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# Guillain-Barré journey transformed priest's life, music

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



Fr. Jan Michael  
Joncas

talk at the NACC National Conference in St. Paul, MN.

The talk by Fr. Joncas focused on his personal experience in 2003-04, when he spent months in hospital and outpatient rehabilitation recovering the use of his arms and legs and the ability to breathe without a ventilator after a diagnosis of Guillain-Barré Syndrome. His talk, titled "Individual Change and Promise: A Shelter in the Time of Storm — Sickness, Healing, Ministry and Music," was interspersed with his own musical compositions that flowed along with his story line, notes climbing and tumbling in tones at times subdued, other times, tumultuous, later, lilting, expressive of

Well-known liturgical musician

Fr. Jan Michael Joncas, SLD, spoke about "what it's like to be on the other side of the bed from the chaplain" during his March 20 plenary



St. Paul, Minnesota, March 20-23, 2010

the confusing, helpless, pleading, hopeful times in his journey. Fr. Joncas said his experience with suffering had transformed his compositions.

Fr. Joncas, a priest of the Archdiocese of St. Paul and Minneapolis, divided his talk into five stages he used to make sense of his own journey with illness: Chaos and Confusion, Diagnosis, The Abyss, Therapy/Healing and A New Life.

He learned from his frightening experience to be freer emotionally, he told the chaplains.

"I am a typical late middle-aged Caucasian American male, which means that I tend to be pretty locked," Fr. Joncas said, adding that he's not embarrassed anymore if he bursts into tears at a movie or watching a TV program. "I don't feel bad that I don't have a stoic face that I face things with. I don't even

See [Transformed](#) on page 6.

"I don't feel bad that I don't have a stoic face that I face things with. I don't even feel bad when I'm doing pastoral ministry and I have nothing in particular to say to a person, and all I can do is just hold a hand and cry."

# Byock: Non-negotiable elements of human caring must be honored

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



Dr. Ira Byock

It's not the capacity for caring, but the commitment to care that is "our most critical deficiency," palliative care physician Dr. Ira Byock stated in a

plenary session at the NACC National Conference in St. Paul.

The chair of palliative medicine at Dartmouth Medical School challenged those listening to ensure that society commits to providing the basics to the dying. "The basic things – hygiene, bladder function, oral care, turning, mopping of the brow, provision of fluids, perhaps canned broth, the keeping of

See [Human Caring](#) on page 7.

# Do we live in joyful hope this Easter season?

**By David Lichter, DMin**  
**Executive Director**

This *Vision* issue comes to you in the midst of our Easter season. Most likely you will receive it in early May, after the Fourth Sunday of Easter that proclaims readings that remind us that we are made new in the Easter mystery – a new heaven and new earth we live in! Do we believe it? Do we see it! I recall the poignant phrase of Dr. Shawn Copeland, one of our NACC 2010 Conference plenary speakers, who noted that “hope is a divine requirement, not a heavenly gift.”

Do we live in joyful hope because of the Easter mystery we celebrate? In this column that is written within days of the March 19-23, 2010, NACC National Conference in St. Paul, MN, I want to comment on three topics – the 2010 National Conference, our membership, and *Vision* – and tie them to the question above. I hope my reflection will be helpful to you.

## NACC 2010 Conference

While I have only a brief history with NACC, and not many NACC conferences with which to compare this last one, I know it was a special conference. When a long-time NACC member and a veteran of many conferences commented that it was the best she’s attended, I asked “Why?” She observed it was a combination of factors for her, although it seemed that the “hunger and need” (my words) to gather to celebrate the mystery and sacredness of the spiritual care ministry seemed the most tangible factor. Given the tough financial times and its impact on members’ professional and personal lives, it seemed that for many of those who gathered in St. Paul, the sense of community and common commitment to the healing ministry of Jesus were palpable and renewing.

While just 15% of our membership (400 of 2,600) was able to attend this year, I believe the conference can be spiritual and professional leaven for all our members to the extent that the participants can share with other members what they gleaned from the conference, implement the skills and learning gained, and bring the renewed spirit back to their places of work. We are so grateful to the 2010 Conference Planning Task Force for the excellent preparation! This conference was a sign of hope for us, as we embraced and lifted up in prayer all our members, entrusted them to our God, and recommitted ourselves to

live in joyful hope and daily dwell in the mystery of our healing ministry – Christ in us, our hope of glory.

## NACC Membership

I shared at the Business Meeting with the conference participants the NACC Board’s 2010 priorities, including membership growth. Some pertinent data was shared. Ten years ago (2000), we had 3,455 members. As of March 2010, we have 2,613 – a loss of 842. In 2000, we had 1,588 religious women. Today we have 845 -- a loss of 743.

The second data grouping was the recent decreases in membership.

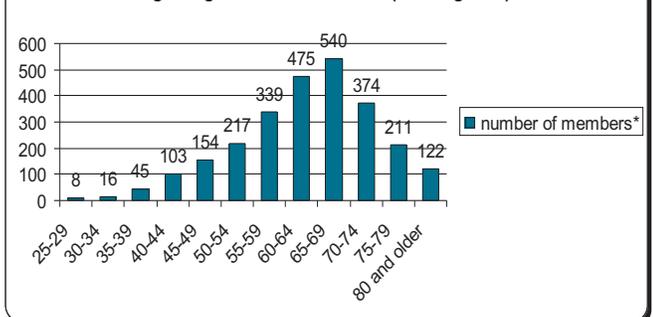
Year	Members	Decrease
2005	3134	
2006	3015	-119
2007	2898	-117
2008	2853	-45
2009	2631	-222

As you can see, 2009 saw a very steep decline. As we contacted members who did not renew their membership, the reasons were most often their financial hardships, whether it was their or a spouse’s job loss or income decline. The day I write this column, I received the following e-mails: “We are being foreclosed.” and “My husband lost his job. Our home is for sale and we could be ‘homeless’ soon.” This is a very hard time for people. Some members took early retirement (45 new retired members). Also, 44% of that loss (100) was emeritus members (this represents about 20% of our emeritus members). Another telling statistic shows the impact of loss of our religious women members, as we had in 2009 a net loss of 80 of those ages 60 and older, but we lost 91 religious women who were 60 and older. This means the number of our non-religious women members in that age category increased.

We continue to plan for the major membership shift we are beginning to experience more each year. It is significant as you view our membership profile. (See graph of our membership profile as of February 2010 that

Given the tough financial times and its impact on members’ professional and personal lives, it seemed that for many of those who gathered in St. Paul, the sense of community and common commitment to the healing ministry of Jesus were palpable and renewing.

Age ranges of NACC members (all categories)



# 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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accompanies this article.)

Where are signs of hope? We are adding new members. In January and February 2010, we gained 12 in the member category, 12 students, and five associates. This is hopeful. Again, when we ask how they learned of NACC, it was both our awareness-building efforts over the past two years, but most importantly the influence and encouragement of our members who invited them to become a member of NACC. How can we be hope-filled people? Please invite colleagues to join NACC!

## Vision

I have been particularly struck over the past couple of years by the number of members who have expressed their appreciation for our *Vision's* improved content, especially with the high quality articles on specific professional themes. Researchers have asked that we improve our archiving of the issues in order to help them locate these fine articles. Up until the past three issues, only a member could access a pdf version of the printed *Vision* document. Now people can go right to the *Vision* section of the NACC website and access these articles in printable form.

More changes will be occurring in the coming months. The NACC Board of Directors, at its March 2010 meeting, decided that *Vision* will be available only in electronic copy in the very near future – at the latest January 2011. As you probably know, our Spiritual Care Collaborative partners have already moved in this direction. This decision will help us financially in a significant way, as each issue of *Vision* costs nearly \$5,000 to print and ship. This will allow us to devote our

resources to sustaining the quality of our content, as well as to make the articles even more accessible. In the future, select articles will be easier to print and you will be able to send a link to this article to someone else as well.

We realize that we still have more than 300 members who have not provided us with an e-mail address. We continue to ask members for an e-mail address, even if it is their religious community's general e-mail address, or their family's e-mail address. Free e-mail addresses are available and free computers can be accessed at libraries. It is a shame that those without e-mail addresses miss the key member communication tool, NACC Now, e-mailed to members every other week, as well as other important member communication items. In the coming weeks we will be working on how and when we will move to the electronic version of *Vision*, and we will keep you informed along the way. We will make every effort to provide a hard copy for anyone who absolutely needs one.

So, how is this hopeful? You might be tempted to say, "Sounds like we are shrinking and cutting services?" I believe it is our joyful hope that drives and leads us to see new ways of responding to our current challenges. Is it not our hope that leads us to dream new dreams, and see new visions (and new NACC Visions)?

Please enjoy this issue of *Vision* as it provides you with a taste of the 2010 NACC Conference. And ... please mark your calendars for *May in Milwaukee 2011* – our 2011 National Conference, May 21-24, 2011, at the Milwaukee Hilton in downtown Milwaukee!

I believe it is our joyful hope  
that drives and leads us to see new ways  
of responding to our current challenges.



## Finding my spider in the web

By **Francisco Cacho, Jr., BCC**

I was commissioned as one of the NACC professional chaplains during the 2009 Orlando Summit. The event reawakened my drive to achieve and my will to dream. At the

same time, the experience reconnected me to groups professing the monotheistic faith, with a refreshed sense of inclusiveness – one that traverses a huge diversity of skin colors, accents, and foods. Orlando likewise provided me a space to meet with a handful of Filipinos and Fil-Americans who are involved in “this village of care.”

Conferencing, dancing, and reflecting with others brought back childhood memories and numerous afternoons I spent finding my spider amidst the webs.

On hindsight, what is a spider? A spider is one of the arachnids characteristically having four pairs of multi-jointed legs. What distinguishes a spider from other arachnids, like the scorpions and mites, is its characteristic of having several spinnerets that produce silk used to make nests, cocoons, and webs.

And what is a web? It is a latticed or woven structure; an interlacing of materials. (It is the structure of membranes connecting the toes of certain water birds. In architecture, it is the surface between the ribs of a ribbed vault. In textile, it is the structural part of cloth as distinguished from its pile or pattern.)

What is the web for a spider? The web is made of sticky, silky threads that a spider spun itself. Spiders spin their webs, cocoons, and nests with materials from within themselves, not collected from the outside world. (The spider’s web is designed to expand symmetrically from its center. The design portrays an efficient network to the outside world. I wonder if this is the prototype of the www — World Wide Web)

The web serves as the spider’s day room. It is connected to a nest — either woven within a leaf, or woven within the crevices of the bark and branches of a plant. It is likewise connected to a cocoon where its larvae are protected and incubated. The web provides an open area to store and preserve the spider’s feed. Related to this, the web functions to catch insects and foreign objects that trespass or cross its span, intentionally or accidentally.

I always look at the center of the spider web. That is the space where I find spiders. During the day, I almost always find a spider anchored at the very center of its own web. At

night, it retreats to its own nest to rest and retire. A spider shelters itself off the center of the web when it rains, or during inclement weather. I also noticed that every spider builds its own web by itself.

I have yet to find two spiders at the same time in the same web. They seem territorial. (We, as young boys, indeed capitalized on this characteristic in arranging a spider-fight. We put two spiders on a single stick, head to head, against each other.)

An occurrence anywhere in the web will alert the spider. The spider always appears to do a “Stop, Look, Listen” protocol before responding. Thereafter, it uses itself and its own resources — its legs, mouth, and spinnerets — to speedily subdue any intrusion of the web under its control and authority. This seems to be the spider’s standard operating procedure.

I have noted how this SOP converts into an emergency procedure. I have seen spiders do a somersault-like jump-off whenever their centers are invaded. Their action resembles the ejection of fighter pilots from cockpits. Both players utilize a kind of lifeline during emergency exit. The source and substance of their lifelines, however, are not the same and differ significantly. Unlike the pilot’s use of a parachute, a spider appears to demonstrate good use of self and inner natural resources.

The spider’s demonstration of its natural instinct of self-protection and preservation amused me as a child. And it continues to amaze me today with insights that I find helpful and relevant throughout my CPE pilgrimage.

Like the spiders, human beings naturally and instinctively seem to do an S.O.S — (Save-One-Self) whenever alarmed and invaded. There have been times when I have felt a need to protect and defend my own web in this village of professional care giving. The fearsome realities of “living intentionally in the web of pastoral care” have occasionally alarmed me enough that I have withdrawn from the center of this bigger web. I instinctively retreat to the haven of my little nest. Unlike the spiders, dreadful instances could parachute me into “nowhere” — with nothing but my very self; left with nothing but a breath of hope.

Hope, I sense, defines my difference from the rest of creation. Hope empowers me with the capability to humanize the spirit. I am capable of embodying infinite possibilities of the human spirit — I am “*capax infiniti*” (Karl Rahner). I cultivated this awareness as I progressed through the educative element of CPE. The Orlando commissioning was such an insightful and momentous learning experience. It informed my potential to spin my web with the breath of human hope.

At the same time, something inside tells me that “use of self” demands giving up parts of my selfhood. Giving up parts

Like the spiders, human beings naturally and instinctively seem to do an S.O.S — (Save-One-Self) whenever alarmed and invaded. There have been times when I have felt a need to protect and defend my own web in this village of professional care giving.



of selfhood could also turn to the most dreadful fear in care giving — because my selfhood is the only one I have. I possess no replica of my “I.”

But is this not the crux of Christian life? Isn't the gift of self the essence of the Christian cross? And, isn't the cross the symbol of Christian hope, of discipleship, of service, including pastoral care?

At this point in my CPE pilgrimage, I can reclaim some “aptitude of empathy” (Daniel Pink) from within me. I can re-claim the human spirit with which to re-structure a web of pastoral care. I am capable of spinning this web of interconnectedness, with the use of the natural resources within me.

A reflection on “nowhere” offered a mirror to look at my self. “Nowhere” is the space I find myself hanging between the many and varied human conditions of frailty and mortality. “Nowhere” is the moment I am suspended between my complacency for the status quo of regularity and ordinariness, and a nagging inner voice to search the shrines of the Sacred and Eternity. These are the moments and spaces in which I did not always find my self — “my spider amidst the web.” “Nowhere” is the space where, and the time when, I also don't always find my Creator.

My Creator finds me, instead. Always.

*Francisco Cacho Jr., on-call chaplain for Bridgeport Hospital in Bridgeport, CT, believes he is the only Filipino board certified Catholic chaplain in the Diocese of Bridgeport. He does volunteer chaplaincy for Danbury Hospital in Danbury, CT.*

### Please remember in your prayers:

**Judy Novak**, an NACC member and staff chaplain with Wheaton Franciscan Healthcare in Racine, WI, who died March 21, at age 54.

She wrote book reviews for *Vision*, the most recent of which ran in the November-December 2009 issue of *Vision* and focused on two books about coping with the complications of Alzheimer's and dementia.

Ms. Novak, who resided in Cudahy, WI, was born and raised in Mobile, AL. She established her home in Wisconsin with her husband Mike, and children, Maura, and David, in 1990.

She graduated from St. Francis Seminary, St. Francis, WI, with a Master's in Divinity, and worked as a hospice and nursing home chaplain. She also had worked as adult and family minister at parishes in Port Washington, WI.

She loved dancing, music, and helping people, and was an active parishioner at St. John Cathedral, where she was a member of the parish council and served on the fine arts commission and in the hand bell choir. A Mass of Christian Burial was celebrated at the Cathedral of St. John the

## The Sparrow

By Deborah Cooper

*This morning, I pray only  
for the sparrow on the deck*

*not for peace, or cures  
for ravaging diseases*

*just this one precise petition  
for this one particular bird*

*stunned, sudden collision  
with the window-glass.*

*I keep vigil for an hour  
until he finally flies away.*

*Tomorrow morning  
I may ask for something more.*

*Deborah Cooper, an Emeritus NACC chaplain, has published her work in numerous literary journals, anthologies and several books. Her latest book, a full-length paperback collection, "Under the Influence of Lilacs," is available on amazon.com. Ms. Cooper, a resident of Duluth, MN, teaches poetry classes in a variety of settings, including a grief support center, a women's shelter, and the county jail.*

## In Memoriam

Evangelist, Milwaukee.

**Rev. Michael Awase Angula**, an NACC member who served as a chaplain at Queen of the Valley Medical Center in Napa, CA, for several years. He died Jan. 29 after a year-long struggle with cancer.

A citizen of Nigeria, Africa, Rev. Angula was born March 11, 1968. He was ordained a Catholic priest on Aug. 6, 1994, for the Diocese of Makurdi, Nigeria. Rev. Angula was assigned as a parish priest to St. Thomas Parish, in Gboko, Nigeria, and then as the secretary to the Bishop of Makurdi from 1995 to 2002. He arrived in the United States in 2002.

According to the Napa Valley Register, Rev. Angula was the associate pastor at St. Helena Catholic Church in St. Helena, CA, for the past two years.

A funeral Mass was celebrated at St. Helena Catholic Church. Father Angula's body was to be sent back to his home in Nigeria and to his mother, Jacintha, and family.

## Transformed

*Continued from page 1*

feel bad when I'm doing pastoral ministry and I have nothing in particular to say to a person, and all I can do is just hold a hand and cry. Part of me feels really stupid doing that, but part of me says, no, I'm getting in touch with something much deeper," he commented.

The priest, who is also associate professor in the Department of Catholic Studies and Department of Theology at the University of St. Thomas, said that he used to teach his students about suffering in an intellectual fashion, telling them that it is a religious mystery and sharing with them a variety of theories about suffering. "I don't do that anymore. I have shifted from seeing suffering as a problem to be solved, much more aware that suffering is a mystery to be engaged. It holds us together."

What's important, he emphasizes in class these days, is "learning how to be with each other in the midst of suffering."

Suffering, he said in response to a question after his talk, is "part of the price of being human. It somehow connects with the suffering of Christ" and is "absolutely redemptive," he believes.

Fr. Joncas said that he has known God by many names from Scripture, but his sudden illness and rehabilitation made him aware of the "God of rescue." "I've come to discover a God who is absolutely committed to working through others.... My family, my friends, these medical caretakers, the people who prayed for me ... they became the hands, the eyes, the lips, the presence of God. We're with an incarnate God, and we're lucky," the priest said.

Numerous family members and friends dropped everything and came to his bedside, Fr. Joncas said. They helped him navigate the complexities of the hospital systems he encountered, sat with him, prayed with him and gave him strength to go on.

The priest said he was amazed at how important the church's rituals became to him. "My friend Fr. Michael Driscoll left behind his professor's podium to come to my bedside. He prayed the anointing prayers. This is what he prayed: 'Father in Heaven through this holy anointing, grant Michael comfort in his suffering, when he is afraid, give him courage; when afflicted, give him patience; when dejected, afford him hope; when alone, assure him of the support of your holy people. We ask this through Christ our Lord. Amen.'"

Fr. Joncas said he had probably prayed that prayer 600 times, but it never hit him as it did this time, prayed by a chaplain who said his name. "It was shattering, but absolutely wonderful. It said to me, come hell or high water, God will not

abandon me. Come hell or high water, the church I believe in will not abandon me. Come hell or high water, my family and friends will not abandon me.

"You chaplains mediate that. I cannot tell you how important that is," Fr. Joncas said.

Complicating his journey was the divergence of two diagnoses by neurologists on the same team at an Indiana hospital. His friends made sure Fr. Joncas was moved from that setting to Mayo Clinic in Rochester, MN. There, with helicopter rotors still spinning, "six different medical personnel came running out ... before I even got to the building they were trying to care for me," the priest recalled.

He had been teaching at the University of Notre Dame in South Bend, IN, when he was struck by Guillain-Barré. He first noticed a problem when he had difficulty lifting the chalice and paten at Mass during Holy Week. He found it hard to get out of bed the next day, he said, and felt as if he had Brillo pads on the bottom of his feet. When he went to Urgent Care, where he underwent many tests, he was told he had a bad case of nerves.

That year, he missed the Easter Vigil for the first time. On Easter Sunday morning he went back to Urgent Care at 7 a.m.

The nurse who had been there the day before "did something I'm sure she could have been fired for. She said, 'Come close.' In a very quiet voice, she said to me, 'I should never say this, but whatever you have we can't handle. What you need to do is get in the car, drive to South Bend Memorial Hospital, and check yourself into the Emergency Room.'

She was wonderful.... An intervention, something beyond the system," Fr. Joncas said.

He called it providential – "God was watching over me. Exactly two hours after checking in (to the hospital), I couldn't walk. Imagine what would have happened if I had been driving when that happened."

At Mayo Clinic, he said, while the medical personnel were phenomenal, he believes Mennonite volunteer singers deserve some credit for his healing. They sang four-part hymns a cappella around the bedside of patients who wanted them. "I became more aware of the part of my soul that responds to beauty. I can't say enough about Mayo, but hospitals are not only noisy places, but ugly places."

His lengthy hospital stay included a urinary catheterization – "say those two words ... and I become like jelly," being wheeled on a gurney to chapel for Mass, drug-induced dreams he has yet to untangle, and the need to give up any sense of modesty due to hospital gown design and the proximity of his room to the Psych Department's smoking area.

The priest said he learned to pray differently during his illness. Conversations he had with God were limited: "So can I live with this?" he would ask. "The answer seemed to come pretty consistently, yes. So, what are you trying to teach me?" He still awaits the answer to this query, he said.

"I have shifted from seeing suffering as a problem to be solved, much more aware that suffering is a mystery to be engaged. It holds us together."



# Human Caring

*Continued from page 1*

company, perhaps in silence, perhaps in prayer, or gentle singing of lullabies — these are the components of care that define a bottom line of non-negotiable elements of human caring that we all must not allow society to sink beneath,” the physician said. “We must commit to be present to the other, including the last, the least and the lost. This is the stuff of basic human responsiveness.”

“Discussions of obligations of care often find little place within the prevailing contractual framework of provider-patient relationships, which emphasize individual rights and liberties, but not so much responsibilities,” Dr. Byock said. One possibility, he said, is to change the framework to focus more on covenant relationships than on contractual ones.

The physician is also director of palliative medicine at Dartmouth-Hitchcock Medical Center and a professor in the departments of anesthesiology and community and family medicine at Dartmouth Medical School. He made the comments March 22 during a talk titled “Professional Change and Promise: The Meaning of Death.”

Linda Piotrowski, Dr. Byock’s chaplain colleague at Dartmouth-Hitchcock, in her introduction said, “Ira’s work is not about death and dying, but about life and living. He tells us, ‘Go out and spread joy!’” She described him as a “leader of international thought” and “a prophet in our midst.”

Death, said Dr. Byock in his talk, is non-being. While life is making order from disorder, death carries with it a sense of chaos. “Because philosophically I can know nothing with certainty about death,” he said, “I must accept that death itself may or may not be meaningless.” Yet, he said, it’s apparent that the fact of death profoundly impacts life’s meaning.

Death, he said, “provides a background against which life is lived.”

If death means “ultimate ego annihilation,” he said, it’s no surprise that people have an aversion to thinking and talking about it. He quoted 17<sup>th</sup> century French writer and moralist, La Rochefoucauld, “One can no more look steadily at death than at the sun.”

As humans are “meaning makers,” theologians and philosophers throughout history have asked questions about life, death, their nature and meaning, Dr. Byock said. Most people, however, avoid the subject, he noted.

However, “even for the least introspective among us, the ever-present fact of mortality constantly threatens to wake us from the dream of life,” he said.

“When sudden death, serious injury, or terminal illness strikes our family or circle of friends, the foundation of our world is shaken. From the moment an individual is diagnosed with an incurable illness, death becomes the alarm that will not stop ringing,” the physician commented.

Western culture, he said, tends to avoid serious consideration

of death. In order to avoid it, he said, “we buy health club memberships, Botox, Nordic tracks — some actually use them, we check our breasts and testicles for lumps, we know how much fat we eat and the kinds of fat they are, we eat fiber until flatulence threatens our relationships. We wear seatbelts and bicycle helmets, and we floss,” he noted.

But when death is confronted, personal growth can take place, Dr. Byock suggested. He quoted from an essay written by his colleague, Dr. Bill Bartholome, about a year after his diagnosis with cancer of the esophagus, at a time when he knew death was imminent. Dr. Bartholome wrote that he considered it “a gift” to have a year to prepare for his death.

“It has allowed me time to prepare my family for a future in which I will not be physically present to them. It has given me the opportunity of tying up all the loose ends that our lives all have. I have been provided the opportunity of reconnecting with those who have taught me, who have shared their lives with me, who have touched my life. I have been able to reconnect with those from whom I had become estranged over the years, to apologize for past wrongs, to seek forgiveness for past failings.”

The physician also wrote that “with death sitting on (his) shoulder,” he was finally done with the “tyranny of all the things that need to get done,” and he had found a new spontaneity and joy in his life that he had rarely known before.

“I like the person I am becoming more than I have ever liked myself before,” he wrote. “I realize more than I have ever before that I exist in a web of relationships that support and nourish me, that clinging to each other here against the dark beyond is what makes us human.”

Dr. Byock said the end of life brings opportunities for communicating with others, resolving relationship issues, grieving, reviewing life and exploring its meaning and purpose, as well as reflecting on spiritual and transcendental realms. In his 2004 book, titled “The Four Things that Matter Most,” Dr. Byock noted that he offered four simple statements that he continues to believe can be powerful tools for improving relationships and lives: “Please forgive me. I forgive you. Thank you. I love you.” This advice, he told chaplains at the conference, is “stating the obvious,” but at the end of life, in particular, he said, “when is it more important to do so.”

Our shared humanity, Dr. Byock suggested, poses fundamental questions about our relationship to each other and our responsibilities to one another. “Perhaps in addition to our opposable thumbs, 46 chromosomes or species specific genome, it is how we are with another in the face of death — including how we care for another — that confers our humanity,” he said.

This prompts further questions, he said, “What responsibilities do we have to those who are dying: our family members, friends, neighbors, and those we do not know? What responsibilities do we have as individuals, and collectively as a society?”

In Dr. Byock’s view, the “barest essential components” of human care at the end of life would be:



## Mary E. Johnson receives 2010 Distinguished Service Award



Ms. Mary E. Johnson

The NACC awarded Mary E. Johnson, MA, BCC, its 2010 Distinguished Service Award March 21 at the NACC National Conference in St. Paul. The award recognizes Ms. Johnson's demonstrated leadership in the professional ministry of chaplaincy, her passion for fostering a community of support among NACC members, and her advancing the mission of NACC in a significant and lasting way.

Ms. Johnson is coordinator of education for Mayo Chaplain Services — Mayo Foundation, and has served in many roles for the Mayo Foundation since 1980. She is the principal investigator of four research studies in spirituality and co-investigator of seven others. She served on the NACC Certification Commission from 1994 to 2000 and was the vice chair of the commission from 1998 to 2000.

She was a site visitor on the USCC commission on certification and accreditation from 1988 to 2000. She trained chaplains as the coordinator and CPE supervisor of the NACC accredited CPE program at St. Mary's hospital and Mayo Clinic from 1984 to 1997. In 2004, the program honored her with their Educator of the Year Award.

Ms. Johnson was a member of the Universal Standards Task Force representing the NACC from 2003 to 2004. She also was co-editor of Clinical Learning Vignettes for The Journal of Supervisor and Training in Ministry and is on the editorial board, Special Articles Section, for The Journal of Clinical Oncology (1999 to the present); she is published in more than 10 national journals, including Vision. Since 1995, she has

delivered 126 invited presentations both nationally and internationally.

At Mayo Clinic, Ms. Johnson is assistant professor of oncology in the Mayo Clinic College of Medicine and is a faculty member in the Mayo Medical School for the following programs: Hospice and Palliative Medicine Fellowship, Continuing Medical Education, Palliative Medicine, Wellness Orientation, Sexual Medicine, Bioethics, Medicine and Spirituality, Convocation of Thanks, and Continuing Nursing Education. In 2001, the Mayo School of Health Sciences granted her its Faculty Service Award.

Rev. Dean Marek, chaplain at Mayo Clinic, in presenting the award, said his first experience of Ms. Johnson as "an NACC personality" was at an association conference in Washington, D.C. some 20 years ago. "We all laughed heartily and repeatedly at her flawless delivery of Ole and Lena jokes.

And here we are in Ole and Lena territory. That certainly was enough to make her memorable to me, but in the ensuing years I have come to know Mary as a colleague, friend, chaplain extraordinaire, educator, mentor, researcher, writer, and Renaissance woman of considerable wisdom and wit."

Rev. Marek said that while Ms. Johnson's credentials and service to the association were impressive, "it is her accomplishments in the broader health care community where spirituality and faith intersect with the talents and gifts" of those in other professions that set her apart for the Distinguished Service Award.

Rev. Marek noted that she has written for professional journals that most chaplains would be familiar with, but also "you may find her name in professional journals that I'm pretty sure most of us have not read," including Oncology Nursing Forum, Journal of Clinical Oncology, Journal of Pelvic Surgery, and the Journal of Urology.

Noting that she has an "enviable ability to collaborate so wonderfully with others," he said that Ms. Johnson has presented to oncologists, nurses, family physicians, obstetricians, hematologists, geriatric oncologists, ethicists, and Latter Day Saints, among others. "She does it all with singular focus, ease and finesse," he said.

"Let us pray that, like Mary, we will be fearless witnesses to the Gospel we embrace," Rev. Marek concluded.

*Following is Mary E. Johnson's response upon receiving the 2010 Distinguished Service Award:*

I don't know if there is anything sweeter than peer recognition.

I am grateful and humbled. Because I am standing here looking out over a sea of distinguished servants, I see several of you with whom I have had the pleasure of serving in NACC activities over many years. And some of you are still serving on committees and commissions and in leadership — still in the saddle after decades of selfless and sometimes thankless work. What's wrong with you? And we all know that this organization and others like it run largely on the kindness and generosity of volunteer servants.

I am aware that we do not only represent ourselves here. Most of us have healthcare and ministry organizations at home that support us and support our efforts here with the NACC.

I actually owe the NACC a deep debt of gratitude. I was very young when I came into this ministry. I was full of energy and zeal, full of conviction and altruism, full of hope and belief in the power of change. Those were the early years of the "explosion of lay ministry" in the post-conciliar church. With all of that energy, zeal, conviction, and altruism I was probably a little dangerous.

Then I got hooked up with the NACC, which provided me with some structure, some professional standards, and marvelous opportunities for collegiality. I learned a lot from you and I have grown professionally. I learned what it means to



May we as chaplains continue to persist — at the bedside, in the care conference, in the boardroom, in the pulpit, and in legislative environments — in our efforts to remain faithful to the people in our care.



Newly certified chaplains and CPE supervisors pose for a photo March 21 at the NACC National Conference in St. Paul. Joining them are Sister Barbara Brumleve, SSND, chair of the board, at far left; Bishop Randolph Calvo, episcopal liaison to the NACC, third from left; and Fr. James Yeakel, OSFS, Certification Commission chair, back row, fourth from the right.

## Transformed

*Continued from page 6*

The priest said he wanted to pray for others not just himself, and started praying for the patients on either side of him, then two rooms on either side, then those in the zones upstairs and downstairs from him.

After he could breathe on his own and one of his fingers started to move, closely followed by the rest of his body, he was released from the hospital to begin three months of physical and occupational therapy and six months of recuperation at home. He has in large part recovered, but Fr. Joncas said he still has tingling in his fingers, ankles and feet. "Drugs don't mask it but make your brain not pay so much attention to it so you can live," he said. He still has waves of unpredictable fatigue, and when he's too tired his gait suffers and he begins to drag a foot. In addition, the priest said, Guillain-Barré doesn't usually recur, but it can, so he does constant self-monitoring.

truly collaborate. I learned to keep the big picture in mind. And I saw how people all over the continent try to maintain our ultimate focus on our own professionalism for the benefit of the people in our care.

I feel deeply blessed by having been able to participate in over 30 years of ministry. I treasure the wonderful colleagues with whom I am surrounded in my workplace. And I treasure the partnership my Mayo colleagues and I have with the Franciscan women who founded that organization and remain influential in it today.

I still have some zeal but have lost much of my energy. I am still quite altruistic but my convictions have softened ... on some issues. I still tend toward hope but any change that is going to

## Human Caring

*Continued from page 7*

- ▼ The provision of shelter from the elements. "We will keep you warm and dry."
- ▼ The provision of hygiene. "We will keep you clean."
- ▼ Assistance with elimination. "We will help you with your bowel and bladder function."
- ▼ Offering food and drink and assistance with eating. "We will always offer you something and help you to eat and drink."
- ▼ Keeping company, non-abandonment. "We will be with you. You will not have to go through this time in your life entirely alone."
- ▼ Efforts directed at symptom management, the alleviation of suffering. "We will do whatever we can, with as much skill and expertise as we can bring to bear, to lessen your discomfort."

In the contemporary context, alleviation of physical suffering is always a possibility, Dr. Byock said. "We may not be able to eliminate physical suffering, but we can always make it a little less severe, a little softer, a little easier to tolerate."

happen will now have to take place before 8 p.m., which is my bedtime.

We now face unprecedented times in healthcare ministry. Access to healthcare, even for the most vulnerable, continues to narrow. Physicians and other healthcare providers face mountains of barriers when it comes to establishing therapeutic relationships with patients. And healthcare organizations struggle to stay true to their missions. May we as chaplains continue to persist — at the bedside, in the care conference, in the boardroom, in the pulpit, and in legislative environments — in our efforts to remain faithful to the people in our care.

Thank you very much.

## Sister Kay Sheskaitis receives 2010 Outstanding Colleague Award



*Sr. Kay Sheskaitis*

The NACC granted Sister Kay Sheskaitis, IHM, DMin, executive director of the U.S. Conference of Catholic Bishops Commission on Certification and Accreditation (USCCB/CCA), its prestigious Outstanding Colleague Award March 21 at the NACC National Conference in St. Paul. Sister Kay has held her position on the

bishops' commission since 1991.

The Outstanding Colleague Award recognizes a person whose work has proven complementary to, supportive of, or otherwise has contributed to the advancement of the profession of chaplaincy in a significant and lasting way.

In the presentation of the award, Mary T. O'Neill, a member of the USCCB/CCA Board of Directors, stated that "as ministry in the church has grown and evolved, Sister Kay has directed the efforts to ensure the establishment of high quality professional certification standards, policies, procedures for the NACC and other professional ministry

groups, as well as accreditation standards, policies and procedures for the USCCB/CCA accredited CPE programs and ministry formation programs."

In the award presentation, Sister Kay was described as "a strong supporter of excellence and professionalism," who has been "especially dedicated to diversity and inclusion of lay people in ministry." Ms. O'Neill praised her for being "one of NACC's biggest supporters in our certification endeavors," who "continues to challenge and walk beside the NACC in our mission of professionalism and certification." Ms. O'Neill also credited Sister Kay with "strengthening our relationships with the bishops and diverse ministry groups within the Catholic Church."

Sister Kay said being honored was "truly overwhelming." She said it has been "a very great privilege" to work with the NACC, in particular with the CPE supervisors who perform their work with such dedication.

"In the words of Sacred Scripture," Sister Kay added, "may your tribe increase."



2010 CONFERENCE

St. Paul, Minnesota, March 20-23, 2010

## Plug for upcoming Annual Appeal given at business meeting

**By Laurie Hansen Cardona**

*Vision* editor

NACC Board Chair Sister Barbara Brumleve, SSND, told those attending the NACC Business Meeting March 22 that when it comes to the NACC Annual Appeal, the size of the gift, though important, is not as important as the percentage of association members making the gift.

In 2006, the Annual Appeal was answered by 6% of the membership. By 2009, that had grown to 15% of membership.

"That's wonderful," Sister Barbara said. She noted that membership organizations are seldom ever supported totally by dues. When donors are asked to give large contributions to support the NACC, the question often is: "What percent of your members donate to your organization?" Sister Barbara said.

"You may say, 'I paid my dues,' 'You did, thank you,' but any additional amount for the annual appeal, which will begin soon after the national conference, would be greatly appreciated, said Sister Barbara. "Wouldn't it great if we could say we have 75% of the association giving to the annual appeal?" she asked, noting that all board members give to the appeal.

NACC Executive Director David Lichter recalled the good work done by the planning group four years ago by establishing the NACC mission statement: to advocate for the profession. "This drives us every day," Mr. Lichter said. The mission

statement goes on to say that the association educates, certifies and supports chaplains, CPE supervisors and all other members, he noted.

He reviewed the goals that are part of the NACC *Vision* statement and detailed ways in which they are being developed. They are: member communication and support, promoting chaplaincy, fostering Catholic relations, fostering growth and unity within diversity, strategic partners, financial stability and staff and board development.

Brian Yanofchick, representing the Catholic Health Association, thanked members for their support of CHA on the healthcare debate. He said he was excited about the ongoing partnership between the CHA and the NACC. "You offer unique resources for this entire ministry," he told the chaplains present, adding that "CHA looks to NACC as an important locus of competence and talent and commitment to promote spiritual care across the ministry."

Nancy Cook, of the Pastoral Care Summit Care Services/Staff Development Task Force, invited chaplains to consider becoming a mentor, a "trusted, knowledgeable person who offers guidance to another." The new chaplain mentor program involves a 12-month commitment. "This is not job



2010 CONFERENCE

St. Paul, Minnesota, March 20-23, 2010

# Bishop: Simple, heart-to-heart dialogue can restore hope

*The following is the text of the homily preached by Bishop Randolph R. Calvo, DD, JCD, at Mass March 21 during the NACC National Conference in St. Paul.*

Margaret Wheatley wrote a book about the power of conversation. It's entitled, "turning to one another: simple conversations to restore hope to the future." She writes, "I believe we can change the world if we start listening to one another again. Simple, honest, human conversation. Not mediation, negotiation, problem-solving, debate, or public meetings. Simple, truthful conversation where we each have a chance to speak, we each feel heard, and we each listen well."

What she says could easily apply to the practice of the spiritual care of the sick. Much of ministry has to do with dialogue, presence, and listening. In a simple, human encounter, the spirit of promise can come with the winds of change.

In the Gospel we've just heard, there are two kinds of conversations. There is one between Jesus and the accusers of the woman caught in the act of adultery and another between Jesus and that woman. The first is really not a conversation: it's a confrontation set up as a debate. And although the woman's life hangs in a balance, she is not the issue, nor is she part of the conversation. She's not interrogated; no one asks her, "What do you have to say for yourself?" The question is directed at Jesus: "Now in the law, Moses commanded us to stone such women. So what do you say?"

It's interesting that Jesus does not engage in this discussion. He's bending down writing something in the ground. We don't know for sure what he's doing. Scripture scholars have speculated about this and some write that he's just doodling. Seriously. You know how you can start to doodle when a meeting goes on and on in circles; you doodle to keep patient or to appear attentive while tuning out the discussion. Jesus is not going to be part of this debate. When he had enough, he stands up and says, "Let the one among you who is without sin be the first to throw a stone at her." Discussion comes to an end as people walk away one by one, beginning with the elders.

Why didn't Jesus engage in this debate? He could have used it to argue about justice and mercy. I would offer this answer — pure speculation but not inconsistent with Jesus' behavior in the Gospels and his mission. He chose not to engage in this conversation because it had no space for conversion: its point was condemnation of Jesus as well as of the woman and its method was to instrumentalize a human being, to make a point by robbing the woman of her human dignity.

We characterize this season of Lent as an opportunity for conversion: "Turn away from sin and be faithful to the Gospel" were words spoken as ashes were smudged on our foreheads as we began this time of penance and renewal. It's a time for promise as well as change. This is what conversion is all about. It's turning to God, which in itself could be a change. It could

also be turning to God in the face of change. Your ministry is often to people who are in the grip of a life-altering experience. Change is upon them because of their illness: it could be as serious as death looming or it could be issues such as Who will take care of me, Where will I live, How will I get around? Where is the Spirit of promise in this change? Often this spirit begins to be discerned in the conversation that is part of spiritual care.

At the end of the Gospel story, there stood just the woman and Jesus. *Relicti sunt duo, misera et misericordia*, as St. Augustine put it. "There remained two, the one in misery and mercy." At last someone spoke to the woman and engaged her in conversation. It was a simple one: "Has anyone condemned you?" "No one, sir." "Neither do I condemn you. Go and from now on do not sin anymore." It was a simple dialogue in which the woman was treated not as an object but a subject of thoughts, choices, feelings and intentions.

Jesus did not condemn her, even though she was caught red-handed in the act of adultery.

So does that mean he condoned her behavior, ignored her sin? Some would argue that if you don't condemn, then by your silence you are condoning. But no, Jesus neither condemned nor condoned.

Instead, he invited the woman into the space where conversion can take place: a place of few words in this case, but one in which heart speaks to heart — *cor ad cor loquitur* — direct and honest

human conversation.

Now that I have thrown in some Latin phrases, allow me to play with the quote from St. Augustine, *Relicti sunt duo, misera et misericordia*, for he himself plays on words. We can't do this in English, but in Latin there's a play on the words *misera* and *misericordia*. In *misericordia* there are two words joined: *miseria* and *cor*, misery and heart. Another person's misery is taken to heart; this is mercy. And so there remained two in conversation: the one in misery and the one who took her misery to heart.

The space between not condemning and not condoning is not narrow as a nuance. It's wide, big enough to allow for human conversation, for the truth to be told, for soul-searching and soul-bearing, for understanding and for challenge, for tears and for joy, all the feelings and thoughts that would tumble into a person's heart in a moment of crisis.

The adulterous woman in the Gospel did not speak words admitting guilt or expressing sorrow. Yet she walked away free; her life was spared. Nothing was said about what she did later on. But she had the encounter, the conversation. She entered the space where conversion can take place, where there is mercy and promise.

*Cor ad cor loquitur*, to quote Cardinal Newman: heart speaks to heart. Isn't this the space where we find a mercy that not only spares a life but also gives it promise? Isn't this the space where our ministry takes us?

*Bishop Calvo of Reno, NV, is episcopal liaison to the NACC.*

5<sup>th</sup> Sunday of Lent (C),  
March 21, 2010



## Copeland: Rely on Spirit in this time of 'impasse,' transition

By **Bruce Aguilar, BCC**



Ms. M. Shawn  
Copeland

After some personal and humorous remarks, the diminutive and bespectacled Professor M. Shawn Copeland, PhD, began her 45-minute speech March 21 entitled "Ecclesial Change and Promise: Living into the Promise of the Spirit." Then she quickly shifted gears to the "serious" topics at hand: naming many "complex and precarious" realities of change in our world — and our church. Chaplains are present

in a variety of "precarious" places where they can offer comfort and spiritual nourishment, Ms. Copeland asserted; at the same time, chaplains themselves are affected by these dangers.

As one of four plenary speakers at the conference, Ms. Copeland was asked to focus on the ecclesial dimension. As a professor and prolific author in theology, she exuded a sense of intellectual depth and groundedness as well as an explicitly structured speech (for which this reporter is grateful!). She promised to address the two questions developed by the conference planners in three stages of her own: How does our story as church challenge us to a future vision of hope? And how can the story move us to prophetic witness?

First, she began with the meaning and promise of the Spirit in the world. Here Ms. Copeland read the story of the universal outpouring of the Spirit in Acts. The Spirit animates the church by providing charisms and gifts needed for the growth and ongoing life of the church. At the same, Ms. Copeland added, the Spirit helps to structure the church and its gifts. She argued that we must acknowledge that order, office, and charismatic life are all integral aspects of the early history of the church as it appears in Acts.

Here Ms. Copeland spends some time clarifying the relationship of church and Spirit. The church of God grasps "tradition — not as a

chain but as a root, something organic," to balance developments that have arisen due to changes. Tradition's balancing seeks to avoid both stagnation and anarchy in the early church.

The church is always inadequate to the Gospel, the normative standard for Christians, yet the church must hold itself accountable to the Gospel, argued Ms. Copeland. Here the Spirit teaches us about the Gospel goal of freedom. "Our consent to the Spirit's gentle will without at the same time renouncing our intelligence and our dignity as human beings

constitutes authentic freedom," she said.

The church is made by the Spirit, said Ms. Copeland, drawing on theologian Yves Congar. Yet, she added, "How unwise it would be for us to romanticize the evolution of the early church." Any tendency to become smug and triumphalistic must be sobered by the weighty mistakes and acts of cruelty throughout the church's history. We should not "assume God has given us a blank check so that in every major instance the Spirit will make sure that the church will muddle through it," she said, quoting Protestant theologian Walter Brueggeman warning us, for a real possibility is that the people of God may need to pay the price of their blundering.

Still in this first section on meaning and promise of the Spirit in the world, Ms. Copeland turned briefly to two post-Resurrection stories in the Gospels that she feels characterize the hope of the early Christians. The women who find the empty tomb bring the Good News to the others and find themselves released "from the bowels of fear" by this new faith as much as the men they announce it to. This same new faith is discovered "beyond all probability" by the disciples who were joined by Jesus on the road to Emmaus: "Jesus is risen, alive!" This prophetic hope lived by the early Christians is about being reckless in love, witnessing to the in-breaking of the Spirit in their lives, and allowing the Good News to break out of them into sharing and living.

Continuing the theme of balancing change and tradition, Ms. Copeland recalled the *Aggornamento* of 45 years ago in the church. Here she sees an example of prophetic ministry by the people of God that was not divorced from tradition and its wisdom; it sought to help the people respond to the Spirit rather than invent a new message. Today we live with fragmentation and losses — our parishes and schools are closing, scandals about sex abuse remain in the headlines. The church as we know it may be passing away even as the church of the future is being born. We need the Spirit to lead us in witnessing to hope during transition.

Returning to our present situation globally and ecclesially, Ms. Copeland said that we are living in a time of "impasse." We need prophetic ministry in order to rightly discern our situation and freedom, she maintained. She encouraged learning from the prophets of ancient Israel about the praxis of prophetic ministry. In a quote recalling Jesus teaching his followers that human beings are not made for the Sabbath, Ms. Copeland stated: "The true prophet sets the audience before the choice, not the choice before the audience." Here Jewish philosopher Martin Buber suggests that the outcome and future is not predetermined; rather the Prophet witnesses to hope, a hope that resides in the disposition of the audience toward its own authentic freedom.

For the third and final part of her speech, Ms. Copeland shared from Walter Brueggeman's study of the Prophet Jeremiah as a guide to the praxis of prophetic ministry. She summarized five points in his book "Like Fire in the Bones:"

"How unwise it would be for us to romanticize the evolution of the early church." Any tendency to become smug and triumphalistic must be sobered by the weighty mistakes and acts of cruelty throughout the church's history.

## He's engaged, energized by Copeland presentation

As I reflected on Shawn Copeland's presentation, a number of things struck me. When she said that the Spirit cannot be restrained, by sex, age or culture, it got me to wondering how I let the Spirit free in my life. Am I allowing the Spirit of God to act in my life, or am I simply restraining God's purpose in my life? This is important because as a chaplain and a deacon, I am called to allow God to act within me and to bring the power of God, not my power, to everything I do. Ms. Copeland said that everything is subject to the Gospel, and that also made me wonder how well I represent the Christ who says to me and to all Christians, "when I was hungry you gave me to eat, thirsty and you gave me drink, imprisoned and you visited me, sick and you comforted me." Isn't this the

role of the chaplain — to see Christ in everyone and to provide comfort to the Christ we see in all people?

Aren't we all called to be prophets who call people to hope? That is not an easy thing, for people who are suffering don't often see hope in what is going on inside of them. Yes, Ms. Copeland made me think about my ministry and how well I act in the Spirit of God's name. Certainly this is not easy, but Ms. Copeland has energized me to look for God's Spirit in everyone I meet, and to allow the Spirit to animate everything I do.

*Deacon Tom Waken  
St. Mary's Medical Center  
Evansville, IN*



## Bilingual chaplain pleased with connections made in St. Paul

**By Wilson O. Villamar**

In March 2010, I attended my first NACC National Conference. The experience helped me to appreciate a line spoken by the character Neytiri in the movie, "Avatar": "Everything is about the connection." Indeed, my participation in the National Conference was an opportunity to connect on different levels. I connected with people: former classmates and people I knew from Boston, as well as new, wonderful friends — people who are doing a job that is passion-driven and much needed, people who share my beliefs, background, and spirituality, and people with whom I could feel at home (thanks to you, Norma and Maria Elena!). I also connected with a God and a church that are wider and bigger, more diverse and welcoming than in my previous understanding. Finally, I connected with my own sense of mission and ministry as a lay, Catholic, bilingual chaplain in a country and a church that longs for compassionate and caring ministry.

The overall structure of the conference, though very

compressed, was enlightening, reaffirming, challenging, and uplifting: The new winds bring new hopes and opportunities. I was eager to meet the family of Catholic chaplains, and I

thought our time together in St Paul, MN, was a wonderful example of Ecclesia.

Back at my home base, The Chaplaincy Center in Providence, RI, I am reminded of the blessings and joys I have had as a chaplain and a CPE supervisory student connecting with patients and students who ground me by sharing goodness and joys, challenges and struggles. The journey ahead looks promising

and, as I wait to meet my first certification committee, I pray that we continue to connect with God's people in the same way Jesus did with his friends walking on the road to Emmaus.

*Wilson O. Villamar is chaplain at Women and Infants Hospital, in Providence, RI. He is a supervisory education student at The Chaplaincy Center, also in Providence.*

Prophetic ministry contests idolatry and ideology — by discerning what claims to be but is "not God."

Prophetic ministry tells us that "God does not absolutize the present." Rather, we are called to see our present situation in the light of a future that God desires for us.

Prophetic ministry uncovers human suffering (a natural for chaplains!)

Prophetic ministry assumes a critical posture toward established power. Ms. Copeland argued that such forms of power seduce us to lower our vision to immediate and tangible forms of security while forfeiting our authentic freedom and God's reign.

Prophetic ministry is an act of unyielding hope that resists despair.

These five points, Ms. Copeland suggested, can bolster our own praxis to live into the promise of the Spirit. Ms. Copeland summarized the main ideas in her talk and ended by saying that the meaning of "the promise of the Spirit" is life — for church, for individuals — and fills us with desire to witness to the Good News and God's reign about which Jesus so often spoke. Ms. Copeland then closed with a prayer — to the Holy Spirit.

*Bruce Aguilar is a chaplain at Spaulding Hospital in Cambridge, MA.*

# González: Catholic organizations need to undergo conversion, reach out to poor

By Laurie Hansen Cardona

Vision editor



Sr. María Elena González

“Culture is not only how we are; it is who we are. It brings us our history, our ethnicity, how we think about our families, who we include in our families, the feasts we celebrate, how we eat, what we eat. It’s how we think about God, how we feel about God, and when and where we relate to God.”

Plenary speaker Sister María Elena González, RSM, challenged the NACC and its chaplain members to look inside, undergo conversion, and reach out to the poor and to people of color by accepting their cultures and responding to their needs.

“Justice demands that our Catholic institutions and organizations not be just parallel structures to others. If this is so, than I ask why do they exist? If we’re not really different in the way we serve the poor, why shouldn’t we close up?” she asked in her March 23 talk, titled “Global Change and Promise: Embracing the Many Faces in God’s House.”

Although Sister María Elena has a long and varied career that includes being the first woman president of the Mexican American Cultural Center in San Antonio, TX, and one of the first women to be named a diocesan chancellor in Texas, she said she grew up “having a shattered mirror image.”

Her parents migrated to the United States during the religious revolution in Mexico. Sister María Elena described them as hard-working and deeply rooted in their faith. “By all standards, all nine of us children have been very successful,” she said. Yet, she said, “for me, it is a constant struggle to recognize that I am a gifted woman.”

Relationships with others give people messages about their identity and self-worth, she said, noting that living in this country as a Latina she has been on the receiving end of many negative messages. “What happens to self-image when you receive messages that are hateful?” she asked.

Sister María Elena talked about the need for those in ministry to be responsive “to the signs and needs of the times.” In order to “celebrate the diversity of our brothers and sisters, we must understand what culture tells us,” she said.

“Culture is not only how we are; it is who we are,” she said. “It brings us our history, our ethnicity, how we think about our families, who we include in our families, the feasts we celebrate, how we eat, what we eat. It’s how we think about God, how we feel about God, and when and where we relate to God. It’s how we relate to the mother of God, the

saints, and the faithful departed,” she said.

It’s also how people think about family, she said. She recalled that when her mother was hospitalized, she would encounter chaplains who didn’t appreciate that she and her siblings wanted to enter the hospital room together to be with their sick mother. “There were nine of us; if one of us wasn’t there, Mom would say: ‘Where’s Nacho?’ She had to have all of us with her. We would gather together and pray the rosary together, and mother would bless us. We couldn’t exist without that,” she said.

Culture is about relationships and how we relate to the stranger in our midst, she said. Everyone has culture, she said, while sometimes it seems people in the United States think only minority groups have culture. “We all have to learn about our cultural roots before we begin to destroy others,” she said.

There is nothing inherently better or worse about one culture or another, noted Sister María Elena. “Every culture has its lights and shadows,” she said. But in the United States, cultural differences seem to create fears and insecurities, she said, that only intensify during times of recession and terrorist threat. “As a society we say we value diversity .... (but) any group that does not easily melt down, any group that cannot change the color of their skin, the shape of their eyes, the

texture of their hair, remains suspect in today’s society.

“We don’t value diversity unless it’s controlled diversity,” she commented. She called it interesting that in the same country where people spend millions of dollars going to tanning salons, people were taken aback when baseball player Sammy Sosa felt the need to lighten his skin.

Years ago when she wore a complete habit, Sister María Elena said she was often asked if she were from the Philippines. When she said, “No, I’m from the United States,” people would persist, “Where are you from?” “Texas,” she’d answer. “Yeah, but where are you from?” “Amarillo, Texas.” “You see what they were doing? They wanted me to say I’m from another country. I was born here with the same rights as everyone else, but still I’m different.”

Sister María Elena said consciously and unconsciously, people carry certain prejudices within them. “Divisions among races and cultures find their expressions within the Catholic Church, within our religious communities, within our Catholic institutions. For we are not separate from the society in which we live. Cries of racism and bigotry seem at times to be quite appropriate,” she said.

She told her chaplain audience about times during her childhood when her Latino culture failed to receive the respect it deserved. In one case, her father was hospitalized in a Catholic hospital and he set up his small altar in a little corner. Each day when she came to visit, she would find that the altar had been put away. Each day, when she visited, her father, who



## Clinics in Twin Cities receive donation

Association members present at the NACC National Conference in St. Paul donated \$3,352 to this year's conference charity, St. Mary's Health Clinics, a ministry of the Sisters of St. Joseph of Carondelet, St. Paul Province.

The mission of St. Mary's Health Clinics is to carry out the healing ministry of Christ by providing needed health services at no cost to low-income, uninsured individuals and families in the Twin Cities metropolitan area.

In a message sent to David Lichter, NACC executive director, Sister Marion Louwagie, CSJ, MA, BCC, a member of St. Mary's board of

directors, shared her gratitude:

"We at St. Mary's Health Clinics feel very blessed to have shared the message of our healthcare services to the low-income and uninsured individuals in the Twin Cities metro area. As the recipient of your generous charity offering at the March NACC conference, we will be able to provide free health care for 13 individuals for an entire year. Thanks for all you do in service to those struggling with illness and once again, thank you for your generous gift to St. Mary's Health Clinics!"

For more information about St. Mary's Health Clinics, go to [www.stmaryshealthclinics.org](http://www.stmaryshealthclinics.org).



## Annual Appeal

*Continued from page 10*

placement, and there is no compensation," Ms. Cook noted. "If you feel called to leadership or you are in leadership and would like to develop your skills," this may be for you, she said. Whether chaplains sign up to be mentors or mentees, they will be promoting individual professional growth, advancing the profession, she said. She noted that information about the

program has been provided in NACC Now.

Jim Letourneau, of the NACC Nominations Panel, said this is a new panel that has as its goal to identify potential future leadership and current leadership for the NACC. Sometimes, he said, people are nominated by others, and other times "there is that fire within, inviting you to discern" whether you should be a candidate. The nominations panel is the "entry to the pipeline," he said. Members will review potential candidates, then pass names to the governance committee, which in turn passes names to the board for consideration prior to an election.

could not speak, would nod his head in the direction of where the altar had been. She would set it up again. "And this was a Catholic hospital," she commented.

Culture also involves language, she noted. When she was a child, her father worked for the railroad. One day, when he was resting after work, men from the railroad knocked at the door and asked insistently for Pete. "Pete! We don't have a Pete at our house." After awhile her father came out; it turned out that's what he had been called at work because the people didn't want to bother learning his real name, Bernardino, or his nickname, Nino. Sister María Elena said she never forgot how humiliated her father looked, answering to his employer's name for him.

Sister María Elena said the dominant culture in the United States seems to have one of three mindsets:

- ▼ **Those with cultural heritage are a problem.** They are the ones who have to have a special Mass or a special service. They need to learn English; they need to learn our ways. This leads to a "we vs. they mentality," she said. "They need to stop bringing their whole family to the hospital," she said.

- ▼ **"The group, the event or the activity belongs to us.** "This group is ours. The way we celebrate and when we celebrate belongs to us. If they want to join us fine, but they have to do it our way. I've heard it said that Sunday seems to be the most segregated day of the week – this mindset might explain why."

- ▼ **The third mindset, she said, equates Catholic and**

**American — "We don't want them in our church."** Ash Wednesday, she said, draws many Latinos that people don't see at Sunday Mass. "You know why? They don't have to answer as to whether they're giving to the collection. They don't have to be identified as legal or illegal. They don't have to say which sacraments they've received....The things we do to keep people from the Eucharistic table," Sister Mary Elena exclaimed. "Jesus wouldn't make it!" At least on Ash Wednesday, she said, it's understood that everyone can receive the ashes just because they are children of God.

Minority groups also embrace certain mindsets, Sister María Elena said. Among them, she cited:

- ▼ **Whatever Father says, goes.** "We were taught not to question, to do whatever Father or Sister or Brother says, to keep our eyes down.... Many of us have been accused of never telling the truth or of hiding something because of no eye contact."

- ▼ **Self-depreciation: Minority groups continue to be oppressed, and this leads to a profound sense of inferiority that is passed from one generation to another.** "This sense of inferiority leads people to believe they are neither capable nor worthy to make a difference in our church and our society. We become slowly but surely what people say we are."

- ▼ **Fatalism.** A belief that things will not get better; it is God's will. This mindset "takes away any motivation to improve our lives."

## 'White paper' workshop points to need for 'interprofessional teamwork'

By **Julia Rajtar, MA**

As a profession, we are privileged to have Karen Pugliese, MA, BCC, and Rev. George Handzo, BCC, serving as advisors in the National Consensus Project for Quality Palliative Care. Their workshop presentation March 21 at the NACC National Conference stressed the need for certified chaplains to be the coordinators of spiritual care for palliative care patients, working together with the team in a more collaborative method. The workshop was titled "Spiritual Care in Palliative Care – An Interdisciplinary White Paper."

Ms. Pugliese and Rev. Handzo made it clear that the traditional concept of interdisciplinary or multidisciplinary team was inadequate to describe how this clinical team would operate. The team would be interprofessional in that each member of the team could perform some of the other's discipline, yet healthcare professionals would still take the lead of their own disciplines. For instance, each member of the team would be able to identify pain, but one clinician was the "expert" and coordinator for managing that pain. The same would be true for spiritual care in that each staff member could identify spiritual distress, but the board certified chaplain would need to be the lead or coordinator and provide the spiritual assessment. Chaplains are interprofessional, in that they are one of the professions, not an ancillary service, but part of the professional healthcare team.

Ms. Pugliese and Rev. Handzo said the project was a consensus project, meaning that not everything that each participant wanted was included, but in the end, the advisors were able to reach consensus. One of the primary purposes of the team was to respond to the question: "How can we all come together in the best way to provide spiritual care within healthcare?" The goal was to provide recommendations to advance the delivery of spiritual care and to be very specific about what that would look like. The team identified these specific elements: spiritual assessment, models of care and care planning, training for the interdisciplinary team, and focus on quality improvement as an anchor for the process. In addition, they saw a need for developing personally and professionally and spiritually the nature and individuals who are part of the team.

The National Consensus Project guidelines identify eight domains of quality palliative care:

- 1: Structure and Processes of Care
- 2: Physical Aspects of Care
- 3: Psychological and Psychiatric Aspects of Care
- 4: Social Aspects of Care
- 5: Spiritual, Religious and Existential Aspects of Care
- 6: Cultural Aspects of Care

7: Care of the Imminently Dying Patient

8: Ethical and Legal Aspects of Care

Domain 5 is the primary focus for chaplains, especially distinguishing between spiritual, religious and existential aspects of care. When trying to define spirituality, two key components continued to be present in almost every definition of spirituality the group studied. These components included phrases about meaning and purpose and connectedness. The group came to consensus on a common definition of spirituality.

SPIRITUALITY is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, self, to others, to nature and to the significant or sacred.

The Consensus Project participants hope is that the above definition will be adopted as the common definition of spirituality used by all chaplains.

Recommendations for providing spiritual care were then presented and divided into seven key areas, which included:

1. Models of Spiritual Care
2. Spiritual Assessment
3. Formulation of Spiritual Treatment Care Plan
4. Interprofessional Considerations: Roles and Team

Functioning

5. Training and Certification
6. Personal and Professional Development
7. Quality Improvement

The INTERPROFESSIONAL TEAM made up of all healthcare providers would ideally be a community that relates to one another as partners for the provision of care to the patient and family that they are treating, that they share their lives and challenges of their work, their learning and that they do interdisciplinary training for one another. Training and certification would be necessary for every member who is identified on the team, and professionalism is continual through professional development and continuous quality improvement.

The model of spiritual care presented included a structure for spiritual screening done by all healthcare providers. Screening will be important because it is vital to all members of the team to have access to the spirit of the person as well as the human and physical aspects. For example, a physician, nurse, social worker, etc., would perform a spiritual history/screening while a professional board certified chaplain would complete a spiritual assessment. Documentation would include all the spiritual resources available to the patient.

Ideally, chaplaincy will have diagnostic labels and codes, i.e., spiritual distress, what is it, what does it look like, how does it manifest itself, what are the symptoms? From this a clear treatment plan would be formulated that all team members can



# First-timer, but not a last-timer

By Sandra Lucas, BCC

I loved having the pink “First Timer” ribbon on my name badge at the NACC Conference. People greeted me, made sure I was all set, and made me feel welcome. I wore my ribbon proudly! After years of wanting to participate at the national level, I loved it all — the pace, the workshops, the speakers, the liturgies, the awards. I was grateful for the opportunity to connect with other department directors over lunch. The opportunity to share strategies and ideas was (almost) worth the price of admission! I even liked the annual business meeting — which I had debated cutting in order to see the Dead Sea Scrolls at the Science Museum. Being a first-timer, however, I didn’t want to miss a thing.

There were three highlights for me, among many wonderful events:

**1. The Missioning of Newly Certified Members.** Since I’d been unable to attend my own missioning (no \$ or sponsoring facility), I participated in the rite during this year’s conference, vicariously. With purpose and joy, I proclaimed, “I do” with the new BCCs. It renewed my commitment and helped heal the sadness of having missed my own ecclesial blessing.

**2. Stations of the Cross.** Sometimes you don’t realize how parched you are until you drink from the living well. That was my experience of the music and prayers of the Stations of the Cross. Station XIV (in part): “I know what it is to grieve, and what it is to walk with those who are stunned by grief, to walk with those whose lives have been shattered by the unexpected loss of a loved one. In the midst of all that,

participate in but that the chaplain leads. All members of the team need to support the patient’s expression of needs and beliefs.

Once the assessment is done and care plan written, chaplains are not finished. Chaplains must continue with follow-up evaluations as patients change. Treatment plans may need to be adapted.

Chaplaincy needs to develop spiritual care discharge plans. Discharge could mean death and dying, but a plan would still need to be developed that also includes bereavement care for the family. Chaplains would need to develop clear procedures so the team knows what the methodology is, what the process is, what the intended outcomes are, whether those outcomes were met, and how we may need to re-evaluate the plan accordingly.

One specific tool to assist chaplains and other professionals in advancing spirituality in healthcare is the book, “Making Health Care Whole,” published by Templeton Press. The book provides information on integrating spirituality into patient care. To delve deeper into the work done through the National Consensus Project, find the PDF file at:

Lord, it is sometimes difficult to remember that you are here too.” Thank you, Chaplain Sharon Mason, for your thoughtful words. Thank you, musicians, for your healing music. Thank you, leaders of prayer, for your reverence. It soothed and revived my soul.

**3. The Mall of America.** (Don’t stop reading!) My parish priest said not to miss the biggest mall of America; otherwise, on Friday, I would not have dropped my luggage without unpacking and jumped on the last hotel shuttle. Otherwise, I

would not have met a chaplain from West Virginia who had done the same thing! Otherwise, I would not have made a new friend.

This happened to you as well — over a meal, collecting tickets, at a workshop — the connections, the networking, meeting old friends and colleagues, making new friends and colleagues. What a joy and blessing.

I came to St. Paul a first-timer. I left with a better understanding and deeper appreciation of NACC at a national level. I left with practical and professional resources. I left with a renewed spirit, colleagues across the country, and new friends. Now, that was worth the price of admission!

*Sandra Lucas is the regional director of Spiritual Care at the Humility of Mary Health Partners in Youngstown, OH.*

I even liked the annual business meeting — which I had debated cutting in order to see the Dead Sea Scrolls at the Science Museum.



[www.nationalconsensusproject.org/guideline.pdf](http://www.nationalconsensusproject.org/guideline.pdf).

Finally, thank you to Karen Pugliese and Rev. George Handzo for their commitment, dedication and passion for advancing board certified chaplaincy. They have assisted our profession in the development of resources not just for palliative care chaplaincy, but also for chaplains in any healthcare setting, developing a way for all chaplains to legitimize their place on the healthcare team.

The Winds of Change and the Promise of Hope, the theme of this year’s conference, was evident in this workshop about the methods of advancing professional chaplaincy into the work of palliative care. Chaplains have much work to do to continue to develop their skills in providing spiritual care. May these resources assist us in whatever healthcare setting we serve and may each of us continue to grow and develop as we serve as chaplains, taking the lead to work collaboratively with all the team members to relieve spiritual suffering and be a healing presence.

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

## Buryska: How do we balance spiritual values, clinical considerations?

By Marilyn Williams, BCC

As an intensive care chaplain and a member of my hospital's ethics committee, I had looked forward to attending the workshop presented by Rev. James Buryska, STL, BCC, titled "Assessing the Ethical Weight of Spiritual/Religious Beliefs." Not surprisingly when it comes to ethical issues, I quickly discovered that Rev. Buryska would raise more questions than provide answers. The priest, a chaplain with Mayo Clinic for 35 years,

started the session with the following question: "How do we evaluate the weight of the patient's spiritual values and/or religious beliefs against the weight of clinical, legal, or other considerations?"

In addressing this question, Rev. Buryska posed a number of questions that were relevant to ask in weighing the spiritual/religious dimension of the patient/family vs. other considerations. Rev. Buryska did this in context of reviewing an ethical case highlighting a son's religious claims that life support be continued because he expected a miracle. The patient ultimately died in the course of a 90-minute full code after seven weeks in the ICU to the distress of staff.

First, Rev. Buryska noted that many times there are no arguments among the diversity of considerations in determining treatment, but when there is a conflict between the spiritual/religious dimension and other considerations, many clinicians are reluctant to engage in dialogue with the patient or

family. Excuses will include "How can any reasonable person believe that?" Also, some years back the attitude, "it interferes with my authority as a physician," was more prevalent, and more recently, a trend towards doing whatever the patient or family wants, perhaps saying, "I don't have time for this."

Yet as Rev. Buryska noted, as chaplains we should be particularly skilled at representing and facilitating the spiritual dimension in conversations among all involved parties. "The challenge is to discuss and assess the spiritual decisions in a respectful, candid, and informed manner.

"The challenge is to discuss and assess the spiritual decisions in a respectful, candid, and informed manner. This is a matter of clinical competence — how beliefs intersect with clinical facts."

This is a matter of clinical competence — how beliefs intersect with clinical facts." Spiritual values or religious beliefs sometimes have a bearing on clinical decisions and religious claims, and thus should be taken seriously but not necessarily literally.

Rev. Buryska claimed spiritual values/religious beliefs have ethical weight, but such claims do not necessarily "trump other considerations." Is it morally relevant, for example, that medical and nursing staff is placed in the position of "ventilating a dead body" as Rev. Buryska said he hears it put? Or I hear the physicians and nurses I work with say they feel like they are engaged in assault and battery when treatment is no longer beneficial. This is an issue of "competing autonomies," Rev. Buryska noted, when physicians or nurses are asked to violate their

autonomy or conscience in order to honor the wishes (autonomy) of patients/families. Another example would be is it morally relevant that the families' religious beliefs are particular to themselves and not part of the established teachings/dogma of an established religion? Rev. Buryska maintained that all of these types of questions are appropriate and relevant in ethical

discussions and that chaplains have a unique role to ensure they are asked and considered.

Additionally, Rev. Buryska asked the participants to consider the question of how to find the proper balance between allowing the "free exercise" of religious belief vs. the "establishment of religion" in giving individuals warrant to make demands upon society to support their exercise of beliefs. And do the established beliefs/values/teachings of a "community" provide a more ethically robust basis for action than those individually held? In other words, should the experience of the medical community, as a "community of efforts," be an ethical basis for making clinical decisions?

In conclusion, this workshop was valuable in articulating the questions/issues that need to be considered in evaluating the weight to give to spiritual/religious beliefs of patients/families in clinical ethics. As such it provided an excellent outline for chaplains who interact with families and clinicians regarding ethical conflicts arising from religious claims.

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



# Chaplains walk 'the Way of the Cross in modern dress'

By Laurie Hansen Cardona

Vision editor

The evening of March 22, several chaplains gathered in a darkened hotel meeting room during the NACC Conference in St. Paul to participate in Stations of the Cross written especially for chaplains by fellow chaplain Sharon A. Mason.

Seated at tables marked with Roman numerals corresponding to each station, the chaplains prayed, sang and reflected on Jesus' difficult path. A cross was carried from table to table, and at each station a reader read a reflection and a second person said the prayer. Refrains from three pieces of music were used.

Ms. Mason wrote in her introduction to "The Stations of the Cross for Chaplains" that it seems to her that "the day-to-day ministry of chaplaincy is truly the Way of the Cross in modern dress."

"Inasmuch as we walk the Stations with the least of our brothers and sisters in the agonies of their lives, we walk the Stations with Jesus," Ms. Mason wrote.

Following is an excerpt from Ms. Mason's "The Stations of the Cross for Chaplains." The work in its entirety, including Ms. Mason's explanatory introduction, is available on the NACC website, [www.nacc.org/resources/education.asp](http://www.nacc.org/resources/education.asp) under the heading "Spirituality and Prayer Resources."



2010 CONFERENCE  
St. Paul, Minnesota, March 20-23, 2010

## XII. The Twelfth Station: Jesus Dies on the Cross

**Reflection:** The cross is raised up and dropped into the hole prepared for it. Jesus' body strains against the nails and is jarred sharply by the drop. He is mocked by those who pass by; only the apostle John and a small band of women dare to stand close to comfort him. One of the other prisoners speaks from his cross: "Jesus, remember me when you come into your kingdom." In response, Jesus assures him, "This day you will be with me in paradise." Yet Jesus shares the fears and darkness that haunt humanity as he says, "My God, my God, why have you abandoned me?" Then in total surrender to the Father, he says, "Father, into your hands I commend my spirit." Shortly afterwards Jesus speaks his last words, "It is finished," and dies.

**Prayer:** Faith and doubt struggle in me and in those whose journeys I share. Jesus, even as I contemplate your final moments, I am grateful that you know the place of darkness that death represents for all of us. I have seen death many times, in many circumstances. I have spent many hours waiting at bedsides as death came slowly; I have been caught up in the chaos of someone who arrives in the ER at death's door. I have seen grief, and carried my own grief. How much I need to see you there, Lord, to take comfort in your words — "you shall be with me in paradise" — "into your hands I commend my spirit" — "it is finished." Help me, Lord, to hear you.

**Silence**

*Adoramus Te Christe by Marty Haugen*

## XIII. The Thirteenth Station: Jesus Is Taken Down from the Cross

**Reflection:** The lifeless body of Jesus is taken down with care by those who love him. Gently the crown of thorns is removed; it leaves deep wounds that detail every thorn on the flesh of Jesus' head. Weeping, Mary cradles his head in her lap for the last time. The wrappings are laid out and Jesus' body is hurriedly wrapped in the traditional fashion. Jesus' agony seemed as if it would never end; these moments fly by in a blur. His loved ones are stunned, groping to take in the reality that Jesus has died.

**Prayer:** Jesus, I too, have felt the weight of a dead body in my arms. I know the heaviness of the inescapable change that is death. I have journeyed with those in stunned disbelief at the loss of a loved one; and I have walked with those filled with relief and its companion, guilt, when one who has suffered long has finally died. You have called me to a ministry that lives in this place of mystery. Lord, your face and your suffering are ever before me when I stand at the door of death — help me to stand there with your children despite my own fears and doubts.

**Silence**

*Adoramus Te Christe by Marty Haugen*

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## How do I obtain letter of ecclesiastical endorsement?

**Q** How do I obtain my current letter of ecclesiastical endorsement for either initial certification or renewal of certification?

**A** The applicant for certification or renewal of certification does not request or obtain the current letter of ecclesiastical endorsement. The NACC National Office requests the letter for you if you are ordained, religious, or lay. Please do not request this letter yourself. We ask that a copy of the ecclesiastical endorsement be sent to you directly by your endorser. This ecclesiastical endorsement is formal approval for ministry by:



1. The bishop of the diocese of the applicant's ministry or;
2. The major superior if the applicant is a member of a religious order or;
3. The ordinary (understood as the bishop of the diocese where the priest or deacon is incardinated) if the applicant is a diocesan priest or deacon.

For lay applicants, a letter of recommendation from one's pastor or from a priest in active ministry is submitted directly to the NACC National Office. This letter is to be a signed original on letterhead. Please do not ask the priest or pastor to send the letter to you instead.

*Thank you!*

Thank you to all those who volunteered at the 2010 conference! Without each of you and your dedication to the NACC, the conference would not have been such a wonderful experience for all who attended.



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## Families rank end-of-life care higher when spiritual care received

By Timothy Daaleman, DO, MPH

Seriously ill and dying patients and family caregivers express a consistent desire to have their spiritual needs addressed in clinical settings. Despite these findings, end-of-life care is often provided in a technological, spiritually barren landscape. In the United States, for example, 67% of people die in hospitals or long-term care facilities without assured access to spiritual care.

Encouragingly, the Institute of Medicine, the National Hospice and Palliative Care Organization, and the Joint Commission on Accreditation of Healthcare Organizations have advocated for attention to the spiritual needs of patients as a standard of healthcare practice. More recently, consensus practice guidelines for high quality palliative care, endorsed by the National Quality Forum, include a requirement for care to meet spiritual needs.

Implementing these guidelines in clinical practice is challenging, since little is known about how dying patients and family caregivers currently experience spiritual care or about the effectiveness of this care. For example, physicians and nurses are increasingly called upon to assume responsibility for spiritual care tasks that have been traditionally assigned to chaplains and pastoral caregivers. Yet pragmatic and ethical issues arise when healthcare professionals take on such roles. In the development of treatment goals and care plans, for instance, autonomy can be threatened when physician beliefs are dissonant with those of patients, or when patient beliefs are at odds with physician recommendations. In addition, healthcare providers may be committed to meeting patient spiritual needs, but there can be considerable variation in how this care is provided, and in the quality of spiritual care that is delivered.

With funding support from the National Institute on Aging and the Fetzer Institute, our research group at the University of North Carolina at Chapel Hill completed a series of studies to understand how spiritual care at the end of life is delivered and experienced by dying patients and family caregivers. To begin, we conducted cross-sectional interviews with 38 seriously ill patients and 65 family caregivers to describe their experience of spiritual care. This study provided primary empirical data on who provides spiritual care, what is provided, and how well spiritual care satisfies the needs of seriously ill patients and family caregivers. We found that spiritual care providers visited frequently, and 63% shared the faith tradition of the recipient. Of the 237 spiritual care providers identified by recipients, 41% were family or friends, 17% were clergy, and 29% were healthcare providers. Fifteen recipients also named God or a higher power as one of their sources of spiritual care.

Between 66-78% of participants reported various types of spiritual care that helped with their relationships with loved ones or God. Somewhat smaller percentages of participants

(45%-73%) reported types of spiritual care that helped with understanding one's self and the illness experience. In response to the open-ended question about spiritual care activities, participants reported help with insight into dying and comfort. The most frequently reported type of spiritual care was help in coping with illness (87%) and the least common was intercessory prayer (4%).

Just over half (55%) of spiritual care recipients were very satisfied or somewhat satisfied with the care that they received. Most recipients (72%) felt that the spiritual care they had experienced was very valuable to meet their spiritual care needs, but smaller percentages felt it was very valuable as a resource to find inner peace (54%), or to help them make meaning (52%). Most provider characteristics showed no correlation with the recipient's report of satisfaction and their perceived value of spiritual care. Specifically, the perceived value and satisfaction with spiritual care did not differ according to the spiritual care provider's age, race, gender or frequency of visits, and did not differ if the provider was family or friend, clergy, or a healthcare provider. Of interest,

satisfaction tended to be lower if the spiritual care provider shared the recipient's faith tradition. However, the perceived value of care was higher if spiritual care included help with understanding, spiritual care practices, relationships, or with coping with illness.

To gain further insight into the healthcare provider perspective, we conducted a qualitative study to explore the experience of spiritual caregiving. There were several themes identified by 12 providers who were nominated as spiritual care providers by dying patients and their family members. Presence was a predominant theme, marked by physical proximity and intentionality, or the deliberate ideation and purposeful action of providing care that went beyond medical treatment. A second theme was opening eyes or the process by which providers became aware of their patient's storied humanity and the individualized experience of patient's current illness. Participants also described another course of action, one that we termed co-creating, which was a mutual and fluid activity between patients, family members, and care providers that began with an affirmation of the patient's life experience and led to the generation of a holistic care plan that focused on maintaining the patient's humanity and dignity.

A remarkable finding was the marked absence of explicitly religious practices or beliefs in our qualitative data. Although this may be attributable to the relatively non-religious self-characterization of study participants, it has an important



This study provided primary empirical data on who provides spiritual care, what is provided, and how well spiritual care satisfies the needs of seriously ill patients and family caregivers.

See [Research Update](#) on page 24

## Research Update

*Continued from page 23*

implication regarding spiritual care. Our participants reported that spiritual care was provided to individuals who were present to them, in the context of recognized human value, dignity, and shared decision-making, rather than through shared practices (i.e., prayer), or through discussions of religious or theological issues at the bedside.

From the patient and family member perspective, there is considerable heterogeneity in satisfaction with the spiritual care received. To deepen an understanding of how structural and process elements of spiritual care impact the overall quality of care at the end of life, we conducted after-death interviews with family members of 284 residents who died in long-term care facilities across four states. A large majority of decedents (87%) received support with their spiritual needs from multiple sources including clergy (85%), family and friends (62%), facility staff (37%), and others (17%). Clergy were more likely to be identified as a source of spiritual care among female decedents (88% vs. 75% for male decedents) and in facilities with a religious affiliation (96% vs. 82%). Long-term care staff (e.g., nurses) were reported as a source of spiritual support more often among non-white decedents (43% vs. 36%), for those in religiously affiliated facilities (63% vs. 30%), and in nursing homes when compared to new-model assisted living facilities (42% vs. 21%).

Although a small number of long-term care facilities have a hospice unit (7%), most facilities reported 1:1 counseling by clergy (70%), on-site religious services (93%), and hospice services (88%). Religiously affiliated facilities were more likely to provide 1:1 clerical counseling (94% vs. 65%), but were comparable to non-affiliated facilities in providing on-site religious services (100% vs. 91%) and hospice. Hospice services were more prevalent in nursing homes when compared to small assisted living facilities (100% vs. 72%) and to more traditional assisted living

facilities (100% vs. 73%). Family members reported two spiritual care process elements: group service activities (e.g., worship services) were used by 16% of residents and individual devotional activities (e.g., private prayer) by 19%. Religiously-affiliated facilities were more likely to assist in individual activities when compared to non-affiliated sites (37% vs. 14%), as reported by family members

Most noteworthy was the finding that family members of decedents who received spiritual care rated overall care in the last month of life more highly, when compared with those

decedents who did not receive spiritual care. In addition, among those receiving support for their spiritual needs, care was rated more highly among those who received support from facility staff, such as nurses, than those who did not; no differences were observed based on the presence of other sources of support (i.e., clergy). Also, individual devotional activities were associated with higher overall care ratings, but care ratings did not vary substantially based on other structure or process elements.

This study was, to our knowledge, the first to systematically describe the sources of spiritual care, the structure and process of spiritual caregiving for dying long-term care residents, and to examine the association between spiritual care and the ratings of overall end-of-life care. The prevalence of those receiving support for spiritual needs in our study was quite high and clergy remained a major source of spiritual support across all long-term care settings; 85% received support from clergy, especially in those having a religious affiliation. Decedents in our study who received spiritual care were perceived by family members to have overall better care in the last month of life. Yet what constituted spiritual care and what elements of spiritual care were associated with overall care? For long-term care residents, spiritual care that was delivered by facility staff, rather than clergy, appeared to be a key component since decedents who received such care had better perceived care. A second and related component of spiritual care for dying long-term care residents appeared to be the provision or facilitation of individual devotional or spiritual activities.

The importance of spiritual care at the end of life — care that invites meaningful reconciliation and inner peace — is unquestioned by patients and family members, and this care is now advocated by healthcare professional and accrediting organizations. Taken together, our research findings have several implications for policymakers who seek to improve models of end-of-life care; for healthcare providers who deliver spiritual care; and for health professional and pastoral educators who teach future generations of providers. First, role-based models of spiritual care, where an interdisciplinary care team member each attends to a specific care dimension (e.g., physical needs addressed by the physician), should strongly be reconsidered. Our data show that characteristics of spiritual care providers are not clearly linked to better outcomes, but some types of spiritual caregiving are associated with greater satisfaction and perceived value. In consequence, spiritual care by healthcare providers needs to move beyond the simple assessment of a spiritual history and referral to chaplains or clergy. Healthcare providers can learn to perform a spiritual assessment; however, for seriously ill and dying patients this level of engagement may be insufficient.

Second, current approaches to improving end-of-life care often view patient spirituality as a potentially modifiable factor. This is theologically problematic and practically infeasible. However, our research demonstrates that a shift in thinking — from spirituality to spiritual care — provides a

Spiritual care by healthcare providers needs to move beyond the simple assessment of a spiritual history and referral to chaplains or clergy. Healthcare providers can learn to perform a spiritual assessment; however for seriously ill and dying patients this level of engagement may be insufficient.



valid framework to understand and improve care at the end of life. For example, our findings showed that outcomes of spiritual care were modest, with only about half reporting they were very or somewhat satisfied with care. Given that measures of satisfaction with other aspects of healthcare are frequently positively skewed, these data suggest that the quality of spiritual care is quite variable and that there is ample room for improvement.

Finally, interventions to improve spiritual care should target the highly interpersonal interactions between healthcare providers and patients. Additional training in palliative care, which has been found to increase the knowledge base of care providers in communication and relational skills, is an option but may not be feasible for a wide range of providers. Although any proposed intervention, such as innovative forms of therapy, should be sensitive and deferential to the patient's perspective, work in other contexts suggests that it would need to take into account the spiritual and/or religious orientation of the care provider as well. Clinical Pastoral Education, which utilizes experiential, reflective learning, may provide both the conceptual grounding and an educational model for this important undertaking.

*Timothy Daaleman is professor and vice chair of Family Medicine and Research Fellow in the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, NC.*

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## Applying this research to our ministry

No surprises here. The findings and recommendations in this research, the inter-relational and multi-disciplinary approach to holistic healthcare are already in practice where I work. What is valuable in my opinion is that our spiritual care matters especially for those who are struggling with end-of-life care decisions and concerns. The research reaffirmed the value of "caring presence" even though the outcomes of spiritual care are often unknown and scientifically immeasurable. The problem is that the majority of people die in hospital or long-term care without access to spiritual care. As a result, this research pointed out, healthcare professionals (doctors and nurses) and family members are increasingly the ones asked to provide spiritual care, which is often not in the best interests of patients. Potential ethics violations may occur or a patient's autonomy may be jeopardized when doctors and nurses influence care decisions based on their medical opinions rather than by listening to patients' wishes. While we cannot cure illness or prevent death, chaplains can provide a safe space for patients and foster the healing process.

The limitation of this research is that the context of spiritual care is defined in absence of explicit religious practices or beliefs. In real life, the religious rituals, i.e. Communion, last rites, anointing, and blessings, increase the healing and wholeness of end-of-life care. However, I agree with the author that the ultimate meaning of spiritual care is in the context of recognized human value, dignity, and a shared decision-making process, not religiosity or theological issues.

*Hyun Underwood, MA, MEd, is a chaplain resident at Queen's Medical Center in Honolulu and Good Samaritan Society at Pohai Nani in Hawaii. Currently he is in a two-year CPE residency with Pacific Health Ministry, ACPE Center, in Hawaii.*

Gloria Troxler Preventive chemotherapy after ovarian surgery Baton Rouge, LA	Mike J. Murphy Cancer treatment Green Bay, WI	Fr. Bill Spacek Detached retina and other eye issues Baltimore, MD
Fr. James Radde, S.J. Radiation therapy St. Paul, MN	Dennis Eldridge (Kathy's husband) Cancer treatment Milwaukee, WI	Sr. Nancy Crane, OP Cancer treatment Akron, OH
Sr. Marian I. Louwagie, CSJ Cancer treatment Woodbury, MN	Joyce Fink Heart attack, recovery from open heart surgery Bethlehem, PA	Sr. Hilda Mallet, MHS Cancer treatment Lafayette, LA
Fr. Bob Nee Intractable epilepsy Cambridge, MA	Lourdes B. Ruta (wife of Peter Ruta) In recovery Milwaukee, WI	Sr. Rita Rzeppa, IBVM recovering/rehab from knee surgery Chicago, IL
Fr. Kevin Ikpah Eye troubles Blue Springs, MO		Sr. Micheletta McGee, RSM Pancreatic cancer Drexel Hill, PA

## 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.

## God called her to ministry of personal conversations



**Name:** Judy Donohue

**Work:** Staff chaplain at St. Joseph East Hospital in Lexington, KY

**NACC member since:** 2002

**Volunteer service:** Coordinate the Kentucky NACC regional gatherings once a year since 2008.

**Book on nightstand:**

“Hope for Today: Hope for family and friends of alcoholics” and “The Love Revolution,” by Joyce Meyer.

**Book you recommend most often:** “Beauty for Ashes,” by Joyce Meyer

**Favorite spiritual resource:** In addition to the Bible, I enjoy “Alcoholics Anonymous (The Big Book)” or anything involving 12-step recovery.

**Favorite fun self-care activity:** Comedy movies, walking the trails around the neighborhood and at the Abbey of Gethsemani

**Favorite movie:** “Brother Sun, Sister Moon” or the “The Blind Side”

**Retreat retreat spot:** The Abbey of Gethsemani in Trappist, KY

**Mentors:** Fr. Dennis Knight, Sr. Ellen Kehoe



**Historic role model:** Mother Catherine Spalding

**Why did you become a chaplain?** I became a chaplain after a career change and much prayer and discernment. I felt that the intimacy of personal conversations with others was what God was calling me to do in my ministry.

**What do you get from NACC?** Continuing education from the *Vision* as well as support from the regional gatherings of Kentucky NACC.

**Why do you stay in the NACC?** Because of the emotional and spiritual support. The conferences are exciting and challenging, and it’s helpful to see what other people are doing.

**Why do you volunteer?** To give back because of what God and others have given to me and in thanks for the many blessings I have received.

**What volunteer activity has been the most rewarding?** I enjoy coordinating the Kentucky NACC Yearly Day of Spiritual Enrichment. I love to see the interaction between members and the satisfaction of growing spiritually and in relation with each other.

**What have you learned from volunteering?** I have learned to lean on others to provide what I am not able to. Someone will help and pitch in when I cannot do something or don’t have the time and this is comforting.

## Service is the rent we pay for living, she believes



**Name:** Mary Patricia Conlan, RSM, DMin

**Work:** Certified trainer for Bridges Out of Poverty, The Community Foundation, City of Dubuque, Dubuque, Iowa

**NACC member since:** 1986

**Volunteer service:** Lifelong commitment inherited from my

parents. At present, I am co-facilitating “Getting Ahead in a Just Getting By World” classes for the homeless and low-income individuals and their families by helping them enhance their dignity as children of God and assisting them in co-investigating and learning skills and resources to envision a future story for themselves and their children. I serve on the Operation Empower Board, supporting, educating and advocating for a sustainable community and employment for low-income men and women. We are developing, in collaboration with local businesses, resources for the rehabilitation, education, formation and recreation of our youth.

**Book on your nightstand:** “Gracism,” by David A.

Anderson, a book inviting us “to lift up, to cover, to share with, to honor, to stand with, to consider and to celebrate” each person.

**Books you recommend most often:** The Bible, because it invites, challenges and enlightens me where I am each moment of every day. “This Flowing Toward Me,” by Marilyn Lacey, RSM, that helps me to meet God arriving in strangers. I believe that we must stand in the margins and honor one another with Amish grace. “How could encountering God face-to-face be disheartening? Where else could I hope to find such a blessing?”

**Favorite spiritual resources:** Sacred Scripture, the Eucharist, Adoration of the Blessed Sacrament, faith sharing and the local faith community.

**Favorite fun activity:** Walking, listening to nature or classical music and sharing stories of ministry.

**Favorite movies:** “The Blind Side” and “Invictus” — building bridges and relationships between economic classes.

**Favorite retreat spot:** Near the water.

**Personal mentor or role model:** My youngest and deceased sister, Grace Ann (Conlan) Gassman, who was a model of hospitality and inclusivity.

**Famous historic mentor or role model:** Thomas



# New documents published that further chaplaincy profession

By David Lichter, DMin  
Executive Director

In the past two years, several new documents on our profession have been published that relate to and build on our NACC Standards for Certification as well as advance the chaplaincy profession. As you know, the NACC Standards for Ethics, Certification, and Renewal of Certification were approved in November 2007 by the USCCB/CCA. They included all the foundational documents of Spiritual Care Collaborative approved in November 2004, plus the specific Catholic standards developed by our NACC Standards and Certification Commissions and approved by our NACC Board in July 2007. We have been implementing these NACC Standards now for two years. These are the standards one needs to meet to become certified and to renew one's certification.

Since then the following documents have been published and are available for you:

In fall 2008, the "Essential Functions of a Board Certified Chaplain" was developed by the Care Services Task Force of the NACC/CHA Pastoral Care Summit to provide pastoral care leaders a precise list of nine functions they can expect a board certified chaplain to provide. These were published and explained in the May-June 2009 issue of *Health Progress*.

In fall 2009, the "Standards of Practice for Professional Chaplains in Acute Care Settings" (SOP's) were published out of the Association of Professional Chaplains' Commission on Quality in Pastoral Services by a subgroup comprised of participants from APC, ACPE and NACC and affirmed by all participants (including the NACC) of the SCC. The chaplaincy profession lacked SOP's that are common among

other disciplines within health care (physicians, nurses, etc.). These articulate the minimal but essential standards so that chaplains can better communicate with their colleagues of other professions and among themselves about chaplaincy. SOP's for long term care are now being developed by a similar subgroup.

In fall 2009, the "Spiritual Leadership Competencies" were developed by the Care Services Task Force of the NACC/CHA Pastoral Care Summit so that pastoral care leaders and those aspiring to pastoral care leadership roles will have a clear and concise list of the skills and training required for a spiritual leader in pastoral care. These were published and explained in the November-December 2009 issue of *Vision*.

In fall 2009, the *Journal of Palliative Medicine* (Vol. 12 Issue 10: Oct. 6, 2009) published the document, "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference," that states that spiritual care is a fundamental component of palliative care, provides recommendations and guidelines of spiritual care, and notes the specific clinical roles of a board certified chaplain. [http://healthcarechaplaincy.org/userimages/doc/Palliative\\_Care/Archstone\\_report\\_in\\_JPM\\_Oct%2009.pdf](http://healthcarechaplaincy.org/userimages/doc/Palliative_Care/Archstone_report_in_JPM_Oct%2009.pdf)

Each of these documents is a significant development in advancing the profession of chaplaincy. They can be accessed on our NACC website under resources and documents (<http://www.nacc.org/resources/documents.asp>). The SCC will soon be creating a task force to review the 2004 Common Standards. These documents, along with others, provide comparative resources to aid in the review and revision of those Common Standards.



Merton, OCSO, who taught me reflection and contemplation as a stance from which to act.

**Why did you become a chaplain?** To discover Christ in others by bearing witness to the compassion and love of God for each person through total inclusivity and boundless forgiveness. To live in total surrender according to God's will and the breath of the Holy Spirit through prayer and contemplation. To share my baptismal commitment of daily dying and rising in my transformation process so that we might reflect the Light within us into our scars, our wounds, and our darkness as we become beacons of hope for one another. To focus on the Word of God in the present moment so that we might deepen our relationships with God and one another. To be compassion in action with a passion for justice. To bring truth-telling to the status quo.

**What do you get from NACC?** Support, connections and an organization with a Code of Ethics, current Standards of Practice, and board certification as we become increasingly more credible, experienced, academic professionals who do research and publish in our fields of expertise and who

collaborate, network, and advocate with other disciplines. I am encouraged to serve our organization and society where I can make a difference with others and actively envision our future as the people of God.

**Why do you stay in the NACC?** NACC motivates and invites me to use my gifts "outside the box" by being a chaplain with the homeless and low-income persons, by ministering on the fringes of society, by empowering "the poverty of our society" to ethical and moral behavior befitting children of God, by challenging unjust practices in corporations and by assisting the local community envision sustainability that enhances the dignity of each person.

**What volunteer activity has been most rewarding?** Ministering with the homeless and/or low-income persons. When we minister "eyeball to eyeball," everyone can own a vision of the future together. One of my greatest joys in life is to celebrate the success of others.

**What have you learned from volunteering?** We need each other. We receive more than we give. Service is the rent we pay for living! Celebrate each other!

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## Calendar

### May

- 1-2 Chaplain certification interviews
- 11 Local gathering, A Day for Professional and Ministerial Enrichment, St. Joseph Medical Center, Kansas City, MO.
- 13 Feast of the Ascension
- 14 APC / NACC / NAJC continuing education event, St. Francis Medical Center, Colorado Springs, CO.
- 17 Local gathering, Worcester, MA.

### June

- 1 Articles due for July-August *Vision*
- 4 Local gathering, Camp Hill, PA.
- 13-15 CHA-USA Assembly, Denver, CO.