

Catholic healthcare and the poor: Exploding the myths

By Fr. Charles Barnes, SJ, MHA, MDiv, BCC

What if Adam and Jamie were asked to devote an episode of Mythbusters to the topic of myths about healthcare and the poor? It may not have the spectacular pyrotechnics of some of the other myths they bust, but the issues are no less weighty. Here I hope to invoke our valiant Mythbusters and evaluate a number of assumptions we hold.

Myth #1: If healthcare stopped being all about money, we could care for the poor.

Do a study of healthcare delivery in the United States and you quickly discover healthcare in this country has always been about money. Even from the earliest days doctors needed to be compensated in order to maintain their livelihood. As medical advances progressed in the 19th century and healthcare began to rely on empirical science, costs increased. In the early 1900s, doctors were no longer expected to treat patients for free if they could not pay. Hospitals began to transform themselves from a place people went to die to a place where people could be cured. All of this cost money. Costs spiraled, and many were locked out of medical care.

The reason many fraternal organizations, such as the Oddfellows or Kiwanis, were founded were to help people with the increasing costs of healthcare. Labor unions also routinely provided insurance for their members and some large employers had medical facilities on site for employees and their families to use. And, in 1929, Baylor University Hospital contracted with 1,500 Dallas teachers for hospital services in a program that was later to become Blue Cross.

Myth #2: Better access will solve all our problems.

Most discussions about healthcare reform revolve around access to healthcare services. If we can provide enough clinics in convenient locations and not charge people a month's salary for a visit, people will come.

The opposite, however, is true. A number of studies have compared measurable outcomes (death, infectious disease, cancer rates and the like) across comparable socioeconomic groups in the United States and other countries. The results are surprising. Even in countries, like the United Kingdom, with universal access the outcomes are almost the same as in the U.S., across all socioeconomic levels. Poor people tend to overuse the emergency departments in the UK as much as they do here, even though they are offered free primary care.

Myth #3: Better healthcare means better health.

When reviewing health policy we need to ask ourselves a fundamental question: Do we want better healthcare or better health? The two do not necessarily go hand in hand. If we want a healthier population we have to move beyond healthcare to look at the underlying reasons why certain illnesses occur. Much has been made of obesity reaching epidemic proportions in the United States, leading to a range of related illnesses including diabetes and heart disease. When we look at the diet of poor people we discover all they are often able to afford are cheap carbohydrates, made worse by the fact that fresh fruits and vegetables are hard to come by in depressed areas. Putting more fruit and vegetables in stores is fine, but are they affordable to people on fixed incomes?

Another thing research has shown is that health is positively correlated to income: The wealthier you are

the healthier you are more likely to be. Therefore, if we want to improve the health of a population we need to tackle the underlying causes of poverty such as: better schooling, improved sanitation in poor areas, finding ways of making healthy foods not only more accessible but also more affordable and desirable. When we think of serving the poor these are not the "glamorous" sorts of jobs we often think of. But perhaps they are the things that will do the most good.

Myth #4: Caring for everyone is too expensive

We Americans like to pride ourselves on having the best healthcare in the world. We also have, however, the most expensive, the most wasteful and the most inequitable healthcare system in the world. Even with the reforms President Obama is implementing, costs will probably continue to swell. As the baby boomer generation ages, boomers will place greater burdens on an already stretched Medicare system. And it will only get worse.

When people ask me how I would reform our healthcare system, my stock answer is, "Throw it out and start over." For the amount of money we spend on healthcare in this country it ought to be possible to provide a system of healthcare that everyone can access that is as good if not better than what we have right now. Ten years ago, the Institute of Medicine, part of the United States National Academies chartered by Congress, bluntly said, "The American healthcare delivery system is in need of fundamental change." What we keep getting are tweaks to a byzantine system we already have. Each change adds yet another layer of bureaucracy and complexity, maintaining separate frameworks for the elderly, the unemployed, children, veterans and Native Americans. Yet too many vested interests insist on maintaining the status quo, and therefore stymieing any hope of root and branch reform. President Obama's efforts are laudable, but they needed to go further.

Epilogue

So, has channeling Adam and Jamie been worthwhile? I spend a lot of time in our hospital's Emergency Department. We are the de facto county hospital in Spokane (all of the fun, none of the funding). We see it all – from gunshots to drug addicts to homeless people who are psychotic because they went off their medication. We treat them all. I am proud to say that my colleagues treat every person who comes through the door with the same respect and dignity, regardless of who they are or their ability to pay. There are a number of people I see on a regular basis, often for the same ailments. And it can feel, at times, like we're treading water and that we have to take on the entire burden of healthcare for the poor all by ourselves. Catholic healthcare has always been at the forefront of treating all who come through their doors, but financial pressures and political dysfunction make that job a lot more difficult. We need to get beyond the myths if we want to provide an opportunity not just to heal and treat, but to improve health as well. We have the resources, and we have the brains. All we need is the political will to make it happen.

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Healing ministry of Jesus continues through care of broken, lost, addicted

By Onie Mision-Reed, MTS, BCC

This year, [Lourdes Health Network](#) in Pasco, WA, celebrates its 95th birthday – 95 years of extending the healing ministry of Jesus to all, especially the poor and vulnerable. This is our mission. It is what sustains and impels us to give ourselves, our talents, our skills, the prime hours of our days and years to this loving service.

But who is Jesus and what is his healing ministry? Jesus (before Christianity) was an ordinary man, a carpenter, a member of a worshipping community who made a difference in the life of those considered nobodies in his time – the poor, the sick, outcasts, widows, orphans and strangers, tax collectors, the undesirables in his time. We can imagine how the marginalized people felt when Jesus cared for them, ate with them, and identified himself as one of them. Although he was radically critical of his society, Jesus was never judgmental. Those regarded as sinners he considered as sick and lost. And so, he healed and gathered them from the periphery of society to the center of God's love.

Who are the nobodies and undesirables in our time? Can we bring ourselves to feel one with people who do not look like us or touch those whose smell is unbearable? Can we empathize with those who are broken and lost, listen without judgment to those who drink too much or take drugs, patiently attend to those who appear superficial, foolish or neurotic? Can we learn to have some sympathy and understanding for those who do wrong? For those of us who work in healthcare, we know that we cannot romanticize the work we do. It is stark reality.

I remember a homeless man we treated and cared for at the hospital. I later saw him outside a grocery store and he called me "Chaplain" and shared that he had found a job. I congratulated him, and encouraged him to "keep it going!" One day, I saw him back at the hospital to bring gifts to nurses who took care of him. God's compassion was shown this man and he recognized his dignity and found hope.

Our work calls us beyond our comfort zones, to make sacrifices beyond our imaginings, to make difficult decisions that can affect our name or reputation. We know we cannot do this just for the money. If it were so, we would have chosen a different place to work or changed professions entirely. And when we give our best with dedication, sincerity and compassion and care for people as Jesus did or as we would our loved ones, it transforms us – our lives, our personhood.

Time and again, from the prophets to Jesus, the only mandate we hear is "take care of the poor, the orphans, widows, sick, strangers among you. God hears the cry of the poor (Psalm 34) and is gracious to those who respond to give them the care they deserve as children of God.

All these many years later, we are still here and flourishing! May God continue to fire us with love as God did our healthcare ancestors, as we faithfully follow their call to care for our "dear neighbor."

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When a non-profit hospital turns for-profit: Embracing change to sustain mission

By Susan Oldrid

Saint Anne's Hospital, a 160-bed community hospital, founded by the Dominican Sisters of the Presentation, has cared for the most vulnerable residents of its community for over 100 years. Today, these residents are largely second- and third-generation Portuguese, with a significant number of first-generation, non-English speakers. The hospital increasingly also serves a growing Thai, Cambodian and Hispanic community. In addition to a busy emergency department, and a full range of inpatient services, the hospital provides outpatient services that include behavioral health, pain management; ambulatory surgery, women's health services, wound care, and a regionally recognized oncology program with a team of physicians affiliated with Brigham and Women's Hospital, Dana-Farber Cancer Institute and Harvard Medical School.

In November 2010, Caritas Christi Health Care, of which Saint Anne's Hospital was a member, completed its sale to Steward Health Care, a subsidiary of Cerberus Equity. The completed transaction resulted in funding of operations and significant capital projects, including upgrades to Saint Anne's emergency department and operating suites, as well as construction of a medical office building on its grounds.

Initially, Saint Anne's transition generated questions about the ability to sustain its mission of serving vulnerable populations. However, Steward's commitment to maintaining our Catholic identity and to continuing to provide established levels of free care for the uninsured, community benefits and pastoral care, combined with a deep-rooted commitment from Saint Anne's staff and senior leadership to the founding vision of the Dominican Sisters, has provided the vehicles to continue our ministry to marginalized members of our community.

From the time the Sisters opened the hospital doors in 1906, to their present-day ministry, change has presented challenges to living our Catholic mission: changes in language as new populations emerged, changes because of the aging of the population, changes created by medical advancements and technology, and changes in our ownership. The Sisters' responses over the last 100 years demonstrate how and why mission remains our hallmark.

In 1911, the Sisters established a free clinic. Initial hospital by-laws stated that physicians could charge private patients for services, but they were to treat those who had difficulty paying for services at no cost. Today, many government and social service programs provide aid to those in need. However, Saint Anne's continues its commitment to the underserved by supplementing these services through programs focused on seniors, health screenings for cancer, diabetes and substance abuse, and assistance with transportation, prescription medicines, and access to care.

In 1926, the Sisters opened the Saint Anne's Hospital School of Nursing. Their philosophy was to "graduate wholesome women intellectually, morally, and spiritually equipped to assume their God-given responsibility in a changing world." The nursing school has shaped and influenced hundreds of nurses in their way of providing compassionate care to patients. Saint Anne's continues to partner with local colleges to provide training for nurses by focusing on both contemporary nursing practice and the legacy of compassion imparted to us by the Sisters.

In 1991, the challenges of operating as a stand-alone hospital led the Sisters to deliberate on how best to preserve the vibrancy of our mission. Their decision to affiliate with Caritas Christi Health Care in 1991

enabled them to do so.

In 2010, two significant events, the passing of the Affordable Care Act and Saint Anne's integration into the Steward Health Care System, provided an opportunity to again explore and reassess how to change while sustaining the mission. Resources from the Catholic Health Association (CHA), an evaluation toolkit from the Public Health Institute's Advancing the State of the Art in Community Benefit (ASACB), guidelines from the Massachusetts Attorney General, and planning tools from the VHA Foundation were helpful in this process.

Recommendations that we believe will support the sustainability of our legacy of care and concern resulted from this assessment. These recommendations will address community benefit planning, implementation, accountability, and review in a manner that strengthens the sustainability of our mission within the for-profit setting.

Other initiatives of the hospital also keep our mission focus alive. Through the Faith Community Nurse and Health Ministry Program the hospital trains registered nurses to specialize in working with faith communities. Following graduation from this nine-month program, nurses work in their faith-based community (almost always in a volunteer capacity) helping to provide connections between faith and health. They may offer health education services, help people understand complicated health issues and emphasize preventative healthcare measures in keeping with the teaching of their particular faith.

With the help of an active Multicultural Health Care Committee, the hospital is able to learn about issues affecting the health and well-being of our multicultural population, and to respond through a range of activities that allow us to provide greater access to quality healthcare for each patient regardless of race, language, or ethnic background.

The mission of the hospital is to continue its healing ministry by adhering to the "Five C's," the founding core values of Saint Anne's Hospital: Charity, Catholicity, Compassion, Community, and Cultural Diversity. The history of Saint Anne's Hospital shows that since 1906 much has changed, with one exception: the mission of the Dominican Sisters of the Presentation has endured through many social and economic changes. Their mission continues to inspire us to be faithful to the vision of serving the marginalized and vulnerable population of Greater Fall River, and to maintain it as the core of all that we do.

In Fall River, MA, Susan Oldrid is vice president of mission and community partnerships at Saint Anne's Hospital, a Steward Family Hospital.

In Catholic healthcare, making poor, vulnerable a priority defines success

By Michele Le Doux Sakurai, DMin, BCC

Years ago, I visited a gentleman who was receiving chemotherapy and was expected to be admitted for several days on our oncology unit. Ruben was a practicing Jew who found great consolation in his faith. As our visit drew to a close, he said, "Chaplain, in this room, the cross is partially obscured by the television set. Are you Christian or not? Why would you hide the symbol of your faith?"

This conversation took me by surprise in part because the question was asked by one who stood outside Christian tradition and in part because it pointed out the power of a symbol. This question also propelled me into a deeper level of questions, and one in particular resonates with me today: How would we in Catholic healthcare define our uniqueness if there were no crosses on our walls? How would Ruben or anyone else know of our Catholic identity if there were no physical symbols evident in our buildings? In essence, what is it in our service that differentiates our care from care given in other institutions?

We live in an ever-changing healthcare industry whereby our quality numbers and Press Ganey scores are the measuring sticks for success, and we are consistently asked to do more with less. I presently work in two Critical Access Hospitals whose quality and satisfaction scores are in the top deciles, yet it is not our attention to these numbers that is our defining strength. In Catholic healthcare, success is reflected through the lens of faithfulness. To live Gospel values means to be willing to live the prophetic voice by making the poor and vulnerable a priority and to risk being called foolish and idealistic when we strive to act in the interest of something greater than ourselves.

I was shocked and dismayed to read in the December 2011 Harvard Business Review (p. 22), a company president's response to a corporate notion of greater good, "The notion that we need to upend human evolution – with its focus on self-interest and replace it with some kind of social-industrial compact where our primary concern is a vague idea of 'the greater good' is sort of silly and dangerously messianic." In a culture that has raised personal autonomy/self-interest as the highest value, Catholic healthcare is indeed countercultural. As Catholics, we seek to find balance between individual wants and community needs.

Chaplains experience this on a regular basis. It occurs at end of life within conversations regarding the limits of heroics; it occurs with decisions impacting beginning of life such as when a 24-year-old woman requests a tubal ligation, and there is no underlying pathology that justifies such an intervention. Community values vs. individual values comes into play whenever personal autonomy conflicts with issues of stewardship, social justice, and even excellence.

The following story is all too common in healthcare: The patient had been engaged in illegal activities, was confronted by police officers, and shot. A first responder noted, "He got what he deserved," and then this responder saw the care and compassion that the patient received in the Catholic hospital's Emergency Department. The dedication and expertise, by the ED staff in an attempt to save his life, transformed the first responder. This patient, who did not respect either the law or the officers, was treated with compassion by the ED team members. They did not judge, they simply lived their Gospel values. "They will know we are Christians by our love." Although symbols such as crosses on the walls help to ground us, it is truly our covenant with God that gives us our identity. Some of the earmarks of faithfulness in Catholic healthcare include:

1. Life is protected and celebrated from womb to tomb.

2. To be in solidarity with the poor and vulnerable means we will advocate for the poor.
3. Living a sense of ethics requires a willingness to struggle with competing values and know that we must enter into a process of prayer, dialogue, church wisdom and grace.
4. All who enter our doors are children of God and entitled to dignity and respect.
5. Reconciliation is an imperative on all levels in our lives.
6. Professional spiritual care is a cornerstone in Catholic healthcare.
7. Catholic healthcare resides within a larger community and is called to be a prophetic voice for community.

As chaplains, we act as ambassadors of the Gospel as we give voice to those who are powerless or alienated, as well as those who are mentally ill, abused, elderly, confused, or dying. It is when we stand in witness of another's fear of the unknown – not with answers, but honoring the questions, that we live our covenant with God and the Gospel.

As I return to my conversation with Ruben, I more deeply appreciate his question for it has impelled me to explore my assumptions and to question what Catholic identity means in healthcare. Such conversations should be encouraged in spiritual care departments, administrative team meetings, and board meetings; all in Catholic healthcare should be invited into this dialogue. Make our difference known in our Catholic systems and in our communities. In doing so, we respond to the call of the Gospel, "You are the light of the world – like a city on a hilltop that cannot be hidden. No one lights a lamp and then puts it under a basket. Instead, a lamp is placed on a stand, where it gives light to everyone in the house. In the same way, let your good deeds shine out for all to see, so that everyone will praise your heavenly Father" (Matt 5:13).

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A New Heart

I knock.
"Come in," you say.
I enter, knees knocking.

Depressed, angry,
abrupt, impatient,
unkempt, dirty, smelly—
words they used
to describe you.

Bread, wine,
water, feet washer
life, light—
words they used
to describe him.

You stare. I wait.

"What's going on?"
Silence.

"How are you?"
Silence.

"You want a visit?"
You shrug. I sit.

You turn. I wait.

"Bad heart.
Need a new one."

I wait.

"Waited too long.
Put it off."

I wait.

"Knew I was sick.
Could not afford it.
Hospitals are
too damned expensive.
I waited—too late."

In silence, I wait.

At last, you speak—

of fishing the river with your son
of taking walks when you could
run
of building bridges, one by one
of skipping rocks on sparkling
water
of stopping, to help turtles cross
of deciding not to hunt again
instead, to let the least little
thing live on
even ants and insects in your
home

on and on
until finally,
you decide

to live
for those you love
and who love you.

And so,
you offer them your heart
let them reach inside
to make in you a new heart
with batteries and wires
that you will carry now
outside

to breathe
to live
to keep on loving
and to feel
love.

And I,
praying now,
hear footsteps
on water
see angels gather
round another man
about to suffer
who needs to be
carried

who loved water
who fished and walked
who built bridges
and cared about
the least little thing

and whose own heart
was pierced
poured out
for you, for me

to breathe
to live
to keep on loving
and to feel
love.

And,
as I leave,
angels whisper
yet again:
"A new heart
I will give you,
and a new spirit
I will put within you;
and I will remove
from your body
the heart of stone
and give you
a heart of flesh."

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Wiesenthal book inspires self-examination, stirs memories of lesson-filled trip to Auschwitz

By Susanne Chawszczewski, PhD

"What would I have done?" After reading "The Sunflower: On the Possibilities and Limits of Forgiveness," by Simon Wiesenthal, I have been haunted by that question, by my reflections on that question, and by some recent memories. Wiesenthal's account and the subsequent reflections from a variety of theologians, rabbis, and others took my breath away. In fact, I felt myself holding my breath at many points during the book until I reached an endpoint.

In October of 2008, I had the opportunity to take a trip to Poland with my best friend from high school. Individually, we had promised each other, that in honor of our parents, all of whom are deceased, we would visit Poland. All four of my grandparents were from Poland, as were my best friend's. In making plans for the trip, we certainly knew that we would have the opportunity to visit Auschwitz/Auschwitz II-Birkenau (Oświęcim, in Polish). While this is not the camp where Wiesenthal is imprisoned during his account, what I didn't expect while reading "The Sunflower" was the flood of memories that came back to me from Poland and from that visit.

I had done some family research prior to my trip and found that my grandfather's brother, Tomasz, had died at Auschwitz. The only record was his birthplace, his date of birth (March 20, 1889) and death (August 24, 1942) and that he was a Catholic laborer. Here was a name without a face, without a context. As I read Wiesenthal's account of the horrors of his time in the prison camp, I realized that Wiesenthal too was a name without a face, like the countless millions who died in the many prison camps at that time. But since I had visited Auschwitz, I definitely had a context.

I remember that of the two and one-half weeks we were travelling, the day we went to Auschwitz was the only day it rained during our entire trip. I remember not being able to speak during the tour, which was conducted by an elderly woman whose father had been a prisoner and was liberated from Auschwitz. At Auschwitz, I remember reading the "Work Makes You Free" sign in German at the entrance and what a chill it gave me. I remember the barbed wire surrounding everything. I remember the starvation cell where St. Maximilian Kolbe died. I remember my horror at the crematoria. I also remember the van ride to Auschwitz II-Birkenau. This is where the trains came with those being brought to the camp and their fate was decided with the flip of a wrist – left for death and right for life. And I am haunted by that image.

As I have reflected on the question "What would I have done?" I cannot seem to find an answer. There are many different opinions represented in the essay portion of the book. As Wiesenthal reflects, has God been on leave? How would I react to such evil? As a non-Jewish person who has no first hand knowledge of the Holocaust, would it trivialize the horrors if I had an answer to that question at all? As a Catholic, would I have an obligation to forgive? (Matt 18: 21-23) Having not had the experience that Wiesenthal had, I can say that I probably would not be able to place myself in his shoes. But one of the most important lessons of the book is that we not forget. And while I haven't come to a point that I would be able to answer the question posed by Wiesenthal, I can at least help others continue to remember the horror.

The book raises another important point for me. Are there instances when I have stood by, as a bystander, when I've seen injustice, hatred, discrimination, and not done or said anything? Am I just as guilty of those crimes as if I had done them myself? I think that this is another important piece for us to reflect on. At what cost am I willing to do something in such a situation?

As I have found much in this book to reflect upon, I hope you do as well. The image that I still carry with me from Poland is that I was walking on the ashes of millions of people while I was there. This book makes that image come more to life for me and it is an image that I will not soon forget.

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Finding resources on Simon Wiesenthal's 'The Sunflower'

The first half of "The Sunflower" is an account of some of Simon Wiesenthal's time in a Nazi concentration camp. As a young man, Wiesenthal was at a hospital providing forced labor, when he was taken to see a mortally wounded SS officer named Karl. Karl had been tormented by the crimes he committed and as he was dying, he wanted to confess to and also receive forgiveness from a Jew. That Jew was Simon Wiesenthal. After hearing the Nazi's story, Wiesenthal left the room in silence but the issue of what he should have done or whether he had done the right thing haunted him. Wiesenthal shared this and discussed what he did with fellow Jewish prisoners. At another time, he also discussed this with a Catholic in the prison camp. Even after being liberated from Mauthausen, the whole event still seemed to haunt him. He even visited the mother of the SS officer after the war was over.

The second half of "The Sunflower" is a collection of essays written by theologians, spiritual leaders, rabbis, authors, and others who have experienced heinous crimes themselves. These essayists wrestle with questions like whether we can forgive crimes committed against others; if we should forgive people no matter how horrific the crime; and what we owe the victims of such heinous crimes. The new edition of "Sunflower," in honor of the 20th anniversary of its publication, adds a number of other voices reflecting a large range of diversity.

Related web resources:

Simon Wiesenthal Center
www.wiesenthal.com

Nazi Hunter Simon Wiesenthal Dies at 96
The Washington Post
www.washingtonpost.com/wp-dyn/content/article/2005/09/20/AR2005092000201.html

Mandel Fellowship Book Reviews
academic.kellogg.edu/mandel/younglove_rev.htm

Random House Reader's Guide
www.randomhouse.com/acmart/catalog/display.pperl?isbn=9780805210606&view=rg

Reflection from a student at the I.L. Peretz Community Jewish School
www.ilperetz.org/graduates/daniel_bish.htm

Facing History and Ourselves: The Sunflower Synopsis
www.facinghistory.org/sunflower-synopsis

SAJES Educational Resource Guide
www.templeinairoslyn.com/EdGuide.pdf

One Book: Discussion questions

1. "In his confession there was true repentance," writes Wiesenthal (p. 53). Not all of the commentators agree with him. Many of them think Karl was angling for "cheap grace," and that his remorse exists only because he finds himself facing death. Which point of view do you agree with? Do you think, with literary critic Tzvetan Todorov (pp. 265-266), that the very fact of Karl's expressing remorse makes him exceptional, and therefore deserving of respect?
2. Eva Fleischner found that almost without exception, her Christian students "come out in favor of forgiveness, while the Jewish students feel that Simon did the right thing by not granting the dying man's wish" (p. 139). Do you feel that the Christian and Jewish writers in this volume are similarly divided? Do their differences stem from first-hand experience, or from different notions of sin and repentance, as Dennis Prager suggests? Do any writers in this book seriously suggest forgiveness and why? Do you believe, with political theorist Herbert Marcuse, that "the easy forgiving of such crimes perpetuates the very evil it wants to alleviate" (p. 208)?
3. Did the mother of the SS Man, by her passivity, acquiesce in her son's crimes? Wiesenthal says that people who wanted "only peace and quiet" were "the mounting blocks by which the criminals climbed to power and kept it" (p. 91). Most of the authors in this volume believe that Wiesenthal did the right thing in not telling her about her son's crimes. Psychotherapist Andre Stein, however, disagrees, saying that "Simon had a responsibility toward past and future victims to tell her the truth. And Karl's mother had the responsibility of rising above her personal pain and telling the world what her son had done" (p. 254). Which point of view do you agree with?
4. "I asked myself if it was only the Nazis who had persecuted us. Was it not just as wicked for people to look on quietly and without protest at human beings enduring such shocking humiliation?" (p. 57). Some of the commentators believe that those who were following orders were just as guilty as those who gave them; others, like Dith Pran, draw a moral line between followers and leaders. Would you hold them equally responsible?
5. "Without forgetting there can be no forgiving," says retired Israeli Supreme Court Justice Moshe Bejski (p. 116); the Dalai Lama, on the other hand, believes that one must forgive but not necessarily forget. Do you think it is possible to forgive and not forget? How would you differentiate between forgiveness and reconciliation?
6. Wiesenthal's friend Josek tells him that no one can offer forgiveness on behalf of another victim. Rabbi Abraham Joshua Heschel writes, "No one can forgive crimes committed against other people" (p. 171). Wiesenthal is not so sure. "But aren't we a single community with the same destiny, and one must answer for the other?" he asks (p. 65). It is a question echoed by the Catholic writer Christopher Hollis when he posits that insofar as Karl's crime was part of "...a general campaign of genocide, the author was as much a victim – or likely to be soon a victim – of a campaign as was the child, and being a sufferer, had therefore the right to forgive" (p. 179). Which point of view do you find more persuasive, Hollis's or Heschel's?
7. Many of the Symposium contributors believe that even as he lay dying, Karl saw the Jews as objects or subhumans, and that his wish to confess to a Jew, any Jew, and a concentration camp prisoner at that, showed that he had learned nothing from his experiences. Do you agree with this?
8. Why does Wiesenthal dream about the little boy Eli (p. 68)?
9. "There are many kinds of silence," Wiesenthal states (p. 97). What messages, positive and negative, does Wiesenthal's own silence convey? What does it tell the dying man? What does it tell to you, the reader?
10. Eugene J. Fisher believes that "...we have no right to put Jewish survivors in the impossible moral position of offering forgiveness, implicitly, in the name of the 6 million.... Placing a Jew in this anguished position further victimizes him or her. This, in my reading, was the final sin of the dying Nazi" (pp. 132-133). Literature professor Lawrence L. Langer and writer Primo Levi share this opinion. Do you agree?
11. Jean Amery, Mark Goulden, and Cynthia Ozick insist that Karl and the other Nazis should never under

- any circumstances be forgiven. Do you find their arguments harsh or just?
12. Theologian Robert McAfee Brown acknowledges, "But perhaps there are situations where sacrificial love, with forgiveness at the heart of it, can make a difference, and can even empower" (pp. 122-123). He cites Nelson Mandela and Tomas Borge as examples of men who have forgiven wrongs that many might see as unforgivable. Do you think that Mandela's and Borge's situations are comparable with Wiesenthal's? Where do the differences lie?
 13. If you believe that Karl should be forgiven, apply Harry James Cargas' reduction ad absurdum (p. 125): If Hitler had repented, should he be forgiven? Why or why not?
 14. Is Harry Wu's reaction to Comrade Ma (pp. 271-274) relevant to Wiesenthal's feelings toward Karl?
 15. How does collective guilt differ from national guilt? Do you believe that future generations should continue to feel remorse for a previous generation's crimes? Martin E. Marty compares the national guilt visited upon the postwar generation in Germany with our own national guilt for the institution of slavery and the genocide of Native Americans, and questions whether the perpetuation of such feelings is healthy. Do you agree with his position?
 16. "Indeed, I wonder if Simon did not receive his vocation from this dying SS man," writes Episcopal priest Matthew Fox (p. 146). Does this seem a reasonable theory to you? Do you agree with Fox's belief that in hunting down former Nazis, Wiesenthal is actually offering them the opportunity for moral conversion?
 17. Does Simon Wiesenthal's life work as a Nazi hunter constitute his own response to the question he poses in this book?

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Continuing Education Hours and opportunities for you to be involved

As a community, when we read one work together, it brings opportunities for us to have a common ground and common place to begin our conversations. This project encourages both individual and community involvement. While we may not always agree with what is written, it is important to discuss both the positive elements of the book and those areas in which we are challenged. Here are some ways in which you can read and reflect with your companions in the NACC.

1. Read "The Sunflower: On the Possibilities and Limits of Forgiveness" and explore the resources provided in *Vision* and on the website to enrich your own experience.
2. Write a reflection on a passage or aspect of the book. Send the reflection to the NACC office for publication in *Vision* or on the website.
3. Host a gathering and book discussion. This is a wonderful opportunity for you to connect with members in your area or even via email. The NACC can help you to organize this gathering. If you are interested in hosting an event, contact Susanne Chawszczewski at schaw@nacc.org or 414-483-4898. We can publish the information in *Vision* and on the website. Additionally, we would be happy to provide mailing labels and lists of those members in your area as well as email the members about your gathering.
4. Utilize these opportunities when preparing for renewal of certification. Please see the Renewal of Certification information found on our website at www.nacc.org/certification/renewal.asp.

Who was Simon Wiesenthal?

Simon Wiesenthal was born Dec. 31, 1908, in Buczacz, Galicia (now the Lvov Oblast section of the Ukraine), then part of the Austro-Hungarian Empire. When he applied for admission to the Polytechnic Institute in Lvov, he was rejected because of quota restrictions on Jewish students. Instead, he went to the Technical University of Prague where he received his degree in architectural engineering in 1932 and worked in an architectural office in Lvov when the Nazis invaded Poland. He married Cyla Mueller in 1936.

Mr. Wiesenthal's wife, a blond-haired woman, was able to pass as an "Aryan" and he made a deal with the Polish underground so that she was taken to Warsaw and worked as a forced laborer rather than in a concentration camp. From 1941 to 1945, Mr. Wiesenthal was a prisoner in several ghettos and concentration camps including Buchenwald and Mauthausen. Weighing less than 100 pounds, Mr. Wiesenthal was barely alive when an American armored unit liberated Mauthausen on May 5, 1945. By the war's end, he and his wife had lost 89 family members to the Nazi genocide.

After the war, Mr. Wiesenthal joined the American Commission for War Crimes and was later transferred to the O.S.S. at Linz, Austria. He helped to gather and prepare evidence on Nazi atrocities for the War Crimes Section of the United States Army. In 1947, with 30 other volunteers, he founded the Jewish Historical Documentation Center in Linz for the purpose of assembling evidence for future war crime trials. While the center closed in 1954, it was reopened in Vienna in 1961. Its task was to identify and locate Nazi war criminals. The center's work was instrumental in bringing more than 1,100 Nazi criminals to justice. Wiesenthal has been honored with numerous awards for this work from many countries. He died Sept. 20, 2005, at his home in Vienna.

For a full biography, see the Simon Wiesenthal Center at www.wiesenthal.com along with a full list of honors and a bibliography.

There's much to see, do in walkable Milwaukee

Leave time to check out riverwalk, gardens, zoo, museums, breweries, historic neighborhoods

By Kathy Ponce, MAPS, BCC

The NACC national office staff and members of the Conference Planning Task Force have been busy since last summer arranging revitalizing professional and spiritual experiences for all members and guests at our May 19-22, 2012, NACC National Conference. Once again the site of our annual gathering will be the conveniently located Hilton Milwaukee Center. This issue of *Vision* provides news of the conference plenary speakers. Let us also provide some information on the social and sightseeing amenities of our conference site, since Milwaukee with its lakeside location is an ideal place for a spring get-away for you and your friends or family members.

Those of you who were fortunate enough to have attended last year's NACC National Conference in Milwaukee may have had an opportunity to see and to partake of the city's many charming venues. You probably have your favorite spots and are looking forward to revisiting them as well as further exploring the city's iconic destinations and neighborhood gems. Those who will be visiting Milwaukee for the first time next May are in for a lovely experience, as the Hilton is a perfect base for visiting many of the area's most popular attractions. With a rich ethnic heritage and cultural mix, some of the finest dining in the Midwest, and an amazing art museum, this city, nestled on the shore of Lake Michigan, is especially inviting as May flowers follow April showers to provide a lush atmosphere in Milwaukee's many gardens and city parks.

Milwaukee's RiverWalk, a delightful stroll ranked third in *Travel and Leisure's* "top 10 coolest River Walks of 2010" and within one-half mile of our hotel, continues to grow as one of the most popular ways to see the city. The world's only Harley-Davidson Museum and Milwaukee Brewers baseball home games from May 18-23 may appeal to the sportspersons among conference attendees. Speaking of the Brewers, Miller/Coors, the Lakefront Brewery and the Historic Pabst Brewery are among the most popular of Milwaukee's brewery tours.

Milwaukee, which ranks 13th among the country's most walkable cities, boasts an excellent and artsy amble through its converted warehouse arts district, the Historic Third Ward. Within several blocks of the Hilton is a three-block historic landmark called "Old World Third Street" with 19th-century European-style buildings including an opportunity for shopping, sipping and snacking at the Wisconsin Cheese Mart, Usinger's Famous Sausage Company, the Old German Beer Hall, the Spice House, the Brat House and Mader's, a restaurant that has served famous German comfort foods for more than 100 years. For a walk on the wild side, consider the Milwaukee County Zoo, considered among the finest zoos in the country, situated on 200 wooded acres, home to 2,500 animals, and reachable by a 15-minute car ride from our conference center.

Cathedral Square, a small urban park within a mile of the Hilton, and bordered by Milwaukee's St. John the Evangelist Cathedral, several galleries, and a tea and gift shop, is an appealing option for a daytime stroll. En route to Cathedral Square is an indoor mall, the Shops at Grand Avenue, part of which is housed in the historic Plankinton Arcade. An extremely walkable distance (three blocks) from the Hilton is the Milwaukee Public Museum that houses permanent and seasonal exhibits as well as an IMAX dome theater.

The Boerner Botanical Gardens, a 15-20 minute car ride from our conference site, include 10 gardens, many of which contain art and sculpture. Among the most interesting are an heirloom garden, an herb garden, a bog walk garden and several acres of experimental gardens. The history of the gardens, which were developed in the early 20th century, includes the post-Depression era work of members of the Civilian Conservation Corp, and the buildings developed during this time are currently horticultural education facilities. A five-minute drive from the conference location is the Mitchell Park Conservatory, made up of three all-weather, geodesic, glass domes in which can be found a tropical jungle, a desert oasis, and a seasonal floral garden (just in case a few of Milwaukee's April showers persist into the merry month of May).

As you plan your trip to Milwaukee, we hope that you'll also add a few days either before or following the conference to explore some of the unique neighborhoods of the city, both within walking distance and short car rides of the downtown area in which our conference will be held. More information on the attractions described above is available by browsing the web (also see related links below). Association members who live in the city that is the NACC's headquarters encourage you to "come early and stay late" in this delightful town on the western shore of the southernmost of our nation's Great Lakes.

Kathy Ponce, a chaplain at Resurrection Health Care in Chicago, IL, is chair for the 2012 NACC National Conference in Milwaukee.

Related links:

Historic Third Ward

www.historicthirdward.org

Milwaukee's RiverWalk

www.jsonline.com/business/130031773.html

Milwaukee Art Museum

www.mam.org

Milwaukee Public Museum

www.mpm.edu

Shops of Grand Avenue

www.grandavenueshops.com

Lakefront Brewery

www.lakefrontbrewery.com

Boerner Botanical Gardens

www.boernerbotanicalgardens.org

Milwaukee County Zoo

www.milwaukeezoo.org

Harley Davidson Museum

www.harley-davidson.com/wcm/Content/Pages/HD_Museum/Museum.jsp

Visionaries, prophets to guide 2012 conference in Milwaukee

By Michele Le Doux Sakurai, DMin, BCC

“Reconciling Journey: A Time to Mourn and a Time to Dance” is the theme for the 2012 NACC Conference. This year’s conference promises to take all into a transformative journey; one that beckons each of us to acknowledge sin, mourn loss, seek healing, and celebrate hope in Christ. This journey will be experienced through the lens of our personal lives, our profession, our church, and our world. Our guides for this journey are visionaries and prophets. These plenary speakers will move us through the process of identifying and reflecting on the brokenness, ritualizing and validating our lament, and celebrating what we have integrated both personally and communally.

The journey begins with **Reconciliation within Our Self** focusing on the question, how do we explore our inner dynamic that is experienced as a tension between who we are and who we desire to be? The plenary speaker is C. Vanessa White, director of the Augustus Tolton Pastoral Ministry Program, a theological and pastoral ministry formation program for African-American Catholics who are pursuing graduate study in preparation for ministerial leadership at Catholic Theological Union in Chicago, IL. Ms. White has a passion for spirituality and ministry formation. She brings more than 25 years of experience as a presenter, retreat facilitator, spiritual director, and teacher. She is a professed Secular Franciscan with the Sacred Heart Province and is co-editor for *Songs of the Heart and Meditation of the Soul* as well as contributing author for *Liturgy and Justice*.

The journey continues with **Reconciliation within Our Professional Settings**: How are we a reconciling presence in professional settings where brokenness appears in many contexts? Presenting will be Jean De Blois, CSJ, who holds a doctorate in moral theology and medical ethics and currently is on the faculty of Aquinas Institute of Theology. She has served on the Board of Directors for the NACC and is attuned to spiritual care and its many demands. Her interests in ethics are varied including end-of-life decision-making, the effects of advancing technologies on the delivery of healthcare, professional ethics, the relevance of Catholic social teaching to Catholic healthcare today, environmental ethics and the future of Mother Earth, and lay leadership and sponsorship in Catholic healthcare and other ministries of the church. She has co-authored with Benedict M. Ashley and Kevin D. O’Rourke, “Health Care Ethics: A Catholic Theological Analysis.”

As the journey moves to **Reconciliation within the Ecclesial Community**, the focus is on how do we live gracefully within a church that embodies “the already and the not yet?” The plenary speaker is Bishop Blase Joseph Cupich of the Diocese of Spokane, WA. Bishop Cupich holds an S.T.D. in Sacramental Theology from The Catholic University of America. Within the USCCB, he currently serves as chair of the bishops’ Committee on the Protection for Children and Young People and is a member of the Ad Hoc Committee on Scripture Translation. Bishop Cupich has been involved in the Emerging Models of Pastoral Leadership Project as well as the 2011 Collegeville National Symposium of Lay Ecclesial Ministry. Recent articles include “Power in the Present: Hope for the Future” in the March 23, 2009, *America* magazine, and “The Emerging Models of Pastoral Leadership Project: The Theological, Sacramental, and Ecclesial Context” (*National Ministry Summit, May 2008*).

The final focus of this convention will be **Reconciliation within Our Global Society** focusing on, how do we serve as ambassadors of reconciliation within the global community? Our presenter will be John Dear, SJ, who is a priest, pastor, peacemaker, organizer, retreat leader, author and editor. John Dear is an internationally known voice for peace and nonviolence. A Jesuit priest, he is the author/editor of 25 books.

In 2008, Archbishop Desmond Tutu nominated him for the Nobel Peace Prize. From 1998 until December of 2000, he served as the executive director of the Fellowship of Reconciliation, the largest interfaith peace organization in the U.S. After 9-11, John served as a Red Cross chaplain, and became one of the coordinators of the chaplain program at the Family Assistance Center. Presently, he lectures and also writes a weekly column for the *National Catholic Reporter*. His books include, "Lazarus Come Forth: How Jesus Confronts the Culture of Death and Invites Us into the New Life of Peace" (Orbis 2011), "Transfiguration: A Meditation on Transforming Ourselves and Our World" (Random, 2001), and "The Questions of Jesus: Challenging Ourselves to Discover Life's Great Answers" (Image, 2004).

In addition to these speakers, the conference will include a "conference weaver" – Fr. Cyprian Consiglio, a monk of the Camaldolese Congregation as well as a musician, composer, writer, and teacher, who will help us move through our journey with the plenary speakers, provide times of meditation, reflection, and contemplation each day. He will draw our theme across the four days we are together in Milwaukee. Fr. Cyprian has recorded and published (OCP) five collections of original music; he has also written "Prayer in the Cave of the Heart: The Universal Call to Contemplation" (Liturgical Press).

With these plenary speakers and the conference weaver, the stage is set for a potentially powerful and prayerful journey that will take us through lamentation to joy as we embrace the words of Ecclesiastes, "For everything there is a season...a time to mourn and a time to dance." Come, let us together be transformed, as personally and communally we experience anew our oneness with God.

Michele Le Doux Sakurai is manager of pastoral care and mission for Providence Health Care, Stevens County, WA, and a member of the NACC 2012 National Conference Planning Task Force.

Related links:

C. Vanessa White

www.ctu.edu/academics/c-vanessa-white

Jean DeBlois, CSJ

ai.connectingmembers.com/AboutUs/FacultyandAdministration/FacultyBios/JeandeBloisCSJ.aspx

Bishop Blase Cupich, "Power in the Present," America magazine

www.americamagazine.org/content/article.cfm?article_id=11527

John Dear SJ's blog | National Catholic Reporter

ncronline.org/blog/1122

Fr. Cyprian Consiglio

cyprianconsiglio.blogspot.com

In 2012, NACC must continue to strengthen, be voice for profession

In preparing for this first *Vision* column of 2012, I reviewed my prior columns of first issues in the four years since I became executive director in the fall of 2007. I was first struck by how readily accessible electronically these issues of *Vision* are now! Only the 2008 and 2009 issues were still in "pdf" format! What a blessing! (You can easily access back articles on the "*Vision* archives" section of our website: www.nacc.org/vision/backissues.asp)

Secondly, I was struck by the themes of these issues: 2008 was Solutions to Charting, 2009 was Reaching Out to the Immigrant, 2010 was Small Workplace, Big Challenges, and 2011 was the Profession of Chaplaincy. These are still vital themes for our members. Thirdly, the topics of my columns were: 2008 – promoting the value of pastoral care. 2009 – our NACC 2009 goals, 2010 – the call to leadership within NACC, and 2011 – what characteristics make chaplaincy a profession.

The theme of this current issue on how spiritual care ministry in healthcare is responding to the needs of the poor parallels well the 2009 theme on Reaching Out to the Immigrant, as both focus our attention on those we serve, especially society's marginalized. We realize how central this ministry is to our Catholic social teaching. Care of our most needy brothers and sisters is the challenge and hallmark of every Catholic healthcare entity.

This issue follows well the November-December 2011 *Health Progress* issue on "Embracing Our Cities," whose articles explore the urban realities that confirm what research informs us about the close association between poor health and poverty and the disparities in health and healthcare access and service for minority and low-income groups, and how Catholic healthcare is responding to these needs. www.chausa.org/HP

In my 2010 column, I asserted the call for leadership within NACC, and invited members to embrace the many ways to exert their leadership on behalf of the other members of the association and our chaplaincy profession. As we head into 2012, the exercise of spiritual leadership in our *ministry settings* will be the theme and focus of several audio conferences, national conference workshops, and conference calls.

We all realize how vital spiritual care ministry is to our work settings. How prepared are we to exercise this leadership in its many forms? How do we discern our call to spiritual leadership? How do we provide this leadership on interdisciplinary care teams? How do we evidence the value and importance of this leadership through research, productivity tools, and quality measures? We will explore these and other themes of spiritual leadership throughout 2012. Please revisit two documents created by the Summit 2007 Task Force on Care Service on the [Essential Functions of a Board Certified Chaplain](http://www.nacc.org/resources/documents.asp) and [Spiritual Leadership Competencies for Pastoral Care](http://www.nacc.org/resources/documents.asp) (www.nacc.org/resources/documents.asp) that provide helpful guidance for us as we address this important topic.

In my 2011 column I explored the characteristics of a profession and how chaplaincy embodied them. As we head into 2012, our membership was unequivocal about what needs to be the primary agenda for the coming months and years – making a case for the value of the profession. So much of our 2012 effort will be devoted to this work. This agenda brings us back to my first January column in 2008 under the headline, "NACC works to promote the value of pastoral care." The need for this work remains ongoing and urgent.

As we head together into 2012, I am deeply grateful for the many partners that are working with the

NACC to promote the profession, including the Catholic Health Association and the many Catholic healthcare systems that have supported our NACC mission (www.nacc.org/advancing/partners.asp), the other spiritual care ministry associations both within the Spiritual Care Collaborative and those who met together in Atlanta Dec.7-8, 2011, to commit to working together to advance the profession (www.nacc.org/resources/e-news/nn_issue_110.asp#1), the graduate theological ministry programs that encourage students to pursue chaplaincy as a profession (for example, see www.msj.edu/agpim/), and the many Catholic ministry associations that promote national certification standards for lay ecclesial ministry (www.nalm.org/mc/page.do?sitePageId=70359). These and many other partners are working with the NACC to promote the profession.

As we begin 2012 together, our NACC mission statement, crafted and adopted in 2007, still serves us well: *The National Association of Catholic Chaplains advocates for the profession of spiritual care and educates, certifies, and supports chaplains, clinical pastoral educators, and all members who continue the healing ministry of Jesus in the name of the Church.*

Blessings on 2012,

David A. Lichter, D.Min.
Executive Director

Q&A with Marjorie Ackerman

By Laurie Hansen Cardona, *Vision* editor

NACC member Marjorie Ackerman, of Bethesda, MD, changed careers from mortgage broker to chaplain after her husband's death in 1997, when she recalls she "lost interest in helping people accrue material wealth and decided that, instead of saying to folks 'tell me your problem, and I will solve it,'" she would say "tell me your problem and I will help you to solve it."

Ms. Ackerman, founder of Life Skills Workshop, a now defunct program that for 12 years helped newly released women convicts, now lobbies for a national program that would help train ex-offenders to transition to new life outside of prison.

Currently on-call chaplain at Suburban Hospital in Bethesda, she is also a disaster spiritual care member of the American Red Cross, and part of the "A Team" at Red Cross national headquarters. Team members, who are located around the country, are working to reassess the role they will play in national and local incidents.

In an interview, Ms. Ackerman noted that California was her first home, but she grew up overseas. She met her husband, a foreign service officer, in Paris, France, and together they raised a family while he worked in embassies in various countries. With her children grown and having relocated to Bethesda, she developed a full-service financial planning company and, in that role, visited 65 American Embassies around the world conducting seminars to help people make decisions in the changing financial and real estate markets. Later, Ms. Ackerman, who became a board certified chaplain in 1996, received a master's degree in theological studies from Washington Theological Union in May of 2003. She agreed to answer questions for *Vision* readers.

Q What led you to found Life Skills Workshop?

A I explored the many potential avenues of service. For a period of time I supervised seminarians who were honing their skills in hospital ministry at the Naval Hospital in Bethesda. Becoming an NACC supervisor interested me. That is, until I visited the jail.

People, especially women, who have been incarcerated are at a great disadvantage. They need guidance and encouragement more than they need help and money. I can remember the exact moment when I envisioned a program that would allow newly released women to learn how to transition to a life that most could hardly imagine. It would be a life of pride, success and example to others. That is how Life Skills Workshop was born. Then came the reality of organizing such a venture: finding interested volunteers, writing a business plan, clearly understanding the goals and aspirations, finding a location for the classes, making contacts in pre-release centers and shelters, involving area churches and the most difficult thing of all – raising money. I quickly found that helping women who are coming out of jail is not the most popular non-profit charity.

Most of the helpers were volunteers, but we needed start-up money for things like forming a 501c3 corporation and the million incidentals that I had not thought about. Later we would need to hire an executive director. The miracle is that the program happened with the help of hard-working, dedicated people. The mentors made the difference in helping to keep fragile human beings from falling, once again, through the cracks.

Q What challenges do incarcerated women face when trying to return to the workplace?

A Imagine this. You are going to your first job interview and you have to write on the application, FELON. Your address is a pre-release center. You have no references. You are very unsure about what to say or how to say it, and you know you look terrible. You gained a lot of weight in jail (the food is almost all carbohydrates) and the one pair of jeans you have are the ones you were wearing when you were arrested and you know they are way too tight. But you don't have any money and the only friends you have are the ones who got you into trouble. You want desperately to be reunited with your children and say over and over to yourself, "If I can have just one more chance, I will be a good mother this time." You pray a lot.

Now imagine this. You have just been released from jail. You were lucky enough to have been accepted in the pre-release center and you hear about Life Skills Workshop. It's a program that meets every Saturday morning for eight weeks. You call and are welcomed, even though you have missed one class. You are greeted by your mentor and are given an outline of the classes. There is someone there who will interview you and work with you to write a resume and someone else who will help you pick out two or three outfits from the LSW Boutique that are appropriate for a job interview. You will be taught how to make an appointment, the importance of attitude, dressing properly and being on time.... For the first time in your life you are among people who care and treat you as an equal. You can't wait until next Saturday. And you get a job.

The most exciting times came when "graduates" returned to tell of their successes. One former participant said, "Look at my dress, I bought it, I didn't steal it." And everyone clapped.

Q What happens to women who find themselves in similar situations but don't have access to a program such as Life Skills Workshop?

A Some women make it without help, but more often, they end up back in jail. The reason is usually related to drugs. They may "medicate" themselves with drugs because of discouragement and depression from failure and then steal money to support the need that quickly becomes a re-addiction. Or they are caught when they are paid (money amounting to 10 times more than they would get all day at McDonald's) for being a lookout for an hour to warn serious drug dealers if police are in the area. The money may be needed for food for their children but clemency is not in the cards for ex-offenders. Or sometimes they go back to the world's oldest profession. Their children learn from them, just as they learned from their parents, and so, without help, the cycle continues.

Q What is the biggest challenge you encountered in your work?

A Trying to raise funds. People were quick to congratulate us on the great job we were doing but the money didn't follow. Until there is a nationwide acceptance of the need for training ex-offenders who are transitioning back into society, the rate of recidivism will rise at a tremendous cost to the taxpayer. Michigan has a program called Michigan Prisoner ReEntry Initiative (MPRI). Why can't there be a national offender re-entry initiative? This is my goal. It's not a question of money. Everyone who works in this field knows that it costs a lot more to keep people in jail than it does to rehabilitate them. It is a question of interest and caring. My small, insignificant program gave over 400 women a second chance and it worked. Our budget was less than \$100,000 a year, but it closed in spring 2009 for lack of funding.

Sen. Jim Webb from Virginia introduced a bill in 2010 to establish a national commission to "undertake a comprehensive review of the criminal justice system." It passed the House vote but recently was defeated in the Senate (by three votes). It will probably not be reintroduced, according to information I received from Sen. Webb's office.

Q In your view, what must Catholic chaplains strive to do to live out the theme of this issue of

Vision, "to serve the poor."

A The biggest reward is seeing the expression on the face of a woman who has given up, but after lots of role playing and dressed in business attire, she comes to us with the most wonderful news: she got the job, she will be reunited with her children and her brother is coming to her graduation. That's as good as it gets! There is sadness in every aspects of chaplaincy but the ability to "find the rainbow" for women who are close to giving up is worth more than I can express. It is watching them take pride in what they have done for themselves that brings me joy and satisfaction.

Q **In your view, what must Catholic chaplains strive to do to live out the theme of this issue of Vision, "to serve the poor."**

A I think we should add "and the poor in spirit." So often we mistakenly think that money will fix a problem when it is more often learning to struggle without becoming discouraged, to accept illness and hardship without being angry at God, and loving those we don't even like to help find peace in the world. The problem is often inside of us. It is attitude and caring for others that can change the problem into a challenge. As chaplains, we can be instrumental in causing positive things to happen.

If you have interest in working with Ms. Ackerman on a nationwide offender re-entry program, please e-mail her at ackerman.m@verizon.net.

Light at tunnel's end: Helping those with mental illness find hope through spiritual assessment

By Deborah Ann Forstner, MA, BCC

Introduction

When people are in acute phases of mental illness, they may feel cut off from God. They might experience an inability to pray, even if this is a practice that has helped them in the past. They may experience spiritual delusions or feel compulsively unforgivable. They may be unable to find a sense of hope. To address these concerns, a spiritual assessment process, developed by two physicians, was implemented on a trial basis at a Community Support Program (CSP) in St. Cloud, MN. The project focused on the CSP's Mental Health Practitioners using the interview tool with clients who are living with mental illness.

I requested feedback from the practitioners and the program director regarding their experiences with the spiritual assessment process, and also in regard to its potential for continuing use when working with clients through their challenges beyond this study. I proposed that a conversation around spirituality would help clients/patients uncover their spiritual resources, and that there would be much we could learn from each other. My claim was that spiritual assessment would make outreach and ministry to those living with mental illness more holistic and effective.

Description of the situation

There are many areas of stigma faced by people with mental illness related to spirituality. Some might believe that experiencing mental illness is a sign of weakness or character flaws, rather than an illness. Others may agree with the medical community that it is a brain disorder/chemical illness, but believe one should just wait until medication or other physical treatment becomes effective rather than entering into spiritual dialogue when a person is experiencing symptoms. Some in community settings (such as psychotherapy clinics or hospitals) may feel it is inappropriate to bring up spirituality due to the separation of church and state. And finally, some ministers may be uncomfortable with people experiencing mental health illness, due to a lack of knowledge or a desire to not interfere with other aspects of treatment.

At the same time, it has been demonstrated that there have been people with mental illness who, by unpacking their spiritual experiences and concerns, have made contributions to both themselves and the church. A significant example of this can be found in the life of Anton Boisen, founder of the Clinical Pastoral Education movement. Mr. Boisen viewed times of mental illness and religious crises as similar. Addressing problems psychiatrically and pastorally can lead to a turning point in the mentally ill person's life. Mr. Boisen lived this concept first hand, as he experienced psychotic episodes with a diagnosis of schizophrenia. Reflections upon his experiences resulted in Mr. Boisen becoming a leader in religion and mental health.

Lives of the saints

There sometimes does seem to be a fine line drawn between what can be a beautiful spiritual insight, and what can be delusional and destructive to a person's ability to function. While seeing visions and hearing voices are often associated today with schizophrenia, a saint and doctor of the Catholic Church who experienced visions and inner voices was Teresa of Avila (1515-1582). At around age 39, Teresa's visions and experiences began, and they were a source of embarrassment, confusion, and shame for her. Indeed, the Oxford Dictionary of Saints notes, "she was helped by both Dominican and Jesuit directors, but

unfortunately her visions and other experiences became known through indiscretion and led to much misunderstanding, ridicule, and even persecution." Some thought her visions were from the devil, but others believed that they were a gift from God.

St. Therese of Lisieux, at one point in her autobiography, translated to English by Ronald Knox in 1958, describes herself as "a mass of scruples" (125). She shared that she would tell her many worries to her sister Marie, and noted that "even my confessor didn't know I suffered from this distressing complaint, because I only mentioned to him the sins Marie had told me I might confess; you'd have thought I hadn't a scruple in the world, when in reality I was as bad as I could be" (120). In Therese's spiritual journey, she comes to free herself from scruples through the concepts of her "Little Way," through which she proclaimed her vocation to be love and she learned to find joy in doing small acts of kindness. Rather than the trap of being a frightened and compulsive child, her lived spirituality, which she documented in her writing, moved to a deep knowledge of God's deep, tender mercy. Teaching people with obsessive compulsive disorder and excessive scrupulosity about "The Little Way," through the example of St. Therese's life and writing, could be a helpful pastoral intervention.

The pastoral response

Holistic mental health: The spiritual dimension

In "When Saints Sing the Blues," author Brenda Poinsett agrees that depression is a medical condition, but adds that "to define depression as strictly a chemical or medical problem ignores the fact that we are more than physical creatures. We are also spiritual, mental, emotional, and social creatures. Depression can enter our lives in any one of these areas, fan out, and affect other areas" (15).

By exploring the spiritual area, focus can be given to what gives life meaning, and a person's beliefs can be illuminated. Community support programs, such as Catholic social service agencies, hospital programs, and outreach through parish communities, can help a person in the process of lighting his or her way through spiritual conversations.

Facilitating a spiritual assessment process

Through a review of literature, I found the HOPE spiritual assessment, which was published in *American Family Physician* (Jan. 1, 2001). Authors Anandarajah and Hight state that spiritual assessment is important for a variety of reasons, citing studies that suggest "positive correlation between a patient's spirituality or religious commitment and health outcomes" noting that "patients would like physicians to consider these factors in their medical care" (81). While Doctors Anandarajah and Hight state that there are many possible frameworks for both informal and formal spiritual assessment, they developed the HOPE questions as a tool for teaching medical students and physicians how to incorporate spiritually related questions into their patient interviews.

While they note the questions have not been studied for validity through research, they view their approach as an opportunity to explore, in an open-ended way, inner spiritual resources, concerns, and support systems. The HOPE assessment is the framework that I chose to use, with slight adaptation for focus upon people living with mental illness, in a pilot project associated with this study. A copy of the adapted HOPE spiritual assessment can be found in Appendix A. The basic flow of the questions is around the HOPE mnemonic, as follows:

- H - Sources of hope, meaning, comfort, connection
- O - Organized religion
- P - Personal spirituality and practices
- E - Effects on care

Partnership with St. Cloud Diocese

Catholic Charities for the Diocese of St. Cloud, MN, has a program called Hope Community Support Program. Hope's client outreach is for people diagnosed with serious and persistent mental illness. There are a variety of ways in which clients access Hope's services, including drop-in visits to the center during its open hours, scheduled appointments at the center, and home visits by the practitioners. Group therapeutic support and recreational opportunities are also offered.

The services of Catholic Charities and Hope Community Support Program are open to people of all faith traditions, and to those not affiliated with any religious faith. Sue Hanks, director of Hope, shared at a meeting in February 2011 that there were no specific spiritual assessment processes in place for clients at that time. With Ms. Hanks' support of a vision for holistic treatment of clients, she scheduled time for me to present the HOPE spiritual assessment tool with her staff. She told the staff that as employees of Catholic Charities, they were in unique positions of not needing to discuss spirituality or religion with clients, but that this was an avenue open to explore. She encouraged the mental health practitioners to consider trying the HOPE assessment tool with clients –both with those they thought would be open to it, and with those they might guess would not be. Either way, the feedback obtained from trying to open up the conversation would be helpful toward a better understanding of their clients, and for the purposes of this study.

In March 2011, I presented to staff at Hope Community Support Center. I began talking about the rationale and importance of discussions about spirituality for people with mental illness. I referred to the work of Sister Nancy Kehoe (2009) and her spirituality and values groups that were held in a setting similar to Hope. We went through the content of the HOPE questions, encouraging staff members to use their clinical skills to modify the wording or to flow along with their clients' responses. One staff member who leads a weekly group asked if this was something that could be used in that setting. I highly encouraged that idea. This group leader shared her observation that when members of the group say something about spirituality/religion, they often look to the leader as if they are wondering, "Is that OK?" Therefore, she said she welcomed the idea of trying out the tool. Another worker asked if they could tell clients that this is for research, since the topic and process would be so different from anything discussed before. The agency director replied that use of the tool would be akin to staff members attending workshops and deciding to use information provided there with clients. I noted that if the research project was mentioned to clients, they would need to be assured of their total confidentiality, and that the focus of the research was the usefulness of the process rather than data about the clients' beliefs.

In April 2011, I again attended a HOPE staff meeting. The first activity was for staff to complete an anonymous written survey (see Appendix B for that survey and results). Data from 12 mental health practitioners was available. The responses show that nine practitioners responded that they used the spiritual assessment tool. Of the two who said "no" and the one who did not check "yes" or "no," their comments were that it had either been used informally, in a modified form, or resulted in the practitioner being motivated to talk to clients about spirituality without using the format. I viewed this as total participation, since my perspective on the spiritual assessment process was that it could and should flow in a conversational, informal style; the questions could be modified; and the main goal was for people to have an opportunity to be questioned and listened to in regard to their spirituality. One suggestion was to make the items less open-ended, as a worker noted that it allowed clients to go on and on. I took this as a positive indicator regarding the importance of the topic. If clients would give long responses to the HOPE questions, there seems to be a confirmed need to explore spirituality in conversation with another. Overall, 10 of 12 respondents replied that they thought spiritual assessment/structured conversation should be part of the services offered through Hope Community Support Program, and two were undecided.

After the anonymous survey, the group held an open discussion of questions I presented to them in a handout. Several positive comments were given in response to their experience with the questions of the HOPE spiritual assessment. One worker stated that she was surprised at how much of a response she received, adding that spirituality was an area she had not asked about before. Another worker found

approximately one-half of her clients seemed interested and open, and the other half did not. She cited privacy as a reason some did not feel comfortable sharing. In the Depression/Bipolar Support Group, the co-leaders found that members were open and wanted to talk about the topic. In just presenting the first question, it seemed that the dynamics of the group brought out answers and discussion. One worker noted that the clients with whom he used the tool seemed to want to talk about the effects on care first, including the impact their mental illness had upon their access to attending church and practicing their spirituality, with issues such as lack of transportation and human support. After discussing those concerns, they were comfortable with addressing questions that were listed earlier on the assessment tool.

Impact:

- The HOPE Spiritual Assessment process proved to be a valuable tool for practitioners working with those with a mental illness. Workers learned that many of their clients appreciated opportunities to talk about this aspect of their lives.
- Most of the practitioners plan to continue to utilize spiritual assessment in their work with persons with mental illness.

Recommendation:

It is the hope of this author that use of spiritual assessment/ dialogue by chaplains and others who minister to people with mental illness might be enhanced through the guidance of utilizing the HOPE format.

Deborah Ann Forstner is a school psychologist who works for District 742 Schools in St. Cloud, MN. She received a master's degree in pastoral ministry from St. John's School of Theology in Collegeville, MN, in May 2011. This research was completed as part of the requirements for that degree. Ms. Forstner said she is indebted to Hope Community Support Program in the Diocese of St. Cloud and to Dr. Jeff Kaster, her faculty advisor, for their support and guidance.

References

- Anandarajah G., & Hight. E. (2001). Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician* 63 (1), 81-88.
- Kehoe, N.C. (2009). *Wrestling with our angels: Faith, mental illness, and the journey to wholeness*. San Francisco, CA: Jossey-Bass.
- Knox, R. (trans. 1958). *Autobiography of St. Therese of Lisieux*. New York: P.J. Kenedy and Sons.
- Oxford Dictionary of Saints* <http://www.answers.com/topic/teresa-of-avila> (accessed 3/10/2011).
- Poinsett, B. (2006). *When saints sing the blues: Understanding depression through the lives of Job, Naomi, Paul, and others*. Grand Rapids, MI: Baker Books.

Light at tunnel's end: Helping those with mental illness find hope through spiritual assessment (APPENDICES)

Below are Appendices A and B for the article "Light at tunnel's end: Helping those with mental illness find hope through spiritual assessment."

APPENDIX A

Adapted from G. Anandarajah and E. Hight, "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment." *American Family Physician* 63:1 (2001): 81-88.

H Sources of hope, meaning, comfort, strength, peace, connection

We have been discussing your support systems. What is there in your life that gives you internal support? In other words...

What are your sources of hope, strength, comfort and peace?

What do you hold on to during difficult times?

What gives your life meaning?

What sustains you and keeps you going?

For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs. Is this true for you?

If the answer is "Yes," go on to O and P questions.

If the answer is "No," consider asking: Was it ever? If the answer is "Yes," ask: What changed?

O Organized religion

Do you consider yourself part of an organized religion?

How important is this to you?

What aspects of your religion are helpful and not so helpful to you?

Are you part of a religious or spiritual community? Does it help you? If so, how? If not, why not?

P Personal spirituality/Practices

Do you have personal spiritual beliefs that are independent of organized religion? If you are comfortable with sharing them, what are they?

Do you believe in God? What kind of relationship do you have with God?

What aspects of your spirituality or spiritual practices do you find most helpful to you personally?

(Examples might be prayer, meditation, reading Scripture, attending religious services, listening to music, hiking, communing with nature)

E Effects on your care

Has having a mental illness affected your ability to do the things that usually have helped you spiritually? (Or affected your relationship with God?)

As your worker/group leader, is there anything that I can do to help you access the resources that usually help you?

Are you worried about any conflicts between your beliefs and your medical situation, care and decisions?
Do you think it would be helpful for you to speak to a community spiritual leader/caregiver?

APPENDIX B

Written Survey Results - Hope Community Support Program
12 Staff Respondents
4/12/2011

Did you use the HOPE spiritual assessment with one or more of your clients and/or in a group setting?

9 Yes 2 No

1 did not respond, but wrote this comment: "I used portions of it in a group setting having to modify/divert from the format due to cognitive factors with some members and the group dynamic."

The two respondents who answered 'No' each made comments:

"Did not use actual assessment but it did motivate me to talk with two clients about spirituality."

"Only informally."

Do you believe use of the HOPE spiritual assessment tool was and/or will be of value in your work with some of your clients at Hope Community Support Program?

_____8_____ Yes _____0_____ No _____4_____ Undecided

Is there any way/s you would modify the questions/format of the HOPE assessment used in this trial?

_____7_____ Yes _____3_____ No (1 added "Not sure." 1 did not reply.)

IF YES, PLEASE EXPLAIN WHAT CHANGES YOU WOULD SUGGEST.

- I didn't necessarily go question by question but rather touched on various parts of the questionnaire in more of a conversation vs. questionnaire.
- To build into questions – not utilize as a "separate" tool.
- Less open ended – Seemed to allow clients to go on and on.
- Concepts of questions are good. I would just put in my own words.
- Reflecting on/reviewing the "Effects of Care" may work effectively as a transition into this topic... as an opportunity for clients to explain why they are not attending church, etc. (Note: The HOPE spiritual assessment format's last section is "Effects on Care.")
- Change some of the language to be more inclusive.
- In a few places, it says, "God" when it might be better to say "higher power."

Do you think spiritual assessment/ structured conversation should be part of the services offered through Hope Community Support Program?

_____10_____ Yes _____0_____ No _____2_____ Undecided

If no or undecided at this time, please explain:

One undecided respondent commented: "I am undecided as the clients I used it on were fairly ambivalent about it."

One respondent who answered "yes," commented, "I think it is important the topic is brought up."

To be a healing force for the poor, no matter the changing healthcare landscape

By David Orr, MTS

Jesus went throughout Galilee, teaching in their synagogues and proclaiming the good news of the kingdom and curing every disease and every sickness among the people. So his fame spread throughout all Syria, and they brought to him all the sick, those who were afflicted with various diseases and pains, demoniacs, epileptics, and paralytics, and he cured them. (Matthew 4: 23-24)

When Jesus saw the crowds, he went up the mountain; and after he sat down, his disciples came to him. Then he began to speak, and taught them, saying: "Blessed are the poor in spirit, for theirs is the kingdom of heaven. Blessed are those who mourn, for they will be comforted. Blessed are the meek, for they will inherit the earth. Blessed are those who hunger and thirst for righteousness, for they will be filled. Blessed are the merciful, for they will receive mercy." (Matthew 5: 1-7)

Then the king will say to those at his right hand, "Come, you that are blessed by my Father, inherit the kingdom prepared for you from the foundation of the world; for I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me." (Matthew 25: 34-36)

Matthew presents the mission of Jesus: to go and teach, proclaim "the good news of the kingdom," cure "every disease and every sickness among the people." To whom did he go? To the poor, mourners, the meek, the hungry and thirsty, strangers, the sick, prisoners. Sound familiar? When we remember that Jesus (and we chaplains) are called to this same mission, and that Jesus laid down his life following this call, as Catholic chaplains, can we *ever* allow our mission in the current hospital and healthcare context to erode or be abandoned? I think not.

Instead, we must embrace our call to service and move it forward. We must discover new pathways and innovations to meet and overcome the new challenges for our hospitals and healthcare systems. While we may not have the *same* divine power of Jesus to teach, proclaim, and cure, perhaps we have more power than we think, stemming from our rich Catholic tradition that so values social justice, caregiving, and compassion. Each one of us can have an impact in whatever context we find ourselves, when we follow the mission and call of Jesus outlined above. Since we chaplains are all about sharing stories, let me share a little of mine.

Over the past year or so, I retired from the U.S. Department of Justice, received a master of theological studies degree from Washington Theological Union, and entered my first unit of clinical pastoral education as a chaplain intern at the University of Virginia Medical Center, an ACPE-accredited program. Today, I was writing my mid-unit evaluation, reflecting on learning "the way" of chaplain training and work, and considering my role thus far as a *Catholic* in a non-Catholic hospital with no other Catholic chaplains. My supervisor is Mennonite and my intern peer group has a Jew, Unitarian Universalist, Hindu, Anglican, and Baptist. UVA resident colleagues are Episcopalian, Alliance Baptist and Buddhist. In such a setting, one might expect the lone Catholic to be uncomfortable, but I am not. I have found it very stimulating to listen respectfully to other faith perspectives and to share mine. In fact, my Catholic faith has been strengthened by having to reflect more deeply on and explain my faith tradition to those not familiar with it.

Perhaps because I was raised Baptist and became Catholic as an adult, I find mostly common ground on which to minister as Christian alongside my Protestant brothers and sisters. Instead of highlighting our institutional differences, we are able to act toward our patients and one another and to pray together, as Jesus taught us. Except in rare circumstances, I also find that when we start with the patients themselves, respecting *their* needs for spiritual healing, meeting them where *they* are on their faith journeys, our compassion melds into one love, as the Holy Spirit works its wonder, becomes incarnate in the person of each caregiver, patient or family. Our collective work becomes expression of the one love that joins us all together, through Christ, by power of the Holy Spirit. As Catholic Christian, I am able to sense God's action, the Spirit's great work, among us.

At UVA, although most patients are Baptist or at least non-Catholic, I do encounter Catholic patients and am blessed to be able to meet their unique needs, e.g., for Catholic prayers, rituals, Communion, or even baptism in dire circumstances. I am grateful to meet and minister fairly often to Catholics on my rounds and "on call" in emergency situations. On one occasion, when I was "shadowing" my Mennonite supervisor, we entered the room of a patient and I saw on his wall a prayer card with the image of Jesus whose Sacred Heart was aflame with love. As the patient spoke of his great devotion to Christ and the Sacred Heart, even as his own heart was failing him, I offered to pray aloud with him the prayer on the back of that card. As we left the room, my supervisor told me he would not have known of the prayer on the back of that card, or to use it in that way. Another time, a young Catholic mother who had been hospitalized for many days and was missing her three young children as Thanksgiving approached, asked for Communion and I was able to provide it. Finally, an emergency situation arose in which a mother asked for her child in danger of imminent death to be baptized and I was grateful and happy to do so.

While I feel deeply moved and graced by such encounters, they also cause me to continuously and carefully consider my role, to reflect deeply on my actions, and to grow and develop as a lay minister. I have met with my parish priest and consulted former professors regarding actions and ethics in order to ensure appropriate behavior as a Catholic chaplain. In addition, I am reading about Catholic healthcare ethics to broaden my knowledge and perspective. Also, Protestant patients sometimes ask my faith and when I tell them Catholic, rich discussions ensue. Interestingly, amid illness, pain and suffering, institutional religious barriers diminish in importance, and mere human presence becomes sacred, compassion paramount.

As I contemplate my place in the changing U.S. healthcare landscape, with all its changes, mergers and reduction of Catholic-led institutions, I remain grateful to be Catholic. I am thankful for the hospitals and healthcare agencies established in our name, whose rich tradition of caring for the poor is ours to carry, whose legacy of doors open in love propels us on to help the suffering who need our help. Christ, by power of the Holy Spirit, remains at our center, ever present, showing us the way of mercy, compassion and love. Though powers and principalities may change our systems and cause some to fall, we remain people of the living God, building the kingdom yet to come. By God's love, and as instruments of that love, our great institutions will continue as will we, adapting and innovating to meet the demands of modernity.

And so we are called and we must go. We must follow Christ. We must enter the rooms, wherever we find ourselves, whatever our stations as Catholic chaplains, health care professionals, or others who simply care. We must not be afraid. We must continue to proclaim the good news of God's kingdom, gently and compassionately, in and through the love of Christ, by power of the Holy Spirit. Our poor patients are waiting. It remains our call to go, to be a healing force for the poor, to love and to serve them no matter what. May God be with us in our efforts.

David Orr resides with his family in Lynchburg, VA. He received his master's degree in theological studies in May 2011 from Washington Theological Union, and now is in his first CPE unit at the University of Virginia Health System in Charlottesville, VA.

Meet Lindsey Tews, new NACC certification specialist

By Laurie Hansen Cardona, *Vision* editor

Lindsey Tews, who began working as NACC administrative specialist for certification in September, said she is pleased to have the opportunity to work in a Catholic environment that emphasizes positive personal growth and the value of individuals.

Ms. Tews, formerly Lindsey Smith who in January 2012 was wed to Mike Tews, came to the NACC with an extensive and varied educational and work background. In an interview, she noted that she was born and raised in Milwaukee, WI, where in 2003 she graduated from Pius XI High School. She started college studies at the University of Central Florida and finished her bachelor's degree in history at Mount Mary College, Milwaukee. At Mount Mary she was a member of a social justice-focused group called Caroline Scholars, and she won the Mother Theresa Gerhardinger Award in 2005 for volunteer work related to social justice.

Ms. Tews earned a master's degree in modern intellectual and cultural history at Drew University in Madison, NJ, and a master's degree in English (specializing in writing) at Mount Mary College in 2011. She said she is interested in the history of thought and ideas, 20th century culture, and children's literature, particularly where all three intersect.

Before joining the NACC, she was a full-time graduate student who moonlit as a college professor (teaching American government at Mount Mary College under the auspices of the history department) and as a switchboard operator. She also has worked with children in school settings as an enrichment instructor (teaching classes titled "I Dig Dinos!" and "Crime Scene Investigation," among others) and as a paraprofessional educational assistant at River Trail Elementary School within the Milwaukee Public School system. She found that working as a work-study student during college gave her behind-the-scenes experiences at the colleges and universities that she attended.

In her new role in the NACC national office, Ms. Tews will help applicants through the process of becoming certified, assist the Certification Commission, and coordinate certification interviews, along with other duties.

She already has witnessed the full cycle of certification: applications, the review of binders, and certification interviews. "Everyone in the office has been so warm and welcoming, and I think I have joined a great team," she said.

Ms. Tews said she is glad to have the chance to make herself an invaluable member of the NACC team. "The economic recession has been very difficult for my family," she said, noting that various family members have lost their jobs and their homes, while others have become underemployed. "It is a wonderful feeling to have secured a position in a place where I know my talents are welcome. Thank you for all your support as I begin this new chapter in my life," she said.

In Memoriam: Paul Marceau and Rev. Raymond Wawiorka

Paul Marceau, a member of the NACC Board of Directors from 2005-2010, who died Nov. 6 in North Carolina. Mr. Marceau, 68, of South Bend, IN, had retired two years ago from his post as vice president of mission services and spirituality at Trinity Health.

Mr. Marceau and Bridget Deegan-Krause co-wrote a two-part set of articles that ran in *Vision* in [January-February 2011](#) and [March-April 2011](#) on how the opportunities and responsibilities of the professional chaplain have expanded far beyond the bedside.

NACC Executive Director David Lichter, who knew Mr. Marceau through his role on the NACC Board of Directors, in noting his colleague's sudden death, commented in *NACC Now*: "What a beautiful man, rich human being, person of deep faith, compassionate, who lovingly mixed humor and humility! I always felt called to be more in his presence."

Mr. Marceau was born in Alpena, MI, on Sept. 21, 1943. He was a graduate of the University of Notre Dame, and received his doctorate from University of California at Berkeley. He served with the Congregation of Holy Cross, Notre Dame, for many years. Mr. Marceau retired in January 2009 from Trinity Health, Novi, MI.

Surviving are two brothers, Fr. Emmett Marceau of Bay City, MI, and Don (Colleen) Marceau of Alpena; nieces, grandnieces, grandnephews and a godson, Theodore Pollack.

In his retirement, among other commitments, Mr. Marceau was a community volunteer with the Literacy Council of St. Joseph County, the Center for Hospice Care, Michiana Iraqi Student Project Support Group and Catholic Worker Weather Amnesty Program - Our Lady of the Road. He was also involved at St. Joseph Regional Medical Center with the Sr. Maura Brannick Health Center (Chapin Street Clinic) and chairman of the Board of Directors for Community Health Partners.

The family requests contributions be made to: Sister Maura Brannick Health Clinic, 326 Chapin Street, South Bend, IN, 46601 or Sisters of the Holy Cross, 407 Bertrand Hall - St. Mary's, Notre Dame, IN 46556.

Rev. Raymond W. Wawiorka, a member of the NACC Executive Committee in the formative years of the 1970s, who died Oct. 28 at age 81 after a long illness.

Father Wawiorka was born June 12, 1930, in Kenosha, WI. He was ordained to the priesthood on May 26, 1956, by Archbishop Albert G. Meyer at St. John the Evangelist Cathedral, Milwaukee. As a priest of the Milwaukee Archdiocese, he worked in parish ministry as well as in hospital chaplaincy.

His chaplaincy appointments included ministry as the first, full-time Catholic chaplain at St. Luke Medical Center, Milwaukee, from 1966-70; director of chaplain services at St. Francis Hospital, Milwaukee from 1970-79; archdiocesan coordinator of health affairs from 1972-79; chaplain at St. Joseph Hospital in Tucson, AZ; chaplain at St. Joseph Hospital in Ashville, NC; staff chaplain at Bay Pines V.A. Medical Center in Florida; and associate director of pastoral care at St. Anthony Hospital, Ft. Petersburg, FL, from 1983-93.

He was appointed to the USCCB Advisory Committee on Ethical and Religious Directives for Catholic Health Facilities in 1972 and served until 1979. He was on the NACC Executive Committee from 1976-1980 and served as chaplain to the Archdiocesan Catholic Physician's Guild. In addition, he coordinated the NACC's two-week Institute for Chaplains and Pastoral Associates, evaluated clinical pastoral training centers from 1974-1984 and taught clinical pastoral education for 20 years. He was active in the Wisconsin Association of Catholic Chaplains (president 1971-1978).

Rev. Wawiorka worked with military veterans and used his extensive knowledge of Polish to translate and say Mass and hear confessions in Polish. He spoke to Polish-Americans on the Solidarity Movement during Poland's turbulent 1970s.

In retirement, he volunteered his services at Light of Christ Parish in Clearwater, FL, and helped at St. Elizabeth Parish in Kenosha. He is survived by a brother, Chet Wawiorka, and a sister, Jeannette (Dr. Martin) Setter; as well as seven nieces, four nephews and many great and great great grandnieces and nephews.

Conversational book will help you face change, worry less, trust more

By Laura Richter, MDiv

Living at God's Speed, Healing in God's Time. By Charles W. Sidoti and Rabbi Akiva Feinstein. Twenty-Third Publications, New London, CT, 2011. Paperback, 218 pp. \$14.95

Charles Sidoti's new book is a lovely work addressing the inevitability of change, the theme of time and the need for trust. Sidoti shares his life experience and wisdom gained as a hospital chaplain, husband, father and believer as he offers reflections about God's time and our choices as we respond to happenings in our lives.

The book is broken into four overarching sections, each of which centers on a different aspect of spiritual growth. Part One covers "waiting in hope," and is followed by "responding in trust," "relationship with God" and "the wonderful person God created you to be." Each of the 56 chapters follows a similar format, containing a brief reflection, connecting point (which allows the reader to think through practical applications in their own lives) and a closing prayer all related to a particular theme. Most of the chapters are penned by Sidoti, but Rabbi Feinstein offers his reflections in each of the final chapters in each section. Chapters are short and could serve as daily reflections for the reader.

The book is written in a conversational tone and it is an interesting read. Sidoti and Feinstein draw on the wisdom of Scripture and their traditions. They feature stories about great individuals like Abraham Lincoln and Thomas Edison and include words from well-known writers, including: Teilhard de Chardin, Thomas Merton, Albert Einstein, Henri Nouwen, Thich Nhat Hanh, Joyce Rupp and many others. Sidoti includes references to pop culture, including TV shows ("Seinfeld" and "All in the Family"), movies ("Groundhog Day," "Toy Story" and "The Wizard of Oz") and facets of daily life (Santa Claus, Microsoft and pop songs). All these references help to make real the premise that we are not in control and that one of the great lessons in life is learning to let God be God and appreciate the mystery that surrounds us.

This book contains many pearls of wisdom and offers readers a chance to ponder how they may be letting worry rule their lives. Sidoti and Feinstein offer good suggestions for reframing issues and letting God be in charge. The book is easy to read and it may be just the right thing for a person looking to worry less and trust more. Themes run consistently throughout the book, inviting the reader to a thoughtful reflection on his or her life. This book is a great resource for anyone trying to develop perspective, be open to change and let things happen in God's time.

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

Chaplains, pastoral care team missing, but book still a valuable reference

By John Gillman, PhD

Medical Ethics and the Faith Factor: A Handbook for Clergy and Health-Care Professionals. By Robert D. Orr. Eerdmans, Grand Rapids, MI, 2009. Paperback, 483 pp. \$30.

The author writes from his perspective as a committed Christian and physician who has functioned as a consultant for numerous ethical cases. He has served as the director of clinical ethics and professor of family medicine at Loma Linda University in Loma Linda, CA. The style is straightforward, the cases are concisely presented, and terms are clearly explained throughout. Orr affirms what chaplains and others have long experienced, namely that "a patient's spiritual beliefs often enter into his or her decisions at the end of life" (p. 99).

The book is divided into five parts: In Part I the author briefly explores the foundations of clinical ethics. The heart of the book consists of 137 case studies organized according to several categories: heart failure, lung failure, kidney failure, nutrition and hydration, brain failure, and mind failure (Part II), cultural and religious beliefs (Part III), neonatal matters, children's cases, reproductive technology, issues in pregnancy, and organ transplantation (Part IV). The concluding section is a brief four-page discussion of the priesthood of believers (Part V). There are two appendices (glossary and a case index cross-reference).

For each case Orr presents the vignette, offers an ethical analysis, makes recommendations, and discusses follow-up with additional comments. His purpose, namely, to show that "biblical principles, personal values, and denominational tenets" play a key role in the resolution of ethical dilemmas (p. xxvi), is explicitly addressed for many of the cases presented. As an educational resource, it would have been helpful had the author invited the readers to engage the ethical dilemmas, before offering his own analysis and perspectives.

Given the faith perspective of the author, his practice of asking his patients about their beliefs, and praying with them, I was surprised by the very few times that the hospital chaplain or the pastoral care team was mentioned as players in patient care or ethical consults. Community clergy do make an occasional appearance. In contrast, the direct involvement of several other interdisciplinary team members is regularly noted. If there actually was such limited involvement by spiritual care providers in these cases as a whole, then we as chaplains and educators have much work to do for our profession.

This volume can serve as a valuable reference for community clergy, chaplains, and laypersons.

John Gillman is an NACC and ACPE supervisor, VITAS Innovative Hospice Care, San Diego, CA.

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