diego, and Ples Felix, whose 14-year-old grandson was the killer. This father and grandfather have forged a strong friendship that gave rise to the Tariq Khamisa Foundation, an organization committed to "stopping children from killing children."

I highly recommend this film as a resource for a chaplain retreat or CPE seminar. This can spark an inquiry into recent studies on the relationship between a forgiving spirit and well-being, a new look at what our faith tradition offers, and, more personally, reflection on where we are on our journey and the bridge to forgiveness.

Regarding our faith tradition, I wonder what a film that focused on forgiveness in the Catholic Church would look like. Certainly it would include statements from the leadership, such as John Paul II's message for World Day of Peace in 2002, when he affirmed that "there is no peace without justice" and "no justice without forgiveness." Also, how might it deal with the place of forgiveness in individual cases such as that of an unmarried fifth-grade teacher at a Catholic school in Wabasha, MN, who lost her job in spring 2008 because she disclosed she was pregnant? And how would seeking forgiveness and accountability be handled in other instances, such as the sexual abuse scandal? Questions to ponder.

John Gillman is ACEPE/NACC CPE supervisor at VITAS Innovative Healthcare in San Diego, CA.

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.

Joyce Fink
Bethlehem, PA
Heart attack, recovery from open heart surgery

Fr. Bob Nee
Cambridge, MA
Intractable epilepsy

Mike J. Murphy
Green Bay, WI
Cancer treatment

Fr. Bill Spacek
Baltimore, MD
Detached retina and other eye issues

Lourdes B. Ruta
(wife of Peter M. Ruta)
Milwaukee, WI
Recovery from surgery, rehab

Sr. Hilda Mallet, MHS
Lafayette, LA
Cancer treatment

Sr. Nancy Crane, OP
Akron, OH
Cancer treatment

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

Sr. Rita Rzeppa, IBVM
Chicago, IL
recovering/rehab from knee surgery

Author chose holy men, women who challenge, inspire

Modern Spiritual Masters: Writings on Contemplation and Compassion. By Robert Ellsberg (ed). Orbis Books, Maryknoll, NY, 2008. Paperback, 183 pp. \$18.

By **John Gillman, Ph.D.**

The most prominent tapestry arrangement in the Cathedral of our Lady of the Angels (Los Angeles) is the Communion of Saints, containing 135 holy men and women from throughout the ages. The 12 contemporary spiritual masters selected by Robert Ellsberg in this collection easily belong among their number. Whether participating in liturgy at this cathedral or quietly reading reflections in “Modern Spiritual Masters,” the 21st century pilgrim feels included, but also challenged to be faithful witness to the living Christ.

Mr. Ellsberg chooses mothers and fathers, monks and nuns, bishops and priests, African-Americans and Caucasians, some with questionable pasts but all with the desire to serve others through compassionate action, grounded in contemplation.

Many are well known: Thomas Merton, Dorothy Day, Mother Teresa, Mohandas Gandhi (the only non-Christian included), Oscar Romero, Henri Nouwen, Dom Helder Camara, and Catherine De Hueck. Others may not be so familiar: Sr. Thea Bowman, Mother Maria Skobtsova, Madeleine Delbr el, and Howard Thurman. Mr. Ellsberg introduces each of these with a brief biographical sketch.

Mr. Ellsberg’s selection of passages is judicious and balanced. Thomas Merton’s well-known reflection on his transformative awakening while standing on the corner of Fourth and Walnut in Louisville is included. Seeing passersby coming and going he was overwhelmed with the “secret beauty” of all people — “they are all walking around shining like the sun.” Next time in the Derby city,

Meditations will comfort rosary devotee and novice

Grant Us Peace: Rosary Meditations for Those Who Mourn. By Beth Mahoney. Ave Maria Press, Notre Dame, IN. Paperback, 49 pp., \$4.95.

By **Mary C. Hauke, OSF, BCC**

“Grant Us Peace,” by author Beth Mahoney, aims to provide a resource for those looking to comfort themselves and their families when a loved one dies. Mahoney, mission director for Holy Cross Family Ministries writes in the forward that Fr. Patrick Peyton, CSC, believed and taught that families can grow and be strengthened by praying together. In response to people’s feelings of intimidation at the prospect of leading prayer, Fr. Peyton made it his quest to teach families the rosary and thus founded an international organization, Holy Cross Family Ministries, in 1942.

Ms. Mahoney, as a result of her own pastoral ministry experiences with families, builds upon the work of Fr. Peyton by writing a booklet on the rosary as a communal prayer form

Book Reviews

I would like to seek out this intersection to be reminded of the unique and diverse rays of the Divine that radiate from the prism of the human community.

We hear the prophetic and disturbing words of Thea Bowman, an African-American Franciscan Sister, delivered to the 1989 gathering of U.S. bishops. She starts with the question, “Can you hear me church, will you help me church? I’m a pilgrim in the journey looking for home.” Her message, as apropos today as it was then, calls for “equal access to input, equal access to opportunity, equal access to participation.” She then invites her listeners to “Go into a room and look around and see who’s missing and send some of our folks out to call them in so that the church can be what she claims to be, truly Catholic.”

For the first time I was introduced to Mother Maria Skobtsova (1891-1945), an Orthodox nun, who died as a martyr in a Nazi death camp. Born into an aristocratic family in Russia, a divorced and remarried mother of three children, she was a poet and political activist, working with destitute Russian refugees in Paris. Six years ago she was canonized by the Russian Orthodox Church. I also learned about Madeleine Delbr el (1904-1964), a “confirmed atheist” in her youth whose conversion experience started her on a mission to build a bridge between the church and the secular world, especially to unbelievers.

Collectively these writings portray the many forms of loving service grounded in contemplation by men and women who were not without their own struggles. The selections would be ideal to incorporate into the Liturgy of the Hours, days of retreat, or small group reflection.

John Gillman is ACPE/NACC CPE supervisor at VITAS Innovative Healthcare in San Diego, CA.

appropriate to use at times of sorrow, pain and grief.

“Grant us Peace” can be used by a family member leading the rosary at a wake and by clergy, chaplains or lay pastoral ministers seeking a prayer resource using this traditional prayer form along side the church’s official funeral rites. This devotional book offers an explanation on how to pray the rosary. Hence, it is appropriate for the individual user who is new to this prayer form as well as the regular rosary devotee seeking comfort in the days and weeks following the burial.

Prayer services using the rosary were designed for all four mysteries. Each service is organized to encourage group participation. Brief Scripture readings from Hebrew and Christian scriptures along with a meditation on both precede the recitation of each rosary decade.

This is a worthwhile resource for chaplains and pastoral ministers who value the rosary and are seeking prayers and readings to use during a wake, or who are wishing to have resources on hand to recommend to grieving persons devoted to the rosary or to those who may benefit from the rhythm, repetition and tactile experience of using this ancient prayer form.

Mary C. Hauke is a chaplain at United Hospital System in Kenosha, WI.

Spiritual Leadership Competencies identified

The 2007 CHA/NACC Pastoral Care Summit Care Services Task Force produced in fall 2008 the document, “Essential Functions/Responsibilities of a Board Certified Chaplain.” These essential functions matched up well with the scope of services that introduced the “Standards of Practice for Chaplains in Acute Care Settings” identified by the Association of Professional Chaplains (APC) Commission on Quality Services and affirmed by the Spiritual Care Collaborative (http://www.spiritualcarecollaborative.org/standards_of_practice.asp).

The task force then targeted the need to identify the Spiritual Leadership Competencies — the skills and training required — for a spiritual leader in pastoral care. While a traditional human resource approach would attempt to identify and categorize the skills, knowledge, and abilities required for leaders in pastoral care, the task force rather has identified here “fields” of competencies for what is required to be a successful spiritual care leader. This list is not intended to be a comprehensive nor prioritized list.

We realize that not all chaplains and those who minister to the spiritual and emotional needs of patients, families, and associates are called to become spiritual leaders of pastoral care. The diversity of gifts is critical to meeting these needs. However, we also believe that many of these gifts for leadership are present in those currently serving in the pastoral care ministry, and we hope this work will help call them forward, encourage the discernment of these gifts, and lead to the further development of the structures and resources to prepare them for spiritual leadership positions. Therefore, the task force aims were to assist:

- ▼ Mission leaders and human resource specialists responsible to hire those for spiritual leadership.
- ▼ Those responsible to develop and provide education and training.
- ▼ Current directors of pastoral care for their own professional development.
- ▼ Spiritual care ministers who are discerning their own professional growth and direction.

It also encourages the further collaboration within and among healthcare systems to develop and/or support spiritual leadership opportunities.

I. Leadership: skills and ability to set the goals of a department and inspire/direct the staff to achieve the goals and live out the mission, vision and values of the organization.

1. Model and demonstrate being visionary and inclusive
 - 1.1. Communicate a compelling and inspired vision or sense of core purpose for spiritual care services
 - 1.2. Demonstrate how spiritual care is an integral function of mission
 - 1.3. Articulate the need for making spiritual care more operational, and explore with system leaders ways to do so
 - 1.4. Position the spiritual care department as a resource for spirituality and ethics formation
 - 1.5. Excel in meeting department goals successfully, and constantly and consistently be one of the top performers
 - 1.6. Exemplify personally and professionally the mission, vision and core values of the organization

2. Exhibit a collaborative and interdisciplinary management style with other managers of the organization, as well as with the spiritual care team

- 2.1. Work with other disciplines across the organization demonstrating an agility in understanding organizational complexities
- 2.2. Promote the value of spiritual care across the organization as integral to the organization’s mission of healing
- 2.3. Exhibit management skills that provide excellence in the provision of spiritual care services for the organization developing a spiritual care team to meet the needs of a changing healthcare environment
- 2.4. Demonstrate a servant leadership style that promotes the development of leadership skills in the members of the spiritual care team
3. Exhibit a strategic agility in adapting spiritual care services to the changing needs of the organization in providing a continuum of care
 - 3.1. Collaborate with mission director and/or supervisor in demonstrating and promoting creative strategies for the delivery of spiritual care services
 - 3.2. Rethink strategies and adapt to change for the delivery of spiritual care services

II. Finance/Accounting: knowledge of current principles, practices, and policies to fiscally manage the department.

1. Comprehend, analyze, and monitor balance sheet and income statement of organization particularly as related to spiritual care
2. Build, monitor, and make value-based decisions regarding budget
3. Situate spiritual care services within the business plan of the institution/organization and the standards of the profession
4. Demonstrate to the institution and system “value added” and “cost avoidance” benefit of adequate spiritual care/chaplain staffing

III. Management: ability to administer a department in collaboration with other departments and administration throughout the organization

1. Assess department personnel needs
2. Design a structure for spiritual care department
3. Work with human resources to develop appropriate position descriptions
4. Hire, develop, and evaluate staff, with appropriate knowledge of labor laws
5. Determine needs for and purchase equipment and materials
6. Manage resources and time
7. Prioritize tasks and balance a multiplicity of demands
8. Possess working knowledge of and capability with
 - 8.1. Behavioral-based interviewing
 - 8.2. Career assessment tools



- 8.3. Team development
 - 8.4. Employee coaching and counseling
 - 8.5. Group facilitation
 - 8.6. Conflict resolution
 - 8.7. Succession planning
- IV. Marketing:** ability to direct/process the development/management of services and products from conceptualization through delivery.
1. Collaborate with key partners to identify spiritual care service needs
 2. Identify, assess, select, and develop spiritual care services that meet those needs
 3. Determine cost and price, method for delivery, and promotion
 4. Promote the value and need of spiritual care across the continuum of care of the organization
 5. Develop, tailor, and provide education and information to promote spiritual care services to potential users of the services and to decision makers
- V. Organizational Dynamics:** knowledge of and ability to navigate and maneuver within the structural, cultural, and power relationships within an organization to achieve desired outcomes.
1. Understand how the system operates, i.e., how individuals, groups, and the overall organization interact
 - 1.1. Understand the business of mission and stewardship of resources
 - 1.2. Know and be able to articulate the organization's strategic and mission goals, and know how to relate the spiritual care department's goals and activity to those goals
 - 1.3. Know where the spiritual care department is situated and how it functions within its organizational environment (branches, divisions, departments), and how to communicate/problem solve within the communication/reporting channels of this environment in order to achieve desired outcomes.
 2. Develop and implement departmental goals that align with organization's strategic plan
 3. Demonstrate a personal and departmental accountability
 4. Understand the integral role of spirituality to mission, and communicate with system, administration, and mission leaders the particular and strategic roles of spiritual care
 5. Promote the process of ethical decision-making and theological reflection within the department and within the organization
- VI. Professionalism:** knowledge, conduct, qualities, and capacity that characterize the profession of chaplain, based on professional and organizational standards and ethics and the best practices of the profession
1. View self as professional leader within organization, committed to build professional relationships
 2. Possess the characteristic of being a skilled practitioner; an expert in
 - 2.1.1. Setting up an office
 - 2.1.2. Dressing the part
 - 2.1.3. Communication
 - 2.1.4. Transitioning
 - 2.1.5. Change management
 - 2.1.6. Expanding modalities
 - 2.1.7. Interaction (within all levels of the organization)
 3. Demonstrate confidence in responding to challenges
 4. Promote the professionalism of the chaplain and spiritual care department
 5. Build relationships with key partners in organization and within the professional field
- VII. Quality:** desired outcome of a mission-driven culture that exhibits excellence in going beyond the expectations of those being served.
1. Provide a quality of spiritual care services that is evidence-based, outcome-orientated, and consistent with national best practices
 2. Promote quality as integral to the organization's mission and purpose
 3. Be able to work with colleagues across interdisciplinary lines to create a healing culture of excellence
 4. Demonstrate a quality of work that is mostly error free the first time with little waste of or redone work in areas of
 - 4.1. Metrics
 - 4.2. Cost Avoidance
 - 4.3. Continuous Quality Improvement
 - 4.4. Planning and Assessing
- VIII. Strategic Planning:** Capable of creating the new and different — to be actively involved in setting short-term goals while at the same time being future orientated to establish long-term goals.
1. Know current and possible future policies, practices, trends, technology and information affecting business and organization
 2. Use available information and data in developing techniques to seek better performance
 3. Anticipate future consequences and trends accurately
 4. Possess broad knowledge and perspective
 5. Create breakthrough strategies and plans
 6. Utilize available information and data to forecast techniques to seek better performance
- IX. Technology acumen:** ability to use current and emerging technologies that underlie effective spiritual care management in today's world.
1. Possess competence in Word, Excel, Access, PowerPoint or their equivalents
 2. Know of system/organization software that, e.g.
 - 2.1. Monitor customer and personnel development
 - 2.2. Track productivity
 - 2.3. Create budgets and financial reports
 3. Think and communicate as an expert in technology does, e.g.
 - 3.1. Identify problem and key considerations
 - 3.2. Group data into categories
 4. Be aware of and open to new technologies that can contribute to, and/or impact, spiritual care
 5. Advocate for information and communication technologies that can improve spiritual care, e.g.
 - 5.1. Templates for tracking spiritual care services
 - 5.2. Hand-held devices

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Calendar

November

- 1 All Saints Day
- 1 Certification Commission meeting
- 12 and 19 Audio Conference: Co-Workers in the Vineyard of the Lord – Insights and Implications for Chaplaincy Ministry
- 15 Local gathering
Workshop for Professional and Spiritual Enrichment,
Washington Theological Union,
Washington, D.C.
- 16-19 USCCB Fall Assembly,
Baltimore, MD
- 29 First Sunday of Advent

December

- 1 Articles due for January-February issue of *Vision*
- 3 and 10 Audio Conference: Healing Ministry and the Sacraments – A Contemporary Understanding of Sacraments Can Enrich our Pastoral Care Ministry
- 8 Immaculate Conception
- 24 National office closed for Christmas Eve
- 25 National office closed for Christmas Day
- 31 National office closed for New Year's Eve