Driving the winding back roads of this small New England town, my mind is still back in the hospital room from which I came and where my friend Stephen lay. Nearly two years have passed since he was diagnosed with an inoperable, malignant brain tumor. Not yet 37, a husband and father of three little children, he has manifest remarkable courage in the face of seemingly innumerable physical challenges resultant from the tumor. Partial paralysis, regular seizure activity, blood clots, a medication-induced psychosis, not to mention the radiation and chemotherapy, as well as the onslaught of medicines for this and that side effect. The latest episode of diabetes is related to the effect of the high dose of steroids that he is taking.

The wear and tear of these two years is evident when I walked into his hospital room a few hours ago. He lay on the bed, stomach distended, face all bloated, left hand curled in its atrophied state. Two autumns ago, strong and trim, Stephen jogged 4 miles several days a week, played hockey, managed a successful sales position in a major high-tech company. All that slipped out of his hand with the glass that fell on the floor in his parents’ home signaling that something was wrong here.

Within days, he is examined, scanned, biopsied, and diagnosed.

And paralyzed on his left side.

His care has been excellent since he became the patient of the world’s expert in this particular kind of brain tumor. He has tremendous family support: a wife that gets up each morning to the hard love of “sickness and in health,” two parents in the medical field who care as parents and advocate as professionals working a most complex system, and a network of siblings and friends who are present to help this family in all the practical details of the reality that life continues on.

And there’s the Church.

Or should we ask, where’s the Church?

Initially, in the shock of the news of this young man’s illness, the pastor prayed for Stephen, and I believe, may have had a special liturgy for him. To my knowledge, I don’t think he has ever visited Stephen in his home. My understanding is that he himself is old and frail. But no one else had visited this man, or his family either. I know
firsthand the spiritual care that Stephen has or has not received these
two years. I know because I am the provider, 1,100 miles away, and
then, only through an occasional phone call, and a visit when I come
back to Boston. I know because I am the one who will celebrate the
Eucharist with him and his family, anoint him, pray with him, talk to
him.

I know because prior to this visit I heard from his sister and his
parents. They are concerned about him, about his emotional and
spiritual suffering, about how he and his wife are coping in their
relationship, about how the children are relating or not relating to their
Dad.

I know of no chaplain visits in the multiplication of hospital stays in
four or five different institutions. Perhaps a Eucharistic minister, one
or two of those times. Recently, his mother took him out for a ride
and he went to his college campus and he sought out a priest for
confession.

And so, where’s his Church? Where are we, pastors of the sick, to
this young man, to the dozens and dozens of women and men who
are receiving medical care for their bodies, but no spiritual care for
their hearts and souls? Dozens and dozens? I suspect it is more like
thousands and thousands. My two-year frustration in caring long
distance for my friend is that I know of no place and no one that I
can refer him to for spiritual support and guidance.

So winding through the autumnal colorfest of this country road, I am
reflecting that we need to look at a spiritual health care system that
has faded in its effectiveness, is in fact not working, at least in many
sectors of our Church and society. And I would like to propose that
there are three things that we need to focus on as spiritual care
providers, individually, and collectively, too, as an association.

First, it seems to me, we really need to look at a re-definition of
spiritual health care. Is visiting the sick from a protocol of lists, saying
devotional prayers, checking sacrament lists— is this professional
spiritual health care? Or like the other disciplines, do we need to
tighten the role description of our tasks to a more closely focused
outcome-based criteria for spiritual care? Is it time that spiritual health
care be defined not so much as individually listening on the part of the
chaplain, but rather defined more as individual and group facilitation
of care, be that family, community, church?

We will always need acute care chaplains for crisis intervention, but
should that be the place where most of our chaplains are exercising
their ministry?
A re-definition of spiritual health care might be characterized by individuals and their coping with illness/ dis-ease in the context of where they live, not where they go for a drive-by medical intervention. An older definition of spiritual health care would locate the provider in the hospital for that is the place where people went when they were sick and were discharged when they were better. Spiritual care could be provided over a period of days; now we have minutes, if any time at all. Persons receive their medical procedures, and then go home.

That brings me to the second need for us as professionals—it is time for re-location for spiritual health care. We talk about the ministry following medicine out into the community, but in fact, have we done that? Are we convinced of that direction ourselves?

Re-location to where? The parish. As I have often quoted Father Bryan Hehir, theologian and ethicist, “There are more Catholic churches in this country than there are post offices.” With that infrastructure, can we not go about a spiritual health care that is comprehensive, that is, from pastoral visitor to sacramental minister to professional chaplain to clinical pastoral educator? Similarly, with that infrastructure, can we not go about a spiritual health care that is ecclesially and geographically based—from the parish to the cluster to the vicariate/deanery to the diocese?

Re-location means beginning with those professionals among us already identified as having the parish as the primary location of their ministry (from our statistics, 300 members). What are these chaplains doing that is a proven success? How are they organized? Where do they fit in the ecclesial structure? What are their job descriptions/responsibilities? How are they paid? And how much?

Re-location means creative design. Like building a new home, it takes architects and blueprints; it takes cost analysis and finances; it takes building with good materials; and from the foundation upward, it takes adjustments and alterations; it takes models that inspire others.

Thirdly, and finally, we need a re-allocation of our resources. It seems to me that this is where the Association can and should be a catalyst for change. If we are convinced that this is the right direction to go, then we need to revisit our mission, vision, values—in fact all our documents and structures—and see if in fact we are faithful to our foundation, to our ministry, to the Church’s ministry, which is of course, Jesus’ ministry, as professional spiritual care providers.

Should we not, in fact, be working with the ecclesial structures to
educate them to the resource that is theirs in the professionally
certified chaplain who can facilitate (not simply individually minister
to) the spiritual health care for the sick and suffering in their parishes?
Should we not, in fact, be designing models for partnership between
the health care institutions and the parish communities? Should we
not, in fact, be funding pilot programs that utilize the professional
chaplain in a cluster, vicariate/deanery, or diocesan level?

Perhaps, too, this is the key to the revitalization of a new CPE model
for the future? Many dioceses are now seeking to create education
programs for ministry to the sick. Would it not make sense to have a
parish-based (cluster/vicariate) program that trains ministers to the
sick through the CPE model? One or two units for the volunteer, and
then for those interested and qualified, the program could serve as a
feeder for the future professional chaplains.

The above proposals to look at re-definition, re-location, and re-
allocation are not meant to eliminate the presence of chaplains in the
health care settings. But, it seems to me, that we need to take
seriously the shift from institutionally based health care to home health
care.

Stephen’s is not an isolated situation. Persons like him, and families
like his, are grappling with serious emotional and spiritual issues. He
has the medical resources out in his community and in his home—
physical and occupational therapy, home health aids, medical supplies
—but unfortunately not the spiritual resources.

As one of our colleagues, Father John Grimes, said in an assessment
report for his diocese in the mid-1980’s, “It is time for the diocese to
do for pastoral care ministry in the 80’s what we did for religious
education in the 60’s and 70’s, i.e., train, hire and implement
professional laypersons to exercise their baptismal ministry.”

If this happens, we will no longer hear the question, where is his
Church? We will know clearly that here is his Church.