

vision

National Association of
Catholic Chaplains

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Chaplaincy department responds to challenge of outpatient ministry

In so doing, it helps build patient loyalty, satisfaction

By Michelle Lemiesz, M.Div., BCC

In 2002, the three chaplaincy services departments within the Mount Carmel Health System in Columbus, OH, participated in an individual and system departmental assessment in order to evaluate how our departments measured against Trinity Health's "Standards for Spiritual Care." Each standard was analyzed individually and the evaluation produced a collective examination of how spiritual care was being delivered within the system at each site. The analysis result was to assist in goal formation for each of the hospitals' chaplaincy services departments.

uncovered by the assessment was our hospital-centric ministry with its focus on inpatients and staff. Little to no support was provided to outpatient care areas and there was no communication between the department and numerous physician offices on each of our campuses. This article focuses on how Mount

Perhaps the most glaring observation uncovered by the assessment was our hospital-centric ministry with its focus on inpatients and staff.

Perhaps the most glaring observation [See Outpatient Ministry on page 13](#)

CHAPLAINS in Outpatient MINISTRY

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'Dream job' achieved: outpatient ministry among the poor

By Sr. Andre Dembowski, RSM, BCC

Let us follow the example of Jesus who testified on all occasions a tender love for the poor. – Morning and Evening Prayer of the Sisters of Mercy

Every Sunday after being certified I'd chat with retired health care workers from my parish, St. Vincent's, near Baltimore's Inner Harbor, about the hunt for my "dream job" — outpatient ministry. Responses ran the gamut: from "Never happen! A chaplain for outpatients is a luxury" to "If you ask me it's on the cutting edge of health care today. Patients are in and out ASAP; stick with your dream!" After a few sterile interviews at local hospitals in Baltimore, my mentor for certification encouraged me to "trust and wait," the openings will come. "The openings" turned out to be quite singular — St. Francis Hospital in Wilmington, DE.

When the director of pastoral care called with a job offer, my already discerned response came easily, "It's taken a long time to live and work among the poor in Southwest Baltimore in an 1831 House, a project sponsored by the Institute of the Sisters of Mercy." Emphatically I continued: "First, I'm not moving. Second, if I'm traveling to Delaware (preferring public transportation, the train came immediately to mind), it'll have to be for my "dream job." An empty silence followed. I spelled out what a dream job meant: "outpatient ministry!!!" More silence, followed by a pregnant possibility. I was told, "That's not exactly what we had in mind but don't take a job until we get back to you; we have to return to the drawing board."

Every question on the table during

[See Dream Job on page 6](#)

At halfway point, strategic plan may need tweaking

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

Do you realize that we are almost halfway through the implementation of our 2007-2012 strategic plan? Where did the time go? Do you remember the planning that took place in 2006-2007? We remain very grateful to the leadership of the 22 NACC members of the Vision and Action Planning Committee (VAPC) that drove and directed the planning process. Please refer to the strategic plan for the list of these members, and take time to thank them again for their leadership (http://www.nacc.org/docs/about/SP_NACC.pdf).

Given our nearly halfway point of the plan implementation, the NACC Board of Directors at its September 2009 meeting will reflect on how we are doing with the plan and where we need to adjust it. In preparation for this meeting, the Board invited VAPC members to

participate this summer in two conference calls to provide their perspectives and wisdom on what has changed in the external environment since the plan was developed and how it might impact the plan implementation, what has been successful implementation, and what needs more attention and priority. Let me highlight items from the gathered wisdom of our VAPC members.

External environment: I will note three external factors that were mentioned. Can you guess what was at the top of the list? If you said, “the economic downturn,” you were with the majority. We all know how the financial pressure on the institutions we serve has impacted jobs, work responsibilities, and educational support. It has impacted NACC as members have limited financial means to continue membership or

complete CEH’s. It has raised questions for some members about why we are putting energy into recruiting chaplains (Goal 4) when we have members without jobs. (We have discussed this point in a past *Vision* and NACC Now column.) Our ongoing plan for implementation will need to continue to reflect good stewardship and utilize electronic means. This economic stress, however, has also created even greater urgency to promote the professionalization of chaplaincy

Second, VAPC members cited healthcare reform, calling it urgent that our association advocate for spiritual care to be considered an integral part of healthcare delivery. Again, advocacy activity was emphasized.

Third, it was noted that last fall’s presidential election emphasized the value and impact of networking, and the effectiveness of virtual communal conversations on critical topics. This comment was attached to an expression of appreciation for NACC’s attempts to link interest groups via audio conferences and listservs on a regular basis.

Positives of plan implementation: Most of the participants highlighted the renewed communication and networking among members through NACC Now, state liaisons, conference calls, listservs, and local gatherings. As one participant noted, “Gatherings took off like wildfire — pumped renewed energy in those that had not been able to participate. We have done a better job of reaching out to people.”

Another remarked, “Good steps (have been taken) in promoting chaplaincy, but we have more work to do.” More tools are available, and awareness of chaplaincy as a profession is growing.

Another positive was the growing collaboration with partners within the Spiritual Care Collaborative, the Catholic Health Association, and the potential for greater partnership with graduate schools. These collaborations are seen as critical to our future as a profession.

Areas needing more attention: A lot of energy and passion were expressed that impressed on me the importance and urgency of the following areas. Our relationship with the bishops seemed most important. How do we help them better understand the ministry of chaplaincy? How can we be proactive in helping them reflect on lay ecclesial ministry as it is lived out in our spiritual care ministry, as they try to implement “Co-Workers in the Vineyard of the Lord”?

Another top concern was the accessibility of CPE both through distance learning and connecting to graduate programs. How will we work more closely with ACPE; where will future CPE supervisors come from? How can we better support CPE?

The VAPC participants also raised the status of the discussion with the other Spiritual Care Collaborative (SCC) members regarding the feasibility of administrative efficiencies. Also regarding our joint efforts with other SCC participants, they emphasized pressing forward on the professionalization of chaplaincy and advocating for appointments of certified chaplains in positions of pastoral leadership.

As you may recall, most of these areas are those I included in my July-August column that identified five areas that need attention in the next two to three years. (http://www.nacc.org/vision/July_Aug_2009/ed.asp). They were: the professionalization of the ministry; networking and communication efforts; identifying and encouraging the next generation of chaplains; accessible, quality professional ministry formation and CPE programs; and healthy, vibrant associations to support chaplaincy. The one area needing more attention that I had not included was the relationship to the bishops. This will be very important as we move forward.

So these listening sessions with the VAPC members were very instructive. Do these comments resonate with you? What are your perspectives on the NACC plan implementation? Please e-mail me at dlichter@nacc.org.

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vision

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

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Executive Editor

David A. Lichter, D.Min.

Editor

Laurie Hansen Cardona
lcardona@nacc.org

Graphic Designer

Gina Ruppic

The National Association of Catholic Chaplains advocates for the profession of spiritual care and educates, certifies, and supports chaplains, clinical pastoral educators and all members who continue the healing ministry of Jesus in the name of the Church.

NACC Editorial Advisory Panel: Sr. Michele LeDoux Sakurai; Michelle Lemiesz; Linda Piotrowski; Rev. Freddy Washington, CSSp; and board representative Norma Gutierrez, MCDP.

NACC National Office

5007 S. Howell Avenue Suite 120
Milwaukee, WI 53207-6159
(414) 483-4898
Fax: (414) 483-6712
info@nacc.org
www.nacc.org

Executive Director

David A. Lichter, D. Min.
dlichter@nacc.org

Certification and Education Coordinator

Susanne Chawaszczewski, Ph.D.
schaw@nacc.org

Association Support Coordinator

Cindy Bridges
cbridges@nacc.org

Administrative Specialist/Certification

Rose Mary Blanco-Alvarado
rmaalvarado@nacc.org

Administrative Specialist/Education Programs

Jeanine Annunziato
jannunziato@nacc.org

Administrative Specialist/Information

Technology and Special Projects

Philip Paradowski
pparadowski@nacc.org

Administrative Specialist/Membership

Mary T. Pawicz
mpawicz@nacc.org

Administrative Specialist/Finances

Sue Walker
swalker@nacc.org

Office Assistant – Renewal of Certification

Becky Evans
bevans@nacc.org

Butterfly flutterings abound; watch for long-term effects

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

In my reflections on our NACC 2008 Annual Report, (*Vision*, May-June 2009), I closed with “I wonder what were our 2008 ‘butterfly effects,’ those small variations in a living system like NACC that in the long run may produce large variations.” I cited a few and invited NACC members to add to the list. Today I want to mention a few “butterfly wing flutters” that I have sensed in the past few months.

NACC continues to work with CHA (Catholic Health Association), with schools of theology and health systems across the country. Some of the effects are already seen — advocacy, a brochure, a video, and planning for joint educational offerings. Small flutterings of wings: what will be their long-term effect?

Sue Wintz, APC president and member of the Spiritual Care Collaborative, continues to be deeply involved in the Joint Commission’s revision of standards and design of an implementation guide to help hospitals make the standards come alive. Not only is she focusing on the spiritual components of health care, but she has solicited the help of all six SCC organizations — including NACC. More flutterings!

Several months ago, Deryck Durston, ACPE associate director, researched and published for all ACPE members (*ACPE e-News*, April 21, 2009) a list of ACPE Board motions about ACPE-NACC cooperation, dating back to fall 1995. Let me summarize them:

- ▼ ACPE recognizes NACC units of CPE (Board motion, Fall 1995).
- ▼ In dually accredited centers (accredited by both USCCB/CCA and ACPE)
 - NACC supervisors are able to supervise ACPE students, sign the students’ evaluations, and register the unit with ACPE (Board motion, Fall 1995).
 - An ACPE supervisor shall oversee compliance with ACPE Standards for all units and insure that the NACC supervisor has agreed to abide by the accreditation and ethics standards of ACPE. When an ACPE supervisor is no longer employed by the center, then an ACPE consultant shall be employed by the center to assess this compliance. (Board motion, Spring 1996).
 - NACC supervisors are able to report their own units electronically to ACPE when necessary. Directions for using the Online Student Unit Reporting System can be found in the *ACPE e-news*, April 21, 2009.

Deryck also summarized the reciprocity period when NACC and ACPE fostered dual certification of CPE supervisors.

- ▼ Effective Jan. 1, 2001, ACPE recognized the certification of any active fully certified NACC supervisor who was in good standing and applied for ACPE certification. The NACC supervisor must have been fully certified by May 1, 2001 (Board motion, Fall 2000).
- ▼ A joint task force was established (2001) to address Supervisory CPE (Candidacy and Associate) in NACC and ACPE. This task force was discontinued, however, after NACC chose not to continue in this direction. So further discussion of possible reciprocity was also discontinued. In the spring of 2006, the ACPE Board voted to end the opportunity for NACC supervisors to apply for ACPE certification through this reciprocity agreement (Spring 2006). Where do you sense the “butterfly effect” in your ministry? In NACC?

NACC continues to work with CHA (Catholic Health Association), with schools of theology and health systems across the country. Some of the effects are already seen -- advocacy, a brochure, a video, and planning for joint educational offerings.

NACC Board of Directors Election 2009 begins with new e-balloting voting process

Beginning this fall 2009, our election to fill the one position on the NACC Board of Directors will be conducted electronically with an e-ballot. The association is using VoteNet (www.votenet.com), a highly reputable firm. The NACC Board of Directors has chosen this means as it has proven for other associations to be highly efficient, easy-to-access and use, effective and reliable. Members will receive in the next couple of weeks an e-mail message or letter providing specific instructions. The e-mail

instructions will provide a direct link to the VoteNet website. Those who do not have an e-mail address will be sent a letter with the website address and specific instructions. Members will have one month (Monday, Sept. 14, through Monday, Oct. 12) to submit a vote.

In this *Vision*, you are introduced to three highly qualified board candidates: Rev. Jack Crabb, S.J., Rev. Dean Marek, and Ms. Marie Polhamus. We thank them for offering themselves for this important ministry.

Meet nominees for election to the NACC Board of Directors

Marie Polhamus



When I look back over the last 15 years as a chaplain and director of a Spiritual Care Department, I am so grateful for this profession and the opportunities it has allowed me to follow a call/vocation of ministry to those in need. When I look toward the future, I am committed to the continued professionalization of

chaplaincy, to encourage others to answer the call to service; to work within the NACC to make this profession one in which salaries are commensurate with the education and

experience required for certification. I continue to believe it is very important to have an organization that is there to advocate for the person serving in the healing ministry of Jesus in the name of the church. As I said in another statement, "All of the NACC membership needs the guidance and support of a strong and respected organization such as the NACC."

I will work for the continuation of advocating for all the membership. I will continue to work in promoting full participation of the membership and involvement in the NACC — creating a powerful voice that will be heard in support of this ministry performed by certified chaplains.

Blessings,
Marie

Rev. Dean Marek



As an NACC board member I would bring the experience of hospital bedside ministry as well as 15 years of administration in the Department of Chaplain Services at Mayo Clinic, Rochester, MN. I have served NACC on certification interview teams, on a national conference planning team, with presentations at several

national conferences and invited workshops, through articles in *Vision*, and as a participant in the NACC/CHA Pastoral Care Summit in 2007 and a member of one of the task forces convened to carry on the strategic plans of the Summit. I am

currently retired from administration at Mayo but continue to minister half-time at the bedside. Thus, I am blessed with the time and opportunity to serve our association in other capacities.

As a member of the board, I would advocate for the following: the promotion of professional competence and certification of the pastoral care staffs in Catholic healthcare organizations, an NACC voice in national healthcare policy, a common set of standards and understanding among certifying organizations of the services certified chaplains provide, research to assess patient expectations and methods to determine the unmet spiritual needs, a common understanding of outcome-based practice, and an improved relationship with the USCCB relative to the status of non-ordained members of the pastoral care staff and the anointing of the sick.

Candidate Profiles

Fr. Jack Crabb, SJ



I graciously accept the nomination for 2010 Board of Director's position and if elected am willing to serve. The NACC has been my professional home for the past 13 years after many years in Jesuit high school ministry as teacher and administrator. After my initial chaplain certification and subsequent CPE supervisor certification, I was

active in the New England area as an interviewer and a member of the certification committee. That sparked my interest to be more involved in NACC on the Certification Commission. I finish my six-year term this December, the last three years as chair. I have also been involved with the Vision and Action Committee that saw our five-year strategic plan become reality.

When I saw the announcement seeking applications for the Board of Directors I looked at the five areas and realized that I had numerous experiences in each area (NACC, strategic planning, organizational thinking, cutting edge communication and marketing tools, and board experience). I wish to continue to offer myself and my gifts in service to

the NACC. I have a creative and practical approach to various issues and am a person-oriented individual who enjoys relationship-building and fostering a spirit of inclusiveness. As chair of Certification I invited a native African to read the names of our African brothers and sisters at the Missioning Ceremony during our annual conference as I value each person and want the individual's name to be correctly announced. Yearly I have invited members to become active in the association by starting as members of interview teams.

If elected to the Board my hope would be to see the Board seek greater input from the members via more focus groups and surveys as were part of our Vision and Action Initiative. I would encourage the Board to have more opportunities for members to speak at the annual conference by providing the main reports in writing with the registration packets. I would promote having the members of the Board be more accessible to the membership. I would encourage the Board to make available to the membership key agenda items. Therefore, I would welcome receiving members' input on these agenda items of the Board prior to decisions being made that affect the membership. All of these items would be priorities for me if I am elected to the Board of Directors.

Thank you for your consideration.

Revised Standards call for building peer relationships

By John Gillman, Ph.D.

Peer relationships are deeply rooted in the Christian Scriptures, the most fundamental document for Catholic chaplains. Early in his ministry, Jesus appointed others to collaborate with him in bringing health and healing (Mark 3:13-19), and Paul, though he looms large in the New Testament, worked within a broad network of apostles and evangelists, teachers and emissaries.

We know the names of both male and female disciples who followed Jesus or who were part of Paul's circle of co-workers. To recall a few from the first generation of leaders who accompanied Jesus, there were James, John, and Mary Magdalene, each mentioned in the Gospels. In Paul's letters we hear about the collaboration of Timothy and Titus, Priscilla and Aquila, and lesser-known male and female companions such as Andronicus and Junia, who are called "prominent among the apostles" (Rom 16:7). Although conflicts were inevitable among colleagues (see Mark 9:46), those who worked side by

side, such as the pairs sent out two by two (Luke 10:1), could hardly avoid the task of building peer relationships to be effective in ministry.

Two of our revised NACC standards address the importance of these relationships:

- ▼ 305.2 Establish and maintain professional and interdisciplinary relationships.

- ▼ 305.21 Demonstrate the ability to build peer relationships for the purpose of collaboration and active participation in the creation and maintenance of a healthy work environment.

Our peer relationships with other chaplains and community clergy, our interdisciplinary relationships with social workers, RNs, MDs, and therapists, and our professional relationships with managers and administrators, all form part of the complex network of connections in which we work. These standards address our ability to form such relationships so that we can



— See [Advancing the Profession](#) on page 14.

Dream Job

Continued from page 1

that first interview focused on the poor. “Is there a sincere in-your-face commitment to the poor at St. Francis? The underinsured? The uninsured? Is the mission I’d naturally connect with the saint, Francis, “alive and well?” The mission statement, core values and dynamic witness of the two women across the table assured me I was scouting the right team, plus St. Francis was in a comparable neighborhood to southwest Baltimore, culturally and racially diverse with a high crime rate. I was in the right ballpark.

As an extended student in CPE training I studied with five culturally and religiously diverse supervisors and worked in four different hospitals. My last two units at St. Mary’s, an acute care hospital in Langhorne, PA, excelled in offering opportunities for pastoral outreach. Sites in the four hospitals included: a skilled nursing home; a permanent home for 16 mentally ill women otherwise homeless; a cancer center; and an at-home hospice. I soon realized I’d come to the table with the bases loaded. Cleats dug in, weight shifting side-to-side; focused with a prayer, I was poised for the pitch.

A grand slam! One more interview for clarification and I had a part-time position beginning in July 2006.

“Just one person can bring new life into a stress-filled world.”

—Margaret Silf

St. Francis was my first job as a Board Certified Chaplain. Continuing with a few baseball metaphors, Same Day Surgery (SDS) had a few coaches and signals I had to master before really qualifying as a team member. I was green as grass. Collaboration with the nurse manager of the unit alerted me to the boundaries necessary when scheduling back-to-back surgeries. If not attentive, instead of bringing “new life” I could add to the stress of a team that ran like clockwork. We shared succinctly the nature of my ministry, i.e. identify and relieve any anxiety or disturbing or futile feelings with pastoral conversation and prayer. I assured the nurse manager that when the patient was needed, just a tap on the shoulder or a nod of the head would do to end my conversation with the patient. I wanted to help not hinder. In time I would learn their signals and respond in kind. Once she relayed the plan, we were on the same page. “Having a chaplain on the team added to patient satisfaction on the NRC Picker evaluation mailed to each patient,” I was later informed by the nurse manager of SDS Unit.

Within a week in SDS, I realized time was of the essence. Instead of 8:30 a.m., my day needed to begin at 7 a.m. St. Francis has two waiting rooms: a rather small, sterile room where you register with chairs against the wall on all four sides (about 16) and an additional, well-orchestrated, comfortable room where family and friends wait during the day. A plus for children and others waiting is a huge fish tank, floor to ceiling.

Soon I launched into a Trinitarian (I like thinking in threes) schema: control, compassion and co-union. I remembered that

knowing the lay-of-the-land soothes most. As I entered the smaller room I’d begin: introduce myself as chaplain to the patients and their loved ones, question if anyone had been here before, if so, I’d tell them, fill in if I leave something out. Then I’d brief them on what was to come: Phase I, the patient gets the most beautiful gown and crown then returns; Phase II, nurse comes for the patient; they leave and a series of confidential questions are asked. It’s the only time aside from surgery itself that loved ones are separated from the patient. When the confidential questions are completed, you are then invited to join them again and sit by the bed until the patient is wheeled out; you then exit through the corridor you came in, turn right and go to the “fish tank” room where you’ll find TVs, lounge chairs, complimentary coffee and tea. By 9 a.m. a volunteer in a peach smock and a nurse will be at the registration desk to your left as you enter. Give them your name and who you came with; the nurse is your go-between, keeping you informed throughout the day. Don’t worry if you forget; they’ll come to you for any information they need and keep you informed. You will see someone from the surgical team before you leave the hospital

today. They’ll come to the waiting room or invite you to come to the backroom of SDS. Where they meet you usually depends on how tight their schedules are. Once I forgot to add the last instruction and one distraught woman thought they were calling her to the backroom because a crisis occurred. Knowing is a comfort to

loved ones and gives them control of their day. I try to interject some humor as well; it’s good medicine for whatever ails you.

The privilege of our ministry is to invite people to pray. I then invite anyone who would like to pray not only for their loved one but in solidarity for all the sick here in the hospital and around the world to please join me in the center of the room. As I walk toward the center with outstretched hands, I add that if you’re not comfortable, stay where you are. We’ll still be praying with you. Once in the circle I draw attention to our held hands, “No matter what color, culture or religion when someone we love is ill we all feel the same.” I ask them, wanting to be politically correct and respectful of all religions, Muslims? Hindus? Christian or Jewish? Mormons or Jehovah Witnesses? Seventh Day Adventists? When we’re all Christian I pray in the name of Jesus ending with the Our Father. If not, I address God as the Creator of us all and all respond with an “Amen.” In the two years plus that I’ve been doing this in SDS, I can count on one hand those who have remained seated. Though not sharing bread as in Communion, I feel such a co-union as we, a roomful of total strangers, share prayer with a deep sense of compassion one for the other. Nurses slip in quietly and with a gentle touch to the shoulder direct a patient out of the circle when necessary. Later you often see families talking to each other in the “fish tank” room.

They return to their seats as I quietly approach each group and ask the patient’s name, checking them off my daily printout, adding only the first names of family and friends. Some choose to talk at that time. Others ask me to see them in the back of the room before they go in to surgery. Following are two vignettes of



incomplete pastoral conversations where I feel no one could deny the need for chaplains in outpatient ministry.

Patient was waiting alone for her procedure. She and her husband had prayed in the circle. "I'm so glad you came and prayed with all of us. I've never seen that done before. I sent my husband down for some breakfast. He's such a good man but he doesn't handle sickness very well. I'm so worried about him. We've been married almost 56 years now, and I've always prayed he'd go before me. They're doing a biopsy today. Would you look for him in the waiting room; I know he's very anxious; maybe he'd open up to you? We're not Catholic, but he's a very religious man." This stream of concern trickled from her without taking a breath or waiting for a response. More than words she wanted "ears" to hear her heart. Tomorrow I'd look on the new admit list for her name. I prayed it wouldn't be there.

For comfort, some patients sit in a recliner as they wait. Our eyes locked as I turned from another patient across the room. I remember he opted to pray in the circle as I walked toward him. "I really didn't want to come today, but my wife was determined this not be put off. I'm not complaining. It's just too much time to think. (Slight pause, I waited,) Almost three years ago today, my teen-age twins (a boy and a girl) were murdered in our home by a family friend. Often he came over for dinner; sometimes he just hung out and watched a DVD with us. He was always welcome; only this day he was high. My wife and I were grocery shopping." We have forgiven him but the pain recurs like a wave. Holding hands I prayed for the grace of "one day at a time." He was about 40. We never saw each other again.

SDS at St. Francis has doubled its patients in the last year. I think of outpatient ministry as imperative — "Good News" in Catholic healthcare.

Sr. Andre Dembowski is a chaplain at St. Francis Hospital in Wilmington, DE, and resides at the 1831 House, in Baltimore, MD, one of approximately 10 such houses in the United States that are sponsored by the Sisters of Mercy to be a presence to the poor, living and working with them as their neighbors.

Healing

Last night
so little was said
of what was thought.

On this, my last visit,
as always
everything remained just so,
your chair, your books
your pictures on the mantel
of your lovely daughters
smiling.

You said you were tired now
had seen too many days
life scooting away
had contemplated too much
death coming fast.

You spoke of the cancer
how it consumes entrails
grabs hold of everything,
even your clear mind
still battling, bracing
for the final foray,
contemplating the possibility
of darkness,
imagining a face-to-face meeting
with God.

You let me hold
your spirit in these palms.
We traveled dirt roads,
up winding driveways
to white mansions
in South Carolina,
rocked for hours
on front porch boards
heard crowings at dawn,
waited and watched
for long furrows
to yield plenty.

Every day
with every ounce
you walked, spoke, listened
gave your life
to family
to men who made history
to printed newspapers
to words, stories, poems;
the making of hearts
the breaking of souls.

Last night
I wanted to remove your pain

but could not.
There was no consolation
in watching you limp and wince
settling into the easy chair
from which so often
you had spoken,
but there was a new grace—
surrender,
acceptance,
understanding,
faith,
hope,
love—
big words
too big, perhaps
too abstract,
unsuitable for an ex-newspaper
man's
last offerings
or my last thanks.

But thank you anyway,
for not being too proud
to let me see you
need a cane.

Thank you
for sharing once more
the place by your fire
your lesson of warmth.

Thank you
for the calm of your voice
for your sacred words
that will carry me, always.

Driving from your house
I thought of the quail's choice
to stay or fly
when the hunting dog inches closer,
and a radio angel sang softly,
"Though you may see darkly now,
your faith will move mountains,
and your love will endure."

-- David M. Orr

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



Why a retreat?

Cancer patients seek hope, sharing of journey

By Phillis Bennett, BCC

"Healing is a matter of time, but it sometimes is also a matter of opportunity." — Hippocrates

Course evaluations from Mayo Cancer Center public education events revealed that our patients value spirituality. Breakout sessions on spirituality and hope, as they relate to the experience of cancer, consistently received high ratings and attendance from conference participants. The evaluation of a chaplain presence conducted by Mayo Chaplain Services concerning a year long pilot in 1996-1997 involving outpatient cancer patients and their loved ones demonstrated the need for enhanced spiritual support. Setting apart a special time and sacred space for patients to gather and reflect upon their cancer experience outside the clinical setting would complement efforts provided by a chaplain in the Mayo Clinic Cancer Center in Rochester, MN, to meet the psychosocial and spiritual needs of our outpatients and their families.

A number of patients disclosed during dialogues with the chaplain that even though they had a supportive family, friends and church, they still struggled with loss of hope, feeling isolated and lonely. They expressed interest in connecting with other cancer patients and sharing their journeys. The concept of offering a retreat came out of these expressed needs. A group of us met with a sister of St. Francis who was in the terminal stages of the cancer experience. We asked her as a patient for input on how to put this retreat together. The planning committee included two chaplains, Phillis Bennett, outpatient chaplain in the cancer center, and Scott Jorgenson.

Marty Riley became our event planner. Sr. Linda Weiser, director of Integrative Therapies, Jane Chelf, a nurse researcher and event planner for the cancer center, and JoAnne Lower, a storyteller and artist-in-residence from Iowa, made up our coordinating committee for what we then named The Hilltop Retreat for persons and families living with cancer.

All members of our planning committee had personal experience with cancer through family members. One of the points of interest for us was that the history of the Mayo Clinic had been based on the collaboration between the Sisters of St. Francis and the Mayo brothers after a tornado

went through Rochester many years ago. We saw this historical connection as significant as we planned the first retreat with Sr. Linda Weiser and Integrative Therapies at Assisi Heights here in Rochester. Because of the tornado the sisters and the Mayo brothers were brought together collaboratively and St. Mary's Hospital and the Mayo Clinic became a reality. The first retreat we had was an overnight at Assisi Heights. We were in the hallway at 1 am because of sirens for a possible tornado in Rochester! We decided the primary purpose of the Hilltop Retreat was to provide a non-denominational weekend of reflection, learning, sharing, inspiration and renewal for people affected by cancer.

The retreat provides participants with the opportunity to:

- ▼ Learn to better understand and accept their feelings about cancer from speakers having personal experience with cancer or being knowledgeable about the psychosocial effects of cancer.
- ▼ Interact with others facing similar challenges with cancer.
- ▼ Have some time for personal reflection and solitude.

The secondary purpose was to reinforce awareness that

Mayo Clinic is equally as concerned about the psychosocial and spiritual issues of cancer patients as with providing quality clinical care. Little research is available about how to bring patients and family members together in a protective environment that can foster and maintain hope. Rutledge and

Raymon state that retreats for patients with cancer and their caregivers take the concept of group support one step further by removing participants from their everyday environment and creating a caring community atmosphere. A retreat involves going off to a quiet place to reflect on the events of one's life. It's a time to examine, discover and rediscover the peace in the present and hope for the future.

A retreat opportunity can help patients break through the isolation by sharing their feelings and experiences with others who have experienced a similar situation (Rutledge and Raymon, 2001). We offered time-limited interventions that included group interaction, massage therapy, music therapy, relaxation training and the telling of one's story. Participants were encouraged to use the information from the presenters to stimulate small group interaction. The presenters were peers who had lived with cancer and were willing to share their stories. We also had professional presenters, such as a social worker, nurse, doctor, and chaplains to provide helpful information and support during the retreat. Some of the questions we invited the attendees to reflect on were:



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A number of patients disclosed during dialogues with the chaplain that even though they had a supportive family, friends and church, they still struggled with loss of hope, feeling isolated and lonely.

- ▼ What does hope mean to you?
 - ▼ Share with your group about your own hope. What kinds of things do you hope for?
 - ▼ Identify a source of hope for yourself. What helps you maintain your hope or helps you feel hopeful?
- We established the following as retreat goals:
- ▼ Provide enhanced spiritual care for patients who receive treatment at the Mayo Clinic Cancer Center.
 - ▼ Provide a safe place to explore psychosocial and spiritual issues related to the cancer experience.
 - ▼ Provide patients with options for developing spirituality, such as touch, meditation, sacred ritual, music, storytelling, journaling, reflection time, holistic body therapy.
 - ▼ Create community and the opportunity for connectedness for cancer patients who may be living in isolation.
 - ▼ Enhance the quality of life for persons living with cancer and their loved ones.

Although no universal meaning of hope exists, hope has been described in a variety of ways. Hospitalized cancer patients have depicted hope as a motivating force, an inner readiness to reach goals. It has been defined as a positive expectation that goes beyond visible facts and a belief that a personal tomorrow exists. Hope changes depending on the individual's perception between themselves and their environment. It is based on the realities and values of the individual who is doing the hoping. Dufault and Martocchio assert that there is always some level of hope. Hope is a coping strategy used by those confronted with an acute or chronic illness. A terminally ill patient's level of hopefulness is markedly different from that of someone with a new diagnosis. Hope has many dimensions to it that provide comfort while enduring life threats and personal challenges. Hope and hopelessness are not opposite ends of one continuum, nor is hopelessness the absence of hope. Hope and despair are interactive and intertwined with health and illness.

Several authors cite studies in which a sense of hopelessness resulted in giving up or in experiencing adverse health outcomes. In contrast, hopefulness has been associated with favorable psychosocial adjustment, health and healing. Several factors are reported as contributors to a sense of hope for people living with chronic illness. These include healthcare professionals, spiritual well-being, past successes, a sense of worth, a philosophy that persons have limitless potential, the ability to survey reality, achieving symptom relief and the ability to find meaning in suffering. In contrast, a perceived lack of control, adjustment problems and a negative affect contribute to hopelessness. Social support is defined as "an exchange of resources between two individuals that is intended to enhance the well-being of the recipient."

Social support influences coping. Support enhances self-worth and the feeling of being loved. Perceived social support can be more important than actual social support.

Additionally, the significant other's sense of hope influences the patient's sense of hope. Caregivers were reported to foster hope by being present, giving information and demonstrating caring behaviors. In contrast, caregivers negatively influenced hope by presenting information in an insensitive or disrespectful manner.

Some researchers have proposed that emotional support from others can assist individuals in maintaining, augmenting and even renewing their coping efforts in response to their illness. It has been suggested that hopefulness is a prerequisite to the mobilization of coping resources and strategies. An individual's capacity to cope with and adapt to illness may depend, at least in part, on the ability to sustain hope. The actual role of hope in the coping process is unclear, but it can serve as a personal resource. Hope represents a belief that a desired outcome could occur even though prospects are uncertain.

Outcomes of hope include energy, personal power to confront stress, healthy coping, healing and transcendence. Herth reported a positive relationship between hope and religious faith. Many of my patients when asked about their ability to cope with their illness mention the importance of their relationship with God. They state that they could not have survived without that presence in their lives. Our hope with offering this retreat was that this resource of spiritual and social support would foster hope and promote effective coping and enhanced well-being.

Chaplain Phillis Bennett has worked in outpatient areas at Mayo Clinic in Rochester, MN, for 14 years. She and her colleagues have presented at research conferences on their Hilltop Retreat for cancer patients and their families and on a study on hope building in a supportive community that they conducted during one of their retreats.

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Hope has many dimensions to it that provide comfort while enduring life threats and personal challenges. Hope and hopelessness are not opposite ends of one continuum, nor is hopelessness the absence of hope. Hope and despair are interactive and intertwined with health and illness.

Outpatient chaplaincy means ministry 'in the moment'

By Ruth Jandeska

I have never valued the importance of a good night of sleep as much as I did when I was the chaplain of an Ambulatory Surgery Center (ASC). The word *ambulatory* comes from the Latin "*ambulare*," which means "*to walk*." The day starts very early in the ASC. Patients might arrive as early as 5 a.m. and start registering. By 5:45 a.m. they are admitted and taken for

lab work and other testing. It is a very fast-paced unit with a heavy flow of patients almost every day. One of the characteristics of this unit is that it has its own natural flow. Like most ASC's, patients are admitted, evaluated, moved to the pre-operative room and then to the operating room (OR). Once the surgery is finished, patients are taken to the Post-Anesthesia Recovery Unit (PACU).

I quickly felt my need to be well rested so that I would be more intentionally able to pay attention to my feelings and respond effectively and empathically to my patients.

Since ambulatory surgery involves procedures that can be intensive, but not so much as to require hospitalization, one might think that spiritual care is not required in such a setting. But patients' and families' spiritual and emotional needs may not arise until *that very moment* in which the impending surgery has become imminent, and my goal as a chaplain was to provide a safe space for them to raise those needs, to have them acknowledged and to have them addressed whenever possible. I visualized and compared my "ambulatory ministerial work" ("*ambulare*") in this unit with that of Jesus, when he just walked around the towns and conversed with the people he met. He cured and healed those he was able to, giving them a message of hope and peace *at that moment*. I started every day with this image in my mind.

Patients and families are told by the receiving nurses about the flow of the unit as their day begins. I always found that repeating this information to the patients when I visited them, served as reinforcement and security, and helped them reduce their feelings of powerlessness because of the sense of control they gained with knowledge.

I visited patients during the different stages of their intake depending on their availability. In many circumstances, I visited them along with other medical personnel. I quickly learned to pay attention to my own self, since if I was not careful my introverted nature could prevent my "voice" and "pastoral authority" from being heard and could affect my interaction

with the patients.

I introduced myself and my services. When patients and families expressed no needs or said they were not interested, I offered them my best wishes and prayers for a successful surgery and speedy recovery, then quickly dismissed myself. Since a patient's time in the pre-op area can be brief, I could not elaborate on my spiritual assessment. I asked the patients and their families how they were doing, and I addressed their needs according to their responses.

On one occasion, a patient responded that she was upset and afraid. She had missed Mass the day before and she so much longed to be able to have Communion. The patient spoke of how she had almost never missed Sunday Mass and how Communion was such a part of her spiritual life. She described herself as a very devoted Catholic. She felt frustrated because she could not go to church due to physical pain. The impending surgery prevented her from taking anything by mouth. I listened to her and acknowledged her frustration. I wondered if she was more upset this time than the other times that she had missed Sunday Mass. The patient quickly acknowledged she was more upset this time because of her fears of death, and that if she were to die this day she would

have loved to have had Communion. I sensed her fear of feeling "disconnected" from God. Had she been an inpatient, I would have allowed her to continue to speak and reflect on her beliefs about death and life after death in relation to her fears. But knowing that *momentarily* she

would be taken to the OR, I ventured to improve her spiritual well-being and offered hope and comfort by speaking of the role of Word and Sacrament for those unable to receive, and that although she was not physically able to receive Communion, she was in communion with God by the intentions of her heart. We reflected on the sacred presence of Jesus in the Word and prayed through the Scriptures. Afterward, she expressed her feelings of relief and being at peace, and then she was ready for her procedure.

In many cases patients said they were fine with their upcoming procedure but acknowledged feelings of distress due to a particular situation at either home or work. They wondered about when they would be able to go back and continue addressing those particular issues. By being present to their current needs without carrying any assumptions, I was able to meet them where they were *at the moment* and it allowed them to receive comfort as they released their worries.

Moreover, some of my conversations with my patients were about quality of life. During the intake, patients are asked whether or not they have an Advance Directive and are encouraged to write one before the procedure. As chaplain, I witnessed these documents and promoted conversations between patients and families regarding meaning and hope. For example, one day I visited with a 95-year-old lady and her daughter. The patient stated this was the very first time she

During the small breaks, I checked *in the moment* with the nurses and secretaries to provide them with opportunities for talking about their morning experiences. I liked to establish relationships with the hope of increasing trust, so that I would better serve the whole team in terms of professional and personal needs.



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Q&A with Anita Lapeyre, RSCJ, MA, BCC

By Laurie Hansen Cardona
Vision editor



The poor, the immigrant and the disenfranchised have a friend and advocate in Anita Lapeyre, RSCJ, who recently retired as executive director of the Center for Urban Ministry in San Diego, CA. Born in New Orleans, LA, Sister Anita has

lived most of her religious life in St. Louis, MO, and San Diego. She was coordinator of Catholic chaplains at the USCCB during the middle 1980s and developed the first standards for certification and accreditation for Catholic chaplains and centers. Since 1987, she has been in San Diego, where she founded the Center for Urban Ministry and was a CPE supervisor.

In August 2009, she retired from the center and is now involved in spiritual direction with the Spiritual Ministry Center in San Diego. "Tita" as she is often called, is a member of the Society of the Sacred Heart and celebrated her 50th anniversary of first vows in March 2009. She holds an MA from Loyola University in New Orleans in



educational counseling, a certificate from St. Louis University in corporate ministry, and is certified as an ACPE/ NACC CPE supervisor.

Beyond the field of chaplaincy, she has worked as a teacher, a director of admissions at Maryville College in St. Louis, a counselor, and as president of St. Madeleine Sophie's Center for adults with development disabilities.

Before her retirement, Sister Anita agreed to respond to questions for this Q&A interview with *Vision*.

Q What kind of outpatient ministry do you do at the Center for Urban Chaplaincy?

A At present the center has sites at a hospital five minutes from the border, a social service agency that has multiple programs for runaway teens, homeless families, persons with HIV/AIDS, and persons in need of low cost housing. We also have a program with a residential center for children who need to be removed from the home and have severe emotional and behavioral problems. We supply spiritual care for a mobile health unit that goes to different congregations each day and treats persons with no health insurance. We also supply a chaplain to a government-funded day program

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needed to be in a hospital besides her hospitalizations during the births of each of her seven children. She had never heard of an Advance Directive and was curious to learn about it. I explained to her what an Advance Directive was and the reasons why it was important to have one. She stated that she always had been a healthy and independent woman. She enjoyed her very large family and numerous friends. She felt she had been blessed with a full life. She required at this time a total hysterectomy, without which her health would be extremely affected. She spoke of taking the risks of going through this surgery and expressed her desire that no heroic measures would be taken if her quality of life afterward would not be the same as it was now. Her daughter held her hand all this time and was very gracious to hear her mother's wishes, of which they had never talked before.

Furthermore, the flow of the unit may be affected by unexpected situations that can lead, for example, to inadequate communication among the staff or delay in surgeries. These can cause anger and distress in both patients and staff. I provided space *right in the moment* for staff and patients and families to express their frustrations and offered effective listening through reflective statements. I observed how this greatly helped to defuse anger.

The staff valued my interventions greatly, especially when I visited with those who were evidently distressed. I paid attention to their feelings and allowed them to express their fears. This way of receiving comfort allowed them to relax and to be able to

continue their conversations with the medical team regarding their procedures. I also supported the staff by making my interventions quick so that the team was always ready to move on whenever they needed to do so.

During the small breaks, I checked *in the moment* with the nurses and secretaries to provide them with opportunities for talking about their morning experiences. I liked to establish relationships with the hope of increasing trust, so that I would better serve the whole team in terms of professional and personal needs.

My goal in the unit was to be visible, but not an obstacle. For some, the presence of the chaplain is a reminder of God's continuous presence and care. I aimed to convey that message during my visits and during my rounds throughout the unit and the unit's waiting room. At the same time, my assessing and addressing the needs were aimed to be seamless with the rest of the care provided by the team, so that the natural flow of the unit was not affected. Being a chaplain in ASC provided me with an enormous opportunity for growth and a much greater appreciation for the work that I do, that is, to always *be in the moment*.

Ruth Jandeska is a chaplain in the Obstetrics Department and Neonatal Intensive Care Unit at Loyola University Health System in Maywood, IL. She wishes to acknowledge Fr. Andrew Phiri, chaplain, and Jerry Kaelin, director of Loyola CPE, for their comments on this article.

Q & A

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for the elderly. This program provides meals and all medical needs for low-income elderly adults. Most suffer from mild dementia and the idea is to offer support and care in order to allow them to remain in their own homes as long as possible. Sites vary from time to time and we add or close some sites as finances or needs require.

Q What urban life problems do your chaplains aim to handle?

A Our chaplains don't have a particular aim with the patients they visit. Each person has his/her own needs and these differ from person to person. What are universally common in our patients are multiple grief issues, a sense of isolation and being ignored by systems, the fear of poverty, the inability to have readily available support systems, and multiple barriers to accessing healthcare and resources for a better quality of life.

Q What type of empowerment do the chaplains offer and what methods do they employ?

A There is no one answer to this question. Each person needs to be empowered in ways that are specific to their own needs and development. It may be to help them be empowered to work with their physician regarding the side effects of their medication, to seek help with acquiring skills they need to be employed or more independent. In some case it may be to respect their choice not to seek help or to take their medication. Chaplains serve their clients by making certain they are as informed as possible about the decisions they are making, to offer encouragement and support on the long road of recovery. Chaplains always seek to help clients have a voice, to express their deepest desires and to help them to find ways to achieve their goals.

Q Could you give *Vision* readers an example of the multiple challenges an immigrant patient may be facing?

A Language is always a challenge. Even though a patient/client may have an interpreter or speak English, the complexities of medical options and terminology make it difficult to assure informed consent. Often a lack of family support or any support systems create obstacles to good health practices upon discharge. If the patient is illegal this complicates his/her access to continued healthcare, medication and other assistance. Even if the patient is legally in this country there is fear that other family members may be at risk if he or she gets into the system.

Many immigrants do not know how to access the health system or what assistance might be available to them. Services can often follow the patient upon discharge but because of the demands on social workers and other medical professionals and the short length of most hospitalizations

these options are often not made known to the patient. Chaplains can play a vital role in accessing what might be helpful to the total well-being of a patient and making certain that appropriate healthcare professionals inform the patient as to what is available and how to access these services.

Isolation, lack of familial support, and alienation from what are familiar, e.g. native foods and meaningful spiritual practices, tend to further isolate patients. Simple questions such as "what do you miss most?" may help the patient to trust and to be willing to disclose needs to medical staff and chaplains.

Q I understand your CPE student interns can be placed in maquiladoras (assembly plants owned by U.S. corporations or companies from other developed nations) in Tijuana, Mexico, among other places. What kind of ministry is done with maquiladora plant employees?

A For over two years the center did have a chaplain in Tijuana. What we learned was that to be successful, a bilingual and bicultural person was required to serve in this site. When we could not find a bicultural person we had to drop the site.

This was probably one of our most intense sites with a variety of social problems. There was rampant domestic violence, infidelity, illegitimate children who were not cared for by their fathers, rape, incest, drug addiction, human trafficking issues, and other difficult family and personal concerns. There was also a hunger for the spiritual and a great desire to find forgiveness and peace.

The maquiladora where we served had a socially conscious manager so there was a much higher wage paid workers than at other factories albeit this was still not a truly just wage when compared to U.S. pay. However, there was free healthcare at the maquiladora's clinic, a day care center, and free bus transportation to and from work, assistance with housing and subsidized meals during work hours. In comparison to others, these workers felt that they were being treated as dignified human beings, acquiring skills that would give them a better way of life. The chaplain taught English classes to improve the workers' ability to communicate. There were also classes in Spanish about leadership and empowerment as well as dealing with the personal problems of the employees.

Q Has the struggling economy exacerbated the problems seen by your chaplains? In what ways?

A The economy has made an impact on the people we see. More are in need of health care and avail themselves of the free clinics and the mobile health unit. At the same time they find it increasingly difficult to pay for medication and often do without medicine to buy food or other necessities. The free food distribution lines are longer, and more families are seeking shelter at the various social service sites we service.

Outpatient Ministry

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Carmel East responded to that challenge, and how that changed the focus and perception of our department.

At the time the assessment took place, construction was occurring on the Mount Carmel East campus. There would be increased service lines in cardiology with the inclusion of open heart surgery, and the maternity unit was expanding. Outside the hospital, additional buildings were popping up. These housed inpatient services as well as new physician offices. As a department, we decided that our initial outreach would bridge communication with the physicians who practiced on our campus. I obtained a list from our medical staff office of all physicians on staff and sent a letter introducing the department, our expertise and the various services that we offer in the hospital. I suggested that we could provide spiritual support to those patients who they deemed appropriate right from their offices.

The initial result was silence, and there was no way to gauge whether the letters were actually seen and read by the physicians or simply discarded by office staff. Approximately three weeks after the letters were sent, I received a call from a renal specialist who had an outpatient dialysis clinic on our campus. He shared with me a bit of the clinic's history, the type of patients being served, and the dynamics that occurred with the staff. I told him that I would be happy to come to the clinic and meet the staff in order to discuss services we could offer. That initial contact proved fruitful, and a week later I began to make weekly visits to the clinic.

Dialysis patients have to focus their lives around their dialysis schedules. Activities are planned based on their knowledge of how they will feel both before and after a treatment, and most of them deal with life and death questions on a daily basis. It is not uncommon for them to come in for treatment and find out that the person usually next to them has been hospitalized or has died. These are men and women who spend often three 8-to-10 hour days with one another consistently; in many ways they become family, and that family is extended to the staff caring for them. Ministry to these patients is deeply needed, and in time I began to hear their stories, their hopes and their fears. We had memorial services for their friends and made cards for those in the hospital. We prayed and worshipped together, we talked and sat in silence, and we grappled with the ultimate question of eventually terminating dialysis and allowing death to occur.

Whenever a dialysis patient was admitted to our hospital, our department was notified and pastoral care was then provided here. It was wonderful for the patients and for me to have connection and history, and the insights I

was able to contribute to the multidisciplinary team could never have been gleaned if we had waited and just visited this person in house. Never before did the seamless flow of continuity of care seem so fluid and the result was greater support for the patient both in and out of the hospital.

While I was engaged in the formation of the relationship between the clinic and the department, I also began working with the outpatient pulmonary rehabilitation group. Each group went through an 8-week program that focused on members' ability to cope with chronic obstructive lung disorders and improve their lives. I was part of a multidisciplinary team that presented classes focused on the totality of the patient; my class was in "the spiritual dimension of chronic illness" and eventually a section on advance directives was included. While there

was a common thread of concerns voiced by both the renal and respiratory patients due to their chronic illnesses, the dynamics within each group as well as the questions grappled with were unique. The work with the respiratory patients uncovered a consistent need for encouragement and collegiality and this led to the formation of a support group for patients with chronic obstructive lung issues.

Ministry outside the hospital is not done in a vacuum, and when one is working with patients with chronic illness, there is a consistent ebb and flow in which they are admitted to the hospital for an exacerbation of their illness or something else relating to it. The chaplain engaged in outpatient ministry with these patients has the unique opportunity to form relationships that flow back and forth from the hospital to the outpatient setting. In this time of short hospital stays, this type of connection is invaluable.

In the current economic milieu, it is of utmost importance for hospitals to be recognized for excellence in service. Data has suggested that an encounter a person has as an outpatient can form a lasting impression about the effectiveness and credibility of that institution. Chaplaincy services can become an integral part in the formation of customer loyalty and satisfaction. These two criteria form part of the equation in providing for the financial solvency of an organization. Chaplains have the skills to be part of the financial health of an organization; the challenge is how to demonstrate it in a way that administrators understand. Ministry with outpatients may prove to be a good place to start.

Michelle Lemiesz is director of chaplaincy at Mount Carmel East and Mount Carmel New Albany Hospitals, in Columbus, OH.



Data has suggested that an encounter a person has as an outpatient can form a lasting impression about the effectiveness and credibility of that institution.

Austine Duru named to Editorial Advisory Panel

The NACC Board of Directors, at its May 26 meeting, approved Austine Duru, staff chaplain at St. Margaret Mercy Hospital in Hammond, IN, as a new member of the NACC Editorial Advisory Panel.

He will serve a three-year term that can be renewed one time. Mr. Duru has offered to help with the Research Update section of *Vision*. He had been working with Editorial Advisory Panel member Paul Buche, prior to Mr. Buche's death, to seek out researchers on chaplaincy issues who might publish articles in *Vision*.

Born in Nigeria, Mr. Duru received his bachelor's degree in philosophy (2000) from Seat of Wisdom Major Seminary, an affiliate of Pontifical Urban University in Rome. In the same year, he received his bachelor's of arts from Imo State University in Nigeria.

While in the seminary, Mr. Duru received awards for his creativity, academic excellence and gifts as an artist. He was also on the editorial board of *Pentecost Magazine*, the *Wisdom Magazine*, and the *Magazine of the National*

Association of Philosophy Students (Seat of Wisdom Sector). Mr. Duru also served as the associate editor of *Lumen Newspapers* for his home diocese of Umuahia, Nigeria, for 18 months.

Mr. Duru completed his clinical pastoral education at Northwestern Memorial Hospital in Chicago, and his residency at Rush University Medical Center, also in Chicago.

He began his studies in theology at Catholic Theological Union at Chicago in 2003 and was subsequently awarded both a master's of divinity (2009) and a master's of art in theology (2009), with concentrations in ethics and cross-cultural studies.

Mr. Duru has conducted extensive research on the history of Christianity with a focus on Africa and the African Diaspora. His current research interests revolve around the disciplinary frameworks for the study of spirituality and science.

He now lives in Chicago with his wife and their 8-month-old daughter. He can be reached at gusduru@yahoo.com.

Advancing the Profession

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If you were to name three people with whom it would be wise for you to establish a closer connection, who would they be, how might this happen, and what positive effect would you envision upon your ministry and the well-being of your environment?

collaborate effectively to fulfill the mission of our organization.

It may be helpful to do a brief self-assessment of how well we function as an interdisciplinary team member. How often do we dialogue with physicians about the spiritual needs of our patients? Have we developed professional relationships with our administrators so that their concerns are received and our voices heard? If you were to name three people with whom it would be wise for you to establish a closer connection, who would they be, how might this happen, and what positive effect would you envision upon your ministry and the well-being of your environment?

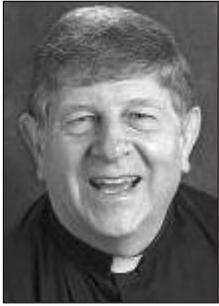
The very first principle in the Ethical and Religious Directives for Catholic Healthcare Services asserts that we work not as individuals but as "a community that provides health care to those in need of it." The introduction of Part Two reminds us that the care provided is to embrace "the physical, psychological, social, and spiritual dimensions of the human person." When the professionals around the table adequately consider each of these aspects at interdisciplinary team meetings, the care

planning becomes more effective and the path toward holistic healing more apparent. The theme of teamwork is sounded again later in the document where chaplains are called to "work in close collaboration with local parishes and community clergy" (principle 12). Opportunities to form peer relationships may extend beyond those of our institution or of our national association, the NACC. For many years, even before I began working in hospice, I had wanted to visit St. Christopher's Hospice in London started by Dr. Cicely Saunders more than 40 years ago. As is well known, Dr. Saunders was a key advocate in improving the quality of care for the dying, and specifically for her understanding of holistic pain. In July of this year I finally had the opportunity to visit St. Christopher's and to establish a connection with members of the leadership team and the chaplain there. We shared experiences and reflected on the challenges of providing spiritual care to increasingly diverse populations.

Now having worked within the hospice world for almost seven years, educating CPE students as they find their place and their voice on hospice interdisciplinary teams, I have come to view the above standards about peer relationships as beacons of light that guide our way along the path of professional practice.

John Gillman is an ACPE/NACC CPE supervisor at VITAS Innovative Hospice Care in San Diego, CA. He also serves as the chair of the Standards Commission for the NACC.

Now a parish pastor, he still relishes chaplaincy links



Name: Richard M. Leliaert (Ph.D.)

Work: Pastor, St. Robert Bellarmine Parish, Redford, MI.

NACC member since: 1987

Volunteer service: NACC Liaison to NCHPEG (National Coalition for Health Professional Education in Genetics)

Book on your nightstand: Bishop Ken

Untener's "The Practical Prophet: Pastoral Writings" (NY: Paulist Press, 2007)

Book you recommend most often: Viktor Frankl's "Man's Search for Meaning"

Favorite spiritual resource: Centering prayer plus "Lectio Divina"

Favorite fun self-care activity: Photography

Favorite movie: "Lord of the Rings"

Favorite retreat spot: Manresa (Jesuit Retreat House in the Detroit area)

Personal mentor or role model: Mother Teresa

Famous/historic mentor or role model: Abraham Lincoln

Why did you become a chaplain? When I left teaching, I felt uncertain about where God was leading me next. There were chaplains in my religious community at the time and I sensed that their ministry was a good combination of pastoral challenge, deep spiritual and sacramental life, and hands-on ministry to people at key/crisis moments in their life. I judged I wasn't prepared then to be a pastor of a parish, but chaplaincy was that right balance of community life and a ministry of healing service to God's people in the spirit of Jesus in the Gospels.

What do you get from NACC? A professional Catholic chaplaincy organization offering certification, excellent

opportunities for ongoing education (especially regional and national conferences), a comprehensive network of support and spiritual bonding anchored in the Catholic tradition, and a wonderful link to the other chaplaincy organizations dedicated to spiritual care in healthcare settings.

Why do you stay in the NACC? Simply because it's still a vital link to and extension of my life and ministry as a pastor of a strong suburban parish with a good school. The

NACC reinforced for me the importance of lay people in the church of the 21st century, the need to develop administrative abilities as part of pastoral ministry, the challenge of leadership and bringing out the pastoral gifts of others, and the key element of service in the healing ministry of Jesus. All this was centered in the rich prayer and sacramental, and liturgical heritage of the Catholic tradition.

Why did you volunteer? I wanted the NACC to be a leader in getting on board early with the impact of genetics in healthcare and the ethical/spiritual challenges it presents and will

present to healthcare in the future.

What volunteer activity has been most rewarding?

My serving as liaison to NCHPEG because of what I've learned and whom I've met, especially Mr. Joe McNerney (the executive director of NCHPEG) and Dr. Francis Collins, currently President Obama's choice to head the National Institutes of Health. I was especially heartened when APC also joined NCHPEG and their representative at the time, Vincent Guss, and I worked with Mr. McNerney to put on a panel at a national NCHPEG meeting on the spiritual and ethical aspects of genetics. The sessions were well received and we were "recognized" at subsequent national meetings.

What have you learned from volunteering? The importance of outreach and the importance of taking risks, based on the saying, "if not you, who?"



"Leaders move constantly back and forth between the present and the future. Our perception of each becomes clear and valid if we understand the past. The future requires our humility in the face of all we cannot control. The present requires attention to all the people to whom we are accountable. The past gives us the opportunity to build on the work of our elders."

— Max Depree, "Leadership Jazz"

On Leadership

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



Chaplain recalls God's presence in twists, turns of his life

By James W. McDermott, MA, BCC

Recently, my twin sister Mary and I were reminiscing about our early years together, including the fact that our parents and their eight children — four boys and four girls — lived in a house with only one bathroom! We challenged ourselves in that discussion to see how many names we could remember from our old family paper route involving more than 80 customers. To our surprise and delight, we recalled most of them.

It's funny, but in my youth God used my bike riding to raise questions for me. I recall riding my bike at age 15 on that paper route and thinking about who I wanted to be and what I would do with my life. Was God calling me to study for the priesthood? The answer came slowly into focus. Memories of studying Latin flowed through my mind. After high school, and with a scholarship from a newspaper company, I went off to study for five years at seminaries in Connecticut and Maryland. After much discernment I found my answer. I withdrew from the seminary in 1965 and started a career in business.

After a few years I met a lovely and very kind young woman, Mary Jane, on a blind date. It was really a chance encounter, as we each took a chance. We married and had two sons and a daughter, Patrick, Jimmy (James, Jr.) and Maureen. The following years were filled with great joys and deep sorrows, including Patrick's death at birth and Jimmy's death at age 16 in a tragic car accident in our town. Sadly, Mary Jane died seven years later after a long and courageous struggle with breast cancer.

New questions arose. Weary, and clinging to my deeply-rooted faith, I was anxious to move away from the business world after 32 years. I rested awhile, focused on my daughter, as lovely as her mother, and another calling stirred within my soul. With my experience of loss, donation of a kidney to my brother, and grief, perhaps God was inviting me to chaplaincy. It was hard to explain to others why I wanted to follow this path after suffering so many losses. I honestly wasn't totally sure myself, but I had learned from remembering the past that God would continue to journey with me in questions of today and tomorrow.

I completed a clinical pastoral education residency in 2000 at the Hospital of Saint Raphael in New Haven, CT, and served there as a lay chaplain for seven challenging and spiritually uplifting years. Another memory surfaces: While on call one day, I spotted an elderly priest eating an ice cream in

the cafeteria. After I introduced myself, I sat down and told him the gift he had been for my wife and me 10 years earlier when Jimmy was transported to his hospital via medical helicopter. I shared with him how his compassionate, Christ-like ministry on the worst day of a parent's life influenced my calling to hospital chaplaincy. Was this a chance encounter or was God reaffirming for both him and me our calls to ministry?

It's been more than 50 years since I rode that bicycle on my paper route, planning my future. I have grateful memories of my parents and siblings, my seminary days, my wife and children, and my second career in pastoral ministry. My daughter, Maureen, a successful middle school counselor in Washington state, and I continue to encourage the ministry of one another.

I retired from active chaplaincy for health reasons in 2007 but I continue to be interested in pastoral care. I've been co-facilitating bereavement groups in my parish, conducting workshops at a local retreat center, and trying to share the rich memories of a life with God.

Memories bring new ponderings. I am beginning to listen to yet another call to service in the autumn of my days. I'm restless. Where is the Lord in this new feeling? Maybe I'm being called to relax, enjoy family and friends, cope patiently with chronic illness, deepen the spiritual dimension in my life, and continue to be a faithful and hope-filled witness to the presence of a loving God on my sacred journey. Or through my memories is God preparing me for something else?

James W. McDermott received a master's of arts degree in religious studies in 2005 from Sacred Heart University in Fairfield, CT.

Vision needs you!

Vision's Editorial Advisory Panel seeks input on the following themes for upcoming issues of *Vision*:

- ▼ November-December: The Role of Chaplains on Ethics Panels.
- ▼ January-February: Chaplains in Small Hospitals (50 beds or fewer)

We are looking for individuals to write articles on topics related to these general themes as well as seeking suggestions of individuals to be interviewed on related issues. For more information or to volunteer ideas, yourself as writer, or others as sources, contact Laurie Hansen Cardona, *Vision* editor, at lcardona@nacc.org.

Thank you!

I am beginning to listen to yet another call to service in the autumn of my days. I'm restless. Where is the Lord in this new feeling?

Saint Paul: Down-to-earth, yet culturally sophisticated

Back in 1883, Mark Twain said, “Saint Paul is a wonderful city. It is put together in solid blocks of honest bricks and stone and has the air of intending to stay.” With its down-to-earth ways and cultural sophistication, ethnic diversity, historic traditions and numerous, newly constructed buildings, Saint Paul has a unique blend of past and present. Saint Paul is definitely here to stay.

Visitors who appreciate history will enjoy The Saint Paul Hotel, built in 1910 in a turn-of-the-century style; Summit Avenue, the nation’s longest span of intact, residential Victorian homes including those of the famous railroad tycoon James J. Hill and author F. Scott Fitzgerald; the magnificent Cathedral of St. Paul, whose dome rises 306.5 feet overlooking the downtown area; and of course, the State Capitol, perhaps the grandest of all the Twin Cities’ sites. Saint Paul is often compared to the great European cities. With its stately, historical buildings and Victorian homes, a bustling Mississippi riverfront, picturesque parks and a wealth of culture, Saint Paul is sophisticated, yet warm and welcoming.

Minneapolis and Saint Paul have been crowned as the “Midwest’s performance capital” with more than 30 theaters in operation. In fact, the Saint Paul–Minneapolis area ranks second only to New York in the number of theater seats per capita. Saint Paul’s Ordway Center for the Performing Arts hosts a variety of performances ranging from Broadway’s best to cultural celebrations of song and dance. The nation’s largest black professional theater company, Penumbra Theatre Company, continues to produce thought-provoking works from the African-American perspective.

Part of the joy in visiting Saint Paul is the ease of getting here. Minneapolis/Saint Paul International Airport, named the “Best Large Airport in North America” by an international traveler survey and ranked among the top five airports worldwide for overall customer satisfaction, is less than a four-hour flight from any part of the United States and less than a 15-minute drive from downtown Saint Paul. If you’re arriving by train, the Amtrak depot in Saint Paul’s Midway area is 10 minutes from downtown. Buses arrive from all over the country and the terminal is located near the State Capitol.

Quality interstate highways make Saint Paul easily accessible by car, whether you’re coming from the North, South, East, or West.

Restaurants reflect the diversity of Saint Paul’s 287,151 residents and the metro area’s 2.6 million (53.7% of the state) residents representing nearly every culture, creed, and ethnicity. Visit the Hispanic neighborhood of the West Side and the Hmong and Southeast Asian neighborhood in the University Avenue area for authentic specialty cuisine.

Saint Paul Demographics

▼ 35,691 Asians, including those from Vietnamese and Hmong backgrounds, reside in Saint Paul, making up 13.4% of the city’s total population. Saint Paul has the largest

Hmong population of any city in the United States.

▼ 33,637 blacks live in Saint Paul, including African-Americans and Pan-Africans, making up 12.6% of the city’s total population.

▼ 22,715 people of Hispanic origin call Saint Paul home, representing 8.5% of the total population.

▼ 3,259 American Indians live in Saint Paul, making up 1.2% of Saint Paul’s total population.

Diversity Resources and Publications

Saint Paul Insight, an African-American owned and community-oriented newspaper with an emphasis on business and economic development.

<http://insightnews.com/>

The Asian American Press focuses on issues facing the Asian community. <http://www.aapress.com>

The Hmong Times provides valuable information and tools to the Hmong community. <http://www.hmongtimes.com/>

La Prensa De Minnesota is a weekly newspaper geared specifically for the Hispanic community. <http://www.laprensademn.com/>

Native American Press/Ojibwe News focuses on Native American issues, and is published weekly. <http://www.press-on.net/>

(Information for this article taken from the Saint Paul Convention and Visitors Authority. www.visitsaintpaul.com)



Mark your calendars for the NACC National Conference, March 20-23, 2010, in Saint Paul, MN. Our hotel site is the Crowne Plaza Hotel — St. Paul Riverfront. Registration Materials will be available in November.

Book Reviews

Authors say faith, prayer stimulate brain, slow aging

How God Changes Your Brain: Breakthrough Findings from a Leading Neuroscientist. By Andrew Newberg, M.D., and Mark Robert Waldman. Ballantine Books, New York, 2009. Hardcover, 348 pp., \$27.

By John Gillman, Ph.D.

The title of this book is a teaser, an attention grabber. The co-authors rely upon solid research to describe the neurological changes in the brain brought about by faith in God and regular spiritual practice. Both Newberg, a physician who specializes in neuroscience, and Waldman, a counselor, collaborate at the Center for Spirituality and the Mind at the University of Pennsylvania.

Written in a clear and lucid style, the narrative explains how belief in a loving God or an angry God affects different areas of the brain. The authors also cite studies using brain scans to demonstrate that daily meditation over a period of eight weeks results in increased activity in the anterior cingulate, that part of the brain associated with emotional regulation, learning, and memory. Faith and prayer stimulate the brain and slow the aging process, Newberg and Waldman conclude.

The chapters titled “What Does God Feel Like?,” “What Does God Look Like?,” and “Does God Have a Heart?” address respectively, the varieties of spiritual experience, visual representations of God, and the perceived personalities of God. A discerning reader will not always agree with some of the concluding observations. In projecting the “Future of God,” for

example, the authors assert that “a God that maintains its [sic] mystery” will replace “the biblical views of an all-powerful, all-knowing creator,” a view that is waning (p. 82). In fairness, I suspect that the God of the Bible also would like to be credited with being mystical. After the burning bush encounter, Moses undoubtedly would concur.

Throughout the book, invitations such as considering “The Chemical Nature of God” or wondering “Is There a God Neuron in Your Brain?” draw the reader ever deeper into an exploration of the bridge between the physical and the spiritual, the neurological and the theological, the human and the divine.

In addition to summarizing the data from a multitude of studies, the authors also turn the last three chapters of this work into a self-help guide that 1) recounts the eight best ways to exercise the brain (the fifth way is — believe or not — to yawn, the best is to have faith); 2) describes how to find serenity through intention, relaxation, and awareness; and 3) provides a model for engaging in compassionate communication. Three brief appendices offer information on resources, workshops, and research.

The strength of this book is the ability of the authors to integrate a multitude of studies, including their own, into the narrative. I recommend this as a resource for both chaplains and CPE supervisors.

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

Simplicity of theme development belies book's depth

A New Heart: Eleven Qualities of Holiness. By Robert Morneau. Orbis Books, New York, 2008. Paperback, 143 pp., \$12.

By Colette Hanlon, SC

Bishop Robert Morneau has a special gift of tapping into simple concepts in profound ways that elicit ongoing spiritual searching. Over the years many of us who have heard him speak at NACC conferences or read his other writings appreciate his wisdom and simplicity as we observe his growth on the journey.

In this volume he builds on another gifted seeker's prayer. Dag Hammarskjöld, a past secretary-general of the United Nations who hailed from Sweden, asks God for a pure, humble, loving and faithful heart. Morneau builds on his request and adds his own: a heart of courage, joy, praise, gratitude, kindness, hospitality, and hope. The chapters are

spread over 11 weeks, each theme developed daily through the use of excellent quotes from classics and contemporary authors. Then Morneau offers a brief reflection and a suggested action.

Do not be lulled into complacency by the apparent simplicity of the theme development. Morneau's prose and poetry flow from a deep relationship with God. He is, indeed, a pilgrim person, and he invites his readers to embrace the spiritual journey as well. His preface begins with the words: “Ezekiel the prophet is a messenger of hope.” We are blessed in having our hearts lifted by Bishop Morneau a modern messenger of hope.

I would recommend this book for retreat or daily quiet reflection. May the pondering give us new hearts to know God more intimately.

Colette Hanlon, SC, BCC, is a chaplain at Berkshire Medical Center in Pittsfield, MA.

Chaplains, nurse colleague present at oncology nurse forum

They see need to help nursing colleagues understand intricacies of chaplaincy work

**By Linda Piotrowski, M.T.S., BCC,
and Karen Pugliese, M.A., BCC**

"Thanks for reminding me that spirituality and religion are not the same."

"Great session, I, for one, badly needed the content. Thank you for having this — would be a great pre-conference session for next year."

"We need more of these types of programs in the practice setting. Spiritual care needs to be demystified. It's as important as patients receiving their daily insulin. It should be mandatory like infection control classes and CPR."

"Great topic and great speakers. It is good to hear from professionals other than nurses. We can learn a lot from other disciplines. I loved this session. Great!!!!!"

— Nurses evaluate ONS clinical practice of spiritual care across the Cancer Continuum Workshop

Almost exactly a year ago an oncology nurse practitioner colleague approached Linda Piotrowski to submit a presentation proposal for the Oncology Nurse Symposium 2009 Congress in April. The Oncology Nursing Society (ONS) is the largest professional oncology association in the world. Membership includes more than 37,000 professionals representing a variety of roles, practice settings, and subspecialty practice areas. Karen Skalla, MSN, ARNP, AOCN, had completed 3 CPE for Healthcare Providers¹ at Dartmouth Hitchcock Medical Center, in Lebanon, NH, where Karen practices in the Head and Neck Cancer Oncology Clinic and Linda serves the Palliative Care Service and the Norris Cotton Cancer Center Outpatient as well as the inpatient oncology unit. Karen Skalla is chair of the ONS Spirituality Interest Group (SIG). Linda leapt at the opportunity!

Because the ONS is highly research-oriented, they agreed upon the topic: Clinical Practice of Spiritual Care across the Cancer Continuum." As it became clear that diagnosis and treatment; survivorship and end of life would be the focus of the presentation, Karen Pugliese was invited to collaborate on the project. Both Linda and Karen feel strongly about seizing every opportunity to present at another discipline's educational offerings. For example, Linda has presented at the American Academy of Hospice and Palliative Medicine Annual Conference, The Vermont Breast Cancer Conference, The New Hampshire Cancer Consortium Conference, the New England Geriatric Nursing Course and Karen has spoken at The National Council on Aging and the American Society on Aging Joint Conference, The American Congress on Rehabilitation Medicine, the Mayo Medical Center Annual Nursing Research Conference, and the Catholic Health Association Annual Conference.

We agreed upon the following as the session description: "Interest in both Spirituality and Spiritual Care has

increased rapidly over the past several years. Similarities and distinctions between spirituality and religion, as well as other issues along the continuum from spiritual distress toward spiritual well-being, will be explored. Spiritual concerns specific to each phase of the cancer continuum will be presented: diagnosis, in-patient and outpatient treatment, survivorship and end of life. Spiritual assessment, intervention, and care planning processes will be addressed. We will discuss strategies to mobilize inner resources for coping, developing resilience, grieving and letting go. Stories of care will provide stimulus for the audience to actively participate in the closing discussion."

On Aug. 26, we received word that our proposal was accepted and celebrated our major breakthrough in that it had been many years since ONS had accepted a major spiritual care session. ONS proposal guidelines are stringent and rigorously screened. The topic submission form required the content outline as well as the session description, level of content, content area, type of session, target audience and our CV's.

What we didn't know was just how rigorous the preparation process would be. Weaving research throughout the presentation, using case studies to illustrate our area of focus, and keeping to the 90-minute parameter proved challenging.

We communicated by e-mail and sometimes by phone, but finding times to meet in different time zones was challenging. In January we learned we would be presenting on May 1, the day before Karen Skalla's birthday. A birthday post-presentation celebration in San Antonio served as a motivating force for us to continue to send one another our work in progress for critique and feedback. However, May seemed like a long way away when we were completing our bibliography and agreeing upon the number of slides, formatting, timing, etc. in January. Just when we thought we were making headway, we would receive a reminder such as this that would send us scrambling:

The syllabus upload must be completed by Feb. 12, 2009, by 5 PM EST. I highly recommend that you complete the upload way prior to the deadline in case there are computer or uploading issues. Any graphics, photos, graphs, etc. that you would like to include in the syllabus must have the granted permission request for each slide sent to the national office. If there is no permission, the slide will not be in the

Another nurse was consumed by a desire to provide spiritual care to patients. She asked how one becomes a chaplain. When Clinical Pastoral Education was described she said she was interested. She inquired, "Is it a three-hour workshop? Is it two evenings?"

Nurse Forum

Continued from page 19

syllabus. With our clinical responsibilities, unplanned emergencies, different time zones and work schedules, communication was mostly via e-mail. We survived experiences of tension, frustration and disagreement. What source should we use for definitions: nurses' perceptions of the challenges of working with chaplains; chaplains' perceptions of nurses over-stepping their bounds; boundary issues in the area of spiritual screening and assessment; competency issues?

Through it all — ever encroaching deadlines. And they were serious. At one point we received word that we had one too many slides; all slides needed to have at least one reference and the changes needed to be in by end of day.

Karen Skalla, as the coordinator, bore the brunt of the last week of touching up and refining the slides, but it was maddening for all of us. When she finally sent them in on April 21, we began working out the logistics of running through our presentation together for the first time in San Antonio. Just as we prepared for travel — the Swine Flu hit with a vengeance, with San Antonio so hard hit we were all packing masks along with our business cards and handouts!

The day before we were due to present our workshop, we arrived at the speakers' resource area, were welcomed, and offered a drink and snacks. We were provided a computer with our PowerPoint presentation already loaded. We fine-tuned our presentation and went to the next room to run through it on the big screen set up to mimic the room assigned us for the following day. The professionalism apparent in this high-tech process left us feeling reassured and valued.

The Spirituality Interest Group of ONS sponsored our presentation "Clinical Practice of Spiritual Care across the Cancer Continuum." We arrived early and were amazed at the size of the room; there was seating for 200. A large-screen LCD projector with our presentation set to run completed the set up.

As time for the workshop drew near, the room quickly filled. Soon we reached the maximum number. People continued to attempt to enter the room. Finally, they put out a sign that said, "Workshop Closed!"

Karen Pugliese, in speaking about the spiritual needs of newly diagnosed cancer patients, used a competency-based model of care and explored dimensions of pain, addressing spiritual suffering including research initiated and conducted by Mary T. O'Neill and CPE students at Calvary Hospital in New York. Karen compared and contrasted nursing and chaplaincy interventions.

Karen Skalla followed with an exploration of the search for growth and meaning in survivorship. She provided participants with several spiritual assessment and research tools as well as a framework for growth and transformation.

Linda Piotrowski completed the discussion with an

exploration of spiritual needs of persons approaching the end of life, including an overview of spiritual/religious beliefs, spiritual assessment in general, two specific tools, and numerous opportunities for growth at the end of life.

Workshop participants were treated to definitions of spiritual assessment, assessment tools and processes and strategies from three differing viewpoints. The use of three case studies/stories gave flesh to the abstract theories and tools presented. The nurses present were eager to engage with questions at the end of our presentation. Many stayed afterward to ask questions and share stories.

Of special interest to us as chaplains was the Spiritual Care SIG Meeting held in the late afternoon following our workshop. Perhaps fueled by interest generated by the workshop, a large group gathered in the same meeting room. Excitement about learnings from the workshop was shared along with stories of nurses ministering spiritually to patients. One story that stands out is that of a nurse who told of tending to a comatose patient and her daughter. The patient was dying and as the end drew near the nurse asked her daughter if she would like the nurse to pray with her. The daughter assented and the nurse proceeded to pray from her Christian faith perspective. When she completed the prayer the woman said, "That was very nice and I think my mother may have liked it but we are Jewish." The nurse went on to say that she and the patient's daughter laughed. The nurse was not telling a cautionary tale of being sure to check a patient's spirituality/faith tradition before offering to pray, rather, she stated proudly that she prayed and provided good spiritual care.

Another nurse was consumed by a desire to provide spiritual care to patients. She asked how one becomes a chaplain. When Clinical Pastoral Education was described she said she was interested. She inquired, "Is it a three-hour workshop? Is it two evenings? Oh, it must be a weekend." When she received the full explanation of the requirement of a master's degree and four units of CPE, she was dismayed and couldn't understand what could possibly take so long.

Many nurses have a strong desire to provide spiritually for their patients. Many believe themselves already competent to provide the in-depth type of professional spiritual care that patients need. Many give no thought to referring to a chaplain.

As our experience at the Oncology Nursing Conference taught us, nurses are hungry to "do spiritual care." They are aware of the importance of the spiritual in their work. Nurses are attempting to return to the roots of their nursing heritage. Patricia Maher describes Florence Nightingale as "one of the first to bring spirituality and science together to improve the care of the sick."² Mary Elizabeth O'Brien describes the theological mandate for nursing care as involving three key activities: being with, listening, and touching. She also addresses nursing assessment of patients' spiritual needs, nursing's role in the provision of spiritual care, the spiritual nature of the nurse-patient relationship, the spiritual history of the nursing profession, as well as looking at contemporary

Nurses are hungry to "do spiritual care."

interest in spirituality within the nursing profession.³

Nurses are forging ahead in exploring ways that they can do this important work. As the quotes at the beginning of this article suggest, our workshop was widely accepted and appreciated. It would lead one to think that more invitations to present would follow. However, just this past week, Linda's colleague, Karen Skalla, informed her that a Preconference Spirituality Workshop had been accepted for the 2010 Oncology Nursing Conference. Speakers for the workshop are already lined up. The speakers are two well known names in healthcare circles. Neither one is a chaplain! They are a physician and a nurse who specialized in nursing research and recently obtained a master's degree in theology. Where, one asks, are the chaplains?

How are we to gain respect as experts in the field of spirituality and spiritual care? How can we help our nursing colleagues to understand the intricacies of our work? How can we partner with our nursing colleagues to provide the best spiritual care possible?

In his book, "Better: a Surgeon's Notes on Performance," Atul Gawande offers five suggestions on how one can go about making what he calls a "worthy difference." He suggests: Ask an unscripted question. Don't complain. Count something. Write something. Change.⁴

As chaplains we would do well to heed Dr. Gawande's advice. When we are with our nursing colleagues, we can be the one to raise a question that leads us all to explore different ways of approaching our work together. Rather than complain that we don't receive referrals or that no one understands us or

our work, we can do some research. We can count something and discover what it teaches us. We can write about what we discover, sharing our findings and ponderings with others inside and outside our profession.

We can embrace new ideas and change things from business as usual to risk-taking and partnering. Instead of limiting our workshop proposals and written articles to chaplaincy conferences and publication, we can stretch and submit to multiple organizations that take us beyond our comfort zones.

In an effort to heed Dr. Gawande's advice we've prepared a brief survey. We ask that you copy and paste this web address into an e-mail to your nursing colleagues.

http://www.surveymonkey.com/s.aspx?sm=BcIroyCBI_2bHDOnPgVz1okA_3d_3d We'll report the results in a future issue of Vision. Thanks!

¹ CPE for Healthcare Providers originated at Massachusetts General Hospital in Boston and takes place during the winter extended unit. It is open to anyone involved in patient care.

² As quoted by Mary Elizabeth O'Brien, SFCC, PhD, MTS, RN, FAAN (2007). *Spirituality in nursing: Standing on holy ground, 2nd ed.* Boston: Jones & Bartlett.

³ Andrist, Nicholas & Wolf (2006). *History of nursing ideas: Reclaiming the spirit in nursing.* Boston: Jones & Bartlett.

⁴ Gawande, Atul (2007). *Better: A surgeon's notes on performance.* New York: Picador.

What are deadlines for renewal of certification?

Q I am scheduled to renew my certification by the end of 2009. What are some important deadlines to note?

A Our Standards require renewal of certification every five years for chaplains and every seven years for CPE Supervisors.

As a final reminder, if the NACC National Office does not receive your renewal of certification application and materials on or before Dec. 31, 2009, your certification will no longer be valid effective Jan. 15, 2010. If the circumstances so warrant, you may request an extension in writing from the Chair of the Certification Commission. Extensions are granted in one (1) year increments for a total of two (2) years and do not alter the original renewal of certification schedule. If requesting an extension, you must submit the appropriate extension fee, which for 2009 is \$30.

You do not need to contact the NACC National Office if you are preparing to mail your paperwork before the end of this year. The date of the next Certification Commission meeting, when action will be taken on renewal of certification

materials, is Oct. 30, 2009. In order to have action taken at this meeting, please submit your materials by Oct. 15, 2009. Please note that the NACC National Office will request your ecclesiastical endorsement.

Any renewal of certification materials that arrive after Oct. 15, 2009, will be slated for action at the March 2010 Certification Commission meeting.

If you have any questions or concerns regarding this process, please contact Becky Evans, the office assistant for Renewal of Certification at the NACC National Office at bevans@nacc.org or 414-483-4898. Our desire is to assist you in any way we can to best facilitate the process of your renewal of certification.

Q What are the Postmark Deadlines and Fees for Chaplain Certification for 2010?

A Postmark Deadlines:
Sept. 15, 2009, for a spring 2010 interview
Feb. 15, 2010, for a fall 2010 interview
Certification Application Fee: \$350



Minister with sensitivity to bariatric patients, their families

By **Carey Landry, BCC**

In 1998, during my third year of chaplaincy, our hospital, St. Vincent-Carmel, in Carmel, IN, began performing bariatric surgeries. Bariatric patients are people who suffer from morbid obesity. This kind of surgery was still relatively new at the time, but the surgeons who became part of our staff already had several years' experience in doing this type of surgery. As the years have gone by our staff has adapted well in serving the needs of the bariatric patient, so much so that in 2006 our center was given the distinction of being named a "bariatric center of excellence." I was here when the first patient came for surgery, and I have had the privilege of being part of an interdisciplinary team that has helped more than 11,000 people who struggle with morbid obesity. To date, more bariatric surgeries have been performed at St. Vincent-Carmel Hospital than at any other hospital in the United States.

Bariatric refers to a branch of medicine dealing with the causes, prevention and treatment of obesity. Morbid obesity is a life-long, progressive, life-threatening, genetically related, costly, multi-factorial disease of excess fat storage with multiple co-morbidities (obesity-related health conditions). Morbid obesity is defined as being 100 pounds over ideal body weight, with a "body mass index" of over 40. Morbid obesity is the second leading cause of preventable deaths in the United States. It is estimated that more than 300,000 people die unnecessarily each year as a direct result of this illness.

Obesity-related co-morbidities include: diabetes, hypertension, cardiac disease, respiratory diseases (including sleep apnea), arthritis, depression, and several different cancers: esophageal, breast, uterine, ovarian, prostate, colon, and cervical. Morbid obesity radically affects one's quality of life. Morbidly obese people suffer from "crippling isolation." They have difficulty doing simple tasks, including walking, playing with their children, or doing ordinary housework.

There are numerous societal views and biases against obese people:

- ▼ Society is not very tolerant of obese people, especially females. Many experience abuse and discrimination throughout their lives. They are often seen as "second class citizens" and described as lazy, dirty, and ugly.
- ▼ They are blamed for their own condition and are not afforded the same consideration as others who suffer from a disability. "Fat jokes" by comedians and derogatory portraits of obese people in popular media are common.

Studies have shown that many physicians view persons who are obese as unintelligent, non-compliant, hostile, dishonest, unsuccessful, inactive, and weak-willed.

- ▼ Obese individuals experience problems in public accommodations and public settings, such as restaurants, theaters, airplanes, buses, and trains because of inadequate seat size and inadequate features such as seat belts. (When our hospital began doing bariatric surgeries we purchased new furniture that could accommodate the obese patient. When we renovated our chapel we made sure that several of the 25 or so chairs in our small chapel could accommodate obese patients and their family members.)

Obese patients also suffer from the biases of healthcare professionals.

- ▼ Studies have shown that many physicians view persons who are obese as unintelligent, non-compliant, hostile, dishonest, unsuccessful, inactive, and weak-willed. Noncompliance was rated the most likely reason for obese patients' inability to lose weight. (I had to overcome my own biases when I began ministering to patients with this illness. It was when I admitted to myself the struggles I have had with my own weight that I was able to overcome my biases. Without their knowing it, the patients themselves helped me to overcome those biases, and now they are the patients to whom I minister the most in our hospital.)
- ▼ Because of these biases, obese patients often shy away from doctors and hospitals because they are afraid of being embarrassed, chided or humiliated by medical workers and their surroundings. Anti-fat attitudes among healthcare professionals affect clinical judgments and deter obese persons from seeking care. A very high percentage of bariatric surgery patients report being treated disrespectfully by medical professionals.
- ▼ Even "good intentioned" professional staff members can make statements that are hurtful and derogatory, such as: "You don't look like you need this surgery!" "You carry your weight well." Staff members will sometimes assume that visitors know what type of surgery the patient has had, and thus may present real risks to breaches of confidentiality.

How have we been able to grow in our own sensitivity to individuals with this disease?

- ▼ In our hospital we try to avoid identifications that indicate obesity to others in signs, return addresses on mailings, messages on phones, marketing campaigns, and identification labels on equipment.
- ▼ All of our associates are trained to 1) recognize obesity as a disease; 2) use sensitivity in their choice of words; 3) refrain from announcing in a loud or public manner that they need help with a patient; and to 4) recognize that obese patients are looking for any sign that indicates that they disgust you.

- ▼ From a positive standpoint, our associates are trained:
 - 1) to be willing to help with obese patients' activities;
 - 2) to include patients in decisions about their care and to ask them what works best for them; 3) to be overly sensitive when weighing patients, to weigh them in a private area, and to never announce their weight loudly.
- ▼ Obesity is a chronic illness. No one laughs at other chronic illnesses, such as diabetes or coronary artery disease. Obesity can be just as deadly. We train our staff to be sensitive by being good role models. We encourage them not to tolerate behind-the-back whispers and jokes about obesity, even in private. Our mission statement states: "All caregivers and support personnel must demonstrate sensitivity to and respect for the obese patient."
- ▼ As with any illness, there are legal implications to good care giving: Bariatric patients who are being treated with dignity and respect and have close relationships with the hospital staff are less likely to bring suit against the program, even when a complication or fatality occurs.
- ▼ There are also marketing implications: Most patients seeking to undergo bariatric surgery have done about a year-and-a-half research on the matter. Even though surgeon skills and multidisciplinary program offerings are important, patients will not refer other patients to a program in which the patient felt he or she was not treated with dignity and respect.

I invite you to describe honestly to yourself the feelings you have toward obese people, especially those who are severely obese. Have you used any labels to describe them? Is the obese person worth your best effort?

Various types of bariatric surgeries are done in the United States today, the most requested being the Lap-Band or Laparoscopic Adjustable Gastric Band, which is a restrictive procedure; the "Roux-en Y" Gastric Bypass, which is both restrictive and malabsorptive; and the "BDP with Duodenal Switch," which is a malabsorptive procedure.

Patients sometimes make tremendous sacrifices to be able to have the surgery. Some insurance companies will not cover this surgery or will only cover partial costs. Some patients to whom I have ministered have had to take out a second mortgage on their home to pay for the surgery.

Bariatric surgery yields many positive physical and psychological aspects. Many patients testify to no longer having diabetes, for example, after having had the surgery and losing a significant amount of weight, and many show marked improvement in hypertension and cardiac-related illness. Numerous areas of one's emotional life improve following bariatric surgery, particularly a marked decrease in forms of depression, greater self-esteem, a more hopeful outlook on life, and overall better mental health. Social functioning, in addition to physical functioning, improves dramatically.

This is not to say that all is "rosy" after bariatric surgery and significant weight loss. Some weight loss patients have unrealistic expectations for the amount of weight they will lose and overestimate the degree of weight loss. "Healthy marriages tend to improve following surgical weight loss; unhealthy marriages tend to deteriorate."¹ I have personally experienced that last phenomenon with some of our patients. Some patients struggle with compliance to the regimen required to maintain their weight loss. Some patients have significant medical problems following their bariatric surgery.

My own ministry to bariatric patients and their families takes place in different ways at five different times:

1. Prior to their coming to the hospital for surgery.
2. With the patient at the hospital just before surgery.
3. With patients who have no significant medical problems after surgery and who are discharged within a few days.
4. When a bariatric patient has significant medical issues after surgery, has to return to the hospital because of medical difficulties, or who has frequent re-admissions because of ongoing medical issues.
5. With those patients and their families who never recover from the surgery.

1. Ministry prior to the patient's coming to the hospital for surgery.

Some might ask, "How is this possible?" In the case of the bariatric patient, there is a series of meetings and required classes before their surgery. Because we believe the spiritual component of care is just as vital as the physical component of care, the bariatric surgeons requested that the "spiritual component" be addressed in one of the pre-surgical classes. Our Bariatric Center of Excellence is located in a professional office building connected to our hospital, and I go to the class every Tuesday and Thursday to provide a short musical meditation based on the passage in Psalm 46:10, "Be still and know that I am God." This allows me to provide a meaningful prayer experience for the patients, and it also "introduces" me to the patients in such a way that there is often an immediate connection with them when they come for their actual surgery. During the meditation I always acknowledge that there may still be anxiety or fear about having the surgery and that God is with them in the midst of those fears. Many patients have told me how much that has helped them to have a greater sense of peace about having the surgery. The feedback

Because we believe the spiritual component of care is just as vital as the physical component of care, the bariatric surgeons requested that the "spiritual component" be addressed in one of the pre-surgical classes.

Bariatric

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about the musical meditation has been very positive, so much so that I made a CD of the meditation so that our staff can use it when I am unable to be there. Because of the calming effect of the musical meditation, I have had several patients call me a week or so before their surgery to request that I be there to have prayer with them when they come for their surgery.

2. Ministry with patients at the hospital just before surgery.

In many ways this is no different than ministering to those who are coming for other forms of surgery. I am able to make an initial spiritual assessment that helps me to determine if they belong to a particular church or other form of spiritual community and if that community is supportive; if they have any spiritual needs that need to be addressed in an ongoing way, and if their spiritual or religious beliefs provide comfort and support. With the bariatric patient there is often anxiety and more of a need to provide a supportive presence. Most of our patients request prayer before surgery. In my prayer I emphasize the new “journey” they are beginning, asking God to be with them not only during the surgery but in the days and months following their surgery. Many times the patient will be in tears after my prayer. I provide comfort and support, but I also try to get them to articulate what they are feeling. For many it is anxiety, but for some, it is an overwhelming feeling that they have finally come to the day when real change can come to their lives. They have been struggling for so long, and there is hope now that good things will come. The majority

of our patients come with supportive family members and some have clergy support both before and after surgery, but others come without family members because they don’t want family members to know they are having the surgery. They rely on the staff to be their “family” while they are here.

3. Ministry with patients who have no significant medical problems after their surgery and are discharged within a few days.

The days following surgery are very crucial for the bariatric patient. Most of our patients have no difficulty with the surgery and are discharged within two to three days. With those patients my ministry usually takes the form of encouragement and tends to take on characteristics of “outcome oriented chaplaincy” as described in the

excellent book, “The Discipline for Pastoral Care Giving.”² I participate with other members of the healthcare team in contributing to the desired outcome of helping the patient to heal, with the motivation they need to begin the new weight-loss journey on their own.

4. Ministry when a bariatric patient has significant medical issues after surgery, has to return to the hospital because of medical difficulties, or keeps returning to the hospital multiple times because of ongoing medical issues.

The percentage of our bariatric patients who have continuing medical issues is small in comparison to the large number of surgeries we perform at our hospital, but when those patients have difficulties they tend to be complex issues that are not easily resolved. This often leads to several readmissions over a period of weeks or months. With these patients and families I seek to form a pastoral relationship of trust. In that relationship of trust I am able to offer a listening presence that is consistent and supportive. I make every effort to provide emotional and spiritual support daily.

Questions often arise for patients who have complications and continuing medical issues after their initial bariatric surgery:

- ▼ Did I make the wrong decision? Or, if it is the spouse of a patient who is in serious or critical condition: should I have let him/her have this surgery? Should I have protested his/her decision more?

My intervention here begins with providing compassionate care and comfort, validating their present feelings, then taking them back to the time of their decision making and how they felt at the time / what they knew at the time. Most often, when I have explored this with individuals, they have responded that their desire for better health was so great that they saw this surgery as their only hope.

- ▼ Is God still with me? I don’t feel that God is with me as much any more. Am I losing my faith?

I seek to validate their feelings of discouragement, and reassure them that there is no dichotomy between being a person of faith and having those feelings. My intervention here includes inviting the patients to examine other difficult moments in their lives and whether they felt the presence of God helping them. Are there some previously helpful beliefs or experiences of the Holy (even early in life) that can serve the patient now, during this period that feels like a significant step backward physically as well as spiritually?

- ▼ Many of these patients exhibit the characteristics of a spiritually distressed patient. Because they are in the

I invite you to describe honestly to yourself the feelings you have toward obese people, especially those who are severely obese. Have you used any labels to describe them? Is the obese person worth your best effort?

hospital for an extended period, intense loneliness or separation from their family is often experienced. Sometimes I have felt that patients were “testing” me to see if I would tolerate complaints about their family or faith community. (“My church (and/or) my family has let me down ... those whom I thought would help have not come to see me.”)

My response is one of “hearing” their disappointment and their feelings of loneliness, but also eventually moving to a place where they can be invited to identify what has become their most helpful community — in some cases, it is the hospital staff itself.

Because I have provided pastoral care to so many patients over a period of several months and have seen them eventually come to healing, I am able to offer other patients authentic hope and encouragement. Prayer plays a significant role in bringing comfort, hope and peace. Quiet music and relaxation techniques are of help to many, particularly in being able to sleep at night. There are times when I need to make a referral for a psychological consult or other form of intervention for the patient. The interdisciplinary team approach (as described in the book, “The Discipline for Pastoral Care Giving,”) to the patient is crucial for the long-term patient and our staff is well trained to provide emotional (and spiritual) support. Our once-a-week interdisciplinary patient care conferences help us work together as a team in providing care to the patients and their families.

5. Ministry to the bariatric patient and family when the patient does not recover from the surgery.

It cannot be denied that the weight loss surgical patient has a risk of not recovering from the surgery. Each of these patients has a higher risk secondary to the health conditions with which they present. Fortunately, the advances in evaluation and surgical techniques continue to improve patient outcomes. There are some patients who have serious respiratory problems and need to be placed in our ICU on a ventilator when they come out of surgery. My ministry then becomes one of support to the patient, the family and/or friends of the patient, acting as a liaison between the family and other members of the staff, and providing the kind of spiritual care needed for an ICU patient.

Four years ago, we had one patient who was in our hospital for 13 months because her insurance would not allow her to be transferred to a Long Term Acute Care Hospital. Her surgical wound never healed because of continuing problems with fistulas and abscesses. I became very close to the patient and her family. Both patient and family went through a variety of emotions from intense anger to a deep sense of peace in their long ordeal. The patient’s illness actually drew the family closer together in ways that several members never would have thought possible. This ordeal profoundly affected our staff members, and my

ministry was as much to our staff as it was to patient and family throughout. Many of us were at her bedside when she passed away peacefully not long after her second Christmas in our hospital. I remain close to the family to this day, and her mother sews “prayer blankets” for me to give to other patients, similar to the one I had given her daughter.

For several years now our Bariatric Center of Excellence has hosted a Christmas Party for patients who have had the surgery. It is an evening that allows us to see the “after” effects of their weight loss, and many of the women wear cocktail dresses that they have never felt comfortable wearing before. Party food consists of fruit, cheese and vegetables, testimonies are given by former patients, and a DJ provides music for dancing after the short program. Former patients cannot wait to reintroduce themselves to staff members as their “new” selves and have their photos taken with the surgeon who performed their surgery. I am always eager to provide the opening prayer and reflection at this wonderfully positive evening for patients, families, and especially for our staff.

Carey Landry is a chaplain at St. Vincent-Carmel Hospital in Carmel, IN. He and his wife, Carol Klinghorn-Landry, are composers of Catholic liturgical music.

¹ Bocchieri, L.E. (2002). Pastoral care ministry to the bariatric patient and family. *Journal of Psychosomatic Research* 52, 155-165.

² Vandecreek, L. & Lucas, A. (2001). *The discipline for pastoral care*. Binghamton, NY: The Haworth Pastoral Press.

A sample prayer before a patient’s bariatric surgery

O Lord, I place _____ and all of *his/her* needs into your loving hands today. I pray that you will lead and guide those who will be working with *him/her* during the surgery. I pray that there will be no complications whatsoever and that *he/she* will have a completely successful surgery. Be with _____ and help *him/her* know that you are there. Be with *his/her* family members (if present). Grant them peace and comfort as they wait, and then help them to be of support to _____ on this new journey *he/she* is beginning in *his/her* life.

Lord, I pray that you will be with _____ not only today during the surgery, but that you will walk with *him/her* as *he/she* walks each day after the surgery. Throughout this new journey, be for _____ a source of strength and courage, peace and patience, and ultimately healing and new life. We ask this in your most Holy Name. Amen

Do we know how to die?

15th-century treatise points to 5 temptations of dying, offers advice

By Peter T. Mayo, M.Div., M.A., BCC

Ars Moriendi is a Latin term that can be translated as the “art of dying.” For centuries it has referred to a genre of literature dealing with the spiritual preparation for death. The paradigm of this genre is the 15th-century anonymous treatise titled, “Tractatus de Arte Moriendi” (“A Treatment of the Art of Dying”). This essay will refer to it as the Art of Dying. Embedded deeply in our history of care for the dying, this 600-year-old artifact of our tradition can speak to us today and enhance our ministry. Do we know how to die today?

There is a great deal for reflection and commentary in the Art of Dying. In fact, for a book once popular for two centuries throughout Western Europe, there has been surprisingly little attention paid to it since. This essay will focus on its five “temptations” of a dying person with only limited discussion of other parts as they relate to the temptations. These five temptations: loss of faith, despair, impatience, complacency, and clinging, provide a thematic structure for spiritual conversation.

The first temptation is to lose faith. Faith is described as the foundation of all health, and goodness. St. Augustine and St. Paul are quoted, “One without faith is already judged” and “Without faith it is not possible to please God.” The Devil is credited as the source of all temptations and though the Devil can tempt, human free will remains the dying person’s most valuable asset, which must be guarded above all. Often enough among the dying, there are people of faith who ask, “Why me? I have been faithful and prayed all my life.” Faith is shaken. Many feel they had a pact with God, that if they followed the rules and said the prayers they would not face death before the fullness of years. The Devil attacks, “You wretch. You have been greatly mistaken.

It is not as you believe or as the preacher says.” The vulnerability or fragility of one’s faith can depend on one’s level or stage of faith. James Fowler describes one of the earlier stages as based on reciprocal fairness and a justice based on reciprocity. A terminal illness can seem unfair, unjust and will challenge faith at that stage. With the illness there may also be unresolved anger that manifests as a rejection of God. Anger is the second stage of Elizabeth Kubler-Ross’s well-known five-stage model of grief. (Denial, anger, bargaining, depression, acceptance). How

might one assist another in coping with loss of faith or with anger?

The Art of Dying recommends recitation of the Creed or expressing belief in God “in a loud voice,” recounting of stories of examples of biblical faith such as the stories of Abraham, Job, Paul, etc. Also relevant to dealing with doubt is the first question: “Do you believe in God (still)?” The great value of questions lies in that they provide opportunity for persons to reflect, articulate, verbalize, proclaim, and affirm their own faith. Pastoral ministry here is not a matter of preaching or judging, but of skilled listening. “Can you tell me more about what you believe about God, your relationship with God?” Pastoral conversation assists the dying in processing the emotional and intellectual response to the illness. The goal is to assist such persons to integrate this catastrophic situation into his or her belief system or personal theology, to perhaps see God in a new way and thus strengthen the faith, grow in faith, and come to a new stage of faith. The creed and biblical narratives then also have new meaning and value. The initial issue, however, is an assessment of faith.

Despair, the second temptation, is hopelessness and failure to trust in God. Sins seem too great and too many to be forgiven. A few people bluster, “I have not been a good Christian all my life. I will not be a hypocrite now that I’m dying.” There is some degree of pride to this, as if the sin or sins of this person are greater than God’s ability to forgive. On the other hand, there are also those who feel, and have always felt, unloved and unworthy of anything but reproach, condemnation and punishment. Psychological issues of poor self-image contaminate spiritual health.

The Art of Dying prescribes a recounting of the scriptural example of great sinners who were forgiven: Peter who denied Jesus, Paul who persecuted the Church, Matthew and Zaccheus, the tax collectors, the woman caught in adultery, etc. It recalls the words of St. Bernard, “God’s mercy is greater than any sin.” Again the questions can serve as starting points for pastoral conversation. “What is your greatest concern right now?” If despair is indicated: “Are you sorry for your sins? Do you believe Christ died for your sins?” (For Christians) “Would you like to make a Confession?” (For Catholics) “Is there anyone with whom you would like to reconcile?” Questions help provide opportunity for the person to express in his or her own words an affirmation of faith. It becomes a process for life review ultimately leading to a shift of focus from “me” to the passion of Christ. In fact, the Art of Dying recommends that a crucifix be always present to gaze upon so that one can consider the disposition of Christ on the cross, “giving all himself” for such sins.

The distinction between a meaningless needle prick and a vaccine shot is easy enough to understand and accept. But the suffering of many human illnesses often makes no sense to us at all and there is no simple advice for the companion or minister seeking to assist the dying.

The following invocation is recommended and is typical of the prayers found in the Art of Dying:

“Also, let him say three times these words or similar ones, which are ascribed to blessed Augustine: May the peace of our Lord Jesus Christ, and the power of his passion, and the sign of the holy cross, and the purity of the most blessed Virgin Mary, and the blessing of all the saints, and the protection of the angels, and the prayers of all the elect be between me and all my enemies visible and invisible in this hour of my death.”

Impatience is a temptation against love because “love endures all things,” as St. Paul said. The ordeal of sickness and death is all too often a grueling journey. Regardless of the length, for the person enduring it, it is too long and too painful. It is no wonder some people opt for euthanasia. Fortunately, hospice care is now the standard of care for the dying. The problem is that many people cannot accept the fact that they are hospice appropriate. They continue to push for aggressive therapy that is essentially futile. Families often play an influential role in this when they cannot accept the impending loss. Instead they continue to encourage the person to fight the disease, arguing, “You can beat it.” Miracles are often expected.

The Art of Dying addresses this tendency. It warns, “Do not tell the person there is hope of cure.” The concern is failure to prepare spiritually. There is a delicate balance between false hope and “false no hope” as Bernie Siegel wrote. The latter is a premature prognosis of death. Science has come a long way and diseases that once were hopeless are now manageable. The skilled minister tactfully helps to frame things in terms of new realistic hopes that make the best of life as it now is. It is a careful endeavor to give full respect to the true gravity of an illness and help prepare for death, while at the same time not aggravating the fear, sadness and anxiety that is already present.

The Art of Dying tells us that suffering, endured patiently, is a cleansing process. Suffering is easier to endure and it is easier to have patience, if one sees meaning and purpose in the suffering. This is no small challenge. The distinction between a meaningless needle prick and a vaccine shot is easy enough to understand and accept. But the suffering of many human illnesses often makes no sense to us at all and there is no simple advice for the companion or minister seeking to assist the dying. The meaning and purpose that an individual might discover in such a situation can be as unique as the person. One person may find meaning in solidarity with the suffering Christ. Another sees the illness bringing family closer together. A third simply accepts the cycle of life and “the way things are,” while a fourth family member speaks in terms of “God needing another flower in His garden.” One must withhold judgment to beneficially journey with people seeking meaning and purpose. Only meaning and purpose, no matter how expressed or imaged, will bring the peace and patience to cope with serious illness and loss. It is interesting to note that the same families that refused to accept the impending

loss, upon seeing their loved one suffering in the last days, then pray for it to end and express some degree of guilt about that prayer. God’s timing is too soon and then not soon enough.

Sometimes worn down people who are so tired of their illness basically refuse to comply with their own plan of care. Not to be confused with a natural withdrawal, this is despair of a different kind, not of their sinfulness, but of their life situation. It is a vast hopelessness due to the loss of worldly goods including health, mobility, physical strength and autonomy. These are some of the same issues relevant to the fifth temptation of avarice. The image of the crucified Christ is recommended for contemplation as he was patient “even unto death.”

Complacency is the fourth temptation. Those who have had strong faith, who have been religious, are most vulnerable to this temptation. It is tantamount to spiritual pride. There is a diminished sense of guilt and exaggerated self-righteousness. It is the opposite of despair and needs to be balanced against it. We are told about the Devil “throwing such thoughts as these against him like darts: ‘How firm you are in faith, how strong in hope, how patient in your illness, how much good you have done! You should take special pride because you are not like others...’” Meekness is the antidote to this temptation and it comes by reflecting on one’s sins. It should be remembered that “pride so offends God that for the sake of it alone he banished the noblest creature Lucifer...” “It is pride alone that makes an angel into a devil.” What is needed is self-examination. One must not simply acknowledge a general vague sinfulness. Self-righteous people acknowledge their general sinfulness as a perfunctory prerequisite to claim the virtue of humility. In so doing they fail to identify, and own, specific failures that are the grist of true compunction and repentance. An honest and specific examination of conscience helps to nurture a meekness that properly disposes one to meet one’s Creator. Examination of conscience with pastoral guidance through a life review process can lead one into significant actionable self-awareness of both the good and bad of one’s life, the blessings and the failures. There may still be an unrecognized need for reconciliation and closure to be discovered.

The last temptation is avarice or inordinate clinging to the world, inordinate as in inappropriate for this moment in

The Art of Dying prescribes a recounting of the scriptural example of great sinners who were forgiven: Peter who denied Jesus, Paul who persecuted the Church, Matthew and Zaccheus, the tax collectors, the woman caught in adultery, etc. It recalls the words of St. Bernard, “God’s mercy is greater than any sin.”

How-to-die

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one's life. If it is within God's will that life is ending, it is then against God's will that one cling to all that is of this world including family, business, pleasures, wealth, etc. Once again, as in the case of impatience with dying, the family

can play a strong role. Perhaps family members are the ones clinging, the ones refusing to let go. The dying person may actually be trying to withdraw and the family cannot accept it. The Art of Dying states, "When one is at the point of death and is hurrying to the end then should no carnal friends, nor wife (husband), nor children, nor riches, nor temporal goods be brought before him...." Fortunately, it provides qualification, "only as much as spiritual health and profit of the sick one asks and requires."

Family attachments are often the chief source of sorrow for the dying person. Not wanting to abandon loved ones may be the only thing holding a person back from "letting go." Yet contact with family and friends may be exactly what is needed for permission and goodbyes, for reconciliation and final words, for blessings and reassurance. Later in the Art of Dying reference will be made to the model death of Jesus, including the transfer of filial responsibility of his mother over to John. Perhaps then, the more appropriate pastoral response is not to keep family and friends away but to facilitate such handing over of earthly concerns, be they possessions, business, or family. Facilitating any communication that needs to take place is a gift. Just because something needs to be said does not mean it will be said easily or perhaps even said at all.

To overcome this temptation to cling to family life, the Art of Dying recommends meditation on the poverty of Christ "as he hung on the cross for you." The key issue is whether the person is tempted to "turn from the love of God." Voluntary poverty of this kind as death approaches is the antidote for the love of worldly goods that separates one from the love

of God. At the time of death, what the Art of Dying calls the "articulus mortis," the "turning point of death," a decision must be made. Of course, we are called to love our neighbors as ourselves, to love all, including family. But God must have priority in this love as Jesus taught, "Those who love mother, father, sister, brother more than me are not worthy of me." The pastoral care giver can help to see the love of family, friends, and the goods of this world in the

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greater context of God's larger plan, God's larger life, thus easing the tendency to cling.

Conclusion

Contemporary training for the professional chaplain involves Clinical Pastoral Education. There, emphasis is placed on respecting the spirituality, the spiritual journey, and religious beliefs of everyone at the moment of encounter. This encompasses a wide range of tolerance for any form of Christian faith, Hinduism, Judaism, Islam, but also Wicca and any mixture of New Age thinking or no apparent religious beliefs at all. As long as a person is not spiritually suffering from their belief system, their spirituality, it is not the chaplain's role to challenge or evangelize in the traditional sense of the word. Rather, the chaplain is there to assist people to access the blessing of their own spirituality and, in so doing, to mediate God's presence. However, that role is not limited to the professional chaplain. Indeed, the purpose of the Art of Dying is to guide anyone, especially the laity and "all true Christians," to learn and have knowledge of how to die well.

Though death is a universal human experience, we all cope with it in different ways. Perhaps everyone does not experience all five temptations as presented in the Art of Dying. Nevertheless, faith, despair, complacency, impatience and clinging serve as a structure for reflection and opening for pastoral dialogue (especially for Christians) that lead people to see, perhaps even for the first time, their belief system, where their faith lies, and how well they have lived according to those values. How one dies is the last statement one makes. It is the last opportunity to reconcile, if needed. It is the last opportunity to proclaim what faith they have and to live through that faith into death. The Art of Dying can be summarized in one line: "*Bene Mori est libenter mori*" — "To die well is to die willingly, freely." We all share in the work to be done toward that final freedom. The 600-year-old "Tractatus de Arte Moriendi," from the heart of the Catholic spiritual care tradition, provides a useful method for that work.

Peter T. Mayo, of Pittsburg, KS, is director of pastoral care at Mt. Carmel Regional Medical Center.

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Please remember in your prayers:

Rev. James Krings, an NACC member who had been a hospital chaplain and was known for his preaching ability, who died June 27 at age 63.

About 1,500 people attended a joyful Eucharistic memorial celebration June 30 at St. Joseph Church in Manchester, MO, according to Sr. Leah Holzum, DC. "For many years Fr. Jim fought his cancer with courage and joy and was an inspiration to all," she told *Vision*.

Born in St. Louis, Fr. Krings attended St. Louis Preparatory Seminary-South, Cardinal Glennon College, Kenrick Seminary and St. Louis University.

Ordained a priest for the Archdiocese of Saint Louis in 1971, Rev. Krings held a B.A. in philosophy, a Master of Divinity degree, and a master's degree in biblical languages and literature. In addition, he had done post-graduate study in Christology and Ecclesiology. He had also completed Clinical Pastoral Education residency.

During his priestly ministry, Fr. Krings worked in secondary Catholic education as a teacher, a campus minister and an administrator. He was a chaplain at St. Louis University Medical Center in Midtown St. Louis, St. Mary's Health Center in Richmond Heights, and mission director at Saint Joseph Hospital in Kirkwood, MO. He served several parish communities in the Archdiocese of Saint Louis.

Rev. Krings received the Aquinas Institute of Theology's Great Preacher Award for 2007. The Aquinas Institute of Theology is a Dominican-run graduate school in St. Louis. The Great Preacher Award is given annually to a priest who "by compelling and imaginative preaching, powerfully engages hearers with the Word of God," according to a statement from the school.

"Preaching is making a connection with the life stories of my hearers — their hopes and fears, their joys and sorrows — ultimately connecting them with the stories Jesus told in his own preaching," Father Krings said upon receiving the award.

"Living with Cancer in Faith," a series of columns by Fr. Krings that ran in the Saint Louis Review, earned the

archdiocesan weekly a first-place award for Best Regular Column for newspapers in general commentary from the Catholic Press Association in 2001.

Rev. Krings regularly wrote Scripture reflections for "Living Faith" magazine. In one reflection, he offered a mission vignette from SSM Health Care, the system where he worked as chaplain:

"On a particularly difficult day, a nurse prayed: 'O God, where are you? Why don't you send help?' 'I did,' God replied, 'I sent you.'" In the Jan. 6, 1997, issue of "Christianity Today," Fr. Krings was interviewed on the importance of community in the role of prayer. He told the story of counseling a young woman named Toni, who had been diagnosed with breast cancer. Her physician wanted to schedule an immediate mastectomy, but Toni wanted to visit Fr. Krings first. Fr. Krings suggested that Toni receive the Eucharist at her church on Sunday, plus a laying-on of hands.

The article said Toni drew desperately needed strength from the church community's response as her illness was made public. Later, she told the church, "Just as Aaron and Joshua [sic] held up the arms of a weary Moses, so you've held me up." As tears filled her eyes, she added, "I sat on the rock of Saint Cronan's (Parish) as I traveled through my sickness."

What followed was a transformation — not just in Toni's life, but in the life of the church, Fr. Krings explained. Since Toni's experience, he said, it had become normal for people at Saint Cronan's, who were facing hospitalization or major medical tests, to request anointing and prayer.

"Church members are much more public about their illness," Fr. Krings noted, "and Toni's experience seemed to give everybody permission to be ministers to each other rather than wait for the 'professional clergy' to meet their needs. Our people always had the ministerial instincts, but Toni's going public set them all free to use them."

In Memoriam

Kelly Elizabeth Sexton
(daughter of NACC member
Melyssa Sexton)
Madison, WI
Cancer

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

Sr. Nancy Crane, OP
Akron, OH
Cancer treatment

Sr. Hilda Mallet, MHS
Lafayette, LA
Cancer treatment

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

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

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.

Giving to the NACC

To give a gift to the National Association of Catholic Chaplains, call (414) 483-4898 or e-mail us (info@nacc.org) at anytime. To discuss making a gift to support specific NACC ventures or projects, contact David Lichter or Cindy Bridges to discuss options.

Annual Appeal 2009

The second phase of our 2009 campaign is currently under way. Thanks to all those who have donated so far this year! The list below includes all gifts received as of Aug. 5, 2009.

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Milwaukee, WI
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patrickb@sa-mercymedical.org

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Bonnie.Burnett@christushealth.org

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Chaplain
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snor@netzero.com

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Notre Dame, IN
ghoyler@cscsisters.org

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baajuizuchi@yahoo.com

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marcwater21@hotmail.com

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Calendar

September

- 16 Local gathering
Toward a Theology of Story
Listening, St. Joseph Hospital
and Medical Center, Phoenix, AZ.
- 18 Local gathering
Retreat for Professional and
Spiritual Enrichment,
Spokane, WA.
- 21-23 NACC Board of Directors
Milwaukee, WI
- 24-25 Local gathering
North Central Prairie Chaplains
Regional Conference,
Alexandria, MN.

October

- 3-4 Certification interviews
- 9 Local gathering, Buffalo, NY.
- 10 Local gathering, Nazareth, KY.
- 17 Local gathering, Boston, MA.
- 18-20 Wisconsin Chaplaincy Association
Fall meeting, Green Lake, WI.
- 22 NACC-APC Spiritual Care Week
Symposium, Sacramento, CA.
- 30 Local gathering, Charleston, SC.
- 30-31 NACC Certification Commission
NACC Standards Commission
Milwaukee, WI