vision

National Association of Catholic Chaplains

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In This Issue:

Our patients are sometimes your patients

By Deacon Mike Steele, PhD, BCC

As chaplain and director of pastoral services at a small hospital located in the southeast corner of Kansas, I welcome you to the reality of state-designated rural health networks. It is from these nationwide networks that most large hospital chaplains greet rural patients as "out-of-towners."

The state of Kansas is a national leader in rural health development with 16 designated rural health networks including more than 80 Critical Access Hospitals (CAH) connected to mid-size and large hospitals across the state. The advantages of being a CAH include cost-based reimbursement for many services, relaxed staffing requirements, and federal grant assistance for prospective CAH's.

Several of the criteria for designation as a CAH are having 24-hour emergency room care services, utilizing no more than 15 acute care beds, or having up to 25 inpatient beds that can be used interchangeably as skilled nursing care; and that the average length of stay is 96 hours or less on an annual basis. Also, the hospital must be more than a 35-mile drive from another hospital or is certified by the state as a necessary provider of health services to residents of the area.

My employer meets these qualifications and after more than 60 years has recently applied for designation as a prospective CAH by Medicare and Medicaid services. Our hope for approval is driven by the availability of federal grants and proposed resources in the current healthcare reform legislation. However, these facts are not the reason for sharing my experiences; instead it is the historical and cultural context of Jesus' chaplain-like life discovered through the second greatest commandment, "You shall love your neighbor as yourself."

Like Jesus, small hospital chaplains know their patients as neighbors, relatives, co-workers, and church members.

While the second greatest commandment is an imperative for every chaplain, it has special meaning

See Patients on page 8

When you're a department of 1

By Cheryl Fitzgerald, MA, BCC

At a small Critical Access Hospital the chaplaincy department will:

- Offer a "reflection/prayer" at the demolition of the older section of the hospital,
- Visit residents in the nursing home connected to the hospital,
- Provide pastoral presence to a patient moved to the hospice room,
- Respond to an RN's referral for a staff member in need,
- Meet with a patient in the Emergency Department,
- Visit with patients being discharged,
- Facilitate a caregiver support group,
- Provide a ritual for the family of a dying patient,
- Contact local clergy,
- Document patient interactions for each day.

How does my day as a chaplain differ from the days of many others

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2010 is the year to accept the call to leadership

By David Lichter, DMin
Executive Director

A blessed 2010 to all of you! 2010! A new decade! I asked myself, "What is the most important emphasis for us this year?" Only one word surfaced immediately – leadership. 2010 needs to be for NACC – "Leadership 2010"! Leadership has diverse definition, such as motivating or directing others to achieve a goal. For NACC, let me offer this leadership vision: be an inspirational, persuasive influence that positively impacts your organization (including NACC) to fulfill its mission. Let me address this from three perspectives.

I have been impressed with the willingness of so many of you to volunteer your time and expertise, whether as state liaisons or on task forces to advance special projects, such as the NACC website, membership, marketing/recruitment, metrics, conference planning, and others.

First of all, each of us, as a spiritual care provider, is called to be this type of leader in our respective settings. It is all the more critical at a time when our institutions experience the social and financial stresses that threaten mission fulfillment. Those of us in organizational leadership roles, such as a director of pastoral care or mission, exercise diverse spiritual leadership functions that require a specific set of competencies, as we outlined in the November-December 2009 *Vision*. However, every chaplain is called upon to provide an inspirational, persuasive influence that positively affects the organization's spiritual and moral climate.

Secondly, the NACC needs this type of leadership from its members to fulfill its mission. I was not with you when the "regional" structure existed. I understand it provided many of you direct volunteer leadership roles. Almost a decade has now passed since that structure, and NACC still continues somewhat to feel the effects of a decade-long dearth of too few leadership opportunities through which members can exercise that inspirational, persuasive influence upon one another and promote the spiritual care ministry (our NACC mission). But it's a new decade with new opportunities!

We are beginning to re-engage you, as members, in new leadership roles. I have been impressed with the willingness of so many of you to volunteer your time and expertise, whether as state liaisons or on task forces to advance special projects, such as the NACC website, membership, marketing/recruitment, metrics, conference planning, and others. Thank you. Conference calls have aided us in mobilizing one another around these projects so that we can be the "inspirational, persuasive influences" that positively impact one another and our profession. Thank you.

However, I see other ways that you are being inspirational and persuasive influences that positively affect one another and the profession. These are exercises in leadership. Some of them are:

- Inviting one another through NACC Now to offer perspectives and resources on ministerial issues and professional needs. Several of you initiated such requests and many of you have responded generously to these requests to help not only the person requesting information, but also to provide all of us a shared pool of resources. This member exchange has been inspirational and positively impacts all of us.
- Participating on member conference calls and/or networking about topics such as palliative care, hospice, and long-term care. Joining in on conference calls that involve conversing with fellow deacons or NACC members of the same age level.
- Contributing through being certification interviewers, interview team educators (ITE's), and site hosts.
- Helping initiate, host, plan, seek sponsors and invite speakers for or be a speaker at local chaplain gatherings.
- Contributing articles to *Vision*, and/or to NACC Now.
- Alerting us to events, books, programs, articles, news, and resources that we can include in NACC Now and *Vision*.

These are examples of the many inspirational and persuasive influences you can have on one another and the profession. Please keep it up! If you have not tried any of these, please make it a priority for 2010! Be part of "Leadership 2010."

Finally, NACC needs members to assume important leadership roles on its board, commissions, and panels that exist to oversee and fulfill NACC's mission to promote the ministry of spiritual care, and educate, certify, and support our members. In the past year the Governance Committee revisited the responsibilities and membership criteria for these entities. They are:

- Board of Directors
- Standards Commission
- Certification Commission
- Certification Appeals Panel
- Ethics Commission
- Ethics Appeals Panel
- Nominations Panel
- Education Advisory Panel
- Editorial Advisory Panel

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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 Rupcic

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 Chawszczewski, Ph.D.
schaw@nacc.org
Association Support Coordinator
Cindy Bridges
cbridges@nacc.org
Administrative Specialist/Certification
Rose Mary Blanco-Alvarado
rmalvarado@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

Vision needs your expertise!

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

- March-April: What does leadership look like?
- May-June: NACC National Conference in St. Paul

(If you are attending, would you like to write about a workshop or keynote talk for *Vision*?)

- July-August: Building awareness of chaplaincy / One Book, One Association
- September-October: Chaplaincy as church ministry

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!

On Leadership

"Leaders are people who are able to express themselves fully. By this I mean that they know who they are, and how to fully deploy their strengths and compensate for their weakness. They also know what they want, why they want it, and how to communicate what they want to others, in order to gain their cooperation and support. Finally, they know how to achieve their goals. The key to full self-expression is understanding one's self and the world, and the key to understanding is learning — from one's own life experience."

— *Warren Bennis, "On Becoming a Leader"*

Call to leadership

Continued from page 2

You can learn more about these bodies on the NACC website (www.nacc.org). Given the purpose of these entities, a level of experience and prior leadership involvement within NACC is expected. In setting the membership criteria for these entities, the Governance Committee struggled to balance the need for sufficient experience with the benefits of "new blood." To help us with identifying and qualifying members for these bodies, we instituted a Nominations Panel, and its work has begun.

The first "test" this fall was with seeking a new member for the Ethics Commission. In September we invited members to apply through NACC Now. We had a good number of applicants, which was really satisfying. Many of them completed application forms that asked them to explain how they met the criteria. The Nomination Panel then reviewed the applications and made their recommendation to the Governance Committee. While not all the applicants were selected, we greatly valued their volunteering because now we are aware of them, their background, and their interests for future NACC needs. Thank you!

We have several "tests" in 2010, as we look to fill at least three Board of Director positions by January 2011. "Leadership 2010" invites all of you to learn about NACC leadership needs, to consider volunteering for these needs, and to encourage and invite colleagues whose experience and gifts match current leadership needs.

My prayer for NACC in 2010 is that each of us will embrace generously this new decade by examining how we can grow in our call to be inspiring, persuasive influences who can positively affect our places of ministry and NACC, and embrace generously the call to lead! It's a new decade! Lead us on, O Lord!

St. Paul, our home city, has a lot to offer visiting chaplains

Don't worry: Skyway network has cold weather 'covered'

By Marian Louwagie CSJ, and Fr. Steve LaCanne

We welcome you to Saint Paul, MN! We think you will enjoy our city. Whether your definition of adventure includes experiencing a slice of history, exploring the banks of the Mississippi River or watching a Minnesota Wild hockey game in "Hockeytown USA," Saint Paul has all the amenities to make your adventure a memorable one. The Crowne Plaza is located in the heart of the city near the sandstone bluffs of the Mississippi.

Culture and Cuisine

Few cities in America combine culture and cuisine as seamlessly as Saint Paul. Restaurants abound throughout the city offering mouth-watering cuisine of Thai, Afghani, Mexican, Nepali, Italian, Russian and Ethiopian cultures. The West 7th, Rice Park and Lowertown areas all have their own style and flare. Looking for that cultural experience? Check out District del Sol on the West Side, where Latino culture, including food, art and festivals, thrive. Whether you're after culture, cuisine, or both, you will find an incredible array of opportunities for your enjoyment in Saint Paul.

Shops and Stops

Saint Paul is a shopper's dream with an exciting balance of brand name staples and small town boutiques; not to mention we are a short distance from the world renowned Mall of America. Saint Paul's bread and butter are the boutique shops. Looking for jewelry, clothing, flowers or the perfect handmade gift for that special someone — you are sure to discover it in Saint Paul. Finally, with more than 500 stores and an indoor amusement park, the Mall of America is sure to amaze you!

Arts and Entertainment

Saint Paul is home to a vast array of theaters from expansive to quaint, including The Fitzgerald Theatre, Ordway Center for the Performing Arts and Lowry Theatre. The live music scene is kicking at venues within the city, from the Artists Quarter to The Turf Club. Several festivals come to Saint Paul annually with national and local acts. The Xcel Energy Center is quite possibly the best concert venue in the United States attracting the biggest acts in music and entertainment.

Historical Landmarks

▾ Cathedral of Saint Paul Tours

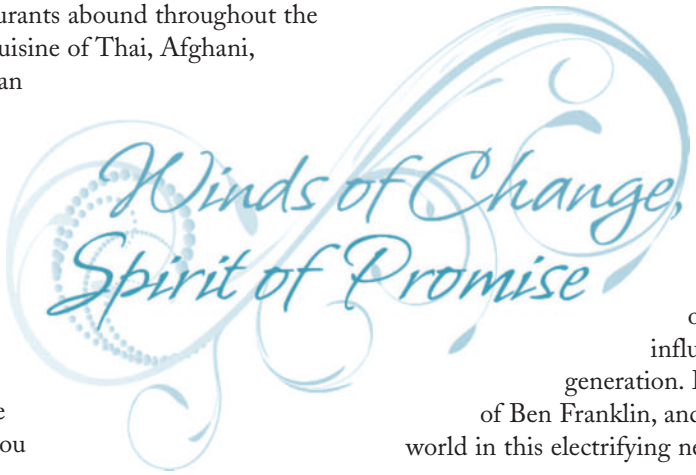
Each year, the Cathedral of Saint Paul welcomes more than 200,000 guests and visitors. The cathedral is recognized as a center of spiritual worship for the Archdiocese of St. Paul and Minneapolis. It is a historical landmark and one of the most prominent buildings in the city.

▾ Minnesota State Capitol

Hear stories about the capitol's history, art and architecture. See the chambers where government decisions are made and, weather permitting, walk to the quadriga (golden horses) on the roof of the capitol.

▾ Minnesota History Center

Learn about Minnesota's history, cultures and neighborhoods. Our traveling exhibit features Benjamin Franklin, our founding father — a scientist, diplomat, humorist, philanthropist, and entrepreneur after being a rebellious teen. He is one of the most remarkable and influential Americans of any generation. Learn more about the many sides of Ben Franklin, and discover his impact on your world in this electrifying new exhibit.



▾ A walk in the parks

The Crowne Plaza is located along a historic section of the Mississippi. Plan to take a long stroll along its banks, which are dotted with historical markers; or head the other direction and you will have a chance to walk in one of our several downtown parks that showcase a famous historical sector of the city.

Our skyways

Don't allow our weather to intimidate you. We have it covered! You can plan on taking the skyways to navigate most of the city. Saint Paul and downtown Minneapolis have a skyway network linking together buildings and attractions. St. Paul's skyway system links 47 city blocks. With five miles of skyways, it is one of the largest systems in the world. Our skyways will protect you from inclement weather and provide an easily navigable connection throughout downtown. Most of St. Paul's skyways are open from 6 a.m. until 2 a.m., although some close earlier — anywhere from 7 p.m. to midnight.

We hope you are able to join us for our conference "Winds of Change, Spirit of Promise" in St. Paul. It will be a chance for you to rejuvenate, expand your horizons, and allow your creative thoughts to percolate and fuel you for the coming year.

Marian Louwagie is spiritual care leader at Woodwinds Hospital in Woodbury MN. Fr. Steve LaCanne, is spiritual care director at St. Joseph's Hospital in St. Paul, MN.

Spiritual Leadership Competencies: Raising the bar

By Michele LeDoux Sakurai, DMin, BCC

Many years ago, I sat in on an interview with members of my department; we were in the process of selecting a new director of spiritual care and had been given questions from the "behavior based" model for interviewing. This model operates from the assumption that our past experience will give insight into future action. This assumption has merit and did help us to focus not on theory (i.e. What would you do if…), but on actual decisions and accomplishments (i.e. Tell us about a time in which you…). Although we were able to choose the questions to use, they were pre-packaged and general; these questions were used by all disciplines. In addition, we had no spiritual care leadership competencies by which to measure responses. As a result, at the end of the interview, there were deep divisions in the department as to how answers were to be interpreted in light of spiritual care leadership. In addition, members were at odds as to the implications of responses to future actions or behaviors. For instance, one of the candidates spoke of her conflict with her vice president of mission. She blamed this conflict on a reduction in staff in her department and used it as well as a reason for leaving her position. While some of the chaplains interviewing were sympathetic to the plight of working for a difficult VP, other chaplains raised concern that the candidate lacked the skills needed in a leader to build relationships. Without established leadership competencies for spiritual/pastoral care leaders, the interview process lacked focus, with interviewing chaplains relying more on intuition than on information. Behavior-based interviewing can be incredibly effective but without professional competencies to weigh responses against, this tool seemed incomplete.

The need for spiritual/pastoral care leadership competencies has been heard by the NACC. In 2007, the Catholic Health Association and the National Association of Catholic Chaplains hosted a summit and one of the areas of focus was "Care Services and Staff Development." From this task force came Spiritual Leadership Competencies that articulate nine skill areas, (i.e., leadership, finance/accounting, management, marketing, organizational dynamics, professionalism, quality, strategic planning, and technology acumen) and specific competencies within each of these areas. As coherent as these seem, would these competencies be practical for interview purposes?

A couple of months ago, one of our mission leaders requested potential questions for interviewing chaplain manager candidates. The work that the task force had done on spiritual leadership proved very helpful; below are a few examples of the Spiritual Leadership Competencies through the lens of "behavior based" interviewing:

Advancing *the* PROFESSION

1. Tell us of a time when you were called upon to communicate a compelling vision or core purpose for spiritual care services. Were you effective and how did you know that you were effective?

2. Give an example of how you have demonstrated a "value-added" or "cost avoidance" benefit of adequate spiritual care/chaplain staffing.

3. How have you, in the past, positioned the spiritual care department to serve as a resource for spirituality and ethics formation? What ethical decision-making model have you utilized? (This is an area that the NACC is working to enhance; not all chaplains are comfortable with ethical decision-making.)

4. Provide an example of process improvement in spiritual care that you either initiated or supported.

5. Give an example of a time when you worked across disciplines to problem solve.

6. Tell us of a time that your administrator asked for a reduction of FTE, services, etc. How did you respond?

7. What does servant leadership mean to you? Give an example of how you have used this model for staff development. (The model the NACC uses in its competencies is servant leader.)

Spiritual Leadership Competencies is a clear, concise, and practical document that can act as a tool for leaders as they hire. I believe it also can be helpful for administrators as they evaluate their spiritual leaders and potential leaders.

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

Without established leadership competencies for spiritual/pastoral care leaders, the interview process lacked focus, with interviewing chaplains relying more on intuition than on information.

130 participated in *Vision* online survey

More than 130 NACC members participated in the recent *Vision* online survey. Their comments will provide valuable direction to *Vision*'s Editorial Advisory Panel and editor as they continue the joint task of making *Vision* ever more responsive to members' professional interests and needs. The next issue of *Vision* will include an article detailing survey results.

From Amman, Jordan: Living everyday with God, *Insha'Allah*

By Mark Lazenby, PhD, AOCNP

When I arrived in Amman, Jordan, on a warm August evening four months ago, the sights of the city confirmed what I felt. It looked so different from cities I had lived in before. Sure, I saw apartment buildings, just as in Boston and New York City. And yes, the university hospital appeared large and state-of-the-art, just as in New Haven, CT, and Lebanon, NH. But unlike these New England cities, where the only prominent religious edifices are the churches that anchor town greens, here minarets rise higher than the highest buildings. And they are not just in the center of town. The mosques these minarets rise from appear on every block, sometimes two or three on the same block. That night of my arrival, with my awareness of how different this Arabian city is from North American cities on my mind, I had lain awake until just before dawn; I was jetlagged. But when the muezzin called the *adhan* (the call to prayer) from a loudspeaker on the minaret across the street from my apartment moments after I had finally fallen asleep, I started. Life here would be different — different, indeed.

Imagine if you told your patient that the cancer has returned but, "*Alhamdulillah*, you have breath today and we will do all we can to give you the best life possible; for after all, all of life depends on God's will." This is not, I tell you, religion New England style.

The difference is that, here, religion infuses everyday life. The *adhan*, heard five times daily, calls the faithful to the mosque to pray. The grocer, the barber, the launderer — whose shops are next to the mosque across the street from my apartment — close up for the 10 or 15 minutes it takes to walk to the mosque, perform ritual ablutions, and pray. The taxi drivers, who drive me to work in the mornings, listen to the radio station that constantly plays recitations of the *Qur'an*. When I arrive at work at the King Hussein Cancer Center (KHCC) and walk into the outpatient clinic building, the waiting rooms of which have flat-screen televisions installed high up on a wall, I see on the screen a picture of *al-Masjid al-Haram*, the Sacred Mosque in Mecca, and hear the lyrical sounds of the prayed *Qur'an*. And when I speak with colleagues and patients, the two Arabic words I hear the most are *Alhamdulillah* (praise be to God) and *Insha'Allah* (God willing): when something has gone well, they immediately give God thanks; and when they make future plans, they give God's will primacy. To be sure, who knows what the future holds?

Imagine how different this feels. Imagine if in your hospital you had five daily calls to prayer, and when you heard one, you said to your colleague, "I will help you in a moment, but now, I will pray." Imagine if in your clinic you say to patients and their families, "We will meet in a month, God willing," and you really meant it, without adding some cheeky qualifier like "and the river don't rise." Imagine if you told your patient that the cancer has returned but, "*Alhamdulillah*, you have breath today and we will do all we can to give you the best life possible; for after all, all of life depends on God's will." This is not, I tell you, religion New England style. Everyday life and religion here are one and the same.

So why go to Amman to study the role of religion in the well-being of cancer patients? Well, the answer I gave when I arrived has nothing to do with the answer I give now. Four months ago, I answered that I came to conduct the study because the literature is virtually silent on the role of religion in the well-being of cancer patients in Arabia; and I, both an oncology nurse practitioner and a philosopher of religion, wanted to know what that role is. But now, now my answer has something to do with this inextricable binding of religion and everyday life. My answer now has something to do with undoing that tidy picture of the New England red-bricked, white-steepled church anchoring the town green, as if its sole purpose is to provide scenic views.

The way Arabs live everyday life recognizes that there is no tidy divide between life and faith. Cancer, for instance, visits rich and poor, believer and unbeliever, young and old. Beyond providing the best evidence-based care possible, which they do here at KHCC, one of the few certainties Arab cancer patients have to grab hold of is God. And they grab hold of this certainty with full grip.

For example, one morning on rounds, my Jordanian colleague, a palliative care physician, and I walked into the room of a woman in her mid-50s. She was dying of metastatic breast cancer. Radiation to her brain had left her in constant seizure, and for a few days, she had lain on the hospital bed curled and unresponsive. Around her were her two daughters and one son, all fairly young, ranging from (maybe) 18 years old to their mid 20s. One had obviously slept in the room on the floor the night before: a small rubberized mattress and a few blankets were rolled up and stuffed between the nightstand and the wall. When I looked into their faces, they were sad and exhausted — no two ways about it. But when I asked them how they were doing — how they were in their spirits, in their hearts, how their faith was — with peaceful faces that confirmed their conviction, they replied, "*Alhamdulillah*." When my colleague told them that their mother may pass soon, and until then, he will make sure she is comfortable, they, in near unison, said, "*Alhamdulillah*." They went on to say that they knew that all would be well, even when their mother passes. They had been reciting *Qur'an* to her, and indeed, the day before, she had awakened to the sounds of the *Qur'an* on the television in her room and had herself mumbled a barely audible prayer. "All will be well, no matter what happens," they told us. My physician friend and the advanced practice nurse

who works with him both acknowledged this family's faith by responding, "*Alhamdulillah*."

The cancer center's chaplain, the only one for the 120-bed hospital, finds herself overworked, not because of a high incidence of negative religious coping. Sure, some are depressed because of existential crises: yes, some do ask why God allowed them to have cancer. However, the reason she finds herself overworked is because most patients and families wish her to pray with them, to recite *Qur'an* to them, to comfort them with holy words when their loved ones die. Most seek her out because, to them, religion and cancer care cannot be separated.

This is not only true of Muslims. When I approached a Palestinian Christian man, whose colorectal cancer had invaded the rest of his body, to see whether he would fill out a questionnaire for my study, he thanked God that I was conducting such a study. "*Alhamdulillah*," he said. "Come back in an hour, and *Insha'Allah,* I will be done." When I returned to his room a few hours later, he was asleep. His wife gave me the completed questionnaire, and, as she thanked me for including her husband in the study, she gave me a small cross made of olive wood with a crucifix on it. On the back were the words "Made in Palestine." She told me, in broken English, "From the Holy Land, our home," the home, I was aware, her husband would never see again, not even allowed to be buried in. Despite the pain of her family having been rent apart by politics and now cancer, she said, "*Shukran* (thank you)," she repeated over and over, "*shukran*."

How do I now, four months after my arrival in Amman, answer the question of what I hope to accomplish in my research? Well, my research aims have changed. Now I am trying to figure out how we in North America can stop pretending that everyday life mirrors the tidy perfection of our town centers, with religion shunted off to a well-designated corner, brought out one day a week for two hours.

Now, I hope to understand how we as clinicians — physicians, nurses, social workers, psychologists, and (yes) chaplains — can open up our hearts to the freedom that comes from acknowledging that, clinically, over matters of life and death we have little control. Now, I hope to understand how giving thanks for all things (good and difficult) soothes our troubled souls. I hope to understand how living everyday life as if it is a gift gives perspective to unexpected twists and turns, such as cancer — and how the people here in Amman do all this without even thinking.

My answer to what am I studying here, as you can tell, is now more personal than scientific. I hope that I myself learn to do all that I wrote in that last paragraph, but not in the generic terms I wrote it in. I want to live every day the same way as Arabs (Muslims and Christians, alike): with God.

Four months after arriving in this Arabian city, I lift my head toward the minaret across the street and, in my heart, I say, "For the chance to learn how to live everyday life with God at home and in the clinic, *Alhamdulillah!* I'm living it here, and, *Insha'Allah*, I will live it back home."

Mark Lazenby received a Fulbright fellowship to study religion in cancer patients at the King Hussein Cancer Center in Amman, Jordan. Before going to Jordan, he spent a month with the palliative care team at Dartmouth-Hitchcock Medical Center in Lebanon, NH. For several days he shadowed Chaplain Linda Piotrowski on visits to patients.

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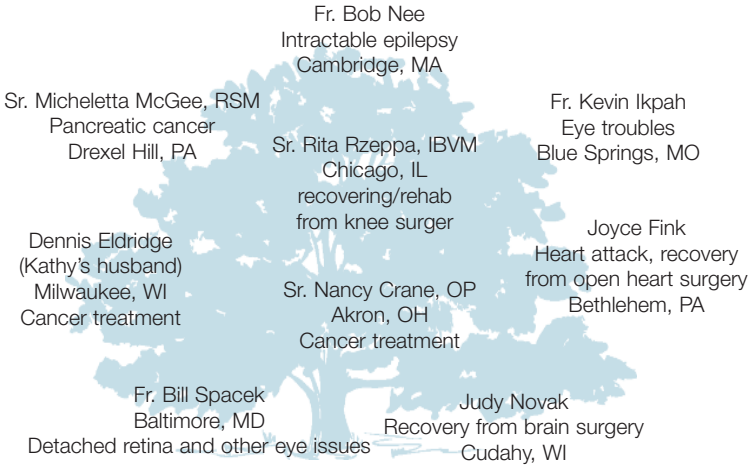

Prayers for Healing

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.

Patients

Continued from page 1

for small hospital chaplaincy, as Jesus was a "hometown boy." He grew up in the town of Nazareth, a small agricultural village with an estimated population of 1,600-2,000. In this sense, like Jesus, small hospital chaplains know their patients as neighbors, relatives, co-workers, and church members.

When I accepted the opportunity to become the new chaplain and director of pastoral care in a community of fewer than 8,000 citizens, it was because of my education, life experience, and chaplain experience at a large and very busy Missouri hospital in the same Catholic hospital system. The Kansas vice-president of mission informed me that the previous director knew everyone in town and that fact might cause some difficulty for me. I was, however, truly unprepared for the actual experience.

Today when chaplains open the electronic chart of an ICU patient, we often read the night notes of a physician visually and voice connected to us, but located 300 miles away.

As I was frequently told, the previous chaplain was born in the same hospital, attended the same elementary, high school, and even college with them or their relatives. For younger patients, he had been their schoolteacher, or their children's principal during his 30 years in the public school system. And, finally, he was the pastor at a local church. Such experiences may occur occasionally in the working lifetime of large hospital chaplains; but unlikely with the regularity that I experienced.

Now, several years later, I am accepted for who I am. This occurred in part because I am the only chaplain here and have the freedom and necessity to solve problems as they occur. I quickly observed that the majority of local inpatients arrive first as outpatients for routine tests and procedures. I reasoned correctly that using my early morning hours to establish familiarity with them would benefit me if I were to later greet them as inpatients. While many patients in large hospitals present in the same way, most chaplains there do not have the luxury of meeting them as outpatients.

This conclusion leads to two other comparisons. The first is a high percentage of our patients are chronically ill or nursing home patients, thus repeat admissions; hence, pastoral familiarity with them and their families is an ongoing process. The second is as a former large hospital chaplain who dealt with more complex and tragic situations than I find in my current role, I quickly learned that verbally comparing such incidents was interpreted negatively. Hence, I am close-lipped unless asked.

Another difference is few rural hospitals are Catholic or faith-based compared to the number of large hospitals. Many large hospitals are sponsored by religious orders of women, but have few sisters who are active in hospital ministry. At our hospital, we are blessed to have two Sisters of Mercy who are an active presence in the hospital. Sister Carmel, at age 92, is spry, gregariously gentle with great intelligence, clarity of thought and memory. She comes to the hospital several mornings a week to visit patients. Sister Margret, who is much younger and wonderfully Irish, is our official "Sister Presence." One of her self-assigned tasks is visiting staff on a daily basis. Because our average daily census is fewer than 25 inpatients, the ratio of sisters to patients and staff and their assistance to me is unlikely matched at any large hospital.

I lament the nationwide decline of religious, but also grieve the decline of Catholic chaplains. My Catholic employer, the Sisters of Mercy Healthcare System of Kansas, a two-hospital system affiliated with the St. Louis, MO, sponsoring Sisters of Mercy Hospital system, is the only system in the area that employs board-certified professional chaplains for its small hospitals. All of the other area small- and mid-size hospitals rely on local church pastors when needed for traumas or deaths. For their inpatients, spiritual care depends upon the passion of some nurses or the discovery of a Gideon Bible in a bedside drawer. As you might expect, our specialized attention to spiritual care is a comfort to our patients and an expectation of our Christian community.

small workplace BIG CHALLENGES

Another issue that connects us as brothers and sisters is the national economy. Small and large hospital chaplains alike have been affected by layoffs and other cost-saving measures, such as flex-time for chaplains. For small hospitals, the impact is profound. For example, in my community, which had a poverty rate of 15 percent, the additional impact of a double-digit unemployment rate decreased admissions and substantially increased poverty and charity care. Presently and personally, I feel the angst of "called off" nurses who are the major source of income for their families.

I hope you do not think that all small hospital chaplains are isolated or disadvantaged by changing technology and resources of modern chaplaincy. To the contrary, innovations are "tried out" on us. For example, our two-hospital system was one of the first to begin electronic charting and benefit from "Safe Watch." Today when chaplains open the electronic chart of an ICU patient, we often read the night notes of a physician visually and voice connected to us, but located 300 miles away. And when we need "to talk," the chaplains and directors in our hospital system located in a four-state area are just an e-mail or telephone call away.

But your question might be what I do after visiting the morning outpatients and surgery patients and when all the inpatients have been visited the previous day. The answer is spending more time in the ER, or with cardiac and physical rehab, or chemotherapy outpatients. On some days, there is also more time for ministry with our in-house and clinic employees. Also, there are the "as necessary" duties, which

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At hospital in the desert, cultural values flower

By Isabelita Q Boquiren, BCC

After years of ministry at one of the largest research and teaching hospitals in California, I was nudged to ask, "Where else do you live Lord?" "Come, taste and see," was the answer in prayer.

So, in 2007, following an invitation, I came to Carondelet Holy Cross Hospital, tucked away in the hillsides of Nogales, AZ, in a desert hamlet setting that skirts the international border of the United States and Mexico. The hospital has a bed capacity of 80, some 200 employees, and is equipped with acute care, emergency, respiratory, labor and delivery, radiology (with the latest state-of-the-art CT scanner), rehabilitation and surgery departments. Lifeflight response is on campus 24/7. The hospital also boasts of a skilled nursing Geriatrics Center that is located adjacent to it. The Nogales community has some 22,000 residents.

I have been here almost three years now as I reflect on the question posed: "What is it like being a chaplain in a small hospital? How does it feel to "taste and see" in this desert border location. Down-to-earth tasting and seeing, I have learned, means, "living with" the community. The gifts behind the challenges slowly reveal themselves. And to learn from each challenge and unwrap the gifts is pure grace.

small workplace BIG CHALLENGES

There is a sense of intimacy, a built-in closeness within a small hospital. Every one seems to know everybody. It comes as no surprise for the chaplain to meet employees with impressive service records of 35 or more years at the hospital. The pervading atmosphere of "family" and "community" is as beautiful a gift as it is a challenge. The sense of community grows from a culture immersed in values of *dignidad, respeto, cariño (dignity, respect, love)*. These values are deeply rooted in the foundations of Catholic healthcare, and in this hospital they seep through into patient care delivery. Other gifts found here are those of acceptance and welcome. The challenge of these gifts is to keep a constant balance between personal and pastoral professional boundaries. While it is a chaplain's mantra to "meet people where they are," it is yet a greater responsibility to hold close to the heart the stories entrusted to the chaplain.

In a culture that is proud of its heritage, one often hears the familiar strain — "this is how we have always done this here and this is the way it is going to be." The chaplain is challenged to bring spirituality to the workplace — a spirituality that allows one to see things differently, a spirituality that lends to communal faith rather than individualism. One gift I have experienced is the opportunity to help build an acceptance of contemporary spirituality while at the same time holding dear the cultural traits embedded in this community. This gift has informed and affected my ministry.

A lady came in to visit the chapel and noted immediately the absence of a baby Jesus statue that had stood in front of the statue of Our Lady of Grace. She spent ample time in search of the infant. Not finding it, she became irate and said she would never visit the chapel again. I suggested that the adoration of the Sacramental Presence of God in the Eucharist takes precedence over all the energy she had spent in looking for the statue. The challenge to initiate clarifications between religiosity and spirituality, piety and even superstition, points to the hidden gift that lies in the present moment: the gift of Eucharist and being Eucharist to everyone being served.

In any hospital setting, it is expected that crises can happen all at once, but the intensity is felt more in a small hospital. This can either be in a Code Blue, a man bleeding from a gunshot wound, a baby who has fallen off a vehicle, a fetal demise, a terminally ill patient, families in conflict, etc. The challenge to maintain focus, to provide deliberate spiritual care in crises or chaos is every chaplain's prayer. Being the only chaplain in a small hospital, I am pulled in different directions on any given day. I find myself working to retain more focus and to act with greater deliberateness and more alertness as I move from one incident to another. The gift behind this is the practice of contemplation or contemplative prayer. Being a chaplain in a small hospital has led me to become less grasping, less falsely striving, for here there is nothing to prove — except the love of a generous God. The gift of being open, humble and receptive has become very real.

Our ER doctor, in the throes of a chaotic day, scribbled on the bulletin board, "Think chaplain."

As I strive to become more deliberate and present to those I serve, others notice. Our ER doctor, in the throes of a chaotic day, scribbled on the bulletin board, "Think chaplain."

There is this gift and challenge of time being a chaplain in a small hospital. Relationship building with patients becomes deep and meaningful, providing for more than adequate spiritual assessment. A chaplain is able to notice even the subtlest signal of spiritual pain or suffering, the need for forgiveness, reconciliation, the offering and receiving of love. One can hear the music in the patient's pain — thanks to the gift of time to listen.

Carrying secrets of the heart on a daily basis requires unloading at appropriate sacred times. One of these times for me, besides at prayer, is during my regular experience of going to the desert, a place "where one sheds the unnecessary," to go to the heart of the matter, to taste and see. It is also where one learns the language of Silence.

To say that I have learned much in my own personal spiritual journey and in my pastoral ministry as a chaplain in a small hospital is to say that I have found a dwelling, a home, where the presence and goodness of God can be seen and tasted freely.

Isabelita Q Boquiren is a chaplain at Carondelet Holy Cross Hospital in Nogales, AZ, and also a spiritual director, providing ministry to the underserved.

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who do the same work? I am a solo chaplain in a small 25-bed Critical Access Hospital with a 58-bed skilled nursing facility. I am there four hours per day, five days per week. When I enter the room of a patient or resident to provide spiritual care, the work is the same: listening, supporting, praying. The difference in a small Critical Access Hospital is that one chaplain is responsible for all of the chaplaincy coverage.

The hospital for which I work contracted with a large teaching hospital for a halftime chaplain. My employer is Dartmouth Hitchcock Medical Center, but my site is New London Hospital 45 minutes away from the medical center. This small rural facility has never had a spiritual care person as part of staff and has relied upon community clergy to provide care. For those who belong to a congregation, and are not uncomfortable calling upon their pastors to visit them when they are in the hospital, that plan has worked. For the majority of the population in the 16 New England towns we service, their spiritual needs have been under-addressed while they were sick or in the nursing home.

I have control over my daily schedule and I am not expected to be on-call. I am expected, however, to be the primary source of education when it comes to defining the role of spiritual care.

There are disadvantages and advantages to being a department of one. Department meetings are non-existent. I have control over my daily schedule and I am not expected to be on-call. I am expected, however, to be the primary source of education when it comes to defining the role of spiritual care. What that has meant in the first 10 months of my new position is attending other department meetings: in the emergency department and patient access, in the medical/surgical unit, in the nursing home, at leadership team and with the area clergy association. Still on my list of educational presentations to define the role of spiritual care are meetings with physicians, specialty services personnel and a community-wide adult education series. I am particularly thankful for my previous experience as an educator for the skills needed to fulfill this aspect of spiritual care in a small hospital.

Unlike most chaplains who have one supervisor, I have four: the director of the hospital at which I work, the director of the med/surg unit, the director of the nursing home and my supervisor at the medical center. This has been a challenge since each of these individuals has his or her own particular style and expectations. I also share office space with the social worker and the case manager. Although these individuals provide me with a wealth of referrals, I have found it difficult not having the opportunity to discuss spiritual care of patients with other spiritual care providers. In order to compensate for this I drive the 45 minutes each way monthly to join in the professional development opportunities provided by the chaplaincy department at the medical facility that employs me.

Another challenge of being a chaplain in a small hospital is what I describe as being a generalist. I was not hired because of my expertise in a specific area of hospital care. My training included emergency codes, oncology, psychiatry, intensive care and a medical surgical unit. Since becoming the solo chaplain of a Critical Access facility I have had the opportunity to use all the skills gained from working with each of these diverse populations. I enjoy the variety of the clientele with whom I work but I am challenged to learn as much about a variety of disciplines as is necessary to be competent in dealing with patients and their families.

Chaplains are not the only generalists in small facilities. The fact is many of the hospital's employees wear a variety of hats. When a crisis occurs individuals will step up to be of assistance. This can be a source of bonding personnel with one another, but it also proves to be a challenge when roles and boundaries are not clearly delineated. Employees in small facilities can become uncertain of their roles and responsibilities. Unlike larger hospitals where a specific person is designated as the point person for a team responding to an emergency, small hospitals do not have that luxury and this can be a source of confusion.

small workplace BIG CHALLENGES

This ambiguity affects boundaries as well as roles. Since a Critical Access Hospital has limited employees and is used by local residents, it is another challenge to be vigilant in respecting patient and employee privacy. In the course of any given day I may encounter as many as 20 familiar faces as I travel the halls of our facility. Although familiarity can be a tremendous source of comfort to those receiving medical care, it can also be the cause of concern for those desiring anonymity. By allowing patients to initiate any interactions, I attempt to set up proper boundaries and prevent undue embarrassment.

Overall, spiritual care in any facility will be about accompanying residents/patients in their search for strength and meaning, but those who work in small facilities have their own struggles and strengths unique to that environment. Although being alone, wearing a variety of hats and juggling familiarity and boundaries can be a challenge, these elements of spiritual care in a small facility can also provide just the right amount of uncertainty to keep us trusting God every step of the way.

Chaplain Cheryl Fitzgerald is employed half-time by Dartmouth-Hitchcock Medical Center in Lebanon, NH, but her site is New London Hospital, which is a rural critical access/nursing home facility. Cheryl also does per diem hospice work for her area Visiting Nurses Association.

Small is beautiful, but face-to-face contact with colleagues rare

By Janice A. Dworschak, BCC

Luther Midelfort Oakridge-Mayo Health System (LMO), a Critical Access Hospital of 18 beds nestled in the hills of western Wisconsin, is an amazing gift to me. I enjoy the benefits of a system striving for integration, utilizing the assets of each site, large or small. LMO provides services for patients and families close to home including:

- In-patient and Transitional Care Services (18 Beds)
- Clinic and Pharmacy Resources
- Nursing Home (21 residents)
- Assisted Living (14 apartments)
- Urgent and Emergency Care
- Cardiac and Pulmonary Rehab
- Advanced Diagnostic Technology
- In-patient and Out-patient Physical, Occupational and Speech Therapy.

Though I find myself in an idyllic setting, concerns live with blessings. Daily census variance with part-time chaplain status impacts patient care. Face-to-face contact with chaplain colleagues is limited, and continuity of care depends on effective means of communication. Palliative care remains a treatment whose benefits seem not to be well understood. As a small, regional hospital, the daily census rises and falls. Whether high or low, riding these fluctuations with ease can be challenging for medical teams. I work three eight-hour days at LMO. While the focus of my ministry is primarily to inpatients/transitional care, I receive referrals to meet the needs of patients in ER, nursing home, and assisted living as well.

small workplace BIG CHALLENGES

Our Spiritual Care Department of eight chaplains serves in four different hospitals, with one chaplain assigned to each of three regional sites. Monthly, regional chaplains meet with our director of spiritual care to address concerns pertinent to our situations. Twice monthly, we meet as a department to support one another as professional peers, address department work plans, and to hone our skills through ongoing educational sharing. Our vision statement reads: "As spiritual companions grounded in the Sacred, we respect each person's truth and journey toward healing and wholeness." As a team, we strive to embody our vision statement. We inspire and challenge one another to be the best persons and chaplains we can be. Annually, we commit to Soul Care Days to nurture the inner spirit and guard against compassion fatigue.

While we serve in four separate hospitals, we endeavor to provide seamless care to patients and their families. We page, phone, e-mail, attend rounds and access pertinent Electronic Medical Records (EMR) in our efforts to communicate well and to meet the needs of our patients. We make every effort to stay connected and work as one, even when distance between units or hospitals separates us.

At LMO in Osseo, a community with Scandinavian roots and the famous Norske Nook Restaurant and Bakery, most patients identify themselves as Lutheran, Methodist, Congregationalist or Catholic. Local clergy, when contacted on behalf of patients and families, respond readily. Catholic patients receive sacramental ministry from area priests, as well as from a priest of the diocese delegated to serve Spanish-speaking patients.

The blessing of this setting for me is to accompany patients over extended periods of time. When patients arrive, many have been through difficult medical procedures. Stronger now, they seem eager in this rehab phase to process the events of their hospitalization to understand the "Why?", "How?", and "What's next?" questions. Some have strong faith traditions; others indicate no preference or faith tradition. Some patients arrive with spiritual care notes indicating "Do not visit." Still, in the new setting, chaplains are asked to check it out. When patients seem surprised by a visit, we seek to simply assure them of care and support and to address spiritual or emotional needs they may have. Continuing in the spirit of human-to-human caring, stories unfold. I have been surprised — even awed — by those who identify themselves as "pagan," "atheist" or "agnostic," as they share the paths that have led them to this declaration, often through years of suffering in their search for truth. It is a privilege to witness their fidelity, integrity and vulnerability as they, too, tend core values.

The blessing of this setting for me is to accompany patients over extended periods of time.

Though palliative care remains a treatment with benefits that are not well-known, our four hospitals are making a concerted effort to educate toward well-integrated palliative and curative care. Each of our four hospitals has a Palliative Care Team. Our goal, as chaplains who serve on these teams, is to assist patients in preventing or relieving suffering and improving their quality of life.

Workplaces, no matter where their social location, have advantages and disadvantages. A favorite mantra, "Lead me where you need me," has guided decisions and directions I have taken. Whether urban or rural setting, large or small medical center, patient room or employee dining room, all hold promise of adventure and God's presence. This treasure hidden in the hills elicits various acts of faith. Most days, our individual and corporate "I do believe!" captures the tenor of the day, but sometimes in the spirit of this Scandinavian town, Uff-dah! may be more accurate. (According to Wikipedia, "Uff-dah! is an exclamation of Norwegian origin relatively common in the Upper Midwestern United States. It roughly means "drat," "oops!" or "ouch!", especially if the "ouch!" is an empathetic one. In Norwegian Midwestern USA culture, "Uff-dah" translates into: "I am overwhelmed.")

Janice A. Dworschak is a chaplain at Luther Midelfort Oakridge in Osseo, WI, a Critical Access Hospital located 25 miles from Luther Midelfort in Eau Claire, WI.

'Cheers' effect: Where everybody knows your name

By Julia Rajtar, MA

I am a chaplain for a rural hospital in western Wisconsin called Westfields Hospital. The hospital is a 30-bed Critical Access Hospital founded in 1950 and three years ago changed from religious sponsorship to public sponsorship. I am the only chaplain and work full-time with some of my hours contracted to provide services to an 80-unit independent/assisted living/memory care facility, The Deerfield, on our campus. I have completed four units of CPE and I am working toward certification within the next year.

A day in my life is a lot like that of so many other chaplains, and yet so unique to a smaller hospital. I arrive around 7:30 a.m. and immediately check e-mails and the patient census information. On this day, as I am preparing to lead the ethics committee meeting, a page is made overhead, Nurse Alert to the ER. I stop what I'm doing in the office and walk to the ER as I am part of the trauma response team. In the ER I meet the health unit coordinator who gives me some background on the patient and directs me to family. I work with staff to find a private space for family, as space is always an issue. I usher the family into the very small waiting room, asking what happened, trying to understand how the family is feeling, what each person's relationship is, and how we will communicate with the ER. I hear a page for Code Blue to the ER and know this might not be good. I call someone to contact everyone on the ethics committee, and tell them the meeting is canceled, because there is no one else to lead it.

As a spiritual leader, I participate on the ministerial association in town. In large facilities, chaplains lean on each other, whereas here, the local clergy serve as my back-up when I need time off or for night on-call.

I sit with family waiting for an update from the ER, occasionally checking in. As the long wait begins, the family is told that the wife's/mom's condition has changed and her heart has stopped. More family comes to the room, which quickly becomes overcrowded. I talk with the spouse about his wife — they've been married 65 years. I talk with the son, who is strong and a support for his father. The family wants their minister notified, and when I call, I am informed that he is out of town. I offer to call another minister from their denomination, but the family declines and I continue to sit with the family, offering prayer and hospitality. After what seems like an eternity, the doctor comes in and tells the family that they cannot maintain the heart, and then the sobs come.

I ask the doctor if the family may come in to say goodbye, and the doctor prepares the family for what they will see. The immediate family, husband, son and daughter, come into the room escorted by the doctor and myself, and are encouraged to touch, kiss, and say goodbye. Prayer is offered, tears are shed. CPR is discontinued, and mom dies. I ask the family members about funeral home arrangements, informing them that the funeral home is called after they leave. Family is welcome to stay as long as they want. Nearly three hours after the nurse alert is called, I complete my ministry to this family, when the funeral home comes to pick up the body and charting is completed.

Then the ministry to staff begins. Because we are a rural hospital, major trauma usually gets referred to the local city. Yet when a trauma does occur, it has a significant emotional impact on us, as we do not have the frequency and level of incidents that larger cities do. Often, the trauma also involves someone a staff member knows. So I debrief with staff and the doctor after the incident.

Then I proceed to inpatient visits, because in the afternoon I have two hours of ministry at the independent and assisted living facility. I am able to do three visits before lunch — two for Communion and one as a follow-up from the previous day. After lunch, I try to make one more visit before the lull after lunch puts the patient to sleep. I walk to the office to prepare for the grief group that night, and at 2 p.m. I go to the Deerfield to visit residents and hold the LITE Group (Life In Transition Everyday) meeting, during which residents can talk about and learn from each other how to cope with the many losses and changes they experience.

I return to the office around 4:20 p.m. to prepare for the next day, only to discover that tonight is also the night that we have a Cancer Support Group meeting. I am not presenting at the cancer group this time, but I still attend as a co-facilitator. At 6 p.m. I am facilitating the grief group, and by 7:30 p.m., I'm back in the office, grateful to be finally going home.

Six years ago at the start of my ministry here, I made an assumption that the hospital staff understood the role of a chaplain as part of the healthcare team. Over the years, I have ministered to patients, families, staff and physicians responding to emergencies, the loss of infants and grieving families. I have developed departmental policies, assessment tools, quality assurance studies, and I chair the Ethics Committee. I work with oncology nurses and a social worker to facilitate the Cancer Support Group and I facilitate the Grief Support Group. At the assisted living facility, I lead various groups, provide worship services for residents with dementia, hold one-on-one visits and participate in rounds. In the community I represent the hospital on the Ministerial Association, provide education related to advance directives, and provide various services for Hospice and other organizations.

I often refer to the "Cheers" effect, "where everybody knows your name." Patients and families in a small community are grateful for that, and it is one of the many reasons they prefer to get their care in the smaller hospital. They also comment how lucky the hospital is to have a chaplain and that they appreciate the visit. Recently, it has become more challenging

Chaplaincy means providing access, healing to homeless

By Pat Thompson, RSM, BCC

During the recent Advent-Christmas season, we heard once again the words, "there is no room." These words are poignant for a chaplain like me who has spent 17 years working with women, children, and men for whom there is no room and no adequate, affordable housing option. Women, children, and men who sleep in an emergency night shelter, on the streets, or in an SRO (a single-room occupancy housing complex) know that, while they struggle to hold themselves together, life goes on unimpeded for so many others. For one reason or another, these women, children, and men have little or no contact with other family members. These women, children, and men move from place to place: walking, begging, searching. They struggle. They cry. They hope. They long for better days and nights. Will this ever end? Will we Americans, the wealthiest people in the world, ever decide that housing is a right, not a privilege? Will we ever tackle affordable housing the way we have tackled affordable healthcare? Or will we settle forever for the reality "there is no room"?

small workplace BIG CHALLENGES

Through my years as a chaplain among those without a home, I have learned so much about the resiliency of the human spirit, especially when people are surrounded by love and respect. I have learned the truth of the words of Blessed Mother Teresa of Calcutta spoken to the Synod of Bishops in 1980. She said, "Our poor people are great people, a very lovable people. They don't need our pity and sympathy. They need our understanding love, and they need our respect. Tuberculosis and cancer are not the great diseases. I think a much greater disease is to be unwanted, unloved. The pain that these people suffer is very difficult to understand, to penetrate. We need to help them not just for the benefit of the people who are poor but also for our own benefit. They have so much to teach us."

The time I have spent being with women, children, and men who are or have been homeless has enriched my life. We have listened to one another, shared with one another, and been vulnerable to one another. We have learned together the values of simplicity, detachment, and authenticity. We have been challenged, and we have been humbled. We have grown in our understanding of the critical nature of personal responsibility for what we think, believe, feel, say and do.

Caregivers often want to "fix" the other person's situation or life. But, that belongs only to each person, something she or he must do for herself or himself. Our job as a caregiver is to build bridges that allow the person in need to access resources, to feel, name, and own personal feelings, and to find her or his truth. We must believe in the other person, respect the other person, and take time to hear the other person's pain. We must be faithful and consistent. We must be real. We must have "room" in our hearts for every person we meet. And, we must encourage the other person to discern and to take action.

Will this ever end? Will we Americans, the wealthiest people in the world, ever decide that housing is a right, not a privilege?

Change (healing) is a process. It takes time, focus, and attention. It calls for determination and perseverance. It involves one's mind, body, and spirit. Ministry among those who are or have been homeless, ministry among those in need, requires all of this. It is, indeed, a ministry of healing beyond the walls of any healthcare institution.

Many dedicated people work long and hard to address the basic needs of those in need, those with limited financial resources, and those with limited access to resources. Food, clothing, employment, education, healthcare, and shelter (housing) are critical needs. Equally critical are the person's

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to see the patient. Some interpret HIPAA to the extent that the chaplain is no longer viewed as a part of the healthcare team, yet as the NACC and APC so well point out, the chaplain is a member of the allied health constellation and is clinically trained. Furthermore, chaplains meet the definition of a member of the healthcare team who has access to patient information as defined by the U.S. Department of Health and Human Services, and are an example of a direct care giver by the Joint Commission on Accreditation of Healthcare Organizations. Our professional organizations have truly been instrumental in assisting the small hospital chaplain with resources and support, in ways that we could never manage alone. I am profoundly grateful for this support.

As a spiritual leader, I participate on the ministerial association in town. In large facilities, chaplains lean on each other, whereas here, the local clergy serve as my back-up when I need time off or for night on-call. We become support to each other.

In the end, though there are significant challenges to ministry in a small hospital, I believe the benefits far outweigh the burdens. What we have at Westfields Hospital — the friendliness, the personal attention, the understanding of the whole person because someone is always related to someone else, or goes to church with them, or goes to school with their children — is what makes us so unique. And like the television show Cheers, wouldn't you want to get healthcare in a place where "everybody knows your name."

Julia Rajtar is director of spiritual care at Westfields Hospital and The Deerfield in New Richmond, WI, which is located 30 miles east of Minneapolis and St. Paul, MN.

When are upcoming certification renewal deadlines?

Q I am scheduled to renew my certification by the end of 2010. 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, 2010, your certification will no longer be valid effective Jan. 15, 2011. 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 2010 is $32.

You do not need to contact the NACC National Office if you are preparing to mail your paperwork before the end of this year. Please note that the NACC National Office will request your ecclesiastical endorsement. All materials for 2010 renewal of certification can be found at the NACC website. The fee for renewal of certification for 2010 is $160.

CERTIFICATION update

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

Q What is the next postmark deadline and fee for chaplain certification for 2010?

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

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include representing pastoral services on the various hospital task force committees, explaining the importance of holistic health and spiritual care as ministry to new employees, and serving various church and civic organizations.

One of the most important "as necessary" responsibilities is responding to ethical questions and dilemmas. While we have few code pages and our most critical patients are quickly transferred to large hospitals, there are still end-of-life issues and dysfunctional families to cope with; and now Kansas hospitals are adapting to an initiative that calls for a shift from doing everything possible to save every life to a model aimed at maximizing the number of lives saved. This shift will present exceptionally painful moments for the medical and clinical staffs of small hospitals that are more likely to be confronted by the families of someone they know and love.

Professional chaplaincy is changing, and our daily activity will soon include increased visits to clinics, outpatient treatment and surgical centers affiliated with our hospitals. Also, some chaplains may become dedicated "e-chaplains," providing e-mail spiritual support for current and former patients as a part of their total care plan. I feel blessed to have worked as a chaplain in both a large and a small hospital.

Deacon Mike Steele is the director of pastoral services and chaplain at Mercy Hospital, a hospital operated by the Sisters of Mercy in Independence, KS.

Homeless

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spiritual and emotional needs. However, the spiritual needs are often overlooked and/or addressed insufficiently. Chaplains are needed everywhere.

I believe chaplains have to face the following issues and challenges in whatever ministry settings they find themselves: role, motivation, preparation, competency, trust, consistency, vulnerability, approachability, openness, effectiveness, team work, and boundaries. As we face these together, we clarify for ourselves and for others who we are, what we are about, and why we do what we do. We learn from one another. That is why we must interact with one another.

As NACC continues into the future, I hope and pray it will be, "we" will be inclusive in planning and implementing educational, theological, and professional workshops and conferences. May the association always make "room" for all chaplains. May the association value and encourage the unique contributions of those who serve beyond the traditional healthcare settings. May we learn from one another and engage one another in conversation. May we never say, "there is no room" for anyone.

Sister Pat Thompson, of Atlanta, GA, works in a ministry she began in 2001 called Circle of Friends, which provides an emotional, spiritual, and social support network to women, children, and men who have very limited economic resources and very limited access to resources. Many are or have been homeless. Sister Pat visits the Atlanta Day Shelter for Women and Children two days each week. On Monday evenings Sr. Pat gathers together interested residents of the Santa Fe Villa housing complex (an SRO) in community activities and hosts a group of others at her home once a week, repeating the activity above.

Seeking, Finding

Men in wrinkled suits, little girls in ribbons deserve truth

By Rev. Mr. T. Patrick Bradley, MA, BCC

It didn't seem like a very different day. Louise, a new chaplain intern, was orientating by accompanying me as I made my rounds. She had been a pastor for about 15 years. Most of that time she had been the pastor in charge of youth ministries and had set up a day care center for the church. She had recently taken over the visitation of patients in the hospital for the church. She really wanted to get a feel for what happens in a hospital and how she could better serve her congregants. She was concerned, however, that the sights, sounds and smells of the hospital might bother her.

Earlier that day we had been involved in the discussion of ending life support for a woman in the intensive care unit, the ICU. Louise commented, "This is not what I expected. I thought we would just peek in and say a prayer with patients. I hope this isn't normal!" "Normal" said I, "perhaps not normal in the sense of daily but ordinary in the sense that we are expected to be able to participate in these discussions. This happens on a regular basis with some patient or another." Louise seemed a little uncomfortable with this, but I assured her that she could handle it.

I don't remember much about the discussion with the medical staff and the husband. It was a routine discussion that the medical staff and I handled with detachment, quite ordinary. The physicians said, "The patient has a brain injury and is essentially brain dead." Quite matter of fact. It was another patient, not a real person. He went on, "She still has lower functions in the brain stem but nothing more. Her personality is gone and she doesn't feel anything; she's essentially dead." The neurosurgeon chimed in with, "We tried to relieve the pressure by cutting a hole in her skull but it didn't solve the problem. Her brain has continued to swell and it will soon herniate into the stem and her heart will finally quit." Next it was the pulmonologist, the doctor in charge of the ventilator that was breathing for the patient. He said, "Everything that can be done has been done. It's just a matter of time." This is a discussion I had been involved in many times and it was rather routine for both the medical staff and myself, the chaplain. Her husband listened and it was as if we were talking about someone else. He had been told that "her heart will finally quit." What does that mean? We never said she would die.

Later that day we were called to the ICU because the patient had died. Louise accompanied me. When we arrived in the ICU, the husband was just coming out of the room and his 3-year-old daughter was there. I remember her standing by the nurse's desk with the unit secretary. The intern recognized that this was a child in distress. She knew that she could help, and she went to the little girl, who looked so cute in her pretty red dress. She must have picked it out just to come see her mommy. You could tell that dad had dressed her. The ribbon in her hair wasn't quite right. Some hair stuck out at an odd angle from under the ribbon. Dad asked if their daughter could go in to see mommy. She had been asking to go in and was excited to see mommy and show off her pretty dress. We, the father and I, took the little girl into the room. Everyone else stayed outside. Gently he picked her up and held her leaning forward so that she could look down on mommy. He was struggling to hold back the tears. The room was quiet for an ICU room. The normal sounds of clicking, beeping, buzzing, and whirring were missing. The nurses had used lotion on mommy when they cleaned her up so the normal ICU smells weren't there. I was glad that the little girl didn't have to say, "Mommy smells funny," as I had heard other children say. The only sound was the little girl saying "Mommy's sleeping." The nurses had taken care to change the sheets and comb the mommy's hair. The little girl looked at mommy and smiled. She looked so peaceful as she lay there. For me, it was no longer just another patient, it was a little girl's mommy.

There was no sign of pain and her body was still warm. There was even a little color to her cheeks. Did some nurse add a little makeup? I'll never know. We walked out of the room, the little girl smiling and hanging onto dad's finger as she walked. Dad had on a brown suit. The same wrinkled suit he had been wearing for two days. The daughter looked so proud. I don't know why, she just did. Perhaps because we told her that we were making an exception to bring her into the ICU. We had just passed through the curtains when the little girl looked up and asked, "When is mommy coming home?" Everyone standing there at the doorway — nurses, techs, other visitors — looked at dad. As he stood there, the tears slowly filled his eyes and started down his cheeks, one drop at a time. He couldn't hold them back, and he couldn't talk. I bent down to the little girl and somehow told her that her mother, mommy, would not be coming home. I don't remember the words I choked out. I do know I had tears in my eyes, but I kept from crying so that I could be there for the little girl. I looked up at dad and said something like, I'm sorry.

Later Louise and one of the nurses told me how great I was and what a good job I did with the little girl. All agreed

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It was just one of those God moments we all experience in chaplaincy. You know what I'm talking about — God just pushes us out of the way, and thank God he does.

Q&A with Jan Heckroth, BCC

By Laurie Hansen Cardona
***Vision* editor**

Jan Heckroth, known as the "cardiac chaplain," currently serves as staff chaplain at Allen Hospital, a 225-bed hospital noted for its new Heart Center, in Waterloo, IA. It is an affiliate of Iowa Health System, the largest health system in Iowa.

Ms. Heckroth and her husband, Iowa State Senator Bill Heckroth, have three sons: Thomas, 26, who works for the Department of Labor in Washington, DC, Andrew, 23, a recent graduate of the University of Iowa, and Patrick, 21, a junior at the University of Northern Iowa. A former speech-language pathologist who holds a bachelor's degree in speech and hearing science, Ms. Heckroth also has a master's degree in speech pathology from the University of Iowa. At midlife, she notes, she experienced a "burning desire to do ministry" and began her journey toward chaplain certification. She obtained a master's degree in pastoral ministry from Loras College in 2002, completed four extended units of CPE, and earned board certification from NACC in 2006.

Q Why are you called the "cardiac chaplain?"

A First, my passion is cardiac patients! My own dad had a major heart attack that would eventually lead to another heart attack and open heart surgery at the age of 55. I was present during his second heart attack. His cardiac disease caught me totally by surprise, shook my foundation, and awakened me to mortality, vulnerability and the fragility of life. My dad is now 80; his healing, recovery, and lifestyle changes showed me the possibilities of living well with cardiac disease!

Second, I am assigned to units in the hospital where cardiac patients are located. I have both intensive care units and the two floors of the Heart Center.

Third, I was given an office in the new Heart Center alongside the nurse manager, cardiovascular surgery care coordinator, case manager, social worker, and cath lab nurse manager.

Q I understand you teach a class titled "Caring for Your Heart." How does this class taught by a chaplain differ from the usual education offered cardiac rehab patients?

A The focus of my class is on holistic healing following a cardiovascular incident, procedure or surgery. Most education to cardiac rehab patients centers on the physical dimension of healing — Cholesterol and Your Heart, Exercise and Risk Factors, and What's the Norm?

Q How and why did the class get under way? What is the goal of the class?

A About six years ago, I created the class and contacted our director of cardiac rehab. The director requested that I teach the class to her one-on-one. When the closing prayer moved the director to tears, and she spoke "very positively" about the class, I knew I had her buy-in and the green light!

The goal of the class is to educate and empower cardiac rehab patients to engage the physical, psychological, social and spiritual dimensions of their lives in their healing and recovery process, thus, contributing positively to their sense of well-being and hope.

Q What do you see as the most important information you impart to cardiac rehab patients in the class?

A Here's my list:

1. To acknowledge the presence of all four dimensions of the human — physical, psychological, social and spiritual — in their own experience of healing and recovery.

2. The teaching of the "relaxation response," the term coined by Herbert Benson, MD, to counteract the harmful effects of stress.

3. Emotional responses to heart disease, heart attack, or heart surgery often follow a common pattern referred to as "the grief process." These stages include: denial, anger, bargaining, depression, and acceptance.

4. Do not underestimate the importance of social support from friends and family during the healing and recovery process.

5. The difference between spirituality and religion — one can be spiritual without practicing a religion and one can be connected to the Holy One without attending church. Spirituality is more an expression of who you are, what is important to you, and what gives your life meaning and purpose.

Q Please give an example of the kind of fruitful discussion that happens in your class.

A When exploring the spiritual dimension of the patients' lives, I often ask, "What has your illness taught you about yourself or about life?" The responses are honest, reflective, and even life changing! "I learned that I am not invincible." "That I don't always have control." "Not to take my life for granted." "How much I want to live." "To restore my belief in the goodness of people." "How much I am loved." "That God is with me and I am not alone and … I learned gratitude." This question encourages patients to find meaning in the midst of their illness and often to identify the blessing within their illness.

Q How does your ministry to outpatients differ from your ministry to inpatients?

A I have often formed relationships with cardiac rehab patients previously while they were hospitalized. Therefore, an environment of safety and trust for the outpatients is established with ease, as well as deeper sharing and learning from their healing and recovery process is made possible due to continuity of care. The group sharing provides added support and collegiality to all participants. Thus, spiritual care becomes an integral part of a multi-disciplinary cardiac rehab team.

Q Do you see outpatient ministry as the wave of the future for chaplaincy? Why or why not?

Truth

Continued from page 15

that they could not have done what I did. I had to say, that I don't know what I did or how I did it. It was just one of those God moments we all experience in chaplaincy. You know what I'm talking about — God just pushes us out of the way, and thank God he does. God steps in and takes over. We speak the right words because they are God's words, not ours.

Louise stayed with me and completed her internship. It has now been five years and still the picture of the little girl lives in my memory. But I know one thing that has changed. I now learn the patient's name and the names of their family members before I go into the meeting. I say, "Your wife is dying." I ask the physicians to turn the statistics around. "There is a 98% chance that she will die" is so much more accurate than "Yes, there is always a chance that she will recover." When families pray for a miracle in these situations, I share my belief that the real miracle is that death is birth into eternal life.

People die, parents are dead, fetal demises are dead babies and they have names. I don't say passed, moved on or didn't make it. Now it is: I'm sorry but your wife died. It isn't as clinical or as detached, but it is true and accurate. Men in wrinkled suits and little girls in red dresses and ribbons in their hair deserve the truth.

Rev. Mr. T. Patrick Bradley is director of pastoral care at Cheyenne Regional Medical Center in Cheyenne, WY.

When families pray for a miracle in these situations, I share my belief that the real miracle is that death is birth into eternal life.

Vision Research Panel established

Twelve research-oriented individuals have volunteered to share their expertise as members of the new Vision Research Panel. They are: Teresa Albanese, Rev. Elizabeth Collier, Gordon Hilsman, Jim Hoff, Sister Maria Theresa Hronec, SSCM, Bill Kramer, Mickie Micklewright, Robert Mundle, Linda Piotrowski, Hyun Underwood, Dacia Van Antwerp and Marilyn Williams.

Their role will be to write up brief reflections on how research published in Vision can be applied to their own ministry or to pastoral care, in general. The idea for this panel came from Vision's Editorial Advisory Panel members. It was suggested as a way to help Vision readers reflect on how the research presented in Research Update articles that are published in Vision can apply to their own ministry and to pastoral care.

The first Research Reflection, published in this issue of Vision, is written by panel member Teresa Albanese, PhD.

A I believe outpatient ministry could be the wave of the future if chaplains are creative and make connections with specialty services and physician offices. Hopefully, health care will continue to evolve in three areas: encouraging patients to become active participants in their own health; promoting self care in addition to surgery, interventions, and pharmacology; and transitioning from crisis care to prevention. As these areas evolve for inpatients and outpatients, chaplaincy has much to contribute because of its commitment to holistic care.

Q **How has your work with outpatient ministry changed you as a chaplain? As a person?**

A As a chaplain, I have reclaimed a more clinical role in patient care. Perhaps this came naturally because of my past work as a speech-language pathologist. In my desire to contribute positively to cardiac patient outcomes I continue to seek out diverse educational opportunities, consider possible research projects to implement, and am a faculty member who teaches a course titled, "Care of the Cardiac Surgery Patient for Critical Care Nurses." This has increased the integration of spiritual care within the cardiac team.

Outpatient ministry has deepened my relationships with patients and the entire cardiac team — including the surgeon and cardiologists. It is life-giving to me!

Q **What keeps you going in your ministry? What inspires you?**

A I keep going because of the desire to make a positive difference in people's lives and my belief in the ultimate value of spiritual care. Practicing centering prayer and reflecting with The Daily Reader for Contemplative Living, frequent retreat time at beautiful Prairiewoods, and the loving support of family and friends keep me moving forward. Reading poetry by Mary Oliver and anything written by Beatrice Bruteau inspire me. I am also encouraged by my deep need to learn and grow and "become all that God has created me to be!"

Q **What advice would you offer a chaplain interested in ministering to outpatients?**

A I would encourage the chaplain to: build caring relationships with the specialty staff; deepen your working knowledge of the specialty and the needs of the outpatients; educate staff by communicating your spiritual care interventions and patient outcomes; be passionate about spiritual care; be creative — create new opportunities to integrate spiritual care within the specialty; and develop your strengths.

At bedside: Spirituality and coping with chronic pain

By Amy B. Wachholtz, PhD, MDiv,
and Rev. Karen Dorshimer-Chaplin, MDiv, BCC

Abstract

Chronic pain is a complex experience stemming from the interrelationship among biological, psychological, social, and spiritual factors. Many chronic pain patients use religious/spiritual forms of coping, such as prayer and seeking spiritual support, to cope with their pain. This article will explore empirical research that illustrates how religion/spirituality may impact the experience of pain and help or hinder the coping process. The article will also provide practical suggestions for chaplains working with chronic pain patients to aid in the exploration of spiritual issues that may contribute to the pain experience.

Introduction

Chronic pain is a complex, multi-dimensional issue, and treatment of chronic pain involves more than treating an ill physical body. The bio-psycho-social-spiritual model of health care offers increased modalities to address and treat all of a patient's disrupted relationships, whether physical, psychological, social, or spiritual. Sufficient research exists to indicate that spiritual health can have a significant impact on physical and mental health. Controversy does continue, however, about whether spiritual health should be seen as a separate entity as part of a bio-psycho-social-spiritual model of health, or should be subsumed into the psychology portion of the bio-psycho-social model. This often becomes a chicken-and-egg discussion that disintegrates into two camps: 1) those who believe that the spiritual aspect has an equal and unique impact into a person's well-being, and 2) those who believe that all of the spiritual well-being effects can be explained by psychological effects. This is where the chicken-and-egg phenomena come into play – is the person depressed because they have a punishing view of God, or does he or she have a punishing view of God because of the depression and feel that everyone is out to hurt him or her? Since empirical testing of this question is difficult, the discussion is likely to continue for some time into the future. On the bright side for those who fall into the bio-psycho-social-spiritual camp, there is certainly more discussion than ever before in the research literature about including spiritual health into the bio-psycho-social model as a separate and unique aspect of overall well-being.

Research has shown that spirituality can influence patients' ability to cope with chronic pain, in both positive and negative ways. In this review, we hope to 1) describe the ways in which people's use of their spiritual resources may help or hinder coping with chronic pain; and 2) provide resources for chaplains working with chronic pain patients.

Spirituality and Pain

Individuals suffering from severe, intractable or chronic pain may seek out alternative pain control sources. When medication is not enough, or when medication side effects are too overwhelming, patients may turn to their spiritual beliefs and practices. It is not unusual for individuals to turn to spirituality after they have tried traditional medications. Generally, the initial coping response to acute pain is self-directive (e.g. taking aspirin, not calling on spiritual resources), but as acute pain shifts to chronic pain, individuals begin to increase their use of other coping resources including their spiritual resources.[1] Once acute pain has developed into chronic pain, more than 60% of pain patients report using prayer to cope with pain and as many as 40% of chronic pain patients report becoming more religious or spiritual after the onset of their chronic pain conditions.[2]

Religious/spiritual (R/S) coping strategies have been linked to a variety of positive mental and physical health outcomes, including improved mood, decreased pain, and shorter hospital stays. There are multiple ways to categorize R/S coping strategies in order to understand how the different coping strategies affect the individuals using those strategies. One way of categorizing R/S coping strategies, similar to secular coping strategies, is as emotion-focused (e.g. "God, please help me cope") or problem-focused ("God, give me the strength to go to physical therapy today"). Since different situations create different coping needs, the application of healthy religious coping strategies depends in part on the demands of the situation.

However, another method of categorizing R/S coping techniques relates to empirical research findings. Based on the mental and physical health outcomes, we can also divide religious coping into positive and negative categories. Positive R/S coping represents a sense of spirituality, a secure relationship with a benevolent God, a belief that there is meaning in life, and a sense of spiritual connection with others.[3] It is associated with higher self-esteem, better quality of life, improved psychological adjustment, and post-traumatic growth. Conversely, negative R/S coping is an expression of a less secure relationship with God, a tenuous and pessimistic view of the world, a feeling of punishment, and a religious struggle in the search for significance (See Table 1). It is related to depression, emotional distress, callousness, and poor physical health, decreased quality of life, and poor problem resolution.[3,4]

Both private R/S activitities (e.g. personal prayer, meditation, individual Bible reading) and public religious activity (e.g. church and Bible discussion group participation) have been shown to impact pain. In a recent study among individuals with migraine headaches, spiritual meditation was related to decreased severity, frequency or duration of migraine headaches as well as improved mood.[5] Frequent church

attendance (i.e., once or more per week) was also linked to lower self-reports of pain intensity among individuals with sickle cell disease. Positive R/S coping techniques are associated with positive outcomes among chronic pain patients.

As mentioned earlier regarding the "chicken-and-egg discussion," R/S beliefs and activities can also influence an individual's mood, which, in turn, can improve pain tolerance. Yates et al.[7] found that mood mediated the relationship between religious activities and reduced the impact of severe pain on oncology patients. R/S beliefs correlated positively with general happiness and life satisfaction, which then indirectly improved pain tolerance. As was found in other studies, while the participants' R/S beliefs did not eradicate the presence of pain, those beliefs and practices did correlate with a decreased level of reported and perceived pain. Longitudinal diary studies of pain patients also support the concept that R/S coping improves one's ability to cope with pain via improved mood and decreased anxiety.[6] For example, case reports suggest that R/S activities reduce anxiety, allowing relaxation and rest. The R/S reduces muscle tension that could exacerbate pain by maintaining muscle contractions that could lead to painful spasms and limiting blood flow to affected regions.

Accessing R/S resources is more often related to improved pain tolerance and less related to reduced reports of pain severity in chronic, intermittent, and acute pain disorders. Individuals using positive forms of R/S coping will often report feeling the same levels of pain as their non-R/S counterparts, however the R/S coping group members appear to have better pain tolerance and better functionality in their activities of daily living. Therefore R/S coping may not necessarily change the level of pain that the individual feels, but it helps them to better tolerate that level of pain.

The relationship between R/S coping and pain may also depend on the way in which the outcome of pain is defined. Specifically, a decrease in pain severity should be differentiated from an increase in pain tolerance. While these concepts are both based on the individual's pain perception, when they are differentiated, a patient may report that he or she is still experiencing the same level of pain, but report or display better coping with that pain.[8]

As a chaplain working with chronic pain patients, it is important to note that the goal of pain treatment is rarely the eradication of pain. The ultimate goal of pain treatment is to have patients resume as many activities of daily living as possible and to maintain their quality of life. In non-oncology related pain, complete resolution of pain is unlikely to occur after someone experienced intractable pain for more than three years. Removing all pain would often require medication dosages at such a high level that patients would be left with limited functional abilities due to the side effects of the medications. Therefore, the best way to help individuals with chronic pain disorders is to help them continue to lead productive lives to the fullest extent they are able. This is where the R/S coping is most critical since it appears to help patients better tolerate pain levels.

Table 1. Examples of Positive and Negative Religious Coping Techniques

Positive Forms	Negative Forms
▾ Seek spiritual connection	▾ Experience interpersonal religious discontent
▾ Seek spiritual support	▾ Accept a punishing God reappraisal
▾ Find religious assistance to forgive others	▾ Accept a demonic reappraisal
▾ Ask for forgiveness	▾ Feel spiritual discontent
▾ Undergo benevolent religious reappraisal	▾ Undergo a reappraisal of God's power
▾ Use religion as a distraction	
▾ Find spiritual role models for coping	
▾ Problem solving collaboratively with God	

'Pain Relief Is the Fifth Vital Sign'

This statement was the headline in a recent article for medical center staff. The article focused on some of the strategies used in patient care for pain management including: medication, massage, and relaxation techniques. There was no mention of prayer, meditation, or how religion and spirituality play a vital role in patient care for pain management. The role of R/S coping is an essential element in comprehensive pain management. Chaplains have a unique role as advocates for the integration of R/S coping into the care plan for comprehensive pain management.

Case Study

A woman in her early 30s diagnosed with metastatic breast cancer that had spread to the bones was admitted to a home-based hospice program. This patient was in constant and intractable pain. She was hospitalized at times as every attempt was made to pharmacologically manage her pain. A referral was made to a chaplain per the team's assessment that the patient was also experiencing intense spiritual pain.

A chaplain made frequent visits with the patient who wrestled with profound psycho-social-spiritual suffering as she grieved the multi-layered losses secondary to her cancer. No longer able to work, the patient was often alone for several hours a day while her spouse juggled the responsibilities of work and family life. She had few distractions and felt isolated from her spouse, family, co-workers, and from God. The patient often commented on the changes in her appearance after the loss of a breast and hair loss following chemotherapy. She felt ugly and grieved the loss of intimacy with her husband. She also grieved the death of her dreams for the future she had hoped to create with her family.

The patient's faith was Jewish and lamenting became a powerful tool for her in coping with her pain. Her sense of deep loss was validated in her visits with the chaplain. She felt permission to cry out to God, to shed tears and to explore her losses. Although her pain was still present; the patient reported

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Spirituality and Pain

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to the medical team that the intensity of her pain was diminished as she utilized these coping strategies rooted in her faith tradition. Some of her visits with team members became punctuated with laughter that served as a further distraction from her pain. The ability to laugh again also meant that the cancer and pain no longer defined her.

Practical suggestions for chaplains:

- Remember that you are standing on "holy ground" in visiting with patients who are the experts on their experience of pain and suffering.
- Recognize that patients who experience chronic pain may be sensitive to noise, bright lights, and interruptions during a visit. Try to diminish these stimuli.
- Invite patients to explore their beliefs about God's role in their pain/suffering and to identify their spiritual resources for coping.
- Explore patients' goals and hopes for living fully with chronic illness.
- Gain experience in mindfulness-based stressed reduction (MBSR) techniques as a resource for patients coping with pain.[9]
- Advocate for the integration of spiritual assessment into patient care plans for comprehensive pain management.
- Create an oasis of refreshment for your own soul as you work with patients coping with chronic pain.

Conclusion

In summary, generally R/S coping is associated with positive mental and physical health outcomes. However, several areas of concern have been identified. If patients attempt to rely solely on their higher power for mental and physical health without any form of collaborative problem solving, or if patients use negative R/S coping styles, they are more likely to have poorer long-term health outcomes.

Because of the critical impact that R/S coping can have on pain and general mental and physical health, chaplains and educators need to advocate for the integration of religion/spirituality into a comprehensive assessment of pain for their patients. Questions about religion/spirituality need to be asked when a provider takes "the fifth vital sign." Part of the calling of a professional chaplain may be to advocate for further research on the relationship between spirituality, pain, and coping. Training for the next generation of chaplains needs to integrate the latest research about religion/spirituality and pain as well as to translate this research into effective spiritual care interventions.

Amy Wachholtz is assistant professor of psychiatry at the University of Massachusetts Medical School in Worcester, MA. She also works in health psychology at the UMass Memorial Medical Center. Rev. Karen Dorshimer-Chaplin is a chaplain at the UMass Medical Center.

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Applying this research to our ministry

The concept of total pain describes the interrelationships between pain and physical, emotional, social, and spiritual well-being. The experience of pain can threaten spiritual well-being and spiritual resources can be called upon to help patients cope with pain. Physicians, nurses and chaplains have observed these interrelationships firsthand when there is a patient whose pain is particularly difficult to treat. It is not uncommon to discover a spiritual issue in need of resolution. The authors provide an excellent case to exemplify how the chaplain's intervention and support of the patient's spiritual belief system made a difference in easing the patient's experience of physical pain.

As the authors acknowledge, these are difficult issues to study, yet we need to advocate for the integration of spiritual assessments into care plans and for further research on spiritual care. Both pain and spiritual health are subjective phenomena, yet there seems to be more acceptance of the validity of pain scales (1-10) than of spiritual assessments. Documentation of both quantifiable spiritual assessments and qualitative stories (cases) provide rich data for research. Elisabeth Kübler-Ross started by listening to her patients and documenting their experiences — these activities can be a source of growth for chaplains and advocacy for further research.

Teresa Albanese, PhD
Research Associate
Summa Health System
Akron, OH

Pennington's work, thoughts on centering prayer shared

Book Review

Transformation in Prayer: 99 Sayings by M. Basil Pennington. Jean Malouf (ed.). New York City Press, Hyde Park, NY, 2009. Hardcover, 99 pp. $14.95

By Laura Richter, MDiv

This book of sayings by Basil Pennington is one of the "99 Words to Live By" series by New York City Press. These small books share inspirational thoughts from well-known authors in easily digestible bites. The excerpts, ranging from one sentence to a paragraph, are taken from a number of Pennington's books, including: "Call to the Center," "A Place Apart," "A Retreat with Thomas Merton," "Thomas Merton — My Brother" and "Who Do You Say I Am?"

The book focuses on prayer practices, centering and the need to connect deeply with God. Pennington's thoughts, woven together with wise observations and Bible passages, invite the reader to a more fulfilling relationship with God. The Trappist monk's words remind us our center is the place where prayer happens and God speaks, enabling us to fully receive healing and love. It is only by leaving the chaos of the world and letting go of ego/self that we can truly enter into full relationship with the One who loves us deeply.

The book offers helpful reminders and could be used as a "thought a day" book or resource for quick quotes on prayer and centering. It might not work as well for someone looking for a deeper dive into prayer, but as long as readers understand the purpose of the book, they won't be disappointed. The book could also be a good gift for a colleague or friend who is interested in prayer or Pennington.

The 99 sayings series also features other writers including: Pope Benedict, John Paul II, John XXIII, Henri Nouwen, Mother Teresa and Theresa of Lisieux as well as themed books on Christmas, happiness, love, peace and friendship.

Laura Richter is director of workplace spirituality at Ascension Health in St. Louis, MO.

It might not work as well for someone looking for a deeper dive into prayer, but as long as readers understand the purpose of the book, they won't be disappointed.

In Memoriam

Please remember in your prayers:

Sister Mary Nora Welter, PBVM, an NACC member whose most recent ministry was as chaplain at Mercy Hospital in Iowa City, IA, where she joined the staff in 1993.

Reflecting recently on her chaplaincy, Sister Mary Nora said, "I find that plans are very short lived. Daily I strive to organize my day with the knowledge that the unexpected often occurs."

She died at age 68 on Oct. 18 at Mount Loretto Motherhouse in Dubuque, IA.

Sister Mary Nora was born Oct. 3, 1941, in Epworth, IA, daughter of Carl and Mary Welter. The oldest of six children, she entered the Sisters of the Presentation in 1960, professing perpetual vows in 1969. Sister Mary Nora received her bachelor's degree and a master's degree in education from Clarke College in Dubuque. She obtained a master's degree in pastoral studies from the University of St. Thomas in St. Paul, MN.

Her teaching, religious education, pastoral and chaplain ministries, spanning 44 years, took her to towns and cities in Iowa, Minnesota and South Dakota.

Sister Joanna Burkhart, SFP, who was among the first women to be certified as a chaplain by the NACC in 1975. She died Oct. 30, at age 88.

After completing a program in Clinical Pastoral Education, Sister Joanna joined the pastoral care staff at Providence Hospital, now Mercy Franciscan-Mt. Airy, in Cincinnati, OH. For 27 years, she ministered there and at Mercy Franciscan Western Hills, also in Cincinnati.

According to Sister Arleen Bourquin, SFP, Sister Joanna "was a welcome sight at both hospitals, comforting patients, soothing their fears as they prepared for surgery, consoling dying patients and their families, and greeting former patients and/or family members."

Sister Joanna was born March 8, 1921, on a farm near Louisville, OH, the fifth of seven children. She professed her perpetual vows as a Franciscan Sister of the Poor in 1952. A good cook, Sister Joanna was given the opportunity to study dietetics at Fontbonne College in St. Louis, MO. She learned to speak Italian and lived in Rome during the time of the Second Vatican Council, thanks to her position in the dietary department of Convento Cuore Immacolato di Maria in Frascati, Italy. She also spent several years providing direct service to the poor in the United States.

"Although her accomplishments in ministry are many, those of us who shared community with her will remember Sister Joanna for her spirit of hospitality and her commitment to the Franciscan Sisters of the Poor," commented Sister Arleen.

We are grateful!

The NACC wishes to thank thefollowing volunteer members who made the Fall 2009 certification weekend possible:

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Mr. David C. Baker, Stevens Point, WI
Mr. Willard J. Braniff, Mishawaka, IN
Sr. Anne K. Breitag, OP, Saginaw, MI
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> "We are especially grateful to the number of institutions who give in-kind donations to allow their sites for our certification interviews."
>
> *— Rev. John T. Crabb, SJ, Chair, Certification Commission*

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The following individuals also gave in-kind:

Mr. Skip Dalle Molle, for the in-kind donation of not requesting reimbursement of expenses and mileage.

Sr. Mary A. Gallagher, OSF, on behalf of Caritas St. Elizabeth Medical Center – Spiritual Care Department, for the in-kind donation of not requesting reimbursement for expenses.

Ms. Jean M. Harrington, for the in-kind donation of not requesting reimbursement of expenses and mileage.

Ms. Janice A. Labas, for the in-kind donation of not requesting reimbursement of expenses and mileage.

Dr. Anne Murphy, for the in-kind donation of not requesting reimbursement of expenses and mileage.

The NACC wishes to thank the following volunteer members who made the Spring 2009 certification weekend possible:

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Mr. Gerald M. Gundersen, Hyattsville, MD
Mrs. Alice C. Hennessy, Philadelphia, PA
Sr. Joanna Hoffmann, OP, North Riverside, IL

NACC welcomes newly certified members

Congratulations to the following NACC members who were approved for chaplain certification following their interviews in May 2009:

Rev. John I. Aduba, Homestead, FL
Chaplain Habteghabr M. Anisera, Chicago, IL
Ms. Kelly L. Bigler, Monrovia, CA
Sr. Ruth E. Brings OSF, Campbellsport, WI
Miss Barbara A. Britting, West Seneca, NY
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Congratulations to the following NACC members who were approved for chaplain certification following their interviews in October 2009:

Rev. Lawrence A. Agi, San Diego, CA
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Mrs. Kathleen Vander Velden, Appleton, WI

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Ms. Nancy K. Cook & CHW, for the in-kind donation of absorbing the cost of two one-hour conference calls.
Ms. Annette Castello, for the in-kind donation of absorbing the cost of two one-hour conference calls.
Ms. Virginia A. Day, MDiv, for the in-kind donation of not requesting reimbursement for expenses.

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Calendar

January

1	Solemnity of Mary; NACC National Office closed
22	Day of Professional Enrichment, Ministering to Those in Decision-Making Time, St. Catherine Rehabilitation Hospital and Villa Maria Nursing Center, Miami, FL
27	Articles due for March-April *Vision*

February

11	World Day of the Sick
15	Postmark deadline for supporting materials for fall 2010 certification interviews
17	Ash Wednesday