THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Defining chaplaincy in a golden nugget

What is professional chaplaincy and how do you explain the ministry to others so that they might better understand it? Two NACC members recognize the importance of encapsulating the non-negotiables of professional chaplaincy, although they express them in distinct ways and from different perspectives. Read their reflections, then try your hand at expressing what chaplaincy is in concise form by sending a comment at the end of their articles.

Laurie Hansen Cardona
Vision editor

A non-negotiable for chaplains: Embracing story

By Michele LeDoux Sakurai, DMin, BCC

Chaplains live in a world where answers often make for cold bedfellows, and questions cannot begin to express the depth of agony. It is a world in which the question "why?" echoes, and all that is left is the silence. Chaplains sit in the silence, not a dispassionate silence, but one that is fully engaged. To sit with others as they wait, often in fear; to seek the meaning of loss; to affirm the pain and not run away; to witness injustice and name it as that; and to continually speak out of a prophetic voice – this is the calling of chaplaincy. When a patient is suffering, in despair, or suicidal, it is with a seeking heart that the chaplain comes to the table. It is a heart that embraces story, and it is within this embrace that the patient can experience community and hope. "What do chaplains do?" As chaplains we learn intuitively through CPE what it means to be a chaplain. And as I listened to this question over and over again from patients, family members and staff, I believed that I knew the answer. Yet my assumptions were not tested until 2005 with the completion of my doctoral dissertation, "Ministry of Presence: Naming What Chaplains Do at the Bedside." It was through research involving chaplains throughout the United States that I began to fully appreciate the depth and breadth of chaplaincy. This research indicated that chaplains experience Attending to Suffering as their primary role; Compassion is the virtue that impels their ministry, and Story is the vehicle for assessment. Inviting or embracing story is truly non-negotiable for chaplains. With or without words our patients tell us what has value to them through each of their stories.

Well, you know how my pain has been, and well it got so bad.
The medicine they [hospice staff] give me just doesn't work. So I bought some drugs.
I shot up for two days. It was wonderful. I had no pain and could go places and…
[voice drifts off]. I used to do drugs before I knew the Lord. But now that I've been saved,
well he can't forgive me because I'm supposed to know better…. And I'm not sorry!
I can't talk to God if I'm not sorry. —AIDS patient

Chaplains in healthcare live in the moment with patients as they confront an overwhelming diagnosis, deal with the reality of mortality, struggle with issues of betrayal and loss, and make meaning of a new world. Sometimes this world is one of new beginnings as in the birth of a baby; sometimes it is a world of chaos and devastation.

Michele LeDoux Sakurai is manager of spiritual and pastoral care and mission at Providence Mount Carmel/St. Joseph's/Dominicare in Colville, WA.

How do you 'make the case' for chaplaincy?

By James J. Castello, MBA, MA, BCC

You enter an elevator at your place of work only to find your organization's CEO joining you in a two-minute ride to the top floor. You introduce yourself as a chaplain in the Pastoral Care Department, prompting the executive to turn to you and ask: "Just what is a chaplain all about? What is it that you do and how do you do it?" Face it, this scenario could happen. And if the question hasn't yet come from the top administrator, I'm sure other staff members have asked you just what it is that a chaplain does. We need to have a clear, concise, well-thought-out and rehearsed answer if we are to be perceived as competent members of the professional healthcare team.

The answer should be less than 100 words and we must be able to deliver it in less than two minutes. Sister Karen Helfenstein, SC, who is director of mission and spirituality for Catholic Health East in Newtown Square, PA, calls this drill "the elevator talk" or "making the case." I believe this exercise forces us to think through what our ministry is really all about as well as what we are about. Having the 100-word ready response can be an extremely powerful tool in the chaplain's toolbox. As a member of NACC's marketing/communications and recruitment taskforces for the past two years, I have come to the clear realization that most chaplains have no idea how to educate people about what their sacred ministry involves, its impact on people and an organization, or the difference we make in people's lives by being a compassionate presence in times of high stress, chaos, emotions, loss, grief and joy.

Most, if not all of us, have grown up with the notion that we should never "sell" ourselves under any circumstances. When I became a marketing consultant after being a corporate marketing executive for over 30 years, I was unable to "sell" myself to a potential client whom I had worked with in a previous firm when he asked me to do just that. I told him I was not raised in a family where you boasted about yourself lest we get a "big head." Needless to say, I didn't get the account.

But I realize now that I need to do be able to do so. When I filled out an application for a chaplain position last night, the very last question was: "Sell yourself. What makes you better than anyone else we could hire?" I rest my case. Each of us needs to be able to do this in order to have the self-confidence of a professional who knows what and who we are about and is not afraid to tell others in appropriate circumstances. There is such a need at all levels – where we work, in our church, in our community and even in our families.

To give you an idea of what a personal mission statement might look and sound like in an elevator, here is my whack at it:

"Chaplains bring compassionate, loving, non-judgmental and safe presence to people in spiritual crisis. The ministry's core is to be totally present – seeing a spiritual need, connecting with people in need, and supporting them. We take time to support people in need for as long as it takes. Training to become a professional chaplain involves a minimum of 1,600 hours of Clinical Pastoral Education under a certified supervisor. We provide extraordinary compassionate spiritual support to patients, families and staff. We make a difference in the lives of people we touch by bringing peace to chaos. Patient satisfaction scores prove it." (100 word count)

The above statement took me six attempts to get the word count to 100, but it was worth the struggle. I would like to urge all NACC members to write their own elevator talk and rehearse it on a daily basis.

Then try it out on different people in your life. You may be surprised by the positive responses. Once you write the statement, edit it, and try it out, please send it to Vision so we may share it with others in coming months. Your current hat size will not change. Promise.

Jim Castello, of Kennett Square, PA, worked 35 years in executive marketing positions for two global manufacturers before becoming a chaplain in 1998. As a chaplain, he ministered eight years at Hackensack University Medical Center and then worked as director of pastoral care at St. Vincent Medical Center in Jacksonville, FL, and Bon Secours Community Hospital, Port Jervis, NY. He is a consultant for NACC on marketing communication projects.

Profession of Chaplaincy: Advances in patient care

(Part one in a two-part series)

By Paul Marceau with Bridget Deegan-Krause

In the August/September 2003 edition of Vision, NACC chaplain and board member Bridget Deegan-Krause wrote an article entitled "From bedside to boardroom: Expanding the healing ministry of Jesus." In that article Ms. Deegan-Krause wrote:

"Our ministry to systems and structures is becoming one of our main priorities, especially in settings where needs are great, stress is high and threats of scandal, dysfunction, and economic, political, and social justice loom large. NACC chaplains are well-recognized for their compassionate, competent, and effective pastoral care of individuals, but we are now called to expand our healing ministry to include spiritual leadership. We must move beyond the bedside."

I thought at the time that this observation was both creative and visionary, offering opportunities for ministry at and beyond the bedside. Now as I am completing my service on the NACC Board of Directors I thought it might be a useful exercise to go back and reflect on how far we as an organization and as a profession have advanced both at the bedside and beyond.

From bedside … Advances in patient care

The profession of chaplaincy faces the need – and opportunity – for advancement in several key areas. In Part One of this two-part series we look at five areas in which the profession of chaplaincy has made significant progress at the bedside.

1. Developing measurable objectives and demonstrating the value of spiritual care

Chaplains are often anxious about being the low-hanging fruit in economically stressed healthcare systems, and they have begun to pay serious attention to the need to demonstrate the value of their spiritual care ministry. As with all other departments, spiritual care has been pushed to develop its own set of measurable outcomes – quantitative and qualitative (Marceau, 2004).

NACC took a leadership role at the CHA-NACC Pastoral Care Summit held in October 2007 in convening stakeholders to formulate and answer key questions that will help us to identify or to articulate the most important benchmarks demonstrating spiritual care's value to healthcare systems and their institutions. The process also helped us think about planning for the provision of spiritual care services, and provided metrics for demonstrating the effectiveness of spiritual care (Lichter, 2008; Burkhart, 2009).

2. Integration of body/mind/spirit care; clinical integration

Our profession has been persistent in calling for spiritual care to be integrated into clinical processes and pursuing dialogue and research in many related disciplines. The centrality of spiritual care and its impact on overall well-being have received close study, and it is now well-established that personal spirituality is integral to the healing process itself. See especially the work of Christina Puchalski at

www.gwumc.edu/gwish/aboutus/puchalski.cfm and also www.nacc.org/docs/resources/(archive)2010 Spirituality and Health Conference Flyer (oct 14 2010).pdf. Whoever touches the patient's body, touches that person's spirit. Whoever interacts with the patient – dieticians, pharmacists, environmental services or volunteers – impacts that person's spirit. This message has become an integral part of end-of-life care in palliative care settings, where it is most obvious, but we still have much work to do if we are to bring the message to all other realms of healthcare.

3. Sensitivity to religious and cultural diversity

Our healthcare system has become increasingly diverse,[1] and chaplains must be sensitive to the religious and cultural environment of the patient, and in fact must demonstrate their competency in this area in order to achieve chaplaincy certification. Diversity is explicitly listed as a formal competency in the profession's common standards: Professional chaplains "respect the cultural, ethnic, gender, racial, sexual orientation, and religious diversity of other professionals and those served, and strive to eliminate discrimination." (Com102.44) and "Respect diversity of age, national origin, and physical ability" (Com102.441). No longer is the "Catholic chaplain" seen as the chaplain only for Catholics. Catholic chaplains, like all other chaplains, minister to a wide range of believers and to non-believers as well. They receive training in the cultures of a diverse population. Chaplain Linda Arnold, who ministers at Holy Cross Hospital in Silver Spring, MD, outside Washington DC, has developed a diversity manual for use in healthcare institutions ("Understanding Other Cultures at the End of Life"), which can be found in the form of a PowerPoint presentation at www.nacc.org/docs/conference/2008 workshop materials/M4 - Arnold.ppt. Holy Cross Hospital has a population that reflects 60 different languages and cultures.

4. Development of spiritual care in outpatient settings

The delivery of healthcare has moved significantly from acute-care hospitals to community-based settings, but spiritual caregivers have been slower than others to move outside the acute-care setting, even as the length of stay in acute care declines and chaplains find little time to build relationships with patients and families.

Integrating spiritual caregiving across the continuum of healthcare is essential in today's healthcare delivery systems. Nurturing relationships in outpatient care settings can greatly enhance relationships when the patient is brought to acute care (Lemiesz, 2009). There is particular opportunity here in the area of chronic disease management, e.g., kidney dialysis and diabetes care.

5. Development of chaplains' competencies

The development of the Common Standards for Professional Chaplaincy provides for clarity in expectations for both chaplains and those who rely on their services. It also lends credibility and consistency. With this effort by the Spiritual Care Collaborative (2004), the major players in the profession have shared their best thinking and begun to speak with one voice.

The changing needs of healthcare present new challenges and opportunities for our profession, calling us to expand our vision of chaplaincy and for some chaplains to set new priorities. The competencies developed in the Common Standards demand the development of skills that serve the chaplain and the healthcare community far beyond the patient bedside, providing expanded opportunities for the profession into the organization and beyond. Standard 305.3, for example, specifically calls for chaplains to "articulate an understanding of institutional culture and systems, and systemic relationships." Many chaplains are meeting such opportunities head on, developing their competencies and expanding their ministries in exciting new ways.

In Part II (March-April 2011 *Vision*), we will review chaplain efforts in the areas of leadership and ministry formation, culture development and transformation, organizational spirituality, education and training, and political advocacy, noting how the profession is responding to expanding needs in new and creative ways.

---

[1] The Alliance of Community Health Plans Foundation, 2007, *Making the Case for Culturally and Linguistically Appropriate Services in Health Care: Case Studies from the Field*. Retrieved from minorityhealth.hhs.gov/Assets/pdf/Checked/CLAS.pdf

References

Burkhart, L. (2009, July-August). Informatics: Capturing and measuring spiritual care. *Vision* 19(4), 16-18.

Lemiesz, M. (2009, September-October). Chaplaincy department responds to challenge of outpatient ministry. *Vision* 19(5), 1, 13.

Lichter, D. (2008, May). Pastoral summit work continues: Task force members tackle major chaplaincy issues. *Vision* 18(5), 7-9, 12.

Marceau, P. (2004, June). Reflection: Translation, please. *Vision* 14(6), 3,11.

Spiritual Care Collaborative. (2004). *Common Standards for Professional Chaplaincy*. Retrieved from www.spiritualcarecollaborative.org/standards.asp

---

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Patient satisfaction scores: How reliable are they?

By Michelle Lemiesz, MDiv, BCC

Mount Carmel Health System in Columbus, OH, which is a member of the Trinity Health System, utilizes the Press Ganey patient satisfaction tool. Surveys are sent randomly to inpatients from all units except the intensive care units and to patients who have been seen in the emergency department. As is true for most hospital surveys, the bulk of the questions revolve around the patient's experience with nursing and physician care. Each of the following disciplines also has one question regarding their services: nutrition services, environmental services and lab/radiology. Hospitals are allowed to customize a few questions, and Trinity Health has chosen to add a question regarding spiritual care that reads: "Were you satisfied with the spiritual care you received from the chaplain?" It is a "yes" or "no" answer, black or white with no middle ground.

In April of this year, I assumed the role of system director of the Chaplaincy Services Departments for the Mount Carmel Health System. The system consists of three acute care hospitals, one surgical hospital, an emergency room/urgent care center with overnight observation beds and numerous outpatient services. For the purpose of this article, I will focus on the first two, since those facilities are the ones in which we have initiated a performance improvement project involving patient satisfaction scores.

Since all of our scores fell below the 50th percentile, I felt patient satisfaction with pastoral care needed attention, but as I began to unearth more about the process used to evaluate patient satisfaction, I started to question more and more the validity of it as the "golden standard" for patient care indices. I would like to outline what I feel are some of the "holes" in the process that makes this a very unreliable tool to gauge patient satisfaction in regards to patient care:

1. **Wording of the question:** The questions are crafted with the intent of "yes" or "no" answers, and while this is an effective means of gauging the effectiveness and timeliness of pain control or the cleanliness of a room, it does not fit for the provision of pastoral care. I have found that many people are nebulous about the word "chaplain" and apply it to their own clergy and volunteer extra-ordinary ministers of the Eucharist in addition to pastoral caregivers in the hospital. If their clergy person did not visit them, or the volunteer is rude, people respond to the survey question with a "No." If no chaplain visited them, patients reply "No" or decide not to answer. When no answer is given at all, it decreases the ratio that is utilized to make the total score. When I had our marketing team look at how many patients actually said "No" vs. those who passed on the question, the statistics were overwhelmingly higher for the latter.
2. **Patients Surveyed:** The overwhelming bulk of patients surveyed were generally medical or surgical in nature. Patients surveyed in the ED are those who are discharged after care and inpatients who are on one of the medical or surgical units. For the most part, given the role of the chaplain as a member of each emergency code such as heart teams, sepsis alerts, code blues, etc., and attending every death, plus following up on emergent referrals, the likeliness that these patients will be seen is few and far between. It is not because they do not have needs, but rather it is a matter of allocating fewer staff to serve the needs of those patients who are high acuity and whose loved ones are in an emergent crisis. Surveys do not count ICU patients or those who die, and that is where chaplains spend the bulk of time.
3. **Randomness of sampling:** I was surprised to hear from one of the chief operating officers of our system that the number of surveys sent to patients is random and span throughout the month.

Therefore, out of hundreds of patients admitted and discharged in a unit, only 20 or so may get a survey. Every patient is not surveyed, so the sampling pool is extremely small in which to get an accurate feel of the type of pastoral care being provided on a given unit.

4. **Generalities:** One of our facilities has been awarded the Press Ganey award for multiple years of being in the top decile for patient satisfaction scores. Their average rate in patient satisfaction scores is 98%. Despite the fact that chaplaincy was provided during that period one day a week in-house, the scores for chaplain satisfaction were also comparable. However, in other facilities, it was noted that if a patient scored one area low and were generally unsatisfied with their care, they tended to continue the trend throughout the entire survey because their visit had been colored by their negative experience.
5. **Employee Satisfaction:** A correlation has been noted about the degree of employee satisfaction to patient satisfaction. Disengaged employees tend to provide lower standards of care and their attitudes are less positive than those who are happy and engaged in their workplace. Patients pick up on the negative energy and can tell when an individual really does not want to be in the workplace, and this produces a less than optimum experience for them. We all have experienced the rude or abrupt clerk in a store, and can pick out the people who are unhappy in their work by their attitudes, demeanor, and body language.

These five points are just a small indication of the problems that exist with random patient care surveys. While healthcare facilities are aware of the holes that exist, the surveys remain the choice for gauging the standard of care provided. Both patient care units and ancillary departments are accountable for the scores given in their area. And so the question remains, how do pastoral care departments utilize this information in a way that is effective for performance improvement? Ideas range from focusing on one unit and doing intentional visiting to incorporating spiritual care into the "marketing" done by patient care services. While these may be effective for a time, I believe they simply do not resolve the issue totally. After discussion with key people in my organization, I have hypothesized that the key to patient satisfaction is employee satisfaction. This is one area that can be affected in a positive manner by spiritual caregivers and is the place to start when seeking to increase patient satisfaction scores in a way that is measurable and non-random.

Michelle Lemiesz is system director of chaplaincy services for Mount Carmel Health System in Columbus, OH.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Navigating the wilderness of illness: Reflections of a chaplain intern

By April Boone, MA

The role of the chaplain is often not understood, not even by others within the interdisciplinary medical team. The following article offers a brief explanation or exploration of chaplaincy from the perspective of a CPE student.

The ailing soul

As an intern in the CPE program, it has been my privilege to "spiritually triage" patients of differing faith traditions or those with none at all. It is a profound opportunity to briefly enter into the mystery of suffering. Sometimes people become despondent or antagonistic because of their sickness and the vulnerabilities that result from it. Sometimes the pain is informative and transformative, enhancing the patient's outlook on life. The healthcare staff does a miraculous job of intervening medically through technology, but the chaplain can often intervene spiritually to resuscitate the ailing soul by offering words of comfort, challenge or by providing a consoling presence.

The binary symptoms: body/soul, informative/transformative

Ancient Western Christian philosophy has taught that humans are a body-soul composite, and in fact, prayer is the most efficacious form of palliative care available to buttress against the loneliness, dread and fear that the soul confronts when the body is impaired. Clearly, there is a correlation between diminished physical well-being and a lukewarm spiritual life that results in a lack of hope. Ideally, chaplains exhort the patient to a heightened understanding that this time of illness can be both informative and transformative, suggesting that the time of trial itself can be elucidating. Often in the sanctuary of imposed bed-ridden silences and interior reflection, patients discover anew tools for coping with crisis and mortality.

Metaphorically, the Christian tradition offers a framework for analyzing illness. Consider "both John the Baptist and Christ himself experience in the wilderness a kind of divine tutorial. Not an experience of yielding to pleasure or delight, it is nonetheless a sacred space where creatures and Creator speak heart to heart" (Thompson, 2009, p. 37). The patient who benefits from medical treatment as well as a contemplative stay in the hospital can find the soul dilated and the heart docile to change.

Just wait

Typically, patients admit that the most troubling aspect of a hospital stay is the prolonged periods of waiting. Patients wait for test results, for the doctor, for the bedpan, for the visitor, for the cure, for heaven. Severe reminders of loss accompany much of this waiting. Loss hovers over the patient as a result of the unfamiliar, loss of health, status, possessions, beauty, and often a loss of faith that makes each moment of unknowing a struggle with vulnerabilities.

Wounded healers

Clearly, healthcare professionals are impacted by the trauma of patients on a daily basis. Most would admit that it takes courage to face suffering everyday, and although ignoring this impact has advantages,

over time the journey into loss and pain takes an emotional or spiritual toll. Chaplains are available for staff to discuss the joys and difficulties of their important work because chaplains are part of interdisciplinary teams.

Medicine is seemingly a performative art as much as a scientific one – the nurses, doctors and support staff must be able to respond spontaneously to human drama and are called upon to access deep inner strength for their jobs. Patients' wounds can often have an unpredictable life of their own and become embedded in the minds and hearts of the healthcare staff that attends to them. A constant stream of needs can be overwhelming. Moreover, staff spiritual needs remain largely unarticulated.

Impending tsunami: hopelessness

Last summer I attended a lecture given by a geriatic specialist whose topic was depression in later life. Sadly he noted with clinical statistics that "50% of people in nursing homes and up to 40% of the general elderly population exhibit symptoms of depression that include suicide. This is a frightening statistic considering that by the year 2050 there will be 80 million people in the United States over 65. I asked the doctor if this wasn't a spiritual symptom as well; he agreed that it was, and characterized it as an "impending tsunami" (Tampi, 2009).

Patients and families who experience long-term illness and dementia benefit from increased attention to the spiritual dimension of their lives. Often, chaplains are a conduit for helping individuals enter into a deeper understanding of the role that humility can play in enhancing human dignity when bodies have been compromised by sickness and aging.

Telos: The end goal

Chaplains are not social workers. Social workers are vital caregivers, and sometimes their role overlaps with the role of chaplains, but chaplains are able to "kick it up to prayer" and are interested in making connections that are philosophical and theological in nature.

Chaplains are not proselytizers. Sometimes patients enjoy the opportunity to discuss various faith traditions and rituals, but chaplains do not impose their faith on others. It is more a conversation about the role of faith in crisis and the consequent questions that patients need to reconcile when encountering disability.

Often, acute symptoms of guilt, sadness, and isolation that accompany illness can best be addressed spiritually. Chaplains can complement healthcare professionals in myriad ways that benefit the convalescing patient. Imagine real healthcare reform that would recognize the importance of the role of the soul in healing — for the patient and provider. The objective of pastoral care is to recognize that the body and soul work in tandem in recovery. The powers of the soul — the intellect, the will, and the emotions — animate the body into wellness.

Surviving in the wilderness of illness means having a compass that points toward the Transcendent. It is recognition that illness need not be passive. It is full of potential for strengthening the interior life. Martin Luther isn't the only one seeking reformation. Reformation in healthcare should include the validity of the spiritual elements of healing. As author Thomas Merton (1989) suggested: "Our real journey in life is interior. It is a matter of growth, deepening, and of an even greater surrender to the creative action of love and grace in our hearts. Never was it more necessary for us to respond to that action."

April Boone is a CPE resident at the Hospital of St. Raphael in New Haven, CT, working toward becoming a board certified Catholic chaplain. She is also an associate of the Sisters of Charity of New York.

References

Merton, T. (1989). *The Road to Joy* R. Daggey, (Ed.) (p. 118). New York: Farrar, Straus & Giroux.
Thompson, C.J. (2009). Beholding the Logos. *Logos*, 12(3), 37.
Tampi, R.R. (2009). *Lecture at John Dempsey Hospital* – University of Connecticut Medical Center [Archived media file]. Retrieved from www.ctn.state.ct.us/ondemand.asp?byDate=7/10/2009.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Consider becoming a mentor: It will benefit the applicant, you, and the profession

By Joseph G. Bozzelli, DMin, BCC

Do you remember what it felt like when you began your certification process? I don't know about you, but I felt overwhelmed! The list of documents that I had to submit seemed never-ending. Where did I put my CPE evaluations? How do I go about writing a narrative statement? I'm supposed to prepare all these documents and still do my job, too! Faced with all these questions and fears, Charlie Brown's cry seemed to best capture my inner feelings, "ARRGGHHH!"

But when I look back on that experience, over 18 years ago, it wasn't as daunting of a task as I had imagined. I found all my paperwork. I wrote the required papers. I submitted my materials in a professional manner. Despite my fears, my certification committee was pastoral and supportive in their interactions with me. The overall process was professionally and personally enriching. But nonetheless, at the time, I didn't think I was going to be able to do it!

Maybe you had a similar experience to mine. But perhaps you were fortunate to have someone walk with you through the process, a mentor – someone that you could bounce your questions off of, ask for advice on what to include in your autobiography, listen to your concerns and fears, cheer you on when you were at the peak of frustration. It was someone who knew the path you were about to take and said, "Yes, you can do this."

I've had the privilege of serving as a mentor for several colleagues. If I knew that a colleague was entering the process, I often would initiate my offer to be a support. Having been through the process myself and having served on certification committees, I knew what was important for applicants to address in their materials. I also knew that they were good chaplains. I wanted them to have the professional accreditation that validated their ministry.

I said it was a privilege to serve as a mentor because of the value I received as I journeyed with each applicant. Just as in patient care, serving as a mentor is a sacred experience. Applicants often invite you into their lives. They share their life journeys with you. In that trust relationship, you serve to guide them in their effort to authentically represent themselves, both through their materials and when they meet their certification team. Although the hope of certification is at the forefront, it's the process that is rewarding. To journey with applicants in their effort to be authentic ministers is the ultimate reward for both of you.

I share these experiences with you in the hope that you will consider volunteering to serve as a mentor for chaplain applicants seeking NACC certification. Your commitment could be as involved as you would like: from offering to read the person's materials for feedback, to being available to answer questions or concerns.

I encourage you to consider this important ministry for several reasons. From a practical standpoint, it's a way to help our profession to thrive by supporting our members. But for me, the most important reason is that I know the value and importance that being a certified chaplain brings to my ministry. It's a professional endorsement from the NACC that states to my peers in healthcare and, more importantly, to the patients whom I serve that I am qualified to provide pastoral care to people in need of God's comfort and peace. Having that endorsement is both a privilege and an honor. I want other chaplains to have that

same distinction for their ministry.

So please consider being a mentor for a colleague in ministry. Your time and effort will be personally and professionally rewarding. If interested, please contact the NACC office on ways in which you can serve as a mentor. Thank you!

Joseph G. Bozzelli is director of pastoral care services for St. Elizabeth Healthcare in Edgewood, KY. He is also a member of the NACC Certification Commission.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Nomination Panel helps identify candidates for NACC Board

NACC Board of Directors needs new member

At its October 2010 Board meeting, the NACC Board discerned its board needs for the coming years. We have two newly elected Board members for 2011, Jane Mather and Mary Lou O'Gorman. We will need another elected Board member for 2012, thus our leadership discernment process has begun anew. Please review the **Board needs and criteria**, and consider applying by completing the **application form** or encouraging another who meets the criteria to apply. If you have questions, please contact the Nomination Panel chair, Jim Letourneau at letournj@trinity-health.org.

NACC members have new opportunities to get to know each other and encourage each other's leadership abilities, thanks to the resurgence of local gatherings beginning in late 2007, the involvement of state liaisons, and engagement on a variety of association task forces. One of the implications of our regional structure, adopted in 2001, was that members felt they did not have a way to get to meet each other, experience each other's gifts, and benefit from a rich diversity of leadership abilities. Knowing who might be a good person to serve on the NACC board was challenging.

In fall 2007, the Board initiated a leadership discernment process asking: "What areas of talent, expertise, experience will we need on the Board, given the challenges and opportunities that lie ahead?" As a result of the process, the general Board criteria was more clearly defined and two or three areas of member experience that could be most helpful for the Board were identified – and will continue to be on an annual basis.

The Board also established a Nomination Panel, consisting of NACC members who represent a breadth of experience, to oversee the process of identifying qualified candidates for election. The panel directs a process that includes an open invitation to members – asking them to discern their desire and availability to be considered for Board election and to encourage other members to bring themselves forward as candidates. In addition, the panel reviews a list of NACC members who have served or are serving in various capacities in the organization, asking them to examine the Board criteria and to consider being candidates for the coming year.

The Nomination Panel then reviews and assesses all applications based on the general Board criteria and the specific Board needs. The top applicants are presented to the NACC Governance Committee, which then recommends the candidates to the Board. The Board reviews the entire process and the finalists, and makes the final decision as to who will be the candidate(s) for member election.

Last fall, in an effort to encourage more membership participation in the election process, the Board asked the executive director to poll members as to why they did not vote in the 2009 election. Since that year was the first electronic voting process, this change was suspected to be the reason. However, the primary reason given (40 percent) was that members did not know the candidates well enough to vote for one or the other. The electronic voting was only noted by 17 percent.

The 2010 applicant pool was rich with many talented and committed NACC members who were willing to be considered for the two vacant 2011 Board seats. The Nomination Panel went through its evaluation process and presented to the Governance Committee five qualified candidates based on the criteria. The Governance Committee noted that, based on both the criteria and the profile of leadership qualities and experience needed at this time, two of the five stood out, and recommended these two to the Board to be the candidates for the two Board seats.

The Board realized that presenting two candidates for the two vacant seats could appear to be giving the members no choice. However, the rationale for the decision outweighed the potential for misperception. First of all, this new process of discerning candidates engages members all along the way: NACC members on the Board discerning needs; NACC members encouraging others to be applicants based on the criteria; NACC members on the Nominating Panel who review and qualify applicants; and NACC members on the Governance Committee who recommend the candidates to the Board. The 40 percent who in 2009 did not know the candidates well enough to vote can be comforted by the many members who worked hard on their behalf to present themselves, qualify candidates, recommend candidates, and ultimately present candidates to them in this process. Your vote is an affirmation of this careful, member-led process to qualify candidates on your behalf. Your vote is a vote of confidence in this leadership discernment process.

Many board members had experience with this type of "slate" presentation of candidates. We look for your feedback on this election procedure as we begin anew the process of encouraging our members to consider how they might be best called to serve NACC.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Three members named to Editorial Advisory Panel

The NACC Editorial Advisory Panel has three new members, Sandra Lucas, James J. (Jim) Castello and Marika Hanushevsky Hull. Members of the Editorial Advisory Panel provide a sounding board for the content and direction of *Vision* and suggest and write articles, working collaboratively with the *Vision* editor.

Ms. Lucas is the regional director of spiritual care for the Humility of Mary Health Partners in Youngstown, OH. She has been in this position for two and one-half years. She lived in Ohio once before when she did her CPE residency at Children's Hospital in Cincinnati in 1992-1993.

Her parents moved from New Jersey to Maine in the 1970s. Sandra and her mother were very involved in the social justice movements of the 1970s. Her mother started Spruce Run, one of the first centers for domestic violence in the country, still in existence today in Bangor, ME. Ms. Lucas learned about Dorothy Day and the Catholic Worker movement and in 1978, she converted to Catholicism.

After several careers in waitressing, typesetting, and proofreading, she won a college scholarship from the Deering Icecream Company in Portland, ME. She finished an undergraduate degree, never completed because of caring for parents and grandparents, then completed an M.Div. degree at Weston Jesuit School of Theology in 1992. It was at Weston that she discovered a call to chaplaincy.

Ms. Lucas also holds master's degrees in writing and literature from Rivier College in Nashua, NH, (1996) and in ethics from Bangor Theological Seminary in Bangor, ME (2009).

Prior to her present position in Youngstown, OH, she worked at Mount St. Joseph, a long-term care facility in Waterville, ME, for 10 years. She was staff chaplain, then director of pastoral care, then director of pastoral care and mission. Every year she put on a Christmas pageant and Halloween play starring the residents.

Mr. Castello, MBA, MA, spent 35 years in executive marketing management for two global manufacturers of consumer and institutional products. He entered Clinical Pastoral Education following the death of his first son-in-law in 1996 and became a NACC Board Certified Chaplain in 2002. He served as a chaplain/supervisor at Hackensack University Medical Center for eight years and went on to become director of pastoral care at St. Vincent Medical Center in Jacksonville, FL, and Bon Secours Community hospital in Port Jervis, NY.

He has been able to apply his corporate training and experience in strategic planning to religious clients as president of ENTHEOS Consulting, Inc. and in the three hospitals in which he has worked. Mr. Castello is co-author of a 27-page booklet titled "Caring Decisions near the End of Life," now in its second printing. He recently wrote an article on promoting chaplaincy awareness for *Vision*.

Mr. Castello now volunteers as a chaplain at A.I. duPont Hospital for Children and the Franciscan Care Center in Delaware. For the past two years he has been a member of NACC's marketing/communication and recruitment task forces. He lives in Kennett Square, PA, with his wife, Frances, who is a hospice chaplain, near their five daughters and 16 grandchildren.

Ms. Hanushevsky Hull, M.Div., is a full-time chaplain at Saint Anne's Hospital in Fall River, MA, a full-service, 160-bed community hospital, including a 16-bed Gero-psychiatric Unit, in a heavily Portuguese- and Spanish-speaking urban environment. The hospital is served by the Dominican Sisters of the Presentation of the Blessed Virgin Mary, and provides care for a broad population, with many new immigrants, elderly, children, and families. Ms. Hanushevsky Hull is also the oncology chaplain at Saint Anne's Regional Cancer Care Hudner Oncology Center, an affiliate of the Dana Farber Cancer Institute in Boston.

She serves as hospital team leader of the Schwartz Center Rounds, a nationally funded rounds for physicians and clinical staff with a focus on the emotional needs of clinical care providers. She is an adjunct faculty member in the Parish Nursing Program, and is active in patient and staff education on wellness and living with illness. She is a member of the hospital Ethics Committee, the Patient Satisfaction Committee, the Oncology Resource Committee, and the hospital Continuing Medical Education (CME) Committee.

She received her Master of Divinity degree from Harvard University in Scripture and the history of early Christianity. While at Harvard, she completed courses in medical ethics, pastoral counseling, and clinical care of the aged at Harvard Medical School.

Ms. Hanushevsky Hull is an Eastern Rite Catholic. She, her husband and youngest child, a teen-age daughter, live in Rhode Island.

Related link:
NACC Editorial Advisory Panel's role and responsibilities can be found at www.nacc.org/vision/panel.asp

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Stay with me

By Monique Cerundolo

Stay with me
I am ailing, frightened and alone
Walk with me
As I tell you my story
Of joys and sorrows
Of proud moments
And times I now regret
Abide with me
In silence, without judgment
Companion me
Pace your step to mine
Walk slowly, tread gently
In the waters of my life
Be with me
A faithful presence
An open mind
A mirror and a well
See with me
What lies beneath
Behind, beyond
This particular place
Search with me
For a guiding hope
And the light
I can no longer see
Feel with me
The anger I may hide
The sadness I conceal
The uncertainty of my day
Hold for me
All that I give to you
In this brief
And graceful moment
Pray with me
To the Love that calls
Us both
To this room today

Hospital Rounds, CPE, 12/5/09

NACC member Monique Cerundolo currently ministers as a chaplain intern at Holy Family Hospital, Methuen, MA. During two years of CPE, she has written a few reflective "Hospital Rounds" poems. In 2009, she completed her master's degree in Pastoral Ministry/Health Care Ministry at Boston College, Chestnut Hill, MA. For her synthesis, she created a traveling exhibit, "Finding Hope: A Visual Journey through Grief," a series of quilts and poetry that she has been using as an experiential learning tool in the Boston area. She is a member of the Boston Area Maryknoll Affiliates.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Chaplains' pathways not always clearly marked, but they lead to healing

By Barbara Malueg, MTS, BCC

Last summer the 2011 Conference Task Force chose the theme "Pathways to Healing: People and Communities" for the 2011 NACC National Conference. I've been reflecting on that theme for the last few months and hope that some of my reflections will spark your thoughts and build your excitement about the conference.

Scripture is full of people who are called to embark on a pathway: Moses, Abraham and Sarah, Ruth and Naomi. Jesus spent much of his ministry on the path ultimately heading to Jerusalem. Paul traveled far and wide. So we are in good company as we trod the pathway to healing.

I think it is significant that the theme is pathways rather than highways. For me, pathway implies a way less traveled, a way that is meandering and doubles back; not a straight line. A pathway may not be well marked, and so is sometimes hard to follow, but it leads to a special place. Our Hebrew Testament ancestors (Moses, Abraham and Sarah, Ruth and Naomi) followed an unclear path calling for faith and courage. Jesus and Paul invited other followers to join their path, which had many twists, turns and dangers. We can be confident in following a pathway to healing because others have been on this path before us.

I see many connections between the image of pathway and chaplaincy. My ministry as a non-ordained, board certified, female chaplain came about through a pathway not traveled by many. There are many ministries much more clearly defined and accepted. I am reminded of this when I hear: "I didn't know a woman could be a chaplain. I expected a man," "Do you get paid to do this?" and "Do you have to go to school to be a chaplain?"

As a chaplain, I walk pathways with patients. Recently I walked the pathway with Mary. She is a long-time dialysis patient with both legs and several fingers amputated who lives in a nursing home. Now Mary may need colon surgery. She wonders if she should discontinue dialysis and decline surgery. We walk a path that is not clearly marked.

Last year, I walked the pathway with Michael. He was serving a life sentence at a local correctional facility. Michael was diagnosed with an inoperable brain tumor. Our pathway included a last visit with his elderly mother and putting his affairs in order (DNR, POA).

Our walk included his sharing the story of his offenses and expressing his concern for his young victims. Michael dictated a good-bye letter to his fellow inmates and I was able to read him their replies. We shared Scripture and prayer. We walked the pathway with two armed guards in the room and Michael shackled to the bed. Our walk ended with Michael's death.

The pathway we are on is headed towards healing. We don't know what kind of healing will take place. I have walked with people in need of healing in body, mind and spirit. Physical healing often does take place. Other times I walk a pathway that does not end in physical healing, but healing of mind and spirit. I see calming of fears, forgiveness, healing of relationships and peaceful acceptance.

We as chaplains walk with individuals but our pathways also intersect with groups that need healing. Workplaces suffer from "right-sizing" and increased pressures about budgets and productivity. Communities suffer from declining economies, high crime and homelessness. Churches suffer as a result of scandal, abuse and rigidity. Nations suffer from wars and violence, racism, political conflict and religious intolerance.

How do we follow a pathway to healing that at times seems elusive? I think the writings of theologian Bernard Lonergan provide us with some touchstones along the path to keep us headed in the right direction. Lonergan teaches us that on the path we need to be attentive, intelligent, reasonable, responsible and committed to love.

When we are attentive we gain insights. Theologian Mary Ann Glendon (2007) explains Lonergan's method in this way. "So we reflect on our insights. We sort them out. We marshal the evidence; we talk it over; we test the new idea against what we know; we investigate its presuppositions and implications; we give further questions a chance to arise; and eventually we make a judgment whether to affirm or doubt it.

"As our insights accumulate and form patterns permitting a better integration of what we have learned, our horizon shifts. When we move to a higher viewpoint, we become aware of a certain rearrangement of all that we have ever known; a certain transformation of our very selves. Parts of the past assume a new relation to one another; feelings change; doors open in the mind and heart. Sometimes the change is so great that when we try to express what has occurred, we use words like conversion and redemption." I would propose that we also could use the word healing.

It all starts with being attentive to those around us and to the movements within us. We, as chaplains, walk with people on the pathway and see their movement toward healing. We, as chaplains are called to be prophetic voices to promote healing in our workplaces, communities, churches and nation. The pathways that brought us to the vocation of chaplaincy are varied. Walking the pathway changes both those ministered to and those who minister. Wouldn't it be a great legacy for someone to say, "She was attentive, intelligent, reasonable, responsible and committed to love?"

Join other chaplains in learning more about Bernard Lonergan in an upcoming NACC audio conference in February. Join other chaplains in exploring the pathways to healing May 21-24, 2011.

Barbara Malueg is chaplain at St Vincent Hospital in Green Bay, WI. She is also workshop chair on the 2011 NACC Conference Task Force.

Resources

Glendon, M.A., (2007, October 1). Searching for Bernard Lonergan: The man behind 'insight.' *America*. Retrieved from www.americamagazine.org/content/article.cfm?article_id=10237

Related links

Information about the May 21-24, 2011 NACC Annual Conference in Milwaukee, WI
www.nacc.org/conference/default.asp

Bernard Lonergan digital archive at Marquette University www.bernardlonergan.com

Repository of secondary source materials that could prove to be valuable for Lonergan studies
www.lonerganresource.com

What characteristics make chaplaincy a profession?

By David Lichter, DMin
Executive Director

Happy New Year to you all! As we begin 2011 together, I cannot but look to our NACC Mission Statement for a renewal of purpose and direction. Do you remember how it begins? "The National Association of Catholic Chaplains advocates for the profession of spiritual care."

This issue of *Vision* devotes itself to the "profession" and contributes several articles to the topic. In preparing for this column, I researched writings that explored the meaning of a profession. What makes a job or work a profession? What are some of its chief characteristics? I came across an article on the characteristics of a profession (www.adprima.com/profession.htms) by Robert Kizlik, Ph.D. I found it was a good summary of a profession's main features. It provided a framework for looking at spiritual care as a profession, which helps to identify some of the challenges chaplaincy faces in its quest to be recognized as a profession. Let me share a few with you.

Professions usually are *related to established institutions* that provide some essential service to society. Certainly our profession of spiritual care is tied, for the majority of our members, to some form of the healthcare field or institution. Our members' ministry is also linked to a variety of other essential services (education, correctional, etc.). The challenge of legitimacy for our profession has been and remains to demonstrate how integrally the success of this service is tied to society. Thus, a book like "Making Health Care Whole: Integrating Spirituality into Patient Care," by Christina Puchalski, MD, and Betty Ferrell, RN, helps to advocate for our profession by emphasizing how a board certified chaplain's service is integral to the service of providing healthcare.

Professions usually are *related to some identified need* or function, such as the need to learn, maintaining health, or preserving rights. The challenge for the spiritual care profession has been and remains, even with all the growing research, to show the spiritual as an essential need that requires "professional" care. Even as Press Ganey uses a question like, "Have your spiritual and emotional needs been met?" that legitimizes spiritual need, linking our profession as critical to adequately meeting those spiritual and emotional needs remains a task of research. What difference does a chaplain's intervention have on the spiritual and emotional improvement of the patient? Linking the board certified professional to the improvement of a person's spiritual well-being remains a challenge and is essential to recognition of the profession of chaplaincy.

A profession also *possesses some body of knowledge, along with a set of skills and behaviors* needed to practice the profession, that are not usually possessed by individuals not in that profession or the non-professional. This may seem obvious. Each of us can name professions we can't do. The spiritual care profession has worked hard over the past years to establish the standards for certification and professional ethics to clearly identify the knowledge, behaviors, and skills required to be a professional. The Standards of Practice also have articulated what makes chaplaincy a profession among other professions. The message is that not just anyone can do this ministry. We have developed and continue to refine this dimension of the profession. The challenges to this area of our profession seem to be two: does each of us embody/demonstrate these competencies and how does each of us communicate to those in other professions that our profession meets this characteristic of a profession?

Another interesting characteristic of a profession is that *professions are engaged in decision-making with those they serve*. We look for the wisdom and counsel of a professional because he/she possesses the background for that field and can help us think through the implications of our decision-making regarding that profession. (I will seek the guidance of the legal profession. It's not my field.) When I think of the spiritual care profession, what efforts have been made to position the spiritual care provider in consultations around patient care, ethical decision-making, and the culture of spirituality because the spiritual care provider possesses a perspective of great value to the decision-making process. Viewing our profession as a player on multi-disciplinary teams is a critical step in establishing the profession of spiritual care. Our perspective is invaluable, and makes a difference.

A profession also *builds its knowledge base through a disciplined way of gaining more insights* into the impact and importance of its field. Research is part of any valid profession. How does a profession grow its knowledge base? This will be an ongoing challenge and invitation to any of us in the profession. How do we contribute to the body of knowledge about our profession? How do we contribute to the research field of our profession? We are indebted to the many dedicated researchers in the field, but they continue to encourage us to contribute in some way. If spiritual care is going to be recognized as a profession, disciplined research to gain greater understanding of and to show the effectiveness of the profession is critical.

A profession does *organize itself, usually through an association, so that it creates a structure for its profession's accountability*, and the conditions needed to practice the profession, such as credentialing, licensing, according to agreed-upon performance standards, ethics, disciplines, ongoing performance review and accountability. Certainly our profession has advanced itself in terms of this characteristic. The Spiritual Care Collaborative has been a vital organ to show to the professional world the common steps that have been taken in this area. The challenge here, of course, is the ongoing maintenance of our unified implementation of this professional practice that deepens the credibility of the profession. Another challenge to our profession is that many organizations/associations offer chaplain "credentialing" that can cheapen our efforts and confuse other professions about our profession.

A profession has *means for preparing for and being accepted into* the profession. How critical to our profession is the quality of our certification process, along with the partnerships with the Association for Clinical Pastoral Education and the United States Conference of Catholic Bishops Commission on Certification and Accreditation that provide the centers and programs for CPE!

A profession has *built and holds public trust* in the professional and those who practice the profession based on how well the professionals demonstrate their capability to deliver their service. This is a good point for all of us to keep in mind. Only we, individually, can strengthen the profession here.

A profession is *embodied by individuals who embrace this service with high motivation and commitment to competence*. Amen to this one again! We hope each of us lives this out.

A profession *holds itself accountable for the competence* of the professional practice, while the authority to practice in any individual's case stems from the organization that hires that person or the person who becomes the person's client. This characteristic puts weight on the NACC to ensure its practices help and hold accountable its members to be competent in the profession of spiritual care.

So, these are a few of the characteristics of a profession. It was helpful to me to reflect on the ministry of spiritual care as a profession. Do these help us to focus our efforts to advance the profession? I would say yes, and we are moving on most of these fronts.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Q&A with Anne C. Butts, MA, BCC

By Laurie Hansen Cardona
Vision editor

Drawn to hospice work after helping to care for her older sister on her end-of-life journey, Anne C. Butts is now a chaplain at Samaritan Hospice in Marlton, NJ. The former teacher and campus minister lives in nearby Medford, NJ. Mrs. Butts, who agreed to share her thoughts about hospice in an interview in Vision, holds a master's degree in ministry from Ursuline College in Ohio.

Q What made you decide to become a hospice chaplain?

A I first heard about hospice when I helped care for my older sister who had been diagnosed with cancer. I did not have direct contact with the hospice organization but a seed of awareness was planted. When I moved to New Jersey from Ohio due to my husband's transfer, I could not work in campus ministry due to the weekend and night work and the need to be home with a daughter who was having difficulty adjusting to the move. I invited some women I had met to explore how to move forward with our relocations. I used a book by Joan Chittister, OSB, titled "The Story of Ruth: Twelve Moments in Every Woman's Life." In the first chapter we named our losses, in the second we envisioned who we could be, given that we were no longer defined by former roles. I remembered my brief encounter with the idea of hospice and decided to explore if I were called to work within that model of care. I had been profoundly affected by my sister Jean's end-of-life spiritual journey and the peace she experienced in surrendering her very life to God. I knew I had witnessed very sacred work.

Q You call the time you and your sisters cared for your sister "the most painfully, growth-oriented time" in your life. How did you change during that period?

A I would have to say that I was broken open. It is very hard for me to describe. I had experienced the death of a father as a child and later the sudden death of a brother in a car accident when he was 21. Jeannie's death was slow. She was diagnosed with stage 4 breast cancer in December 1995 and died in January 1997. My former manner of handling pain was to deny it, try to explain it, but certainly not to embrace it. Jeannie's need for care made running away impossible and our care schedule did not allow us sisters to overlap much. We all lived in different states and took turns flying to California to stay for a week or two to care for Jean, her spouse and her children. I learned my great capacity for pain. I learned my great capacity to listen. I learned my great capacity to follow her lead in caring for her. I learned about her great capacity to forgive and love. Jean's spouse was not very dependable but needed compassion for his own limitations. I remember going to bed at night feeling that I was totally empty. Even now it is almost unbearable to remember how desolate that time was. I prayed and wrote in a journal in order to make some meaning of Jean's illness. She was the one who told me that her love for God was bursting within her, and she knew that everything in her life, including the cancer, was ultimately for her good. Something died within me when she died, and yet I felt a mandate from her to live more fully and continue to grow in faith. She had pre-recorded her own message to us that we heard at her service, and she told us all to "get a passport" for the kingdom by accepting Jesus in our lives and practicing kingdom living. I have taken it to heart.

Q What advice do you offer others accompanying a person in their final days?

A When I visit patients and their families, I use the metaphor of laboring to new life. There is a creative

life force at work during labor and a wisdom of our bodies. The spiritual invitation is surrender – to align with the love and will of God. Those of us who accompany a loved one are the midwives. We notice what is happening and respond. So I remind people to notice. It is mindfulness that helps sustain us in whatever we experience and feel. I invite and encourage caregivers and family to be gentle with themselves and notice what they need on the journey as well as noticing what their loved one needs. I also tell them that we are meant to let our feelings flow for that indeed is the fullness of life.

Q What kinds of non-physical changes have you witnessed in people as they transition from this world to the next?

A I often talk about the mystery of end of life as the receding of the physical so the spirit can be more fully enlivened. The most memorable deaths I have witnessed have been with those people who intentionally chose to explore how God was present to them as their disease progressed. They questioned, admitted their anger, doubts and fears. They developed a prayer practice to sustain them and kept the lines of communication open with friends and family. They talked about what was happening to them. They allowed people to care for them. As all is stripped away, they are able to experience the truth of how they are loved as a child of God – a human being.

Q While the time and nature of our own deaths are out of our control, are there any steps that each of us can take to try to make it more likely that the time leading up to our own death will be grace-filled?

A We are given a gift of life, and it is our responsibility to live it. Grace-filled is an interesting focus, and it is important not to sugarcoat what that means. The dying experience is hard. We live our whole lives becoming independent and individuated and then without our agreement it all begins to unravel. Of course, that is the mystery and irony. Our ego must recede or maybe concede to the power of God and to the truth that we are all one and all interdependent. I think if we can practice that awareness – that we are powerless, that we matter and don't matter, that we are these magnificent creations of God and that we are but a grain of sand, we might find the end-of-life experience to be our final achievement instead of a sign of failure.

Q Can you give an example of what you could describe as a "good death?" If it's not too personal a question to ask, given your own experiences in this ministry, how do you hope to experience the last days before you leave this earth?

A When a person at end of life feels comfortable imagining his or her death, I will often ask them if they want music, touch, conversation, Scripture reading or other temporal expressions of care and presence. So I have often thought of what I would want. I truly am not sure. I think I might want people in the room with me but certainly not holding vigil, staring at me. I might want some hymns reconnecting me with liturgy, but I might want the music to be most comforting for my family. I do know that if my husband (of course, if he is still living) starts rubbing my arm mindlessly, I will probably rise out of my serene posture and swat his hand! What I hope for myself is that I will be open to the mystery of letting go who-I-think-I-am and become more welcoming of who God has always known me to be. I hope I can be more generative than self-absorbed, more receptive to care than dismissive and able to bless those in my midst.

Q Are families aware and receptive to hospice?

A I think that hospice is still the best-kept secret of Medicare. One of the misconceptions people have of hospice is that we are "the dying people." I often tell patients and families that our goal is to support someone to live fully. Often good symptom management can extend someone's life expectancy. When emotional and spiritual support are added as well as home health aide physical care, we create an

opportunity for individuals and families to reframe and prepare for their end-of-life experience. While the guideline for admission to hospice is a projected life expectancy of six months or less, we are finding now that doctors are waiting to admit patients until they are very close to death. At a past team meeting, we noticed that half of our new admissions died within one week of admission. We find ourselves operating on crisis mode more than ever before. I pray that increased awareness by medical practitioners might allow this grace-filled service to reach more individuals earlier in their end-of-life journey.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Gestures, eye contact, stillness central to chaplains' listening

By Robert Mundle, MDiv, STM, PhD(c), BCC

Be sure to read Gordon Hilsman's response, "Applying this research to our ministry", immediately following this article.

A couple of years ago Charles Farrar's piece for Vision entitled "He Walks Like a Chaplain" (February 2008) got me thinking more deeply about how chaplains embody their role. I wanted to learn more about how chaplains are recognized in healthcare environments and how they are then hailed or called into therapeutic relationships to be listeners. I explored these kinds of questions in a qualitative research project I developed with my colleagues Jim Huth and Brett Smith. We recruited 10 professionally trained and board certified hospital chaplains to our study. The chaplains participated in individual, confidential, thematic, and informal semi-structured interviews. We then subjected the interview transcripts to a categorical-content narrative analysis.

Results

The significance of listening

All the chaplains we interviewed deemed listening to be vital. Moreover, how they listened, and their ability to listen well, was constituted in and through the body, according to the following five categories: (a) eye level, (b) eye contact, (c) engaging with emotions as embodied narrative plots, (d) being and having a still body, and (e) distancing the body-self from religion. I will describe each of these five points briefly in turn.

Eye level

All of the chaplains interviewed spoke at length about the importance of having and being a body that was at a similar eye level to the person they were listening to. To achieve this, the chaplains would often need to sit down. For example, one chaplain said, "The very first thing that comes to mind for listening well ... is that I sit down – I'm very aware that not many other staff members sit down ... families do notice who sits down." Similarly, another chaplain commented: "I've had patients say, 'I knew you were a chaplain,' but I don't know how they recognize me. Maybe because I take time with people.... I always sit down with somebody when I listen and a lot of the medical people don't have time to sit down, or don't think they do, anyway."

The chaplains perceived eye level as an embodied social act to enhance their ability to empathize and create a feeling of intimacy. As one chaplain said, "When I come down to their level, it's me joining them where they are and moving with them and helping them travel through unfamiliar territory." Moreover, the chaplains perceived that being at a similar eye level to a patient by moving from a vertical body to one that "sits" had the benefit of helping to minimize power imbalances between themselves and patients when listening.

Eye contact

Eye contact is a subtle yet significant point of intimate bodily encounter and engagement. It is helpful to listening because it acts as an invitation for patients to share verbal stories they need to tell and, in turn, be witnessed by another. As one chaplain said, "I make eye contact to listen well.... I think that might be an invitation to people to tell the stories they need to tell and be heard." Likewise, another chaplain commented, "I make eye contact, I walk over, and before I even introduce myself the patient is pouring out his or her whole story to me." And yet another chaplain commented, "I think the fact that I'm not rushed, I think the fact that I'm sitting and making eye contact, all of these things are very, very important because (it) creates an empathic bond, and it's healing." In this regard, the chaplains embodied what recent research in neuroscience has found (e.g., MacDonald, 2009).

Emotions as embodied narrative plots

Another way the chaplains listened within the hospital was by engaging with the emotions of others as "expressive bodily actions," which people do inter-corporeally. For example, one chaplain signalled the importance of understanding emotions as embodied and relational for listening when she said, "I read emotions in people in how they act and these emotions help me listen better.... I take one look at the person and am drawn to them." The chaplains also suggested that attending to a patient's embodied performances of emotional life was valuable because it helped them in the process of listening to sad or horrible stories -- stories that others might fear and not want to listen to. As one chaplain put it, "People's tears don't scare me, it's like, now, okay, we're getting some place, and I'm here to listen." And another chaplain said, "To walk about, to get a sense of what's happening in the hospital, personally, I think it's not difficult to pick up whether people are anxious, busy, if the place is crowded, or empty, what the tone of voice is like of patients, families, and staff. To listen well – I see that as part of my job."

Being and having a still body

By being and having a still body the chaplains felt a sense of calm that helped inform and maintain their ability to attend to the stories told through the other's body, to stay with the other as the other, and to be there when time is precious. The chaplains also perceived that being still projected calmness from their body onto the other person. In such ways, they perceived stillness to be valuable because it projected and offered a story to the other that said, "I'm here for you" (Frank, 2004). As one chaplain said, "It's not just about being there; there's something too about the way of being there, without a lot of action. As a chaplain I'm not forcing any movement in any direction, it's more like a still point."

Distancing body-self from religion

If they were to listen well the chaplains perceived that they needed to sometimes distance themselves from religion, or downplay their connection to it in the eyes of the person to whom they were listening. This distance helped to provide the other with the space and opportunity to tell their stories. It was also vital given the ideological beliefs staff and patients can hold about chaplains. In other words, chaplains perceived listening to be constrained at times, especially when others held stereotypes that peg all hospital chaplains as proselytizers of religion (Norwood, 2006). Yet, as the chaplains testified in our study, this is not always the case, and any universal notion that depicts all chaplains as peddlers of religion can be far from the case. Indeed, the chaplains in our study typically did not approach either staff or patients to talk religion because they did not see their role in hospital chaplaincy as initiators of religion, ritual, healing, or change but rather, as facilitators of caring and connection (Norwood, 2006). And important to this caring and connecting process was listening.

Discussion

It is important to emphasize that listening, as an embodied act to develop empathic relations with other people within hospital environments, is no straightforward or easy task. As one chaplain who is also a teaching supervisor put it, "sit still, be present – I often tell students being is the hardest thing you are ever going to be called to do, and I think we give more value to the action part of our society than being

still." Also, listening to sad, chaotic, and horrible stories can be easier said than done for all people because these kinds of stories might captivate audiences, but they might also wear out empathetic audiences (Smith & Sparkes, in-press).

Also, when listening and empathizing the goal should not be to internalize the feelings of the other, but "resonance" with the other so as to feel the nuances and appreciate the story being told as embodied. Furthermore, as Frank (1995) argued, when empathizing and listening with stories it is important not to move on "once the story has been heard, but to continue to live in the story, becoming in it, reflecting on who one is becoming, and gradually modifying the story. The problem is truly to listen to one's own story, just as the problem is to listen to others' stories" (p. 159).

As well as highlighting potential problems and dangers, some limitations of our research need to be recognized. We do not know how patients perceived the quality of chaplains' listening abilities. Are being and having a still body and having eye contact seen as "good" listening qualities by patients too? Thus it is important in future research to interview patients as well. It would also be valuable to examine the listening practices of other health professionals (e.g., nurses, social workers, etc.) and how they might shape patients' expectations of chaplains and their understanding of how, where, and when they listen. Moreover, our study relied upon interviews. To complement this systematic method of data collection, it would be useful in the future to explore the social organization, interactional dynamics, and content through which listening is sustained or reconfigured.

Conclusion

Examining how hospital chaplains seek to listen well to others reveals various ways in which the body via its postures, gestures, and movement (stillness) is central to the manifestation of the listening self. Of course, not all the ways that chaplains listen described here will be useful for all people working in hospitals or be valuable on all occasions. But they are potential resources for other healthcare professionals to draw on in certain circumstances to improve their listening skills, not only with patients but also with other staff members as well.

Learning about the practical ways that chaplains listen might affirm what one is doing well already. Furthermore, how chaplains listen well raises possible dangers involved in listening when, for example, one attempts to empathize with others by identifying with them too closely. If, as Charon (2005) suggested, attentive listening is a "most pivotal skill" for "any health professional who wants to be a healer" (p. 263), then we believe that the embodied listening practices chaplains conduct in relation to other people are worthy of consideration.

We hope to publish the complete details of our study in an interdisciplinary health care journal in the future.

Robert Mundle is chaplain at the Toronto Rehabilitation Institute, one of Canada's largest academic health sciences centers dedicated to adult rehabilitation, complex continuing care and long-term care in Toronto, Ontario.

References

Charon, R. (2005). Narrative medicine: Attention, representation, affiliation. *Narrative*, 13(3), 261-271.

Farrar, Charles P. "'He Walks Like a Chaplain': Purposeful Stride Comes Only From Letting Go of Control." *Vision* 18:2 (National Association of Catholic Chaplains), (Feb 2008), 8-9.

Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: University of Chicago Press.

Frank, A. W. (2004). *The renewal of generosity: Illness, medicine and how to live*. Chicago: University of Chicago Press.

MacDonald, K. (2009). Patient-clinician eye contact: Social neuroscience and the art of clinical engagement. *Postgraduate Medicine*, 121(4), 1-9.

Norwood, F. (2006). The ambivalent chaplain: Negotiating structural and ideological difference on the margins of modern-day hospital medicine. *Medical Anthropology*, 25(1), 1-29.

Smith, B. & Sparkes, A. (in press). Exploring multiple responses to a chaos narrative. *Health*.

Applying this research to our ministry

The value of this subjective writing for a department of pastoral care lies in its descriptions of the five aspects of listening. Discussions of each of these in groups of professional chaplains or CPE students could reveal richness in the practice differences and similarities that would emerge. Cultural differences regarding eye etiquette and stories of dealing with patients' religious wounding would be obvious examples. Thirty minutes on each of the five listening aspects would be a great start.

In addition, and even more interesting, however, could be an organized appraisal of one another's listening as experienced by peer chaplains in day-to-day interaction with one another. Virtually everyone considers her/himself a good listener, unaware of his or her significant deficiencies in this key chaplain function, perhaps for decades. Some facilitated (and moderated!) peer feedback on colleagues' listening habits would spice a staff meeting and could prove to be quite fruitful.

Gordon Hilsman, DMin, BCC
Manager of CPE
St. Joseph Medical Center, Tacoma, WA

Martin Luther King's prophetic words create unity in hospital setting

By Mary Elisa Rose, MA

During my Clinical Pastoral Education residency last year, one of my fellow resident chaplains volunteered to organize a memorial service in the hospital for Martin Luther King, Jr. Day. My colleague, an African-American female, invited all the resident chaplains, two chaplain interns, and some members of the hospital staff to read different selections of Dr. King's writings. We were males, females, black, white, pastors, seminarians, and lay people.

I am an Italian-American, Caucasian, lay female. Participating in the Martin Luther King, Jr. Day memorial service was an honor for me. The honor was not only in helping to plan and research a prayer for the service, but also in speaking the words of a man who sought justice through peace. I was honored to speak the words of an eloquent orator and communicator who knew how to speak to his audience.

The selection that my chaplain colleague assigned me to read was from the last public speech of Dr. King. I read the opening paragraphs of the "See the Promised Land Speech" given April 3, 1968, in Memphis, TN. The opening paragraphs clearly communicated that Dr. King believed that he was living at the right time and in the right place:

"As you know, if I were standing at the beginning of time, with the possibility of taking a kind of general and panoramic view of the whole human history up to now, and the Almighty said to me, 'Martin Luther King, which age would you like to live in?' – I would take my mental flight by Egypt through, or rather across the Red Sea, through the wilderness on toward the Promised Land. And in spite of its magnificence, I wouldn't stop there. I would move on by Greece, and take my mind to Mount Olympus. And I would see Plato, Aristotle, Socrates, Euripides and Aristophanes assembled around the Parthenon as they discussed the great and eternal issues of reality. But I wouldn't stop there."

He continued to list other major events in Western Civilization like the "heyday of the Roman Empire," the Renaissance, President Abraham Lincoln signing the Emancipation Proclamation, and President Franklin Delano Roosevelt leading the United States out of the Great Depression. In the last paragraph that I read, Dr. King requested a period of time that is as important to humanity as those he had just listed. Dr. King said:

"I would turn to the Almighty, and say, 'If you allow me to live just a few years in the second half of the 20th century, I will be happy.' Now that's a strange statement to make, because the world is all messed up. The nation is sick. Trouble is in the land. Confusion is all around. That's a strange statement. But I know, somehow, that only when it is dark enough, can you see the stars. And I see God working in this period of the 20th century in a way that men, in some strange way, are responding – something is happening in our world."

My assigned portion ended here; and other speakers read different material from Dr. King's public life. My chaplain colleague was the last to read, closing with the last few paragraphs from the same speech that I had read. These were the eerie words that acknowledge his mortality. Again, Dr. King said that this –1968 – was his time, his place and that he understood that his time would not be long. In stating his mortality,

he also stated that change was only beginning.

Dr. King knew his audience that day was more than those he had come to Memphis to support – the local male, African-American garbage collectors striking for better work conditions and pay. He knew his audience included clergy from different denominations and people of different races. European Jewish rabbis, American white Catholic priests, mainline Protestant clergy from the National Council of Churches of Christ, college and high school students all listened to Dr. King. He brought these diverse individuals together with his words and actions.

At the end of the memorial service, my CPE supervisor used a narrow strip of ribbon to bring each member of our audience into a state of togetherness. She was closing the service with a benediction and had asked us to form a circle. Now, we in the audience came from different faith groups, different social settings and economic strata. There were employees of the hospital as well as guests from organizations outside of our hospital system. And we were of different races and skin tones. But we all knew the best way to form a circle is to join hands. So there we stood, about an arm's length away from each other, holding hands, anticipating a quick blessing. My supervisor told us to drop our hands. Then she took out two spools of colorful ribbon, and instructed us to hold a small portion of the ribbon as it unrolled from the spools. She sent one spool down each side of the circle.

As if we were of one mind, the circle became smaller as people moved closer together in order to make the two lengths of ribbon meet. No longer was I connected physically only to the individuals on either side of me. Now I was connected with each person holding the ribbon. Each one of us was needed to keep the ribbon from falling to the floor. Each one of us was needed to make sure that our neighbors had a piece of ribbon.

The ribbon was a physical reminder that the involvement of each member of the community is needed to uphold justice and make it real. The ribbon made tangible Dr. King's words that we had spoken.

Elisa Rose, a writer and theology instructor, has completed four units of CPE at Howard Regional Health System in Kokomo, IN.

Related links

Video of the first part of the Rev. Martin Luther King's "See the Promised Land" speech, April 3, 1968, Memphis, TN.
www.youtube.com/watch?v=BI_tQ5DdFAk

Text of the Rev. Martin Luther King's "See the Promised Land" speech, April 3, 1968, Memphis, TN.
www.americanrhetoric.com/speeches/mlkivebeentothemountaintop.htm

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Featured Volunteer

Name: Reverend Michael Burns, SDS
Work: Director of Pastoral Care, St. Anne's Salvatorian Campus, Milwaukee, WI
Member since: May 1, 1988
Volunteer service: NACC national conference volunteer, interviewer for certification and renewal of certification
Book on your nightstand: "The Gift of Peace," by Joseph Louis Bernardin, or "The Journey to Peace: Reflections on Faith, Embracing Suffering, and Finding New Life," by Cardinal Joseph Bernardin, Alphonse Spilly CPPS, and Jeremy Langford
Books you recommend most often: "When Bad Things Happen to Good People," by Harold S. Kushner
Favorite spiritual resources: The Bible and my spiritual director
Favorite fun activity: Lunch/dinner with friends, co-workers and peers, movies, working out
Favorite movies: "The Never-ending Story" and "The Sound of Music"
Favorite retreat spot: Franciscan Retreat Center in Malibu, CA
Personal mentor or role model: Fr. Frank Keferl and Sr. Bernice
Famous/historic mentor or role model: Joseph Cardinal Bernardin
Why did you become a chaplain? I became a chaplain to deal with my fears of being around sick people and hospitals and in the midst of doing that I found that I really enjoyed helping people.
What do you get from NACC? I get to be a chaplain, friend, and peer to some of the best people in the world.
Why do you stay in the NACC? I believe in our organization and the professionalism that NACC stands for and is working toward.
Why do you volunteer? I volunteer to give back to the organization because I get so much more from the service that I do for NACC. It is also a great way to meet people who have the same vision and goals.
What volunteer activity has been most rewarding? Interviewing applicants for certification.
What have you learned from volunteering? I have learned that I can be a part of the whole picture of who and what the NACC stands for just by volunteering for this organization.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

In Memoriam

NACC pioneer, Fr. Baeten, dies

Rev. David R. Baeten, who served the NACC as executive secretary from 1972 to 1976, died unexpectedly Nov. 27 at the Bellevue Retirement Home, Bellevue, WI, where he was a resident and served as sacramental chaplain. He was 74.

In the early days of the NACC, Father Baeten worked closely with other pioneers, like Rev. Frank Garvey, retired NACC supervisor and hospital chaplain now serving as a parish administrator in the New Ulm Diocese. Reached by telephone, Father Garvey remembered Father Baeten as "a very dedicated, hard-working priest, who served the NACC in a very efficient way. He was very determined and enthusiastic. Under his leadership the NACC was able to develop its own certification and accreditation process. He did a marvelous job for the NACC. He helped in the process of moving the office from Washington, DC, to Milwaukee, and worked hard to develop relationships with other associations, like ACPE."

In 1973, when the NACC considered and acted to accept pastoral associates into its membership, Father Baeten was serving on a three-member committee "to define the nature and role of the pastoral associate. Their efforts clarified and enhanced the understanding of the NACC," according to *The NACC: A Twenty-Year History*.

The NACC honored Father Baeten with the Prestigious Award in 1979.

Father Baeten was born in Green Bay, WI, graduated from Saint Francis Seminary in St. Francis, WI, and was ordained to the priesthood in the Diocese of Green Bay in 1962. Over the years he served in numerous parishes in the Green Bay Diocese and at St. Vincent Hospital in Green Bay.

THE NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

Book humbles, stretches readers' worldview, deepens appreciation for others

Learning from the Stranger: Christian Faith and Cultural Diversity. By David I. Smith. Eerdmans, Grand Rapids, MI, 2009. Paperback, 184 pp. $20.

First, I need to make a confession: I love a book that challenges my assumptions and experience. Knowing that, you will understand why I found Smith's well-researched, Scripture-based, practical book to be so compelling.

The author uses passages from Genesis, Luke and Acts to weave together both theological and everyday concerns in learning to welcome the stranger. As Americans we are often so influenced by the view that our culture is at least equal, if not superior, to others. This book stretches our worldview and humbles us so that we can deepen our appreciation for other cultures and human values. Smith's hope is that the reader will move from a stance of bringing gifts to those who are different to humbly accepting the wisdom and experience of others. Humility and hospitality are virtues that will enable all of us to improve our intercultural relationships.

As chaplains who interact with interdisciplinary colleagues, as well as with patients/residents and their families, pondering biblical wisdom and embracing Smith's challenge will prompt us to widen our circle of comfort and compassion.

In addition to a well-crafted explication of the subject, there are extensive endnotes, a bibliography and an index. I recommend "Learning from the Stranger" for personal pondering as well as for a teaching text.

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

SOURCE: *Vision*, January/February 2011

Visit www.nacc.org/vision to read or subscribe.

Vision is a serial publication of the National Association of Catholic Chaplains.