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NACC values the efforts of partners working for advances in field of palliative care

This *Vision* issue is dedicated to the palliative care ministry. We are using this issue also to more formally announce and introduce the NACC Palliative Care and Hospice Specialty Certification. Other articles in this issue offer details about this specialty certification. (www.nacc.org/vision/2014-Jan-Feb/Palliative-care-and-hospice-a-new-NACC-specialty-certification-by-David-Lichter-DMin.aspx, www.nacc.org/vision/2014-Jan-Feb/NACC-Standards-for-Specialty-Certification-in-Palliative-Care-and-Hospice.aspx, www.nacc.org/vision/2014-Jan-Feb/Palliative-Care-and-Hospice-Specialty-Certification-Process.aspx) In this column, I would like to set a context for the NACC's new specialty certification and acknowledge the work being done by so many in this field.

First of all, we recognize the very important work done by other professional chaplaincy organizations, particularly HealthCare Chaplaincy (HCC) (www.healthcarechaplaincy.org) and the Association of Professional Chaplains (APC) (www.professionalchaplains.org). HCC has re-envisioned its mission to reflect its focused dedication to the field of palliative care. While continuing to provide high quality chaplaincy service, HCC mission is now: *To improve the effectiveness and efficiency of healthcare through the innovative ways chaplains promote and advance palliative care research, education and practice* (www.healthcarechaplaincy.org/about-us/mission-summary-description.html). It took the initiative to seek a major grant from the Templeton Foundation to create and support a "community of researchers, including professional chaplains, to grow the field of research on spiritual care in palliative care" (www.healthcarechaplaincy.org/templeton-research-project.html). Through the Templeton Foundation funding the HCC was able to award \$1.5 million funding grants to six research projects to advance the research of chaplaincy services in palliative care. Each research project includes a board certified chaplain as part of the research team. We look forward to learn of the preliminary findings of the research when HCC offers in March 2014 its first annual conference on *Caring for The Human Spirit: Driving the Research Agenda for Spiritual Care in Health Care*. Finally, it is also collaborating with the California State University Institute for Palliative Care to provide "the first online professional certificate course in palliative care for chaplains and other spiritual care providers" (www.healthcarechaplaincy.org/about-us.html). We appreciate the pioneering and important work of HCC in the field of palliative care.

We also recognize and appreciate the work of the APC in palliative care. The APC partnered early with HCC in developing and vetting standards of certification for a specialty in palliative care. In spring 2012, George Handzo (www.handzoconsulting.com), HCC director of health services, research and quality, partnered with APC in vetting these standards/competencies with members of the other chaplaincy cognate groups and refining those standards for certification. In spring 2013, the APC announced and launched its specialty certification in palliative care (bcciprofessionalchaplains.org/content.asp?admin=Y&pl=45&sl=42&contentid=49). In fall 2013, this was changed to Hospice and Palliative Care Certification. This specialty certification is offer to board certified members of the APC. If an NACC member wanted to pursue this certification he or she would need to become certified with APC. APC's Quality in Chaplaincy Care Committee has assembled a task force of chaplains with experience and expertise in hospice/palliative care to work on Standards of Practice for Professional Chaplains in Hospice/Palliative Care. This task force invited all of us to review these Standards of Practice for Professional Chaplains in Hospice and Palliative Care (www.professionalchaplains.org/files/professional_standards/standards_of_practice/SOPs_Hospice_Palliative_Care_for_comment.pdf) and to send suggestions and comments to the task force via sop@professionalchaplains.org to be used to refine a second draft to be presented to the APC board for affirmation in June 2014. We appreciate the seminal and high quality work of APC to advance the chaplaincy profession in this field of palliative care.

Finally, I want to emphasize and express deep appreciation for NACC's partnership with the Supportive Care Coalition (SCC) (www.supportivecarecoalition.org). The SCC was founded 20 years ago (1994) by Catholic health systems, and currently is composed of 22 Catholic healthcare organizations (www.supportivecarecoalition.org/index.php/about-the-coalition/member-organizations) to advance "excellence in palliative care." (www.supportivecarecoalition.org/index.php/about-the-coalition/mission-vision-a-guiding-principles) Its goal is "to ensure that every Catholic health ministry has palliative care as a part of its core services – (www.supportivecarecoalition.org/index.php/about-the-coalition) so that we are known as much for palliative care as for our concern for the poor and vulnerable." Since early spring 2012, Tina Picchi, MA, BCC, SCC executive director and an NACC member, has been in dialogue with the NACC about how to foster and support the needed competency and credentialing of chaplains in palliative care. One of the objectives of the SCC Strategic Initiatives 2012-15 (www.supportivecarecoalition.org/images/reports/sp.pdf) is to "support competencies for palliative care chaplains." Tina has taken a very active role in the development of the NACC Certification Specialty in Palliative Care and Hospice. Also, several of our NACC members serve on SCC committees and work groups, particularly its Education Committee and Spirituality Steering Committee (www.supportivecarecoalition.org/index.php/our-work/coalition-committees). We are deeply appreciative of the invaluable partnership and collaboration with Tina and the SCC to providing direction and professional supports for our members working in palliative care and hospice. While I highlighted these three organizations, I need to also acknowledge the critical role of the work of the National Consensus Project (www.nationalconsensusproject.org) with its purpose "to promote the implementation of Clinical Practice Guidelines that ensure care of consistent and high quality, and that guide the development and structure of new and existing palliative care services." Its *Clinical Practice Guidelines for Quality Palliative Care 3rd edition 2013* were released in early spring 2013, and its Domain Five on Spiritual Care was vastly expanded and improved from its earlier editions. On the invitation of the task force working on this third edition, George Handzo and Sue Wintz, both of HCC, gave significant input to this revision, virtually all of which was accepted. BCC chaplains are included as stated below, as well as in Domain One: The interdisciplinary palliative care team, in all settings, includes spiritual care professionals; ideally a board certified professional chaplain, with skill and expertise to assess and address spiritual and existential issues frequently confronted by pediatric and adult patients with life-threatening or serious illnesses and their families (www.nationalconsensusproject.org/Guidelines_Download2.aspx).

The NACC was one of the endorsing bodies to the National Consensus Project's work (www.nationalconsensusproject.org/DisplayPage.aspx?Title=Endorsing%20Organizations).

We are deeply appreciative and indebted to these organizations, and look forward to continued partnership with them to advance the chaplaincy profession's work in palliative care and hospice.

David A. Lichter, DMin
Executive Director

Opportunities, challenges abound on interdisciplinary palliative care team

By Linda F. Piotrowski, MTS, BCC

It is Tuesday noon, time for the weekly palliative care interdisciplinary team educational conference. After a brief service honoring those who died under our care the case presentation begins. The palliative care fellow (this year it is a female physician) shares her PowerPoint slide describing a recent patient. The patient, a 72-year-old male, had multiple co-morbidities. Among them were pulmonary hypertension, history of a leg amputation due to complication of diabetes, chronic obstructive pulmonary disease, and worsening kidney function. The fellow directs us to write down questions we would want answered before we decided to go down the road of offering the patient the choice of kidney dialysis.

Knowing that each of the patient's symptoms was life-threatening, I did not have a deep enough medical knowledge to know what questions to ask related to the details of the medical conditions limiting his life. I did not know the statistics predicting the outcomes for a 70-year-old man undergoing dialysis. I did, however, know what to ask to ascertain what might motivate him to pursue treatment.

My initial observation was: "This is bad, bad, bad!" Everyone laughed. Then I asked my questions: "What gives meaning to his life. Does he have relationships that enable him to face grueling ongoing treatments? Does he have a relationship with a Higher Power or the Sacred? Is he part of a faith community? Does he have relationships to repair or tasks to complete that would make him feel his life had been well lived? What would his quality of life be if he chose treatment? Does he have supports at home to help him during dialysis? Does he have rides back and forth for treatment? Was someone at home to help when the fatigue that dialysis causes sets in? What about payment for the treatments? How will all of this factor into decision-making when the doctors speak to him about treatment choices?"

A visiting nephrologist from the VA (Veterans' Administration) Hospital across the river from us commented, "This is why I wanted to visit your team. You have members who ask questions that I would never think about asking. I am so focused on the patient's renal needs and physical conditions."

The above is an example of a benefit of being a chaplain embedded with a palliative care team. I am able to raise issues that my medically focused colleagues may not ask. Other benefits include being present and participating in daily one-hour interdisciplinary team rounds where the team discusses and develops the plan of care for hospital in-patients as well as for the patients who come to the out-patient palliative care clinic. I have the opportunity to interact with and teach fellows, residents, and interns from specializations, including oncology, anesthesiology, pain clinics, psychiatry, intensivists, clinical pastoral education, social work and nurse practitioner students as well as visitors from numerous medical institutions. Chaplaincy is present at the table and has a voice setting an example and expectation for all of these participants.

It means teaching palliative care fellows for two weeks during the fellowships. Helping them to experience the various skills, techniques, and personalities of not only the palliative care chaplain but also the other chaplains in our institution. It means involving the fellows in planning and participating in our quarterly services of remembrance where the families of patients who died having had a palliative care consult are invited and many attend.

Being embedded with the palliative care team is not without its challenges. An ongoing challenge is attempting to remain an active fully functioning member of two teams: chaplaincy and palliative care. This means multiple meetings and varied assignments. As a member of the chaplaincy staff it means being committed to providing services to one in-patient unit as well as the out-patient oncology services, sharing in on-call, attending chaplaincy department meetings as well as helping to plan and participate in various chaplaincy sponsored events. As a consult service, palliative care in our setting is not confined to a particular nursing unit. Patients are scattered throughout the hospital. With patient-centered care as our focus, we need to constantly communicate about which chaplain will best serve the patients.

Because ours is a teaching institution the make-up of the interdisciplinary team is constantly changing. Core staff remains the same but each week brings an influx of learners and visitors. Physician members of the team cycle in and out due to days off and other assignments. We constantly form and re-form as a team. This stretches us in terms of hospitality and accommodating different personalities and ways of functioning.

A chaplain member on the palliative care interdisciplinary team must have a strong sense of self and call as well as a commitment to the necessity of spirituality as integral to care planning. Along with my social work, healing arts, and artist and writer members of the team, I at times struggle to have my voice heard in the face of necessary medical clinical discussions seeking to alleviate pain, and assist patients and families in making decisions about goals of care, and other life and death decisions.

These challenges of being a member of the interdisciplinary palliative care team are minor when compared with the opportunities afforded to fill the chaplain's many roles. Primary to these roles is assessment of the patient's spiritual needs and resources. This is essential to the chaplain's ability to fulfill his or her other duties to advocate, educate and coordinate.

(This article is not a comprehensive examination of the benefits and opportunities afforded to a chaplain member of an interdisciplinary palliative care team. Rather, it is a glimpse into some of the ways one board certified chaplain attempts to live out her role on an interdisciplinary palliative care team.)

Linda F. Piotrowski, MTS, BCC, holds a master's of theology from Saint Francis Seminary in Milwaukee, WI. In addition, she was educated in the Center to Advance Palliative Care programs and completed the Metta Institute's Compassionate Care for the Dying Training. A chaplain for 24 years, Ms. Piotrowski has ministered in acute and long-term care, home hospice, and parish and congregational settings. A member of the Dartmouth-Hitchcock Medical Center's chaplaincy department, she currently ministers as the pastoral care coordinator and chaplain for palliative care and oncology services at Dartmouth Hitchcock Medical Center and the Norris Cotton Cancer Center in Lebanon, NH.

Palliative care and hospice –a new NACC specialty certification

The NACC is now offering a new certification specialty in palliative care and hospice. This article will provide a background and rationale on its development, an overview of the process of certification, and a commentary on the standards.

Background and rationale

The NACC Board of Directors, at its October 2012 Board meeting, devoted time to prioritize under each goal of the NACC Strategic Plan 2012-17 a primary objective for 2012-2013. Under Goal Three, To Enhance Advocacy Efforts with Strategic Partners, it identified the objective: *Continue dialogue with other key professional organizations integral to advancing the profession of chaplaincy*. The Board charged a Strategic Goal Three work team with coming to the April 2013 NACC Board meeting with a recommendation regarding a palliative care certification specialty. Either the NACC should or should not offer one. The key strategic partner in this study was the Supportive Care Coalition. Mary Lou O’Gorman, NACC Board chair-elect was the Board liaison, and Gary Weisbrich chaired the Goal Three work team. They explored the rationale and feasibility for a palliative care specialty certification.

As the work team explored this issue, the rationale for offering this specialty became clearer. This rationale was based on three realities. First of all, within Catholic healthcare (70% of our members identify themselves with Catholic healthcare organizations), palliative care is viewed as a hallmark of Catholic healthcare, intrinsic to its healing mission. Palliative care in Catholic healthcare is grounded and guided by the *Ethical and Religious Directives for Catholic Health Care Services*. Developing a certification specialty in palliative care that is rooted in our Catholic mission and in partnership with the Supportive Care Coalition that represents many Catholic healthcare systems was a logical step. Secondly, as this question was being explored, the National Consensus Project (NCP) (www.nationalconsensusproject.org) published in early spring 2013 its *Clinical Practice Guidelines for Quality Palliative Care 3rd edition 2013*. Its Domain Five on Spiritual Care was vastly expanded and improved from its earlier editions. While considering the Association of Professional Chaplains (APC) Hospice and Palliative Care competencies (bcciprofessionalchaplains.org/content.asp?admin=Y&pl=45&sl=42&contentid=49) as a basis for developing its own, the NACC deemed it valuable to use these NCP revised clinical guidelines as the framework for developing standards for the NACC palliative care and hospice specialty certification. Thirdly, many of our board certified members work in palliative and hospice care, and certification and credentialing in this special ministry is called for more and more. With APC requiring board certification with APC in order to apply for its hospice and palliative care specialty, it was important that our NACC members also have this specialty certification for their ministry.

At its April 2013 meeting, the NACC Board of Directors approved the recommendation of the Goal Three work team to proceed with developing and offering a certification specialty in palliative care. In early May 2013, a task force composed of members of the NACC Certification and Standards Commissions, as well as other select NACC members, began working on both the process and standards for this specialty.

As the process and standards were developed, the members viewed palliative and end-of-life care to be overarching care service under which hospice care is viewed as a specialized palliative care for terminally ill patients who may have only months to live. Thus the process and standards use Palliative Care and Hospice as the title of specialty certification, palliative care/hospice when referring to the chaplain or the care team, and palliative and end-of-life care when referring to the services provided.

An overview of the process

As the Work Team identified the prerequisites for an applicant, the applicant needed to be board certified with the NACC, this person’s prior experience in palliative or hospice care would be required in clinical hours, as is done in nursing, and not by a number of years. This allows for someone to have worked more intensely over a briefer period to qualify for applying for the certification. As an applicant needs to show “extensive education in the field,” what type of education is not specified. Thus, someone might have a more formal training, such as the certificate program of HealthCare Chaplaincy, or can evidence a variety of education, such as workshops, reading, and other training methods. It is also important that the applicant evidence some form of supervision of consultation as way of growing personally and professionally in the field.

The Work Team spent significant time discussing/developing the applicant process. Highlights of the process include letters of recommendation, as they give people with whom one worked in palliative care or hospice an opportunity to affirm and endorse one’s work in the field. Also, the applicant will find the expectation of a written narrative that includes how one entered into this ministry, one’s spirituality and theological underpinnings for the ministry, examples of one’s educational role, and a description on how one meets the competencies for palliative care or hospice. One will also need to prepare a case study that includes at least five (5) successive palliative and end-of-life care interventions/consultations with accompanying reflection and medical record charting notes.

The Work Team decided early in their deliberations that an in-person interview, rather than a phone interview, was important, albeit a significant investment for both the applicant and the NACC. As in the case of one’s initial certification process, the interview team would be comprised of three individuals: a minimum of two (2) board certified chaplains with palliative care or hospice experience and/or palliative care and hospice certification, and one palliative care/hospice interdisciplinary team member. The other elements of the process follow closely NACC’s certification interview process. The interview team will make a recommendation to the NACC Certification Commission. The interviews will normally take place during the regular NACC scheduled certification interviews, first weekends of October and May.

It was also decided that the renewal process of one’s specialty certification will coincide with one’s normal five-year renewal of certification, with the requirement that fifteen (15) of one’s fifty (50) continuing education hours (CEH’s) must relate to palliative and end-of- life care, beginning in the year that specialty certification was received. The peer reviewer must be an active or retired certified chaplain or CPE supervisor (as applicable) with palliative care and hospice specialty certification or experience with whom one does not share a reporting relationship.

Commentary on the Standards NACC Standards for Specialty Certification in Palliative Care and Hospice

As noted above the NACC Standards for Specialty Certification in Palliative Care and Hospice (SCPCH) are presented in the context of the National Consensus Project *Clinical Practice Guidelines for Quality Palliative Care (3rd Edition)*, which includes a definition that characterizes palliative care in the United States, also used by the U.S. Department of Health and Human Services (HHS) Centers for Medicare/Medicaid Services (CMS) and the National Quality Forum (NQF). It was important that the NACC SCPCH reflect the content of these clinical practice guidelines with their distinguishing features of interdisciplinary team coordination, collaboration and communication among patients, families, and care providers, services available either concurrently with or independent

of curative or life-prolonging care, and respecting and supporting the patient and family hopes for peace and dignity throughout the course of illness, during the dying process, and after death.

As APC's competencies for hospice and palliative care, the NACC's SCPCH structure follows the fourfold division of the NACC (and Common Standards) certification standards: theory of pastoral care, identity and conduct, pastoral, and professional. However, one will see emphasized in diverse ways the interdisciplinary team, proficiency in communication and facilitation, application of the Ethical and Religious Directives for Catholic Healthcare (ERD's), and learning, articulating, honoring the patient's and family's dignity and desires. So, for instance, among the theoretical competencies one finds an emphasis on the chaplain's ability to articulate and/or facilitate discussions with the interdisciplinary care team on a theology of suffering, loss, and pain, as well as to understand and integrate the consensus definition of spirituality into palliative and end-of-life care. The chaplain also needs to demonstrate the knowledge and skills in addressing ethical issues that arise in palliative and end-of-life care, especially in applying the Ethical and Religious Directives for Catholic Healthcare Services (ERD's).

Among identity and conduct competencies, the chaplain is expected to function within the interdisciplinary team in a way that models and facilitates communication that honors human dignity and highlights the relevance of the spiritual, religious, and existential dimensions of care. "Model" is frequently used in this section as it emphasizes that the chaplain not only does his or her own self-awareness, self-care, and self-reflection, but can confidently help provide education for and facilitate this reflective process among the palliative and end-of-life interdisciplinary team members.

Also among the pastoral competencies, one will see again the verbs "lead," "teach," "assist," "mentor," and "model," in referring to the chaplain's roles with the interdisciplinary care team, in patient/family conferences, support groups, and bereavement support. The pastoral competencies also include promoting the inclusion of spiritual/religious symbols sensitive to patient/family beliefs, leading and facilitating rituals, and ensuring access to religious leaders as needed.

Finally, the professional competencies emphasize the chaplain's working knowledge of key principles and research-based best practices in chaplaincy palliative and end-of-life care, and of community resources for palliative and end-of-life care. They also include the chaplain's ability to integrate chaplaincy care into the organization through diverse and appropriate means and measures.

How are we implementing this certification specialty?

The Palliative Care and Hospice Implementation Team will initially select six NACC members who have the prerequisite experience in either palliative care or hospice to participate in the initial certification process. These six members with select interviewers meet in Milwaukee to go through the initial round of interviews, in order to help us also to refine the interview process, as well as to become prepared to be future interviewers for this certification specialty. This will occur during the first half of 2014.

As mentioned above, future interviews for this certification specialty will coincide with NACC normal certification interview times and places, the first weekends of October and May. Therefore, deadlines for materials for application for the certification specialty will also be Feb. 15 and Sept. 15 of each year. We realize the Feb. 15, 2014, deadline will likely be met by few applicants.

Please watch for further information in NACC Now and other NACC communications.

Please join us in praying for the success of this much needed certification specialty.

David A. Lichter, D.Min.

Reflection on forgiveness in pastoral and palliative care: A case study

By Gerald M. Gundersen, MA, MTS, BCC

Palliative care is a comprehensive approach to preventing or relieving all types of human suffering, physical, social, psychological and spiritual. Pastoral care shares this same goal with special emphasis on spiritual intervention. Just as God, the creator and source of all goodness, is in a unique position to forgive sins and take into account human failings, the chaplain is in a unique position to talk with patients about God and forgiveness, and does so by combining pastoral with palliative care. This brief reflection touches on forgiveness in relation to patients who struggle with mental illness, addictive behaviors and post-traumatic stress disorder. Participant observation, pastoral counseling and shared learning with patients in a psychiatric hospital over a period of five years form the foundation of the case study methodology.

By definition, forgiveness includes the concept of "letting go," of pardoning oneself or others for an offense. One of the intended consequences of "letting go" is reconciliation with the source of one's pain in such a way as to be able to release oneself from the bondage of negative thoughts and feelings. In this context, reconciliation becomes analogous to liberation from the hurt and pain associated with particular persons or events. The chaplain often serves as a sounding board for patients as they start to think about forgiveness, assess its importance, and decide whether they are ready to make a commitment. Many patients who understand and verbalize the importance of forgiveness to move on, prefer to "sit on the sidelines." Others have tried and failed or have had mixed results. Many fear making a commitment. All too often, their human frailty, marred by mental illness, addictive behaviors, and traumatic events, impacts recovery and can overwhelm their best of intentions. For many of these patients who may lack hope and are not ready to take forgiveness seriously, pastoral care may consist simply of words of encouragement to remain open to forgiveness as an option, to keep God close and not to abandon God as co-participant and healer. The effects of such exhortations usually are short-term, superficial and fail to give patients the tools by which to strengthen their resolve over time. They are similar to giving a person a fish to forestall hunger for a day when teaching a person how to fish can forestall hunger for a lifetime.

One of the premises of this paper is that moving beyond an understanding of forgiveness requires a strategy and game plan that can strengthen individual recovery and improve one's personal relationship with God. This dual challenge is met in part by looking for useful tools to help guide the process. Sacred Scripture is a rich resource for this purpose, and, in particular, the example set by Jesus. A brief synopsis follows highlighting the applicability of his approach to forgiveness of others.

Forgiveness of Others: At the time of his crucifixion when he experienced his most intense human suffering, Jesus cried out, "Forgive them Father for they know not what they do." His expression came spontaneously in response to callous and brutal treatment from others. He could have said, "I forgive them Father for what they have done." But, he asked the Father to do something that he was not ready to do for himself because of his pain and suffering, deal with forgiveness and impart forgiveness in God's own way and in God's own time. Patients are asked to consider doing the same thing, relying solely on God until they are ready to forgive on their own. This approach separates patients from direct confrontation with the source of their pain and entrusts to God the responsibility for doing the "heavy lifting" in support of those unable to help themselves. "Come to me all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble in heart and you will find rest for your souls" (Matthew 11:28).

Part of the process of working with patients on forgiveness of others entails having them identify their expectations from God and their expectations of themselves. What would patients want God to do as an intermediary? Patients can be quite expressive on this subject, and there is always a wide range of possibilities in response to this question: God can help their offenders become more aware of the harm they have done and the pain they have caused because of their actions; God can help them to repent of their actions and atone for their sins; God ought not let them forget their offenses or rejoice in their evil deeds, and so on.

In focusing on their expectations of themselves, patients can speak of their need to change, "to get off the merry-go-round that is killing me," and of renewing their efforts to improve their relationships with God. They can identify the need for personal repentance for their own sins and failings. Some can relate their own difficulties and lapses to their attitudes toward themselves, others, and toward challenges in their lives, such as coming to grips with forgiveness. Many look to God for help to provide structure and meaning in their lives. They cite a need for paying closer attention to a daily routine with positive supports to aid recovery. Frequently mentioned activities include: prayer, Scripture reading, spirituality groups, avoidance of negative influences, gainful employment and service to others.

Forgiveness of Self: One patient helped to clarify why forgiveness of self is so difficult and demanding. She noted that she had to live with herself 24 hours a day, and could not take leave of her feelings or of the memories triggering her depression. Therapy helped her to identify specific areas that she could work on while in the hospital, but she could not escape from her feelings of having done something wrong. She could not avoid self-chastisement, denigration, and the belief that somehow she was responsible for the abuse she experienced at the hands of others.

This example highlights the challenge for chaplains in working with patients to promote healing through self-forgiveness. Many victims of abuse can be harder on themselves than on their abusers, and struggle to release themselves from the bondage of shame and guilt. This seeming paradox can present special challenges for chaplains in response to the complex and at times overwhelming problems presented by patients. Another example that is less extreme, but equally daunting, is self-forgiveness in ministering to patients who have addictive problems, many of whom have experienced repeated disappointments and failures because of their use of drugs or alcohol, and in spite of having turned to God for support.

The chaplain's role and effectiveness as a pastoral care provider in matters of forgiveness continues to center on bringing God into discussions as a divine reality, a loving presence, an intermediary and source of strength and security for people who are hurting. Even though forgiveness plays out differently in each person, patients generally appreciate options or strategies that offer them a glimpse of hope. Occasionally, patients need to be reminded that their persistence in asking God for help, their courage in facing hardship, their sense of compassion for themselves and others, and the insights they share along the way with all of us are those easy-to-miss signs of God's presence continually at work in their daily lives.

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Get out the word on benefits of palliative care

by Robert Mundle, MDiv, STM, ThM, BCC

Palliative care has a marketing problem. Many Canadians think that palliative care is only for cancer patients and fear that palliative care is equivalent to giving up on life (Parliamentary Committee on Palliative and Compassionate Care, 2011). Likewise, key findings from recent survey data in the United States (n=800) indicate that palliative care is a relative unknown among consumers. When asked, "How knowledgeable, if at all, are you about palliative care?" 70% of respondents said that they were "not at all knowledgeable" (Center to Advance Palliative Care, 2011, p. 3). Yet, once informed, 92% of respondents said that it is important to have palliative care services available. In turn, 95% of respondents agreed that more education is needed to inform patients and families about palliative care (p. 13).

The Center to Advance Palliative Care recommends providing consumers with a clear definition of palliative care that uses "new language" about improving the quality of life and not necessarily about hospice care or end-of-life care. It states, "Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stresses of a serious illness — whatever the diagnosis. The goal is to improve the quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age at any stage in a serious illness, and can be provided together with curative treatment" (p. 7).

One of the recommendations of the Canadian Parliamentary Committee on Palliative and Compassionate Care (2011) was for the federal government to fund a national public awareness campaign on palliative and end-of-life care. Perhaps there are similar large-scale initiatives underway in the United States. In the meantime, there are a variety of ways to promote the aims and benefits of palliative care at the grassroots level. For example, in addition to the work you are doing already, perhaps you might give a talk or host a panel discussion on palliative care at your local church or community center. You might write a short article for your community newspaper on the palliative care needs and resources within your local area. Or you might highlight the need for more education about palliative care within your social media networks. As one (now anonymous) physician commented recently in a professional social media forum on palliative care, "We are each responsible to continue to EDUCATE, EDUCATE, EDUCATE - Community, Houses of Worship, Students, Rotary Clubs, Geriatric Case Managers, ...OUR COLLEAGUES, each discipline.... I speak anywhere, and anytime I am requested. We in the Hospice-Palliative Community MUST remain focused, passionate, non-threatening, and simple. We must also make it as easy as possible to access our services" (Palliative Care Network group on LinkedIn).

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References

Center to Advance Palliative Care (2011). 2011 Public Opinion Research on Palliative Care: A Report Based on Research by Public Opinion Strategies. www.capc.org/tools-for-palliative-care-programs/marketing/public-opinion-research/2011-public-opinion-research-on-palliative-care.pdf (Accessed Dec. 4, 2013)

Parliamentary Committee on Palliative and Compassionate Care (2011). Not to be forgotten: Care of vulnerable Canadians. pcpcc-cpspsc.com (Accessed Dec. 4, 2013)

The Empty Chair

There is an empty chair at the table this year.
It is cold, hard, and rigid – so unlike the person that used to fill it.

As dishes are passed and conversation is shared, there is an air of longing.
Longing for the way things used to be.

We try hard to remember that though the chair is empty, our hearts are not.
They are full of lessons learned, love shared, and memories made.

We will carry this love and these memories in our hearts forever.
The empty chair will be filled over the years, and the sense of longing diminished.

May this love and these memories begin to fill the hole in our hearts and the void in our lives as we move forward,
Remembering what a beautiful difference one life made.

Jennifer Ellsworth, MSW

Clinical Social Worker
Palliative Care Service
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Physician finds teamwork helps palliative care patients and families

by Robert Gerard, M.D.

As a palliative care physician, I have learned from thousands of encounters with patients that the work of caring for them is complex and filled with daily challenges. Vulnerable to burnout, I have also learned that the complete psychosocial, spiritual, physical care of a patient demands more than what I can provide. It requires an interdisciplinary health care team.

It was perhaps by chance that a health foundation manager approached me 10 years ago to spearhead the initiation of palliative care services for our healthcare members. Notwithstanding the challenge to learn a new paradigm of care, I endeavored to study and practice this newly designated medical specialty in mid-career. I didn't realize it at the time – just as I hadn't when I chose the life path of medicine at age 16 – but my family had shaped my devotion to this calling. My father's joy of reading and reflecting, mother's ambition to succeed in business, grandmother's compassion for others, and grandfather's religious and spiritual devotion all contributed to a lifetime commitment to learning.

Early in my new endeavor, I was fortunate to meet an extraordinary registered nurse and chaplain at Holy Cross Hospital practicing as a new inpatient palliative care team. From the moment I experienced the radiant compassion of the chaplain and helpful mentoring by the nurse specialist, I knew my collegial work would be satisfying.

I began a home-based palliative care program and collaborated with a nurse and social worker. Even though chaplains were not following my palliative care patients, I sometimes shared home visits with the chaplain once a patient transitioned to hospice care. In several encounters in the homes of dying patients, I received solace from the chaplain's presence. I gathered strength to face the challenges of easing people's suffering at the end of their lives.

In establishing two hospital-based inpatient palliative care programs, I collaborated with a complete interdisciplinary team including a chaplain (plus physician, nurse, social worker). I was able to work with chaplains training in the residency program of clinical pastoral education at the Washington Hospital Center. Together, we have been able to reflect the latest clinical practice guidelines from the National Consensus Project for Quality Palliative Care. With respect to spiritual care:

"The interdisciplinary team regularly explores spiritual and existential concerns and documents these spiritual themes in order to communicate them to the (health care) team. This exploration includes, but is not limited to: life review, assessment of hopes, values, and fears, meaning, purpose, beliefs about afterlife, spiritual or religious practices, cultural norms, beliefs that influence understanding of illness, coping, guilt, forgiveness, and life completion tasks."

We have discovered that the team is both interdisciplinary and multidisciplinary. With time, we developed the trust to wear the hat of another team member when necessary. Families and patients are often at their worst when they agree to meet with us, and trusting that your team will carry the conversation during a meeting when one is stuck or in conflict becomes invaluable. Becoming adept at "passing the ball" between team members enables us to move forward and maintain momentum during a goals of care conversation.

It became commonplace to see the chaplain raise issues about physical pain when it was appropriate. The physician thought nothing unusual about discussing the spiritual background of a patient and how it affected the medical decision process. The nurse delved into the social fabric of the home, and the social worker would page the patient's primary nurse or physician for extra help if a crisis occurred during our meeting.

After our meetings, a debriefing has provided us an opportunity to unpack the facts and emotions of an encounter: What went well and what didn't? What discomforts were we carrying, and how could we improve our process in future consultations? A seasoned team can offer feedback with carefully worded criticism. The palliative care team's occasional afternoon teas with the spiritual care department have given us time to socialize, share the news of our departments, and enjoy some lighter moments together.

I reflect often how the presence of the chaplain in palliative care consultations has humanized the team and our work. Even though a handful of folks have refused their presence in our family meetings, their knowledge of palliative care has been integral for the continued holistic care of the sick. It has not been unusual for patients or families to comment how relieved of stress they feel after meeting with us.

According to families and patients, we are often the first healthcare providers that hear what they are saying. The meeting becomes a safe place for them to express anger, frustration, tears, and sometimes rage – but also to be receptive to compassion. When appropriate at the end of a meeting, a hug, an expression of thanks, or a meaningful prayer allows both the patient/family and the interdisciplinary palliative care team to have some closure for the difficult journey ahead.

Robert Gerard, M.D., is a palliative care physician at Mid-Atlantic Permanente Medical Group in Silver Spring, MD.

Changing lives changes chaplain's life, too

By Patricia Regan, BA, MS, BCC

For two years I was a hospice chaplain visiting patients in their homes and as in-patients in rooms dedicated to palliative care in two local hospitals. When I began as a hospice chaplain in 2001, the first thing I did was get a cell phone. Now everyone has a "smart phone" and all kinds of connections to bring the patients soothing music or things that can comfort or distract. My cell phone allowed me to alert the patient or caregiver that I was in the area so they were prepared (perhaps their hair was combed or the door was opened). It also allowed me to call the office if an immediate update was necessary or there was a problem. When the hospice team was given the name and address of a new patient, we took out the maps, located the home and planned the best route to get to the home. Now, chaplains type in the address in their GPS and directions are given quickly.

There has been progress and change in some things but I feel that the experience of working as a supportive team is invaluable. It's needed for patient and family as well as for the chaplain and caregivers. Experiences need to be processed and a sense of peace found.

As I prepared to leave the hospital one day, I received a message to bring a Bible to the Pediatric ICU room right near the nurses' station. A minister was there to pray with the family of a 10-year-old boy who was dying. Entering the darkened room, I found the family was gathered around the bed. After standing in the sacred space for a while, I quietly said: "There was a request for a Bible." A woman took it from me saying: "My Dad's our minister. This is Joey, his grandson, and he's dying." She handed the Bible to an elderly gentleman who stood frozen near the bed. Again we stood in silence and I asked: "Does Joey have a favorite story or psalm?" The grandfather seemed to wake from a trance and read several passages from the Bible. Then silence descended again. I spoke softly: "Does he have a favorite hymn?" Everyone joined in singing several songs. The music was beautiful. It was a reverent prayer of all assembled.

Then the door opened and a teenage girl came in. The woman standing by the window immediately said: "You did this to him. You were always picking on him ... pick, pick, pick. You said he stole your money." The girl fled the room in tears. The father and I followed. The father held the girl and comforted her saying: "Grandma's very upset and angry Joey's so sick, and there's nothing more the doctors can do. It's not your fault, honey. It just hurts our hearts so much." The father looked at me, and his eyes seemed to plead that I leave them and go back into the ICU room.

I found the grandmother also in tears. She was being held. There is little anyone can say other than: "It is so hard...." The family then told me about Joey and his illness.

When I went to the desk to note the visit, the staff said they had seen and heard what went on in the room and they were so thankful that I had been able to get the family to share, to pray and to sing. It was so important to them.

Another time I was passing a nurses' station and already had my coat on ready to leave. The nurse said: "Barbara, the new hospice patient in Room 102, is fighting the medication and she's in great pain. Could you try to talk to her?" Barbara would not make eye contact and she was crying. "I can't feel God anymore" was her comment. I knelt by her side. She let me hold her hand and we began a dialogue about when her experience of God had been most intense. She spoke of her First Communion, the dress she wore, and the church she attended. Then she went through Confirmation experiences, her marriage, being a eucharistic minister and lector, and special verses of the Bible that were meaningful to her. It was obvious that the medication was working; the physical and spiritual pain was less. Barbara told me about her children and their experiences in church and things they said about God. She thanked me for bringing God alive again, and then asked me where I was supposed to go next. I told her I was going to my Mom's house to take her food shopping. I think I'll always remember her saying: "Patricia. Go to your Mom now. She's waiting for you."

There is one couple I think I will always remember. I visited them in their home for more than one year. Ray was declining slowly. They had become Mormons and wanted to share about their faith. Ray was a priest and he showed me his vestments and told me of the duties he had when he was well. I'm sure he felt good that he was still teaching people about what he believed. When the new Mormon Tabernacle opened in New York City, Ray gave me two tickets so my husband and I could see the house of worship. We did go and even visited another tabernacle when we were on vacation in Hawaii. Vividly I can remember our times sitting at the kitchen table, then later around the bed, and finally at Ray's wake. Signs and symbols were important to this special couple.

Some people can openly share their faith, experiences and feelings. Others cannot do it easily. But some experiences can be so powerful that the people feel compelled to share it with someone they have come to trust. I had visited a 32-year-old woman dying of breast cancer. She worried about everyone: her three children, her husband who was a police officer and not able to express his feelings well, and her parents. Focusing on others made it easier when we first started talking. We did have enough time for her to get in touch with her own fears, anger and faith. The husband surprised me one day when his wife had slipped unconscious. He said he was driving to the hospital and was stuck at a light. He was thinking that he was not going to be able to handle his wife's death. He happened to notice the license plates on the car ahead of him. The numbers were those of his wife's phone number. When that car started to go, it was a sign for him that his wife had to move on ... and he did, too. They both would be OK. He was a man who needed to find his own sign and symbol, but share it, too.

As a hospice chaplain, I have been blessed to be with people in unique and moving times.

Patricia Regan is a retired chaplain who lives with her husband, Thomas Regan, also a retired chaplain, in New York.

Chaplains key component of developing palliative care programs at CHRISTUS Santa Rosa

By Rich Woodley, MAPM

As I write this article, it is the middle of the Advent season. A question I often ponder during this season is why? Why did Jesus come at the time he did in the course of history? Why am I living in this time in human history? Obviously there is not an answer to either question. But what I have come to understand is that events happen, people come into our lives not by accident but for a reason, and often that reason will not become known until later.

In 2011, through an initiative by the ethics committee, an ICU support team was formed. The focus of the team, which included a chaplain, social worker and ethics director, was to identify patients in the intensive care unit where the goals of care were not clear or there was a disconnect between the expectations of the patient and family and the treatment team. Over the next year, this concept of the ICU support team was utilized in all three of our adult facilities and was successful in decreasing length of stays in the ICU and dramatically reducing the need for conflict resolution ethics committee meetings. However, the team became aware that while patients were being moved out of the ICU much more quickly, the overall hospital length of stay did not improve. The patient just spent more time in the medical-surgical unit since the ICU team did not have the resources to follow the patient's progress after leaving the ICU. Thus the need to revive the palliative care program became apparent.

In 2012, I became the interim vice president for mission at CHRISTUS Santa Rosa and I made the palliative care initiative a priority. In a casual conversation during the ICU rounds, a staff member mentioned that there was a new hospitalist who had just joined the service and he had some background in palliative care. I would later discover that this physician was board certified in palliative care but was also determined to make his career solely focused on palliative care. The moment in time had come for the program. With the assistance of a multi-disciplinary advisory committee and the support of my colleagues on the executive team, a plan was formulated. In August 2013, the first of the three adult facilities began providing palliative care consultations. The first team consisted of a chaplain, social worker and a palliative care physician. This was a second palliative care physician that had been in the system for several years who also had a desire to develop a more robust palliative care program. While I would like to report that the program is going strong and having a major impact, that is not the case. Rather it has been a slow process. There was a missing part to the team which I would discover after we began to provide services in the second adult facility.

In the second facility the team again was formed with a chaplain, a social worker and the new palliative care physician. The next moment in time came with the hiring of a dedicated palliative care RN, who brought both expertise and passion to the service. I am happy to report that the service is now well-established at this facility and a dedicated RN will be added to the first team shortly.

In early 2014, the palliative care initiative will begin at our third adult facility. The team will look similar to the other two but the difference is that this team has been together the longest as they were the original ICU support team. The hospital system's foundation office is currently securing a grant for educational development for the palliative care teams; this will likely allow several team members to attend the CAPC conference in Orlando, FL, in November 2014.

You may be asking yourself what is significant for chaplaincy in this story. There are two parts to the answer. The first is somewhat obvious. In all of our formulations of the palliative care teams, the chaplain is a vital team member. The chaplain brings not only the skills of working with patients and families in exploring their spiritual resources and spiritual dynamics, but also brings spirituality to the palliative care team. At our facilities, the chaplain staff is highly regarded by nursing and physician staff. We are blessed to have chaplains who are passionate about palliative care. They have taken on the task of pursuing certification in palliative care chaplaincy.

There is a saying that if you have seen one palliative care program, you have seen one palliative care program! This is the second part of the answer. While there are common characteristics of palliative care programs, the teams are made of different personalities and the institutions in which they work have different cultures. Our first facility is in an area of a major concentration of retired persons and so the patient population is the oldest in our system. It is also the smallest census-wise and was recently acquired by the system. The general population of the city is Caucasian in ethnicity. The second facility is in an area of significant medical competition, with four major hospital organizations in a two square mile block. The patient population is younger than at the first hospital, but is shifting to a more geriatric focus and the population has a greater Hispanic component. The third hospital is the newest and largest with a much more diverse ethnic mix than the other two. These cultural and population differences influence the scope of the palliative care service. We are still learning the nuances of this as we develop the program.

There is a third element that is significant to the future of chaplaincy. The challenge of in-patient consultation model palliative care programs is the follow-up process post hospitalization. Out-patient clinics are very expensive to maintain and require a significant service population to sustain them financially. An approach we are taking is to develop relationships with the long-term facilities (rehab, nursing homes, among others) in our service areas. This would offer a great opportunity in the future for chaplaincy to develop ongoing follow-up with patients/clients/residents in the palliative care service. The future of healthcare is in the development of integrated networks to improve health outcomes.

Rich Woodley is director of ethics for the CHRISTUS Santa Rosa Health System in San Antonio, TX.

‘Till Death Do Us Part’: Three weddings in palliative care

By Rev. Brenda Haggett, Janet Stark, and Rev. Barbara Moulton

Think of a time when you have gone the extra mile in your role in healthcare. It doesn't matter what your health discipline is – I'm sure you can easily identify those moments when your interaction with a patient, client, resident or the family has brought you a profound sense of satisfaction. It doesn't have to have been earth-shattering or expensive. In fact, it is often the little things that mean so much to the persons who are sick and suffering as well as their families. When we healthcare workers meet a need and see the fruits of that work on the faces of our patients, we know we have helped in facilitating healing. In palliative care, this does not mean "cure."

One can die "healed" by having a spirit of peace. Nurses who are comfortable and creative in embracing personalized spiritual care receive many gifts. I believe it is a positive thing that we live in an environment where spiritual care includes, but is so much more than, religious care alone.

The following is a collection of three moving incidents that took place recently in hospital palliative care. These stories affirm the value of providing patient-centered care. Ripples of goodwill in going "the extra mile" can profoundly affect the quality of life for the dying and their families. These acts can also become waves that sustain and encourage staff to continue in this intense field of healthcare.

[1] Wedding celebrated in hospital unit where 'death hovers':

www.nacc.org/vision/2014-Jan-Feb/Wedding-celebrated-in-hospital-unit-where-death-hovers-By-Rev-Brenda-Haggett.aspx

[2] Ma couldn't miss granddaughter's wedding:

www.nacc.org/vision/2014-Jan-Feb/Ma-couldnt-miss-granddaughters-wedding-By-Janet-Stark.aspx

[3] 'Yes,' is best response to requests for spiritual, religious care:

www.nacc.org/vision/2014-Jan-Feb/Yes-is-best-response-to-requests-for-spiritual-religious-care-by-Reverend-Barbara-Moulton.aspx

In summary, I was recently at chaplaincy education where I learned that "every encounter has the capacity for healing." This is a profound concept, and one that I knew integrally, but hadn't verbalized in such a way. Let's break down the sentence: Every—each time—we encounter—meet someone—we—ALL—have the capacity—ability—opportunity—for healing. Read that line again. Now we can flesh out that word "healing." For some, healing means cure. Often it means to come to terms with what is happening. It can mean reaching a place of peace; it can also mean finding spiritual wellness. Spiritual care can be provided in quite simple ways. It can be a genuine smile as we pass one waiting for an appointment; it can be engaging someone with your eyes as you tell them your name; it can be your bedside manner as you administer pain medication; it can be bringing in a CD player and their favorite music; it can be accompanying the pet therapy dog. It can also be when you really listen and participate in simple but genuine conversations. And as we have just read, it can also be helping facilitate a wedding at end of life!

I have seen spiritual care provided by nurses, doctors, housekeepers, chaplains, dietary aides, occupational therapists, administrators, volunteers, visitors, financial analysts and more. Think on these things as you walk the halls or deliver patient care.

Editor's Note: All of the individuals mentioned in the wedding stories gave full permission to use their names.

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Wedding celebrated in hospital unit where ‘death hovers’

By Rev. Brenda Haggett

Life is full of moments. Some of them we miss because we are thinking of moments already gone by or worrying about moments still to come – but in the end when we look back at life, we remember moments – births, special occasions, weddings, and funerals. We remember moments that change our lives whether for better or worse. Some may have said it was too late and unnecessary for a wedding to take place; others may have said, “Why bother, she is going to die soon anyway;” yet others said, “What a wonderful way to culminate a lifetime of love!”

Life in the palliative care wing is precarious at best. Some patients come to us for pain and symptom management, while others come because they are unable to die at home. Life in palliative care is anything but normal and yet the experiences of patients and families usually have some level of predictability to it: death and grief.

To those looking on, a wedding seemed out of place in a unit that encounters death on a daily basis. Even though she was dying, couldn’t she too have a wedding?

It was a question that came out of the blue. I was visiting Lawanda Badour, her common-law husband Kevin Hoogwerf, and their young daughter Jessica, who was struggling to understand why mommy was lying in bed all the time. They were concerned for their daughter and wanted her to know that mommy was dying. Oh my. I spent several hours with the couple helping them talk to their 4-year-old daughter about life and death. Then, like a lightning bolt on a clear day, the man asked the question, “Could you marry us?” Initially, I was surprised, having assumed they were already married (Lesson 1. Never assume anything.). My answer was yes. I am a licensed minister within the province and I can solemnize weddings. I spoke with the patient’s partner and he expressed again his desire to marry the love of his life, who lay in her hospital bed, dying.

I asked her if that was her wish, too. The answer: Yes, I want to marry him. In less than 24 hours, this couple would be married.

I rushed out of the building and down the street to the town hall to get a marriage license and returned within the hour with the documentation in hand. When I told the palliative care team that there was going to be a wedding the next day, they jumped into action. The next day there were beautiful decorations – a tiara, lights, candles, music, something bubbly to toast with, and the hospital photographer. The palliative care department clerk, Dana Knapp, brought in a beautiful flower girl dress for the couple’s daughter to wear. But it wasn’t just the unit that got on board with the big event, the community did too: donations of food and flowers from local businesses and the surprise gift from the flower shop – a beautiful brooch for the bride to wear with the instructions that it be kept for the little girl’s future big day. Word spread very rapidly that something wonderful was going to take place in a hospital unit where death hovered.

As a minister, I was overwhelmed thinking about how I would approach the wedding vows. The traditional words “till death do us part” felt out of place especially given that the bride was nearing the end of life. What could be said that would make it meaningful? I wrestled with the words and then landed on the idea of using the marriage celebration as a moment to be remembered, celebrated, and honored.

I spent several hours that evening writing and rewriting, trying to find just the right things to say about the joys of marriage, the commitment of marriage and – in this couples’ case – the trials of marriage.

When the time came, 3 p.m., the nurses wheeled Lawanda’s bed just across the hall into the sunroom, which had been transformed into a beautiful chapel. The doctor had cut back on the strong medications she had been taking so she would be lucid for this moment. She would go back on the strong painkillers soon after.

It was, as if for a moment, the dark shadow of death had parted to reveal the joys of life. The groom had purchased rings and managed to get a mate to stand up with him. The bride had an attendant, too, and the little girl Jessica sprinkled rose petals around the room.

This is what I said to Lawanda and Kevin as I joined them together:

“We are gathered here today in the presence of the Divine Creator to give witness to a ceremony that will join Lawanda and Kevin in the sacred union of marriage.

“In many ways this ceremony represents the culmination of a love that has already had the traditional marriage vows tested and proven – they have faithfully loved and cherished one another in sickness and in health, through trials and tragedies, through the blessings and challenges of parenthood; and now in the face of limited time ... their love has brought them to this moment. Life is made up of moments and moments are all we ever really have... for yesterday’s moments are spent with only memories to recall, and tomorrow’s moments are never guaranteed for any of us. All we have is this moment, and how we spend our moments matters a great deal.

“And so, today in this moment, Lawanda and Kevin desire to affirm their love and commitment to one another by giving themselves to the other in the sacred union of marriage. This ceremony does not create a relationship that does not already exist between you. Rather it is a moment in which all of the moments leading up to this one are celebrated and in which a lasting symbol is made of the commitment you both have already demonstrated each to the other in your life together.

“This ceremony truly is a symbol of the unspoken words that have kept you together through the ups and downs of life. It is a symbol of the never-ending love you have for each other that has carried you each moment and will carry you into the future, regardless of the moments you face. Today, in this moment you tell the love story of your lives and we as witnesses to this mystery feel blessed and privileged.

Please repeat after me...

“I, Kevin, take you, Lawanda, to be my wife. As I have loved you, I will continue to love you, through trials and hardships, through joys and sorrows, through every moment we are blessed to share. My heart is yours.

“I, Lawanda, take you, Kevin, to be my husband. As I have loved you so I will continue to love you through trials and hardships, through joys and sorrows,

and in every moment we are blessed to share. My heart is yours.

"This ring I give you is a symbol of my never-ending love for you. I receive this ring as a symbol of my never-ending love for you..."

"I consider this a special honor – by the powers vested in me, from the Province of Ontario, I now pronounce that you are husband and wife. You may kiss your bride.

"May every moment you are blessed to share be moments that pay tribute to the love you have shared, and may you know the Great Spirit's peace, comfort, and hope. Amen."

Lawanda was visibly happy throughout. The room held an atmosphere of holy reverence mixed with barely stifled emotion. There were a few family members and very special friends present. The nursing manager and a few of the floor nurses were in the room, and other nurses lined the hall just outside the door. Most of them were crying. The couple both signed the hospital marriage register. Their names were the first ones for a wedding in a book that held many recordings of funerals and memorial services.

Earlier in the day it was discovered that a fellow who worked downstairs in finance sang and played the guitar. He was briefed and went home to get his guitar. The mood in the room as Andrew Dion sang, "Have I told you lately that I love you" was rich with feeling. I wonder if he went home that day feeling he had been in a very different and honorable role, one of the care team.

Afterward, there was a party, a celebration with wine and food; congratulations all around. Too soon it was over and Lawanda was back in her hospital room, asleep. All was quiet on the floor again. The wedding took place on a Friday afternoon. On Sunday night, Lawanda died. It is my hope that her husband finds immense comfort in knowing that Lawanda had a dream fulfilled, that she died happy. May the union of her parents provide comfort for little Jessica as she struggles to grow up without a mom. May the extra special actions of so many staff members that day serve to provide a unique job satisfaction in a place where circumstances are all too often somber. I am honored to have played my role in this couple's journey.

In reflection, there is no guarantee that we will have any more moments than the one we currently experience. Past moments are gone, and new ones may never happen.

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Ma couldn't miss granddaughter's wedding

By Janet Stark

Madeleine Gaetanne Séguin, (Ma), was the mother of four daughters in a close-knit French-Canadian family from Prescott, Ontario. One day in early June she was a perfectly healthy 86 year old, exercising and enjoying her daily walks, and the next day she went to see her doctor with a bloated abdomen. After a whirlwind of tests, she was given a diagnosis of terminal ovarian cancer. Madeleine accepted this news 100%. She had a strong Roman Catholic faith and knew she would soon be united with her husband of a 52-year marriage. She insisted on immediately making all her funeral arrangements. A few days later, she was brought to palliative care at the Brockville General Hospital.

The thing that most disturbed Madeleine about the fact that she was now dying, was that she wouldn't be able to attend the wedding of her granddaughter, Josée. It was going to be in only six days, and here she was dying in hospital. Another granddaughter, Krista, had an idea. When she visited Ma in the hospital, she asked the nurses, "Is there Wi-Fi here in this room?" The answer was yes, and she immediately put her plan into action.

On the morning of the wedding, June 15, 2013, Krista brought in her Apple iPad, and briefed the nurses that her grandma was to participate in the wedding "in real time" over Skype! Usually the nurses in palliative care are very busy, but as providence would have it, on this day, there was an extra nurse, Lisa Desormeaux, a young nurse still on orientation. Lisa knew all about technology and happily took over the project. She sat with Madeleine holding the iPad up for over an hour so that "Ma" could watch Josée and Tyler get married, in the church in Russell, Ontario. The family now refer to that young RN, Lisa, as their "guardian angel." When the wedding started, a friend of the bride sang a solo as Josée walked down the aisle, and according to Mary Bailey, palliative care RN, it was a very emotional moment and there were tears in that hospital room!

Ma waved and said "hello" as Krista held her cell phone up to the bride and groom at the front of the church. She blew kisses and the guests in the church laughed. Ma watched the entire ceremony as if she had a front row seat. She even shared the fun of the Dickie-Dee ice-cream man bringing treats outside the church after the ceremony.

All her life, Ma had been an excellent seamstress, and she had altered the scalloped lace hem of the mother-of-the-bride's dress. Even from her hospital bed, Ma wanted to see the hem of her daughter's dress, and that it lay perfect and even. Krista was able to scan the phone down over the dress until the camera was focused on the hem, and the result met with Ma's approval!

Floor nurses flowed in and out of Ma's room, as time permitted, genuinely interested in the wedding. Even the nurses that were not working that day came in to ask about it over the next few days. Within three days, the family had put together a huge frame of family photos, with lots of wedding shots. Ma said that this collection could be used at her own funeral, but she was lucky enough to see it herself. Full of pride for her family, she showed everyone who came in the room to visit.

Toward the end of Ma's life, Charleen Findon, the manager, gently told Madeleine's daughters that it might be helpful to tell her, "It is all right for you to go." Patients often struggle with leaving this life when they sense loved ones will not be all right. When they are given "permission" it sometimes helps them to let go and slip away peacefully. Ma understood the concept right away. She spoke of seeing a beautiful light and people waiting for her in the corner of her room. She wanted her husband Ovilla to come and get her. She asked her daughters, "Is it OK that I leave you today?" One daughter replied, "Not today, Ma, it is our sister Danielle's birthday today. Can you hold on? In two days it will be Pa's birthday, and you can go then."

This is exactly what happened. In the early morning on July 13, Madeleine died.

The family, although still grieving the loss of their beloved Ma, wanted the hospital to know how greatly they appreciated the attention she received while in our care. Friends and family have donated more than \$1,800 in memory of Madeleine Séguin. It is the hope of the family that palliative care will use these funds towards the purchase of an iPad, laptop and cellphone for others to use for their special family events! This story shows the far-reaching impact of a relatively small deed. It has made a difference in the grieving process to this family. One thing palliative care nurse Mary Bailey said to the new nurse Lisa, before she left the hospital that day was, "You are just beginning your nursing career, and you may never experience something like this again. This is really something you're going to remember."

Janet Stark is a certified multifaith chaplain and grief services provider and the author of "FINAL SCENES: Bedside Tales at End of Life." She can be reached at the Brockville General Hospital in Brockville, Ontario, Canada at staja@bgh-on.ca

‘Yes,’ is best response to requests for spiritual, religious care

By Reverend Barbara Moulton

The call came to me unexpectedly from the hospital switchboard after I had left work one day. I was told that a palliative patient desired to be married, and they hoped I could officiate.

I had not had any interaction with this patient, prior to the request. So it was important that I clarify the circumstances. I assured them that I would be happy to do the ceremony, as long as certain conditions were filled. I mentioned the need for a marriage license and confirmed that this would be a religious ceremony as my ordination is with a denomination that would not allow me to perform a civil ceremony. With the agreement in place, I said I would see the patient the next day.

When I arrived at the hospital the next morning, I was told that the marriage license had been obtained, and they were hoping for the wedding to take place that day. This was a little sooner than I had anticipated, so I headed to the palliative room immediately. While I was happy to conduct the wedding in principle, I knew that I had an ethical responsibility to confirm that both participants were willing and able to fully understand and consent to the commitments of the marriage vows.

The meeting was brief but put my concerns completely to rest. The patient was the groom-to-be, Michael, who clearly expressed that it was his desire to marry Aileen. They had been together for 25 years and, while his death was not imminent, the news of the past few days had not been good. They recognized that the medication required to control his pain would soon make it difficult, if not impossible, to meaningfully participate in the marriage vows.

I agreed to perform the marriage, and told them I would go home to change and prepare the wedding ceremony, which we agreed would take place at noon.

As I was driving home, it occurred to me that Aileen might not have a bouquet. As soon as I got home I phoned the florist we had used for both weddings of my daughters and asked if they could put together a hand-tied bouquet for me to pick up. I asked that it be charged to my church account, knowing that my faith community would be happy to participate in this compassionate act. Without breaking confidence, I provided the reason why it was needed quickly and they volunteered to deliver it to the hospital in time for the ceremony. They delivered it to the front desk in my name.

When I arrived back at the hospital, the bouquet was waiting, along with two stands of silk flowers for the room. The florist provided these without rental charge. I later realized that they had no desire to charge me for the bouquet either. They never billed my church.

The witnesses were the sister of the bride and one of our volunteers. Aileen had changed into a simple outfit; Mike into a shirt and bowtie. The colors of the bouquet and floral stands blended well and we proceeded with the short ceremony. They both spoke their vows with strength and purpose.

So many times I have heard couples promise to love each other until the parting of death. But on this day those familiar words were so poignant. Everyone in the room was deeply moved. As Michael placed the ring on Aileen's finger I said a prayer of thanksgiving within my heart, reflecting the gratitude I felt for being part of the day.

At the end of the ceremony, I blessed the couple and left them to privately take some photos. It had been an emotional day for me but, as I drove home, I knew in my heart that it had been a good thing.

Close to his death, Mike was back in our hospital. I visited with him and he thanked me for conducting the ceremony that day. He knew that he was now nearing the end and as I spent time with him I was happy that I

had been able to journey with him and Aileen those few months before.

Mike moved to a local residential hospice shortly after that visit and died in the presence of his wife. I was honored to be asked to conduct his funeral and as we celebrated his life together, it felt right that I was there.

As I have reflected on the part I played in Mike and Aileen's wedding, I have realized that it demonstrated the patient-centered care that we hope to provide. Patient weddings are not part of my job description as coordinator of spiritual care, but the willingness to facilitate a wedding certainly falls within its scope. I took part by virtue of my ordination but if I had not been able to perform the marriage according to the requirements of my faith tradition, I would have found someone who could.

Palliative care is both compassionate and affirmative. We focus most often on compassion, responding to physical, emotional and spiritual distress. We do our best to alleviate pain and provide comfort.

But it is not enough to provide comfort measures. Approaching the end of life will often cause patients and their families to listen to an inner voice of spirituality and seek spiritual renewal. Spiritual care affirms this process.

For Mike and Aileen, the knowledge of what lay ahead brought to the forefront a desire to be married. As I met with them, I did not have any sense that their life together had been lacking without this ceremony. Their love and commitment to each other was evident to anyone who met them. The evidence of that love informed my decision.

As the end of life approaches, we will often focus on what is most important to us. We seek to affirm these things and, in so doing, find a blessing. Marrying the person he had loved for more than a quarter of a century did not make the love real for Mike. But as he affirmed that love and the woman who had devoted herself to him, he participated in an act of spiritual grace. My role, as a provider of spiritual care, was to support him in this.

In spiritual care, we differentiate between religious needs and spiritual needs. Religious needs can be very specific to a faith tradition. Ceremonies and rituals bring comfort and the onus is upon all caregivers to ensure that religious needs are met.

But although Mike and Aileen were agreeable to a religious ceremony, the wedding was far more spiritual than religious. It was a way to acknowledge the meaning that each of them brought to the other. It was a way to celebrate their love. It gave words to the promises that they were already keeping.

It is not something that will happen often in the hospital setting. However, if we take patient-centered care seriously, our response to any kind of request for specific spiritual and religious care must be "yes, if at all possible" rather than "we don't think that is possible."

Staff members who were present on the wing that day told me what it meant to them to see our hospital respond to a request in this way. As I carried the bouquet down to the patient room, it seemed to me I was walking a path of grace and blessing.

I can't help but feel that our hospital community was at its best that day as we responded to a patient's need.

Reverend Barbara Moulton is the coordinator of spiritual care at Headwaters Health Care Centre, Orangeville, Ontario, Canada. She can be reached at bmoulton@headwatershealth.ca

Palliative care is ‘extra blanket of care’ that builds trust, strengthens relationships

By Margaret Y. Jones, MA, BCC

Imagine for a moment that you have a car you depend on daily to transport you to work and anywhere else you wish to go. You have had this car for quite some time, you have taken care of it (and it has taken care of you); you are just about to make your final car payment. Suddenly the “add oil light” appears for no apparent reason. You check the oil level and find it to be normal and continue to drive the car. Days later, the headlights stop working. It is urgent that you take your car to a mechanic because you are now unable to drive at night. The first mechanic that inspects your car tells you that a very expensive part needs to be replaced. This part, you are told, will correct the “check engine light.” But the “check engine light” was never on, you explain. Is he not listening? You now search and find a second mechanic, who keeps your car for two days and afterward assures you that everything has been corrected. Trusting what you have been told and having little knowledge about car repair, you pay him a high amount of money. Driving away from the mechanic’s garage, you discover that your car is making a new noise. Fortunately, the garage is still open and you take the car back where it is found to have a loose hose. The problem is corrected and you cautiously drive on your way. Two days later, the noise once again appears. It is a holiday weekend and the garage is closed. What will you do now, and who will you call? The car crisis places you in unfamiliar territory; one of vulnerability, loss of independence, and a sudden need to rely on those you would not ordinarily ask for help.

Imagine now, that the vehicle is your body. You have not been feeling well for quite some time, but keep on going. When your health continues to worsen over time, you decide to see a doctor to try and diagnose the warning signals. Spending several days in a hospital, you are diagnosed with a serious, chronic, or life-limiting illness. You have surgery and are told that the symptoms of the illness can be managed. You are given treatment and sent home. Two days later, your body begins to malfunction again. There is great pain. You phone the physician and receive the answering service. Where will you go from here? The emergency department may be your only resource as the pain is intense and it is late at night, a holiday, or weekend. The acute care system is used as a safety net when there is no other support available. You now find yourself on a journey down a dark and lonely road. You are not dying, but need help in managing your pain, coordinating your medical care, assessing your options, and addressing your fears. What will you do now, and who will you call?

To have a car that does not function optimally is inconvenient and expensive at the very least. Independence is lost and the need to depend on others becomes a reality. To have a body that is in need of repair or that is in pain is frightening. As illness and disease take control, life can appear to spin out of control. We as healthcare professionals can offer meaningful, added support and coverage to our patients with an extra blanket through palliative care. The extra layer of support palliative care offers to patients and their families is significant and offers rapid rewards. In the absence of a social support system, the patient or caregivers have little to no resources other than to call 911 when in crisis. A palliative care team within the hospital system allows for broader and deeper conversations with patients and their families. We are able to explore questions, such as, “what matters most to you” and “what are the goals of care?” Highest on the wish list for most individuals is “remaining independent.” Palliative care matches services with gaps in needed care. Added focus is put on pain and symptom management, social, spiritual, and behavioral health. The palliative care team is trained to have conversations about what matters most to the patient. Evidence-based research has shown that patients who are given an opportunity to discuss their advance care planning have significantly higher satisfaction scores. Being witness to this gratitude expressed by our patients is quite humbling. I have been at bedsides where patients have kissed the hand of our palliative care physician after she asked, “what do you want/not want in terms of life-sustaining treatments?” Treating people beyond the disease and providing an extra blanket of support with integrated care is palliative care. This is asking the patient, “how do you choose to live with this illness?” Palliative care replaces ignored issues and unspoken feelings with a sacred space of compassionate listening. An unmet palliative care need may be a gap between what is said and what is heard.

“I don’t know how much you make, but I do know you make a difference.” Although unclear which member of the palliative care team this was said to by a patient’s daughter, it is evident that good work was happening. Trusting that we are all here to make a difference, and that we are a community of inspired people is what truly matters most. Investing in a palliative care team in hospitals across the nation is now critical. A palliative care team consisting of a physician, a nurse/nurse practitioner, social worker, and chaplain can provide that extra blanket of coverage. Gaps in care can be identified that can then be matched with resources. Allowing poor quality of life and excessive suffering by not providing for the broader needs of patients and families is not the kind of healthcare that makes a difference.

According to recent statistics, more than 50% of adult children do not live in close proximity of their aging parents. Patients may have several doctors, which increases the risk for poly pharmacy. There may be little to no home care support and the emergency department may be the only crisis support available. This is not quality care and not the kind of care that makes a real difference. Spiritually, as a person faces the progression of their illness, existential crises often occur. A strong palliative care team within the hospital system can make a real difference.

At its inception, palliative care was thought to be about “pain control” or “comfort care.” Some patients and families may still have a negative perception or misunderstanding of palliative care, viewing it as a “giving up” or “final stage.” Attending physicians may fear palliative care discussions will provoke anxiety or anger in their patients. Palliative care will actually build trust, establish understanding and strengthen relationships. The palliative care team can help patients and caregivers walk through ambivalence and the mystery of illness and disease. The future of healthcare is here now, and it’s called palliative care medicine.

Margaret Jones is in her 10th year of ministry with CHRISTUS Santa Rosa Hospital. She serves on the palliative care team in New Braunfels, TX, with Dr. Julia Kellcy, Deborah Calhoun, RN, and Fayemeh Hagne, LMSW.

When end of life is near life's start, palliative care helps family members embrace short time they have together

By Linda M. Bollenbach, MDiv, BCC

I recall an eventful day in NICU when a nurse practitioner called me over to her desk with an urgent inquiry, "Linda, aren't you the chaplain on the palliative care team? Could they help us?"

A full-term baby named Trevor was dying. After days of growing increasingly ill, he was diagnosed with an HSV infection that would ultimately take his life. His young parents had been informed and were grief-stricken.

The palliative care team was not integrated into NICU, so we did our best within the unit to provide the physical, emotional and spiritual support the family needed in the weeks to come. One day Trevor's mother said to me, "I don't understand why this is happening. All that I know is that Trevor's life has meaning. I don't want to think about his death. I want to focus on his life and cherish every moment that I have with him."

We honored her wishes, and gave her the space she needed to love and care for her son. She and the father of the baby had different needs, which we respected. I listened to the father, who expressed his sense of responsibility for the situation, as well as guilt over having to continue working.

Trevor lived for another month. He remained in NICU, because the couple's living situation did not provide needed support. During that time we helped his family create memories. RNs took photos. Child life specialists made hand and foot molds. I encouraged the family and nursing staff to allow Trevor's 3-year-old sister to see her little brother and take photos of them together.

After Trevor died, we gave the family keepsakes, such as blankets and the thermometer that his father requested. I helped them discuss burial arrangements and provided them with information about area support groups, one of which would invite them to a candle lighting service the following Advent.

I have been the palliative care chaplain at Mercy Hospital in Springfield for several years. During that time, I have also covered NICU, Labor & Delivery, and helped to coordinate the Infant & Child Bereavement Program.

Wearing different hats has given me the opportunity to consider what palliative care could look like along the full continuum of life, particularly in regard to one aspect of palliative care: end-of-life care. As I witness the difference that palliative care makes for patients and families who are nearing the end of a long and meaningful relationship with one another, I want to see that for patients and families who will likely have a short but meaningful relationship.

Palliative care is more about living than it is about dying. It is about freeing patients and families to embrace their lives and the time that they have together. If this is important for one who has had the opportunity to live a full life, it is equally important for one whose time on earth is brief yet precious.

I came to fully appreciate the value of palliative care when my father was diagnosed with ALS last February. Just six weeks later he died a peaceful and beautiful death. I learned that one gift of ALS was that the certainty of the outcome freed Dad from fighting death, so that he could embrace what remained of his life. We were able to focus on simply being a family together during that sacred time. We didn't have to struggle with visiting hours in an ICU or burdensome therapies that would have prolonged his suffering and limited our interactions with him. My memories of those days inspire me to advocate for other families to have that meaningful time together.

When a family receives news of a life-limiting perinatal diagnosis, they ought to have the opportunity to embrace that sacred life and their time together as a family, however brief it may be. Sometimes in an attempt to shield them from hearing the harsh news that their child is likely to die, they are offered false hope and potentially robbed of the opportunity to fully embrace the limited time that they have.

As our understanding of how to support families experiencing the death of a child grows and as palliative care programs become more prevalent, it is natural that we begin to pull this knowledge together to develop perinatal and neonatal palliative care programs.

At Mercy in Springfield, we are beginning to formalize our process of providing perinatal palliative care. An interdisciplinary team, which includes obstetricians, neonatologists, RNs from L&D and NICU, a genetic counselor, social worker, bereavement coordinator, chaplain, ethicist, and palliative care NP meets monthly for an "Antepartum Ethics Case Review" meeting. The cases we review include diagnoses such as: Trisomy 13, Trisomy 18, anencephaly, Potter's syndrome, certain heart conditions, babies of mothers who are HIV positive, etc.

We review each case and anticipate the best way to respond to each diagnosis. When there is an in utero diagnosis of a fetal anomaly incompatible with life, a family meeting is set up with several members of the team, who will help the family to do advanced care planning and develop a birth plan, if they so choose. The birth plan will address how the family wishes to spend time and create memories with their baby, as well as what rituals, keepsakes, and experiences are important to them. Members of the interdisciplinary team that will care for the family will review that birth plan, in preparation for the delivery.

Our program is still in its developmental stages, as I suspect many others are. It will take time and sharing of experiences to expand our understanding of how to better meet the needs of families whose children's lives will be limited. Most of all, it will take the realization that true hope lies not in pretending that everything is going to be OK, but in being freed to cherish those we love, strengthened by supportive and compassionate caregivers.

Linda M. Bollenbach is chaplain at Mercy Hospital Springfield in Springfield, MO.

Matching treatment plans to patient goals involves piecing together patient puzzle

By Towana L. Ernst, APN, FNP-BC

As an advance practice nurse working with an in-patient palliative care consultation service in a 600+ bed acute care facility, establishing goals of care for a patient is one of the primary reasons our team is consulted. Our team consists of two physicians, six advance practice nurses (APN), one counselor, one social worker, and pastoral care. On any given day we have between 25-30 patients on our service with average of 98 consults per month and greater than 580 bedside visits per month.

Every day, Monday through Friday, one of our team acts as the quarterback who, when a consult is placed in the Electronic Medical Record (EMR), receives the initial report and assigns the patient in rotation to either the physician or APNs. Information is typically brief and related to the reason for this admission. Our goal is to complete all consults that come in until 4 p.m. as well as round on the patients we are currently seeing. We also rotate weekend coverage with only one provider, who is responsible for seeing the consults as well as rounding on patients that need to be seen. As much as possible we attempt to have continuity of care at the bedside; therefore, we try to limit the number of changes in who is seeing the patient as this typically provides a sense of trust with the patient and goals of care have a more consistent focus.

In order to ascertain the treatment plan, we first identify the healthcare goals of the patient. When we receive the consult, we enter the patient's chart and begin to gather the pieces of this puzzle. We review demographics, emergency room (ED) notes, history and physical (similar to an admission summary) as well as progress notes, other consultant notes, vital signs, medication records, lab results, imaging studies, notes from social work, physical and occupational therapy. Code status is always reviewed. We are also able to view records from previous admissions and physician office visits if they utilize the same EMR.

Our EMR has a tab marked "Advance Directives" and we review and evaluate the many different documents that might be located in that file such as a Healthcare Power of Attorney (HCPOA), Living Will, Appointment of a Surrogate, or an old or new version of the Do Not Resuscitate (DNR) order. There may also be a document that has been scanned into the chart that identifies a conversation between the patient and a member of a healthcare team that dealt with the subject of advance care planning. The picture that is created throughout this process enables us to look for patterns in the choices patients have made in the past and to better understand the reason for their current admission and choices made up to the present.

Most of us involved in our team might say nothing in life can prepare us for this role, yet everything in our lives has prepared us for this role. While all of the preparatory work is significant, the focal point of the consult is the patient. As we enter the patient's room we first lay eyes on the person. He or she may or may not be able to communicate with us. Perhaps there is family at the bedside, perhaps not. Has the patient or family or friends ever heard of "palliative care" or when we present the service do facial expressions change from inquisitive and open to overwhelmingly sad? Our patients have many faces. My patient may be a 66-year-old man on his fifth admission this year for advancing end-stage lung disease who is already on the ventilator or will soon need one. In this case, our goal may be to assist this gentleman in establishing his short-term and long-term healthcare plan.

Perhaps the patient is a 72-year-old who came to ED with a persistent cough that has failed antibiotics. A CT scan has revealed multiple lung tumors. She is now facing consults with oncology and surgery and being asked to consider a biopsy as well as further imaging studies that will reveal possible other sites in the body where there may be cancer. Maybe the patient will be a seemingly healthy 42-year-old man who just "dropped" at work and 911 was called, only to find the patient without a pulse or not breathing. Paramedics worked until they regained a heart rhythm; however, time without oxygen to the brain was significant. Patient is on a ventilator and they have his core body temperature down to 92 degrees as part of a protocol to decrease tissue damage and we have been consulted to determine "goals of care." The patient is sedated and on a ventilator and there is no family at bedside.

These scenarios offer a glimpse of the lives that we touch every day in our practice. We meet with the patient and try to draw out of the conversation the things in life that matter to THAT person. We ask about their life experiences and dare to tread on what will matter in the future. Many times I liken healthcare to a huge bag of goodies filled with tests, treatment, procedures, medications, and machines and encourage them to determine which of these match with their goals for the focus of their care. We review any existing documents where they may have written down choices which also provide guidance for their treatment plan, although each admission may cause the patient to reconsider previous choices and opt for more aggressive treatment or less aggressive treatment.

We also make a special attempt to have a family conference with the primary physician team, the patient, as well as family/friends that are involved in the life of the patient. During this conference, the goal is to establish a treatment plan that is consistent with the goals and choices of the patient or his or her spokesperson. Unfortunately, there are times when the patient has not had discussions with those around them regarding goals for healthcare treatment, and we must look to other individuals for answers. This proves to be an emotional time for the decision maker(s), often times complicated by their own moral and ethical viewpoints.

The mission of palliative care as it relates to establishing a treatment plan based upon the patient's goals of care is a puzzle. The pieces must be gathered carefully, sometimes daily, although some may be missing. These pieces, together with other components, create a picture that in the end most closely resembles that of the patient. There are no right or wrong answers as each person is an individual who looks at the puzzle today and decides if it looks appropriate for him or her. Life, of course, is not set in stone, and tomorrow the individual may wish for the puzzle to resemble them differently.

Towana Ernst is an advance practice nurse with Palliative Care Consulting Service at OSF Saint Francis Medical Center in Peoria, IL.

NACC Standards for Specialty Certification in Palliative Care and Hospice

Final Draft September 25, 2013

Those seeking NACC specialty certification in palliative care and hospice are required to have current certification and be in good standing with NACC.

NACC Standards for specialty certification in palliative care and hospice are presented in the context of the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care (3rd Edition) which includes a definition that characterizes palliative care in the United States, also used by the U.S. Department of Health and Human Services (HHS) Centers for Medicare/Medicaid Services (CMS) and the National Quality Forum (NQF):

Palliative Care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information and choice.

The following features characterize palliative care philosophy and delivery:

- Care is provided and services are coordinated by an interdisciplinary team
- Patients, families, palliative and non-palliative healthcare providers collaborate and communicate about care needs;
- Services are available concurrently with or independent of curative or life-prolonging care;
- Patient and family hopes for peace and dignity are supported throughout the course of illness, during the dying process, and after death.

NACC Standards for specialty certification in palliative care and hospice also draw from the National Hospice and Palliative Care Organization *Competency Grid* and both draw from and parallel the Standards set forth by the Association of Professional Chaplains Board of Chaplaincy Certification, Inc. *Palliative Care Specialty Certification for Board Certified Chaplains*. These standards use palliative care and hospice as the title of specialty certification as hospice care is viewed as a specialized palliative care for terminally ill patients.

901 Theory of Pastoral Care Competencies

The applicant will demonstrate the ability to:

901.1 Integrate a theology of spiritual care into the practice of palliative and end-of-life care.

901.11 Articulate and/or facilitate discussions with the interdisciplinary care team and patient/families with regard to the theology of suffering, loss and pain as they relate to the practice of palliative and end-of-life care.

901.12 Articulate an understanding of the consensus definition of spirituality and its integration in palliative and end-of-life care. Spirituality is defined as, "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, to self, to others, to nature, and/or to the significant or sacred." (NCP Guidelines)

901.13 Recognize spirituality as a fundamental aspect of compassionate, patient- and family-centered care that honors the dignity of all persons.

901.2 Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of palliative and end-of-life care.

901.21 Provide examples of one's ability to explore, document and communicate spiritual and existential concerns including, but not limited to, life review, assessment of hopes, values, and fears, meaning, purpose, beliefs about afterlife, spiritual or religious practices, cultural norms, beliefs that influence understanding of illness, coping, guilt, forgiveness, and life completion tasks.

901.22 Demonstrate a working knowledge of how patients and families function as a system and how group relationships impact the practice of palliative and end-of-life care.

901.3 Incorporate the spiritual and emotional dimensions of human development into the practice of palliative and end-of-life care.

901.4 Demonstrate knowledge and skill in addressing ethical issues that arise in palliative and end-of-life care.

901.41 Understand the role of a chaplain on ethics committee or ethics consult team.

901.42 Understand the Ethical and Religious Directives for Catholic Health Care Services as they apply to Catholic institutions and healthcare or home care settings.

901.43 Apply the Ethical and Religious Directives for Catholic Health Care Services in the care of the seriously ill and dying, serving as an expert resource to patients, families and the interdisciplinary care team.

901.5 Incorporate a working knowledge of the unique aspects of group process and organizational behavior important to palliative and end-of-life care.

901.51 Describe the role and responsibilities of the chaplain as an integral member of the interdisciplinary palliative care/hospice team, advancing excellence in spiritual care.

901.6 Integrate the history, philosophy, current research and goals of palliative and end-of-life care into practice.

902 Identity and Conduct Competencies

The applicant will demonstrate the ability to:

902.1 Function in a manner with patients, their families and the interdisciplinary care team that honors the dignity of all persons and the relevance of the spiritual, religious and existential dimensions of care in palliative and end-of-life care.

902.11 Act as a model and mentor for the interdisciplinary care team in respecting, exploring and communicating with patients and families regarding their beliefs and practices.

902.12 Facilitate the religious, spiritual and cultural rituals/practices desired by patients and their families – especially at/after the time of death.

902.2 Model appropriate pastoral leadership and articulate the unique professional role of the chaplain as a core member of the interdisciplinary care team.

902.3 Identify one's professional strengths and limitations within the interdisciplinary care team .

902.4 Articulate how emotions, values and assumptions affect caring relationships.

902.41 Understand and respect personal and professional boundaries.

902.42 Model non-judgmental behavior and communication.

902.43 Model the ability to maintain personal integrity while addressing the moral, ethical and existential challenges that confront patients, families and caregivers.

902.5 Advocate for the physical, psycho-social, spiritual and cultural needs of patients and families related to their goals of care.

902.6 Model healthy self-awareness, self-care and self-reflection both personally and professionally.

902.61 Articulate one's own spirituality, grounded in relationship with God, self and others in a way that respects patients, families and members of the interdisciplinary care team.

902.62 Facilitate spiritual reflection and practices within the interdisciplinary care team.

902.63 Demonstrate an understanding of when to seek help to avoid being overwhelmed, enmeshed or otherwise ineffective.

902.7 Provide educational programs for the interdisciplinary care team that facilitate a greater understanding of their role in addressing spiritual and existential issues frequently confronted by patients with life-threatening or serious illnesses and their families, including spiritual pain and distress.

903 Pastoral Competencies

The applicant will demonstrate the ability to:

903.1 Lead, teach and assist the interdisciplinary care team in integrating spiritual screenings, histories and assessments into their professional scope of practice to identify and relieve spiritual and existential suffering.

903.2 Respect the spirituality and beliefs of all members of the interdisciplinary care team and contribute to the creation of a healing environment.

903.3 Provide opportunities to engage the interdisciplinary care team in self-care and self-reflection of their beliefs and values as they work with seriously ill and dying patients.

903.4 Mentor and model the inclusion of the patient's and family's spiritual beliefs and values in advance healthcare planning and goals of care conversations, patient/family conferences, support groups and bereavement support.

903.5 Promote professional and institutional use of religious/spiritual symbols and language sensitive to cultural and religious diversity and support patients and families in their desires to display and use their own religious/spiritual and/or cultural symbols.

903.51 Lead and facilitate rituals for patients, families, community and all levels of the organization.

903.6 Facilitate patient's access to clergy, religious, spiritual and culturally-based leaders, and/or healers in their own religious, spiritual, or cultural traditions.

904 Professional Competencies

The applicant will demonstrate the ability to:

904.1 Utilize a working knowledge of the key physical, psychological and social issues/principles in palliative and end-of-life care sufficient to effectively communicate with other palliative care/hospice team members.

904.2 Keep current and participate in evidence based, research-informed best practices in chaplaincy and spiritual care.

904.3 Integrate chaplaincy care into the organization through appropriate measures, such as policies and procedures, use of evidence informed spiritual screening, history taking, assessment and documentation processes and education of the interdisciplinary team about the role of the professional chaplain.

904.4 Demonstrate a working knowledge of the palliative care/hospice team model and the scope of practice of the interdisciplinary care team members and refer effectively to each.

904.5 Foster and enhance inter-professional and team relationships within all levels of the organization.

904.6 Demonstrate working knowledge of community resources, such as hospice and home care, as well as grief and bereavement services and be an advocate/resource for palliative care in the community.

904.7 Address and document spiritual/existential care needs, goals and concerns identified by patients, family members, the interdisciplinary care team or other spiritual care professionals in accordance with established protocols, emphasized during transitions of care, and/or in discharge plans.

904.8 Participate in palliative care-focused quality improvement projects.

904.9 Facilitate ethical decision-making for patients and families of diverse populations informed by the Ethical and Religious Directives for Catholic Health Care Services.

Related: Palliative Care and Hospice Specialty Certification Process:

www.nacc.org/vision/2014-Jan-Feb/Palliative-Care-and-Hospice-Specialty-Certification-Process.aspx

Palliative Care and Hospice Specialty Certification Process

October 2013

Prerequisites

1. Board Certification as an NACC chaplain or supervisor
2. Documentation of at least 500 hours of direct spiritual care ministry dedicated to palliative care or hospice (e.g. patient and family visits, ethics consultations, family conferences, medical record documentation)
3. Completion of extensive education in the field of palliative care, hospice philosophy and/or thanatology
4. Ten hours (not in succession) of direct clinical supervision or professional consultation regarding one's personal and professional growth in palliative care or hospice ministry (conducted by the CPE supervisor or other member of the interdisciplinary team that provides supervision)

Application Process

1. Completed application form
2. The certification application fee, two-thirds of which is non-refundable if the process is discontinued for any reason
3. Letters of recommendation addressing how the applicant meets the palliative care and end-of-life competencies from three palliative care or hospice practitioners, only one of whom is a palliative care or hospice chaplain
4. Narrative to include the following:
 - A. The applicant's thinking, values and life experience that led to her/his involvement in palliative and end-of-life care ministry
 - B. The applicant's spirituality and theology of palliative and end-of-life care, human qualities, and pastoral abilities for ministry in palliative and end-of-life care
 - C. Summary and examples of the educational role of the chaplain within the interdisciplinary palliative care or hospice team, and
 - D. Documentation of how the applicant meets the competencies required for palliative care and hospice specialty certification
5. Case study to include at least five (5) successive palliative and end-of-life care interventions/consultations with accompanying reflection and medical record charting notes
6. The certificate of completion and summary of curriculum from a formal educational program in palliative and end-of-life care, if applicable, or documentation of extensive education
7. Copies of notes from, or a two page narrative of the applicant's clinical supervision or consultation of her/his palliative care or hospice ministry re: sessions of direct clinical supervision.
8. Copy of the most recent peer review if applicable

Interview Process

1. Interview team to be comprised of three members; a minimum of two (2) Board Certified chaplains with palliative care or hospice experience and/or palliative care and hospice certification and one (1) palliative care or hospice interdisciplinary team member as an active member in the interview process.
2. The interview team meets to collaboratively draft the Presenter's Report, Part I.
3. The interview lasts fifty (50) minutes.
4. The Presenter prepares and makes available the Presenter's Report, Part I to the applicant one hour prior to the interview.
5. Following the interview, the team votes to either recommend or not to recommend the applicant to the Certification Commission for certification and orally shares the Presenter's Report, Part II, and the recommendations for further work.
6. The Presenter's Report, Parts I and II, are forwarded to the Certification Commission for action at its next scheduled meeting.
7. The Certification Commission, at its next scheduled meeting, reviews the Presenter's Reports, Parts I and II, and the recommendation of the interview team and determines whether or not the applicant meets the NACC Standards for Specialty Certification in Palliative Care and Hospice

After the Certification Commission meeting, the applicant will be notified both by email and formal letter of the Certification Commission's decision regarding his/her certification status.

Renewal of Certification Process

Suggestion A:

1. For renewal of certification, the palliative care/hospice chaplain must adhere to the applicable NACC chaplain or supervisor renewal of certification procedure as specified in the NACC Certification Procedures Manual, and
2. For certified palliative care and hospice chaplains, a minimum of fifteen (15) continuing education hours for renewal of certification must relate to education in palliative and end-of-life care beginning with the year in which the palliative care and hospice certification was granted, and
3. The peer reviewer must be an active or retired certified chaplain or CPE supervisor (as applicable) with palliative care and hospice specialty certification or experience and with whom the palliative care or hospice chaplain does not share a reporting relationship.

Suggestion B:

1. If granted palliative care and hospice certification, the chaplain's BCC renewal of certification date will be reset to the year in which the specialty certification was granted, and
2. Prior to December 31 of the year that is five (5) years after the granting of the palliative care and hospice certification, the palliative care/hospice chaplain must adhere to the applicable NACC chaplain or supervisor renewal of certification procedure as specified in the NACC Certification Procedures Manual, and
3. For certified palliative care and hospice chaplains, a minimum of fifteen (15) continuing education hours for renewal of certification must relate to education in palliative and end-of-life care beginning with the year in which the palliative care and hospice certification was granted, and
4. The peer reviewer must be an active or retired certified chaplain or CPE supervisor (as applicable) with palliative care specialty certification or experience and with whom the palliative care chaplain does not share a reporting relationship.

Related: www.nacc.org/vision/2014-Jan-Feb/NACC-Standards-for-Specialty-Certification-in-Palliative-Care-and-Hospice.aspx> NACC Standards for Specialty Certification in Palliative Care and Hospice

Vision: Goodbye Laurie! Welcome back, David!

I want to begin by thanking Laurie Hansen Cardona for her years of service to the NACC and the chaplaincy profession in her role as editor of our *Vision* for the past six years. When I became executive director of the NACC in August 2007, David Lewellen had been editor of *Vision* and was doing a high quality job. When in early 2008 he let me know he was taking an editorial position with the *Milwaukee Journal Sentinel*, we were fortunate that Laurie Hansen Cardona expressed interest in becoming editor. I had known of Laurie's work when she was managing editor of the Archdiocese of Milwaukee's *Catholic Herald*. She also had national experience in working for *Catholic News Service*. I was excited to have a person of her background and expertise assume this role.

Laurie's work over the past years has exceeded my expectations, as she helped guide *Vision* from a printed medium to an online product; worked closely with NACC Editorial Advisory Panel members to map out themes for *Vision* issues; solicited, screened, and guided writers; worked closely with our research member, Austine Duru, to include regularly high quality research contributions; sought editorial consistency with the invaluable proofreading help of Becky Evans and Susanne Chawszczewski, when she was with us, and worked with Phil Paradowski, our website specialist, to ensure an overall visual appeal for the online publication. In summary, Laurie did not work alone, and an important part of her success was that she was able to be in communication with our members, writers and book reviewers, our Editorial Advisory Panel, staff members, and a myriad of other constituents to ensure a high quality product each time. Laurie did all this on contract with the NACC, while being a full-time mom and wife and teaching English as a second language, which had been her aspiration and goal well before giving NACC six years of her professional life. Laurie is a lovely human being, a woman of faith, a person driven by a love for family and those in need. Please join me in wishing her all the best.

As we move forward, I am delighted to let our members know that David Lewellen will be reassuming the *Vision* editor responsibilities. Again, I am excited that David was interested in returning to the NACC in this role. While he continues his editorial work with the *Milwaukee Journal Sentinel*, and his life as a loving father and husband, he will start his editorial work with the next issue of *Vision*. In many ways, David has remained close to NACC staff members, exchanging emails, sharing the growth of his children, and offering me comments on NACC Now and *Vision*. Please join me in welcoming David back.

David Lichter
Executive Director, NACC

A Letter to Laurie Hansen Cardona

Dear Laurie,

You have been a great editor of *Vision*. So it is with some sadness that we offer our congratulations to you on your new path as an ESL teacher. We know that this has been a long-term goal for you, and that it is a positive move for you and your family. We wish you the very best in the years ahead.

We have greatly benefited from your leadership over the last six years. You guided us with choices of themes and (gently) prodded us to submit our work by the deadline. Your editorial skills improved and focused our submissions. You have written many articles on a wide range of topics. The challenging transition from hard copy to an electronic publication was made under your guidance. With your vision, skills, and commitment you have shaped *Vision* into a valued journal and resource for chaplains.

We will miss your leadership. Most of all we will miss your gentle presence, which we felt in spite of the distance through emails and phone calls.

Thank you so much.

Blessings and best wishes,

Isabelita Boquiren, James J. Castello, Elaine Chan, Austine Duru, Marika Hanushevsky Hull, David Lichter, Sandra Lucas, Michele Sakurai
Members of the NACC Editorial Advisory Panel

2014 NACC National Conference to be entryway to strategic, compassionate leadership

Plenary speakers will be theologian, social scientist, ethicist and health executive

By Peg McGonigal, BCC, and Father Jack Crabb, SJ

Say “St. Louis,” and the iconic gateway arch comes to mind. Built to honor Thomas Jefferson and all of the pioneers who dared to consider the opportunities as the young nation expanded, the arch signifies that St. Louis is the gateway to the West. How fitting then, the 2014 NACC National Conference gathers on the same banks of opportunity and promise to pioneer a shared vision through the “Gateway to Compassionate Leadership.”

Like the pioneers who sought new opportunities in the West, professional chaplaincy must consider the expansion of ministry in new settings to meet new needs – all with the skills found in compassionate leadership. The Conference Planning Task Force identified four pathways of such a leadership: we begin *from a renewed spirit*, consider ministry *in new settings, with new partners, through new services*. These pathways are as much about being strategic as they are about being compassionate.

To this end, the task force has enlisted the expertise of four national leaders from four diverse disciplines to serve as plenary speakers: theologian Sister Patricia Talone, physician and ethicist Dr. Daniel Sulmasy, social scientist Wendy Cadge, and executive Chris Lowney.

Sister Patricia Talone, RSM, is vice president of mission services for the Catholic Health Association of the United States (CHA). She lectures extensively on mission and healthcare ethics.

Dr. Daniel Sulmasy, OFM, currently the University of Chicago’s Kilbride-Clinton professor of medicine and ethics in the Department of Medicine and Divinity School, is also associate director of the MacLean Center for Clinical Medical Ethics. His research interests encompass both theoretical and empirical investigations of the ethics of end-of-life decision-making, ethics education, and spirituality in medicine.

Wendy Cadge is an associate professor in the Sociology Department at Brandeis University, where she is currently working on a series of new projects about religion and spirituality in secular settings, including port and maritime contexts, airports, and the U.S. Senate.

Chris Lowney, formerly a Jesuit, chairs the board of Catholic Health Initiatives, one of the nation’s largest healthcare/hospital systems. His new book, titled “Pope Francis: Why he Leads the Way He Leads,” explores the compassionate leadership style of the first Jesuit pontiff.

When we go to NACC conferences we experience a wealth of hospitality, colleague interaction, and well-prepared liturgies. We look for opportunities to broaden our knowledge base as chaplains. We desire to find educational workshops that help with those famous 50 annual hours of continuing education hours (CEHs). This year, as has been true in the past, the NACC Conference Planning Task Force has sought to provide all you want and more in the workshop offerings. We listened to critiques of past conferences and have reinstated three workshop times. We had abundance of proposals – 38 to be exact– for the 24 slots. What a challenge to narrow them down to 24! The selection committee for workshops has encouraged the NACC to consider some of the other 14 as webinars. We likewise had an abundance of choices for the pre-conference four-hour workshops. From the 12 proposals, we selected four. Let us highlight some of the choices we have for your selection and educational learning.

Our pre-conference workshops will see topics of self-care, motivational interviewing, and two theological topics, healing suffering and end-of-life issues. We all talk about self-care, but do we actually practice it ourselves? The pre-conference workshop will offer “proven techniques to reduce the “stress response” in the moment and over

time.” Motivational interviewing “is an evidence-based approach to helping people name and address ambivalence when looking at change.” With so much change occurring in healthcare we are faced with the ambivalence daily. The workshop on Healing suffering will highlight use of what chaplains do intuitively with a spiritual assessment tool to communicate with the interdisciplinary team. The end-of-life workshop will discuss the difference between palliative care and hospice, explain some of the tasks at the end of life, and assist in reflection on one’s own hopes and fears.

Here is just a taste of what to expect when you receive the conference registration material for the 75- minute workshops. We have three different self-care presentations, one in each workshop section. There are three workshops on working with and building volunteer programs to supplement the work of the certified chaplains, again one in each workshop section. How would you like to be able to dialogue with your bishop to advance diocese-wide healthcare? Or maybe you want to work collaboratively with clergy of different faiths and cultures in your area to respond to the diverse populations in your institution. Another workshop will assist in the struggle we all have on how to decide who needs us most. This workshop will have a screening tool to assist with that decision-making process.

As we begin to look outside the acute care center, we have workshops to assist with ways to begin that journey of leadership, as one of the workshops is titled “Thinking Outside the Box....” There are workshops on prison ministry, working as chaplains in physicians’ offices, using the PACE model, a panel about palliative care, and the challenges for chaplains entering the world of the researcher.

We have workshops that are theological in focus. Suffering is a topic that we chaplains deal with daily. One workshop explores the different ways people experience suffering and offers practical strategies for helping ourselves and those we serve “to grow through the natural suffering that is part of life.” Many chaplains find themselves involved with neonatal units and the joys and sorrows that follow. A workshop called “From Newborn Loss Comes the Gift of Hope” speaks theologically about loss and hope. “Celebrations of Life in a Changing Culture” makes us aware of different ways families grieve and how the culture has changed. And if you want to know more about the spirituality of Pope Francis, we offer a workshop called “In Dialogue with St. Ignatius,” which provides the chaplain a prophetic role in the institution.

Look over the forthcoming registration packet and you’ll find workshops that are about self-care, multi-ministry or new ministry, forming partnerships or being leaders, palliative care, theological or volunteer programs, even drumming. There are many valuable workshops that will enhance our learning and competencies as chaplains and supervisors.

The setting for the national conference will be in the magnificent St. Louis Union Station Hotel. Built in 1894, this gem of a building was once considered the “most beautiful terminal in the United States.” After a multi-million dollar renovation, the St. Louis Union Station Hotel, a Double Tree Hotel by Hilton, will provide comfortable accommodations and amenities to restore one’s spirit. The hotel is close to many St. Louis points of interest. Clearly, this will be a conference worth attending!

Peg McGonigal and Father Jack Crabb are members of the 2014 NACC Conference Planning Task Force.

Q & A with Cynthia X. Pan, MD, AGSF, FACP

By Elaine Chan, MSW, MDiv, BCC

Cynthia X. Pan, MD, chief of the Division of Geriatrics and Palliative Care Medicine at New York Hospital Queens in Flushing, NY, created an in-patient palliative care program in September 2010 that has helped more than 2,600 patients and their families. She works collaboratively with hospital leadership and community agencies to optimize palliative care and transitional care for patients with serious illnesses. She has presented in both geriatrics and palliative care national societies and international audiences, and works to bridge the gap between the two fields. In the diverse Queens community, Dr. Pan is able to use her Chinese and Spanish language skills to facilitate communication with patients and families.

Q To what extent does spiritual care participate on the interdisciplinary team in your clinical setting? What role does the chaplain play?

A The palliative care program at New York Hospital Queens (NYHQ) has worked collaboratively with the spiritual care team from the start (since September 2010). We have shared in the care of many patients and their families. Because the palliative care program cares for patients with serious or life-threatening illnesses, and their families, these populations often need strong spiritual care and support. Chaplains can play a variety of roles for seriously ill patients. These include: offering emotional support, spiritual and/or religious guidance about decision-making, helping to answer spiritual or existential questions, performing prayers, supporting patients and families at the end of life, and much more. However, chaplains perceive that they are called very late in the course of illness and wish they could participate in patients' care earlier, so that they can form more solid relationships and be in a position to offer more help. More recently, Rabbi David Keehn (director of chaplaincy services at NYHQ) has offered for the chaplains to play a more active role within the palliative care program. We began by inviting chaplains to join our team in morning sign-out meetings to learn about patients on our service. Chaplains also round with the clinical team to see patients together, allowing the patients to benefit from the medical visit as well as the spiritual visit.

Q Can you give an example of how a chaplain's involvement made a critical difference with a patient or family?

A Yes. One example was an elderly woman who had end-stage respiratory failure and did not want to live on life support; she was ready to accept she was at the end of life. However, her son insisted that the patient be intubated and live on life support. The rabbi was instrumental in joining our family meeting, helping to counsel the son, communicating with the son's rabbi to clarify concerns, and work through the decision-making process. Another example was an elderly man with advanced heart failure who enrolled in hospice services. He spoke with the chaplain about many regrets in his life and broken relationships. The chaplain helped this man coordinate his last birthday party, inviting many of his friends and family members, to be able to say the most important things: "I love you," "Forgive me," "I forgive you," "Thank you," and "Goodbye." As a result of this farewell party, the man influenced his estranged brother to take a second chance at repairing his marriage and change his life for the better.

Q Do you engage patients in conversations about their spirituality or faith? How do the patients and families respond?

A I always keep in mind that everyone has a "spiritual" dimension. I often ask my patients about their spirituality or faith. Not everyone wants to discuss this matter with their physicians. Thus, I have experienced a wide variety of responses. Some patients do not want to engage in this conversation. Some patients want us to

pray for them; some patients offer to pray for us. Some patients become very animated and tell me all about their spiritual or religious experiences, about how they turned over their struggles to God, and made peace that way. I do teach our doctors- and nurses-in-training about how to ask about spiritual orientation and how clinicians can help facilitate their spiritual care. I also teach our trainees about how to access the chaplains for our patients and families.

Q What aspect of caring for patients is the most emotionally/spiritually challenging for you?

A When I see patients who are so ill and struggle, I feel grateful for my own health and well-being. I learn not to take things for granted. I try not to take life or myself too seriously. One challenging aspect of palliative care work is the balance between caring, but not caring so much that you lose your perspectives or boundaries. Another challenging aspect is not to take things too personally. If a patient or family becomes angry or upset, there are often underlying frustrations or fears. Also, we must always listen actively, and really hear what the patient is saying, rather than imposing our own opinions and values on them. Many times, it is all about shared decision-making, and allowing time for emotions to settle.

Q How do your colleagues look at spiritual care as part of interdisciplinary care? Is there discussion in professional circles about the value of spiritual care in the clinical setting?

A My palliative care colleagues (whether it's physicians, nurses, or social workers) very much value spiritual care as part of interdisciplinary care. It is a given. We often wish that spiritual care counselors could write notes and communicate through the medical chart, so that we understand what is going on at the spiritual level with the patient. Among colleagues in general medical practice, I find that their knowledge about the role of spiritual care counselors is limited, probably because their training did not incorporate or emphasize this aspect of care. Now that we have medicine residents rotating with our palliative care program, hopefully this will change.

Elaine Chan is staff chaplain at New York Hospital in Queens, New York, and is a member of the NACC's Editorial Advisory Panel.

Basketful of Hearts

By David Orr, MTS

You handed me
a thousand hearts
to hold and carry
deep inside
my own dark basket
for a whole year.

At first
I was afraid of you.
I wondered why
you trusted me
to bear this load
of such strange fruit.

Some of it
was cut too deep
bruised too dark;
so soft it bled
on every side
if touched at all—

so I did not touch.

Some of it
was far too heavy
loaded down
by too much fear
too many tears cried
over years—

so I did not cry.

Some of it
was covered
by a blanket
of sun too bright
to reveal anything
precious underneath—

so I left it covered.

And some of it
was dead, rotten
from the start
no chance to drum
or begin a dance, no hum
that might invoke a trance—

so I let it rest in peace.

I searched
and searched
but could not find
the saving fruit
the healing kind—

but slowly
I began to learn
that I could touch
and I could cry
or throw back covers
to the sky
that breathing in
and breathing out
was fruit enough
to make one shout.

And then one day
you spoke again:

"Dig deeper, man,
go deeper still
down in the dark there
if you will
down in the dark there
where it's still."

So I kept digging
in those hearts
until my hands were tired and
sore
and I thought that I could dig no
more.

But I kept on digging
in the dark
until my hands had reached the
last
and touching it I was aghast.

"Hold it up," I heard you say,
"and tell me what you found
today."

And from below
my voice rang out:
"I found the heart
I thought I'd lost
beneath these others
in the dark!

It lives, it hums
it dances, too.
It beats in rhythm
next to you.
It rests in shadow
sunshine, too.
It climbs the ladder
up to you.
It lifts, it cries
it touches, too,
and best of all,
says, "I love you."

David Orr, who resides with his family in Lynchburg, VA, received his master's degree in theological studies in May 2011 from Washington Theological Union. He wrote this poem for CPE residency graduation at Georgetown University Hospital in Washington, DC. He writes that he was grateful "for being able to hold hearts for a year, and have mine transformed by the experience."

Featured Volunteer: Deacon Thomas J. Berna, BCC

For him, volunteering equals ownership

Name: Deacon Thomas J. Berna, BCC

Work: contract chaplain, State Correctional Institution – Pittsburgh (medium security state prison for men)

Member since: 2010

Volunteer service: At the NACC National Conference 2012, I was a workshop moderator and assisted at Sunday Mass. At the NACC National Conference 2013, I was a local host (helped with planning, assisted as needed during conference, assisted at Sunday Mass, provided poster on “No One Dies Alone,” hosted and introduced two speakers at the conference.

Book on your nightstand: “This Our Exile: A Spiritual Journey with the Refugees of East Africa,” by James Martin, SJ

Book you recommend most often: “Tattoos on the Heart,” by Gregory Boyle, SJ

Favorite spiritual resource: The Bible

Favorite fun self-care activity: Fly-fishing and hiking; reading when weather is not suitable for hiking or fishing

Favorite movie: “The Princess Bride” (1987)

Favorite retreat spot: Annual deacon and wives retreat (various locations)

Personal mentor or role model: I have a friend in his 80s whom I have known for nearly 40 years. He is deeply rooted in Scripture. He and his wife each minister to people “on the fringe” of society. I admire their dedication, their commitment to each other and to the Gospel. My wife and I are both active in ministry to the poor, and we continue to explore new ways to serve.

Famous/historic mentor or role model: Dorothy Day

Why did you become a chaplain? I served as a volunteer chaplain in a maximum security state prison in Texas for about six years and really loved the men and the ministry. As I prepared to retire from my 30-year career as an engineer, a friend (permanent deacon and board certified chaplain) told me about an opening for a CPE resident in the hospital where he worked. I felt excited at the prospect (hoping to improve my ability to minister to prisoners as well as to hospital patients). The residency was a time of unparalleled growth. When I completed the residency I moved with my wife to Pittsburgh, PA, where our three married daughters and their children were living. I worked three years part-time as a hospital chaplain and as a contract prison chaplain. I recently left the hospital to provide more balance in my life. As a deacon I visit many parishioners who are ill – in their homes and in healthcare facilities. CPE helps me daily in ministry.

What do you get from NACC? Support, encouragement, challenge to grow, opportunities for continuing education (at conferences, local events and online)

Why do you stay in the NACC? For personal and professional benefit and to support NACC as it supports chaplains. My job does not require that I be a board certified chaplain, but I require it of myself.

Why do you volunteer? For me, volunteering equals ownership. I want to be more than a member “in name only.” I volunteered to present a workshop at the 2014 conference. I believe I have something to offer – and a lot to learn.

What volunteer activity has been most rewarding? I think my role as a local host for the 2013 conference was most demanding and most rewarding. I volunteer extensively outside of NACC, but within the organization the 2013 conference was my most rewarding experience.

What have you learned from volunteering? By volunteering on the 2013 conference planning task force I met wonderful people, I was able to express my opinions, and I learned how much work is involved in the conference. By volunteering in simpler roles I learned that everyone is welcome and encouraged to support the NACC; not every organization welcomes and encourages its members to this extent.

Featured Volunteer: Judith A. Shemkovitz

NACC staff takes 'work' out of volunteering

Name: Judith A. Shemkovitz

Work: spiritual care/bereavement coordinator, Visiting Nurse Association of Ohio - Hospice

Member since: 1984

Volunteer service: Since 1986 I have served as a certification interviewer, regional certification chair, an Interview Team Educator (ITE), on the Certification Commission (currently the chair) and co-chair of one of our annual conferences.

Book on your nightstand: Right now it's "Rich in Years," by Johann Christoph Arnold. I'm finding it relevant to my ministry in hospice.

Books you recommend most often: This is a three-way tie – "The Prophet," by Khalil Gibran, "The Little Prince," by Antoine de Saint-Exupéry and "The Velveteen Rabbit," by Margery Williams.

Favorite spiritual resource: Monthly reflections from Joan Chittister, OSB. I often use them as a centering tool at interdisciplinary team meetings.

Favorite fun self-care activity: I love working in my yard and also figuring out major league baseball strategies.

Favorite movie: Shawshank Redemption

Favorite retreat spot: Mercy Center in Madison, CT. There's nothing like being by the water to soothe my soul.

Personal mentor or role model: Ann O'Shea. Ann was my CPE Supervisor and became my counselor, confidante, teacher, and longtime friend. She helped me to embrace the joys and challenges of ministry.

Famous/historic mentor or role model: My role model is not someone famous or historic, but rather my friend Ethel, who offers countless time in volunteer service and, in her 50s, became guardian for two granddaughters. And then selflessly took in to her home her dearest friend who experienced a stroke.

Why did you become a chaplain? On a number of occasions, taking people to the Emergency Department at a local hospital I witnessed people receiving devastating news and then being left alone to process and cope with the situation. I just knew I had to find some way to offer support and compassion in those times. Becoming a chaplain offered me a way to do so.

What do you get from the NACC? I have found this organization to be a place where I can grow professionally and personally. If I am effective in my ministry and I believe I am, the NACC is partially responsible for that.

Why do you stay in the NACC? It's like being with family. This organization supports, educates and is dedicated to its membership and loves us all.

Why do you volunteer? I first volunteered as a means to connect with other chaplains in my area, and that was quite successful. Once I established a relationship within the NACC, I found a welcoming "family." Now I feel I would be missing something important in my life if I did not have this relationship.

What volunteer activity has been most rewarding? I must say that all of the opportunities have been and continue to be rich treasures. But, since most of these activities have been associated with certification, I have had the great pleasure of working with the staff at our national office. All of them are incredibly dedicated to our organization. They take the "work" out of volunteering with NACC and make it a joy. I feel blessed to work with such wonderful people and even more blessed to consider them to be friends.

What have you learned from volunteering? I always receive much more than I give!

Book reveals vibrant faith lived out amid struggle, poverty

By John Gillman, PhD, BCC

A Maryknoll Liturgical Year: Reflections on the Readings for Year A. Judy Coode and Kathy McNeely (eds.), Orbis Books, Maryknoll, NY, 2013. Paperback, 208 pp. \$20.

One of the principles of biblical interpretation is to read it in light of human reason and experience. The reflections in this volume engagingly do that using multiple lenses from Maryknollers throughout the world who hear the sacred texts from within the diverse communities where they serve.

The 48 different authors are Maryknoll sisters, priests, brothers, and lay missionaries, some of whom have served up to 50 years among the people. The stories are filled with touching human encounters where vibrant faith is lived out in the midst of struggle and poverty. Having seen how forests have been ravaged and the land abused, the authors again and again call for the need to respect the environment, following the injunction of Pope Benedict's plea: "If you want to cultivate peace, protect creation."

The rhetoric can get overheated, when in her reflection on the Palm Sunday readings, Sister Antoinette Gutzler pronounces that "the modern-day choice for Barabbas is a choice to harm the environment and to protect our national and world securities through the building of armaments over the way of life that God has given us in creation" (p. 86). Still, such fervor and respect for *Madre Tierra* becomes a clarion call that awakens the consciousness of readers to pay attention and take action.

Responding to the story of the Canaanite woman in Matthew 15, Brother John Beeching reflects on how much he has learned from the Buddhist monks in Thailand who risked their lives caring for wounded Burmese refugees who escaped the repressive military regime of their home country. Noting that Jesus singles out the Canaanite woman, a foreigner, for praise, John wonders "how often we find ourselves praising the faith of a Muslim, a Hindu, or a Buddhist" (p. 153).

In another essay we hear about how Bishop Bunleun Mansap is inspired by his Buddhist friends in the field of peace and justice, leading him to say: "This is the Good News that the Buddhists give us. They are evangelizing us" (p. 145).

What I found most inspiring was the radical faith and profound trust these many Maryknoll missionaries embody each day, strengthened by their love of God as manifested among the immense web of people where they live and serve. Through their response to the call of the Gospel, the living Christ is incarnated.

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Book offers insights for chaplains, reflections on ethics, spiritual care

By Colette Hanlon, SC, BCC

The Soul of Medicine: Spiritual Perspectives and Clinical Practice. By John R. Peteet, MD, and Michael N. D'Ambra, MD, (eds.), The Johns Hopkins University Press, Baltimore, 2011. Hardcover, 260 pp. \$50.

Chaplains are privileged these days to be in the midst of a healthcare system that is rapidly moving from one of medical paternalism to a more holistic and patient centered calling. The timing is right for physicians and other providers to begin to take seriously how individuals' values, especially spiritual concerns and practices, affect healing and dying.

With eagerness, then I approached this volume with high expectations of the learning awaiting me and I was not disappointed. It is divided into three parts: the historical and clinical context, major traditions and medicine, and implications and applications. The largest section discusses particular issues relative to a variety of spiritual perspectives. I found some of the material uneven – a few traditions were well written and provided other resources to ponder. Others, particularly the chapter on Christianity, were slim and definitely not descriptive of Catholicism or many strains of Christian practice.

Having addressed this limitation, however, other religions, eclectic and secular essays were more thorough and descriptive of the varieties of spirituality we encounter in our practice. Each one offered insights that are helpful in informing ministry to those not sharing a Christian Catholic practice and understanding. As those we serve increasingly describe themselves as "spiritual but not religious," chaplains are called to deepen the capacity to be present as companions on life's journey.

The final section includes reflections on ethics and the implications for medical professionals, spiritual care and chaplaincy, and how teaching and learning are at the interface of medicine and spirituality. Here readers will find insights into issues they face daily – boundaries and challenges for all healthcare practitioners – and be uplifted by the awareness that medical training is increasingly more focused on spiritual and ethical perspectives.

Until I finished studying the text I was not aware of the cost of this book: \$50. The price may be prohibitive for individual chaplains. However, it would make a wonderful resource for libraries and spiritual care departments.

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