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The challenge: Making electronic health record capture wide range of pastoral interventions

By Brad Hood, MA

Documenting spiritual care is not quite like herding cats but there are probably similar frustrations on the feline frontier. When Catholic Health Partners (CHP) launched a relationship with Epic Systems, a healthcare software company that is supporting CHP’s electronic health record initiative to improve clinical quality, safety and efficiency, representatives from various regions of CHP began working on multidisciplinary pieces of the big puzzle.

Spiritual Care joined the process in July 2010. The directors of spiritual care from across our five-state network met in Cincinnati for a preview of the electronic documentation of spiritual care. There was a consensus of those present that the electronic record did not fully capture the range of pastoral interventions and spiritual care responses.

This is how I remember the earliest phase: there was a call for a show of hands as to who would like to work on a computer based software project of development blah, blah, blah. Over the deafening silence someone cleared his or her throat and a team was formed. It might have been the most reluctant work team in history! We were excited for the opportunity to create something different but the direction and process was a mystery. Amy Marcum, director of spiritual care at St. Rita’s Medical Center in Lima, OH, and I became co-chairs of this collaborative project.

It was a multifaceted challenge for the following reasons: 1) Some of us tend to have a natural aversion to technology; 2) There was the difficult notion of objectifying our work in an electronic format; and 3) We had to compensate for the time constraints of working closely with a team of individuals whose schedules are interrupted frequently by emergencies. We did all of our work via conference phone calls and web-based meetings in which each member could view the product creation in real time.

Across our network of regional health systems, CHP spiritual care providers had a variety of policies and procedures relating to documentation. Some hospitals were electronic, using different but similar products. Other hospitals documented in a paper record at various places within the chart.

Epic and CHP knew this was a unique opportunity. As one of the largest faith-based healthcare organizations, CHP was invested in making the spiritual care documentation a vital part of the patient’s electronic record. And Epic, a company committed to team-based patient care, was eager to take the information we gave them to make this component better.

Our team included spiritual care leadership as well as chaplains who have daily patient care responsibilities. We had one member from each

Most of our struggle came with the process of condensing narrative to terms or phrases that would adequately describe the care we provide to patients and families.
of the regional health systems within CHP. The stage was set, the players assembled, but no one knew quite where to begin.

We began by asking these simple questions:

“What do you know before meeting the patient?” (This question describes who referred you and for what reasons.)

“How would you describe the intervention?” (This is your professional assessment and intervention).

“What do you hope to accomplish?” or “What would you recognize as an outcome of your intervention?” (We called these outcomes but it eventually spun off a discussion concerning our plan of care.)

Most of our struggle came with the process of condensing narrative to terms or phrases that would adequately describe the care we provide to patients and families. There was the danger of sacrificing the narrative of spiritual care documentation to fit the electronic format. So we reserved space on each screen for annotation as a way for the chaplain to provide more or different information.

Once the team settled on “the lists,” we began using case scenarios to see if the complicated dynamic of our work could be adequately described. We reminded the team that the disciplines viewing our documentation were not necessarily schooled in theology and religion. And yet the beauty and uniqueness of our vocabulary describes a part of the patient’s experience not documented elsewhere.

Electronic documentation is driven by the user selecting the most appropriate description from a variety of choices. Multiple choices can be made before moving to the next part. As each selection is made, a logical or related element must be available in the next set of choices.

For example: if your encounter with a patient or family involves their consideration of palliative care, the emotional/spiritual needs might include choices such as “calm, anxious, grieving, spiritual struggle or anticipatory grief.” Then the chaplain’s interventions might be described by “active listening, explore thoughts/feelings/concerns, explore coping resources and/or discuss meaning and purpose.” After this initial conversation, you might document the outcome as “receptive, less anxious, expresses feelings, shares life review” or “refused/declined or did not respond.”

It has been a worthy project. The success depended on contributions from our shared experience, wisdom, and research. It required the best from every person on the team. As we steered down the middle of the road, it also depended on compromise, openness, and negotiation. While electronic charting is not “uncharted territory,” this opportunity created another way of telling our story.

In the end we landed on the moving target of communicating spiritual care in a language that fits the parameters of electronic documentation. It captures the multi-faceted, sometimes intangible work that chaplains do. It demonstrates and promotes the role of spiritual care by making our documentation accessible to the entire interdisciplinary team. Eventually electronic charting may facilitate research by generating measures about which we can now only dream. We appreciate the emphasis that CHP places on holistic care that raises the work we do as chaplains to the same level as that of clinicians and other caregivers – and that being able to document our efforts to help those in need to heal is an important component of patients’ and residents’ electronic health records. We also hope this tool will decrease the amount of time spent documenting our work, thereby increasing the time we have to do what we do best, providing spiritual care to the individuals we serve.

_Chaslain Brad Hood is the mission leader for Mercy Medical Center West in Knoxville, TN, a member of Catholic Health Partners._
Bullet-point charting makes for interdisciplinary respect

By Gordon J. Hilsman, DMin, BCC

The field of spiritual care may now be at a crucial time in its evolutionary development as a key component of person-oriented care. There is nothing at all in the pages of the initial federal health reform bill about spiritual resilience, spiritual pain, or spiritual care. That relative invisibility could be reduced by a simple but pervasive and earnest movement to improve our medical record charting. It may take years of dedication, collaboration, and sturdy leadership. But it would be likely to go a long way towards establishing chaplaincy in healthcare.

We need to courageously march down that road with some collaborative spirit. We can start with this question: How can certified chaplains quickly learn how to make our medical record charting useful, substantive, and worth reading by busy healthcare professionals?

It is in the trenches this war will be won. We need to show our usefulness day to day, day after day. There will be no nuclear bomb to settle things once and for all. Spiritual assessment has challenged us to identify substantive spiritual issues and find words to describe them that make sense to ordinary people. Our reliance on religious, theological, and ecclesiastical jargon has been toned down. We are ready to learn to fashion our chart notes crisply and non-defensively, with substance that matters.

One format that is being tried, and may be our best current attempt, is a combination of succinct narrative and two or three bullet points.

- The brief narrative helps to preserve the human character of all patients. Chaplains may be the last healthcare discipline left to describe people in their humanity and their current pain. The narrative's brevity doesn't allow for facts of age, gender, and marital status, which are already available throughout the chart. But it includes unique aspects of that patient, how she or he related to the chaplain, who might be supporting her, and what continues to plague her mind as she copes with her hospitalization and the reason for it. Hopefully even electronic chart formats still include areas for brief narrative.

- The two or three bullet points identifying salient spiritual pain issues are the heart of a chaplain note and may often be the only ones read by physicians. What the chaplain identifies as significant issues, of course, will depend on the framework of spiritual assessment she uses. In one or two lines for each issue each bullet point clearly describes the issue in such a way that the reader cannot miss the pain. A quote of the patient from the chaplain visit can add richness to the note and clinch its usefulness. The bullet point section also mentions what the chaplain did about these issues so far, whatever that is.

- A third aspect of a chart note that is useful to interdisciplinary staff and The Joint Commission in evaluating spiritual care in your facility is a pastoral plan. A sentence or two on what this chaplain intends to do for the patient's issues, and to whom referrals are made, ends the note.

Chart notes can be improved also by paying better attention to what should not be there. Immaturity of
the writer can be very visible to adult professionals reading a note. Self-reference should be sparing, over-explaining is quickly nauseous, and statements evaluating the interdisciplinary staff or even a single member of it are taboo. These notes appear in court cases more often than most of us think. And repetitive sentences, those darlings that appear frequently in some chaplains' notes, will not be read by anyone.

Gordon Hilsman is manager of CPE at St. Joseph Medical Center in Tacoma, WA.

SOURCE: Vision, March/April 2011
Time and activity tracking offers multiple benefits

By Margot Hover, BCC, DMin

For many years, chaplains were largely exempt from the detail work required of their peers in other departments — accountability for their time use, charting, and care plan design, for example. The payoff for that may have been greater freedom. But there are two drawbacks to that approach. One is the lack of benchmarks and practice/outcome tracking that demonstrates value. Congregational clergy hate the “easy one-day-a-week job” comments of parishioners, and lay caregivers feel both undervalued and frustrated. Often, this involves their sense of pastoral authority as well as how they define their ministry for themselves and for their various publics.

As supervisor for the Barnes-Jewish Hospital Community-based CPE program for rural Missouri and Illinois lay and clergy caregivers, I required both congregational and institutional students to maintain a weekly time-and-motion record. I gave them several sample formats, but invited them to design their own to yield the information they might find useful. As we discussed those in weekly supervision, I discovered that the students invariably didn’t consider phone calls as pastoral work, although they spent hours each week on the phone with congregants or patients’ families. For example, the way they arranged home visits or bereavement calls set the tone for the pastoral visits themselves. Isolated congregants sometimes even preferred telephone contact. A quick call was an efficient and economical way to check in with congregants between longer home visits. Lay caregivers generally undervalued both their time and the impact of their contributions — “I’m just helping out” — and documentation gave them realistic feedback.

So, for example, when one pastor’s church council decided to cut her hours and benefits, she calmly presented charts documenting the hours and number of contacts involved in liturgical preparation and arrangements, bereavement and memorial activities, communications (Sunday bulletin), community outreach to the local high school and Ministerial Alliance, home visits to congregants on a rotating basis, preparation of required denominational reports and attendance at deanery and diocesan meetings and functions, and support of congregational committees and outreach services. The council rethought its decision, and with her data in hand, was able to look with her at functions that could be more efficiently handled by a part-time secretary and parish volunteers. This freed her for work the council saw that only she as pastor could do.

Similarly, a local hospital was in the process of making decisions about resource allocation, and opted to move the ER chaplain to the outpatient areas. The chaplain, whose well-known pattern of data-keeping led to her involvement in the decision process in the first place, was able to show how many of the outpatients in each of the clinics either came with a pastor or claimed adequate pastoral care from them at home. The relatively greater needs of emergency patients and their families kept that chaplain position open, and indicated avenues for staff training in the clinic areas so that Lay caregivers generally undervalued both their time and the impact of their contributions — “I’m
appropriate referrals to a chaplain could be made.

In both cases, time-and-activity tracking provided information to administrators that was crucial to their decisions about positions and assignments. More important, however, is the second purpose of record keeping — the information this yields to practitioners about their own work priorities and operations. Jay Lebow in a short article, “Do-It-Yourself Research: The practical advantages of studying your own practice,” (The Family Networker, November/December 1966, 61-63), describes a discouraged family psychiatrist who wondered if any of his patients actually got better with treatment. He tracked his clients, their diagnoses, and their length of time in treatment, as well as the type of treatment he used in each case. At the end, he learned that his sense of his success was obscured by his memories of those patients who did not improve. Chaplains have only to look at how often they remember complaints; pastors dwell on congregational fracases rather than on well-accepted liturgies and bedside reconciliations.

Further, the psychiatrist was able to see practice patterns emerge. What types of patients did well in brief strategic therapy, and what groups did better with other modalities? Ultimately, he saw the results of his labor more realistically, and was then able to match his approaches more accurately with his clients’ diagnoses and needs.

“We’ve always done it that way” or “We have to cut five positions” as a rationale for staffing decisions and time/asset allocation isn’t reliable or effective. Nor does it help pastors and chaplains to look realistically at how they do their work — and how to do it better. Close, structured study of one’s practice provides data both for institutional decisions and for practice improvement and satisfaction.

_Margot Hover, an ACPE/NACC supervisor, resides in Claremont, CA._

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SOURCE: _Vision_, March/April 2011
In chaplain’s day, plans are meant to be changed

By Georgia Gojmerac-Leiner, BCC, DMin (ABD)

It is difficult to imagine making and sticking to any firm plans in the dynamic work environment of a chaplain. Yet, practically speaking, we must have some plans in place if we are to function within a healthcare team. Several realities will affect how we go about making plans.

In some institutions where there are teams of chaplains, the patient population is small, or the institution is a long-term care facility, the expectations may be that every in-house patient will have been seen before he or she leaves. I work alone at a community general hospital licensed for 177 inpatient beds in Concord, MA. Seeing every patient that comes through the door would be an unrealistic expectation. For this reason I have instituted a referral system which allows me to see everyone who said, “Yes,” to seeing me. This is an electronic system. When the patient is admitted, one of the nursing assessment questions to the patient is whether he or she would like to see the hospital chaplain. The answer “Yes” triggers a referral to me, via the printer on my desk.

Every morning I print out the in-house patient census and match my referrals with the names on the census. The census gives me important information such as the patient’s religion and the trigger for the hospitalization. When I attend morning interdisciplinary medical rounds, I pay special attention to the reports about the people who have said they need to see me. My plans are to see all of the people for whom I have received referrals. However, I also pick up patients based upon the rounds report, so a patient may be added to my list even if he or she did not initially request a visit.

Once I have my plans in hand, I carry them with me throughout the day. I aim to attend the Critical Care Unit (CCU) interdisciplinary rounds daily. This unit has the sickest patients in the “house.” The rounds are run by the unit’s medical director at a clip pace and do not waste anyone’s time.

Attending the CCU rounds can change my plans very quickly. On one particular morning, a man who was found not breathing by his wife was brought into the emergency department of our hospital. No one knew how long he had been “down,” but it was long enough that he had become unresponsive and needed a ventilator to breathe. His wife, numerous children and some grandchildren, were all on the unit. I chose to go first to the wife. The patient and his wife were observant of their faith. The wife told me, “God is watching over him.” I told her, “God is also watching over you, too,” but she was too distraught to hear this. Time went by and I spoke to her sons and her daughters as well. Eventually I asked the wife whether she thought that her husband would like to have a priest come and bless him with the Sacrament of the Sick. This brought tears to her eyes but I was able to console her. Eventually she said, “Yes. I think that would be good.” Later on she would tell me how good it was that I thought of calling the priest.

I waited for the priest to brief him about the situation. He took much longer to arrive than his office had said. When he arrived, and we were about to gather the family around the bedside, the neurologist came to see the patient and said he needed to enter first because he had patients waiting at his office. He was nice about it and told us, “I know you are very important.” I looked at the priest; he was fine with having to wait and I was thankful.
Time passed as we waited with the family. The neurologist came out of the patient’s room and wanted to address the family. After the neurologist explained everything and took questions from family members, he told the family that he was glad to leave them in my hands. I am glad that he appreciates pastoral care. Not every doctor does. If this were a different doctor he or she may have shut me out of the process without even realizing it.

Almost two hours have gone by since I first met the family. During that time, if things had gone according to plan, I might have seen three to five people, even seven people, depending on the assessment of their needs.

Finally, the priest and I gathered the family around the patient’s bed. The priest offered a prayer and began the Sacrament of the Sick rite. After the priest finished, it was almost noon and all I had done was stay with one family since about 9:30 a.m. I explained to them that I would now go and have lunch and could come back to be with them at any time. All they needed to do was to ask their nurse to have me paged.

I looked forward to charting my visits. My plan was to chart after I had eaten and my mind was alert again. After charting the morning visits, I triaged. Who is the sickest? Who is new? Whom have I seen but needs to be seen again? Who is the neediest? I stopped by CCU to see how the family of the unresponsive man was doing. They had gone home. I planned to look for them in the morning. By the end of the day I had seen about seven people, some very briefly, in my seven-hour day.

The next morning after rounds I looked for the family members of the unresponsive man. They were not there yet. I saw other patients. Strangely, their problems seemed much smaller because they had a chance of recovery. I also had a couple of babies to bless. These are always moving, joyous events.

When the family members of the unresponsive man arrived, I found them to be realistic about their loved one’s prognosis. There would be no recovery and they were willing to let him go, except for the wife who said she wished that she had found him earlier and was sad and unable to let go. Hours later she told me that she realized that she should let her husband go. Immediately after her decision, she told me, “I feel so much better now that I have decided to let him go.” We told the nurse, who in turn told the attending physician. We waited for her. It was the end of my workday and she had not shown up. I did not want to stay indefinitely. I had to go home. I gathered the family around their loved one’s bed and said the Prayers of Commendation for the Dying and Consolation for the Family. They were moved and appreciative. “If your husband, dad, granddad, is still here tomorrow, I will come and be with you,” I told them. This lovely family understood that I needed to go home. They thanked me. I wished them well.

When I came back in the morning I found that the man had passed away at about 5 p.m.

Plans are meant to be broken. Assessments are meant to be flexible. I carry a “myriad” of assessments in my head. Each patient is different and has a specific set of concerns, and each set of concerns requires a different approach to ministry and different kind of interventions. A well-trained, board certified chaplain knows better than to be sticking to any plans.

*Georgia Gojmerac-Leiner is a board certified chaplain and a Doctorate of Ministry degree candidate at the Boston University School of Theology (May 2011). She is chaplain at Emerson Hospital in Concord, MA.*
Chaplains are flexible, available to patients and their families, but also must be able to maintain a healthy sense of self so that we can be the peace in the storm rather than be a part of the stormy healthcare environment.

This is why before any plans there have to be preparations. The preparations start long before we arrive at our place of work. The preparation may be a prayer practice, such as morning prayer, a walk, zazen (sitting meditation), or other spiritual practice, such as listening to music in the car on the way to work, as I often do.

My preference for a piece of music can change from day to day. I may listen to the liturgical music of the season, especially during the Christmas time. Or I may listen to Neil Young singing, “Heart of Gold.” There was a period when I listened to a George Harrison CD that carried the song, “All Things Must Pass.” I have a CD of a Croatian a cappella group called Klapa Kumpanji. They sing a song about saying “thank you” to the body when it is worn out and dying, for the life it allowed one to live in it. All of this music supports me in my ministry.

Lately, I have been I listening to a CD by Marty Haugen with a song titled, “The Song and the Silence,” (1998, Haugen). It is one of those wonderful CDs to listen to in preparation for a day of ministry. It begins with a long introduction of piano music, synthesizers and hand bells. Throughout, an occasional subtle sound can be heard, which for me is a sound of the “deep calling to deep,” a sound of longing, a sound of need. The chanter then invokes and cries out to the Spirit of God,

Spirit of God, open our hearts
 to your song and your silence,
 darkness and light.

Come, O come, Great Spirit of compassion,
 Come and turn our hearts to you.

Sometimes I am in the hospital garage before the song is over. As I sit and wait for the song to finish, I watch the long pine needles of the trees outside the garage swaying and nodding. This day this song is my prayer, prayer to be with my patients with an open heart, a prayer to know when to listen and when to “sing” or speak, a prayer to be present to both the dark and the light of their stories, and a prayer for compassion. The song is 6:52 minutes long, yet it will affect my demeanor for hours.

Georgia Gojmerac-Leiner is a board certified chaplain and a Doctorate of Ministry degree candidate at the Boston University School of Theology (May 2011). She ministers at Emerson Hospital in Concord, MA.
Reference


Related links

Marty Haugen: www.martyhaugen.net

George Harrison, “All Things Must Pass:” www.youtube.com/watch?v=GytPv_v29lc

Neil Young, “Heart of Gold:” www.youtube.com/watch?v=eKFXd86d878

Klapa Kumpanji,"Kada jednom ovom zafalim se tilu:" www.youtube.com/watch?v=iycyFE4UNbI

SOURCE: Vision, March/April 2011

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Vision is a serial publication of the National Association of Catholic Chaplains.
Electronic charting as a creative pastoral endeavor

By Marika Hanushevsky Hull, MDiv, BCC

"For sale: baby shoes, never worn."
– Ernest Hemingway

Six words that tell a story. This apocryphal flash vignette attributed to Ernest Hemingway was way ahead of its time. In our electronic world, we are surrounded by ways to communicate quickly – texting, Twitter, instant messaging. These are the new modes of person-to-person communication. Each mode has its own unwritten rules, formats, and expectations. In a few words, carefully and quickly chosen, personal, practical and meaningful information is conveyed to unseen persons, and, more than likely, is stored indefinitely in permanent, retrievable form.

The short, carefully chosen burst of information has its classic literary antecedent in Aesop’s Fables, and in Scripture in many of the Psalms and Proverbs. In its new form, as foreseen in Hemingway’s classic line, the flash contains basic story elements: a protagonist, a problem to be solved, and a resolution. The flash differs from the classic short story because the specified or accepted word, or character length forces many of the components of the story to remain implied, but unwritten.

These same elements apply in the world of electronic charting in hospital ministry. The space for commentary on the electronic chart becomes a choice of boxes to be checked, or a drop-down menu, with a very small space for longer notes or comments. Even though there may be no technical limit on the length of words you can write in the box, the electronic rectangle itself gives an instant visual limit to the words. When the comment note feature is clicked, if you have to scroll down too far you know that you will lose your reader, and that your message will lose its impact. Twenty-five words or so, or whatever will fit easily into the space, becomes the ideal goal.

Charting is not just a chore at the end of a visit, or an already long day. It is an integral part of pastoral practice in healthcare institutions. It is a way for chaplains to continue to "care" for the patient in a permanent record. It is a way for chaplains to hone their pastoral practice and assessment framework, to provide time for reflection, and it is a way for the chaplain to choose whom they are "messaging."

A chart note is a way to speak to a particular audience, whether it is the nursing supervisor, the physician, the occupational therapist, the next chaplain-on-call, or even the patients themselves, or their families. Furthermore, it communicates the singular contribution of spiritual care to the patient’s healthcare team. The chart note has a protagonist (the patient), it has a problem (identified need or concern), and it has a resolution (support, follow-up, referral, etc.) A chaplain’s version of Hemingway’s note could read:

Charting is not just a chore at the end of a visit, or an already long day. It is an integral part of pastoral practice in healthcare institutions. It is a way for chaplains to continue to "care" for the patient in a permanent record.
“Chaplain met and prayed with PT’s family in ED. PT’s mother said: ‘He never wore his new baby shoes.’ Chaplain will follow-up with staff.”

Marika Hanushevsky Hull, a chaplain at Saint Anne’s Hospital in Fall River, MA, is a member of the NACC’s Editorial Advisory Panel.

SOURCE: Vision, March/April 2011
Time management means careful structuring of day’s ‘precious moments’

By Romona Nowak, OP, MST, BCC

Documentation is a standard of practice in the healthcare system. Professional chaplains accept the responsibility for assessments, care plans, and charting. It is a privilege to be part of an interdisciplinary team offering such total comprehensive care. However, oftentimes the volume of ministerial visits needed is greater than the available hours. What can be done?

Time management is a structuring of precious moments that fill the day. Instead of preparing a specific schedule to complete each day, I find that prioritizing events works best for me.

There are 200 residents in our Rehabilitation/Skilled Nursing Center. I am the only chaplain with a volunteer staff. Initial visits are provided by the Activities Department whose members distribute a brochure of Spiritual Support Services as well as a calendar of religious services.

Volunteer pastoral visitors known as "shepherds" follow-up with welcome visits and a prayer booklet for our diverse religious backgrounds (i.e., Catholic, Protestant, and Muslim). Shepherds visit some of their 15 residents weekly. As soon as a relationship develops between the shepherd and resident a Spiritual Self-Assessment is completed. The assessment asks some informational questions and provides a review of spiritual strengths (i.e., fullness of life, hope, sense of being forgiven, and belonging). After reviewing the resident’s chart, other discipline’s assessments and documents, I create a Care Plan for the resident that involves active listening, empathy, and focused questions for insight awareness for the shepherd to use as their relationship grows.

I base my visits on referrals from shepherds and other healthcare professionals. For triage, I utilize my time with residents who ask to see the chaplain or are dealing with end-of-life issues, depression, caregiver concerns, crisis intervention and/or grief work. I chart after each visit and provide a Care Plan for all disciplines to view, which always involves the shepherds.

Volunteers are shepherds, religious worship leaders, or office assistants. Following my initial interview, potential volunteers go through the healthcare system’s volunteer process.

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Volunteers are shepherds, religious worship leaders, or office assistants. Following my initial interview, potential volunteers go through the healthcare system’s volunteer process.

Once the process is completed shepherds are mentored by trained shepherds whom they accompany on pastoral visits. Along with a formation handbook the new trainee becomes familiar with communication skills, theological reflection and our assessment tool and care plans. Each month all shepherds meet for ongoing education. Recently we began a process of Resident Review where they share their experience with a specific unnamed resident for the group to ponder and discuss. This is much simpler than verbatim used in CPE, yet yields positive training. This year we are focusing on grief work and forgiveness issues during our monthly sessions.
According to our customer satisfaction scores gleaned from My Inner View (a national survey), we ended 2010 in the 96th percentile in meeting residents’ religious and spiritual needs. Upon discharge, residents are given the survey. Our scores have improved in the past year since I have implemented this time management style.

In addition to this facility I also manage the spiritual support needs of 250 more residents in a non-clinical independent living, assisted living, and an Alzheimer area. There are shepherds in the assisted and memory lane sections. With a total of 37 volunteers -- always needing more -- the spiritual needs of residents are met.

Obviously my energy is spread between being part of a care team of professionals, resident visits, and volunteer training. I feel privileged to be part of this setting and ministering here as chaplain.

Chaplain Romona Nowak is coordinator of spiritual support services at Oakwood Common, Oakwood Rehabilitation Skilled Nursing Center in Dearborn, MI.

SOURCE: Vision, March/April 2011

Visit www.nacc.org/vision
With this spiritual assessment, it’s ‘just the FACTS’

By Barbara Zitrick

At the sound of the beeper, the trauma chaplain is alerted that a trauma patient will arrive at our Trauma II Center within 10 minutes. Not knowing whether the patient is young or old, a victim of violence or the survivor of a motor vehicle accident, the chaplain joins the response team in the Trauma Bay. As trauma chaplains, we know that it may only take a moment of interaction with a family in crisis to help them recognize their sources of emotional and spiritual support. We recognize that a trauma injury event may devastate or even destroy a family or its faith; however, we also know that one’s faith and spirituality can sustain, renew and even rebuild relationships with family and with the Holy. Time for the chaplain is measured in how soon we can contact the family and the amount of time that the chaplain can be present for emotional and spiritual support.

To find that valuable moment of connection, the burden of documentation must be limited to information that is relevant to the development of spiritual outcomes. To minimize charting and maximize available time with family and/or patient, information is gathered in accord with a documentation system termed FACTS (Zitrick, 2010):

F (Family members identified). This could be different from the emergency contacts identified and could be persons who have yet to arrive but are important persons for the patient’s support system.

A (Assessment). This spiritual assessment is the chaplain’s impression of the spiritual status of the patient and/or family at the time of the initial interaction. Based on the Mt. Carmel Assessment protocol (Burns-Haney and Stoddard, 1990), a notation is made relevant to spiritual thriving, being at risk for spiritual concerns, experiencing spiritual distress or being in spiritual despair. Any of these states are indicated by checking yes or no boxes.

C (Conference/Communication). The chaplain is responsible for facilitating the delivery of medical updates from the trauma team to the family. Checking “yes” means the family has met the trauma surgeon and has received information. A “no” means that this communication needs to be facilitated at a later time as the family may not have arrived before the patient is moved from the Trauma Bay.

T (Travel). Was the patient admitted? Room number? Was he or she discharged? Was the patient transferred to another facility?

S (Support Needs). Is there a faith community that needs to be notified? Has a priest been contacted? Has the family communicated special needs that should be conveyed to the interdisciplinary team?
Using the FACTS system, our trauma chaplains have increased their available time to be a listening presence to assist the patient and family, to identify their resources of family support, and to be spiritual care members of the interdisciplinary trauma team. FACTS helps the trauma chaplain remain person-centered as a compassionate presence, even in the midst of the confusion and anxiety common to the Trauma Bay.

*NACC member Barbara Zitrick is staff trauma chaplain at The Reading Hospital and Medical Center in Reading, PA. She is a graduate of the Institute for Lay Ministry, Diocese of Allentown, PA, and expects to graduate in May from Chestnut Hill College in Philadelphia, PA, with a master’s degree in holistic spirituality.*

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*SOURCE: Vision, March/April 2011*
From bedside to boardroom: The expanding ministry of chaplaincy

(Part two in a two-part series)

By Paul Marceau, THD, with Bridget Deegan-Krause, M.Div, BCC

(In Part One [January-February 2011 Vision] of this two-part series we looked at advancements in the traditional role of direct patient care. Now we look at how the opportunities and responsibilities of the professional chaplain have expanded far beyond the bedside.)

1. Leadership/Ministry Formation

The dramatic (and continuing) transfer of sponsorship and management of Catholic healthcare institutions from religious communities to lay leadership is the most remarkable development in Catholic healthcare in the past 25 years. The responsibility for handing on and nurturing the legacy and tradition of Catholic healthcare has passed for the most part to a well-educated and skilled laity. At the same time, lay boards and management are themselves increasingly diverse and come from a variety of religious traditions and not through the “pipeline” of Catholic education.

This has demanded a unique challenge of providing “crash courses” on religious sponsorship and Catholic identity. Witness the pioneering work of Sister Catherine DeClercq, OP, of Trinity Health, and the coalition of Catholic healthcare systems that she led in the formation and education of lay boards of “public juridic persons,” which assumed canonical responsibility for the mission and ministry of religious community sponsors (Kelly, 2007).

Central to this effort in ministry formation has been the role of the mission leader. Catholic chaplains especially have been recruited into these efforts, some even serving formally as mission leaders because of their specific knowledge and experience of the tradition. Likewise, because of their expertise, many chaplains are asked to collaborate with mission leaders in formation work. For many chaplains this added area of responsibility is a welcome challenge, although some are less comfortable moving away from clinical bedside care. (Others are rightly protective of the spiritual care of patients and advocate for greater staffing levels to meet the added demands of formation work and mission leadership.) Collaboration between the professions of chaplaincy and the relatively new field of mission leadership continues to grow.

Key to this transition of Catholic healthcare to lay responsibility is leadership formation. Leaders within our institutions are highly skilled professionals in finance, information technology, human resources, strategic sourcing, etc. Learning to integrate the mission and ministry of the organization into these leaders’ own operations requires some very intentional education and training on their part. In turn, it

Those who have been trained have a responsibility to train others in care of the spirit. They cannot hold it unto themselves as a specialized professional competency that they alone can deliver.
demands of the mission leader and chaplains a willingness to move into new cultures as they serve and support professions very different from ours. Chaplains need to explore new “turf” and speak new languages in order to tap into and nurture the leader’s own sense of vocation and the leader’s understanding of themselves and their professions as ministry. It also demands new creativity, with the development of skills in the areas of public speaking and writing, even spiritual direction and retreat work. These can prove to be useful in new leadership and board orientations.

2. Organizational Spirituality/Culture Development

The ministry of chaplaincy has traditionally extended far beyond direct patient care at the bedside. Chaplains have been counselors and comforters for staff and administration, for the unit manager who is going through a painful separation and divorce, for the vice president who has lost a child in an auto accident. Chaplains have been sought out and responded to the spiritual needs of a broad population.

Recently, in light of growing diversity and multiculturalism, healthcare systems have become more focused and intentional about developing the spirit and culture of their particular religious tradition. Catholic institutions are learning to address the challenge of preserving and nurturing their cherished legacy and religious spirit and identity. Leadership includes having the “skills and ability to set the goals of a department and inspire/direct the staff to achieve the goals and live out the mission, vision and values of the organization,” according to the NACC Spiritual Leadership Competencies for Pastoral Care.

Naturally, chaplains, those specifically charged with caring for the spirit, have seen expanded opportunities for their ministry in an organizational, communal manner, beyond one-one ministry to patients and staff. They collaborate with mission leaders and other body-mind-spirit caregivers in articulating and nurturing the organization’s spirit and culture. They have become creative and adept at honoring healing gifts, for example, through the blessing of hands, as well as with celebrating important transitions in institutional life, as with the leaving of a colleague or the opening of a new unit. They engage with the spiritual aspects of work, finding ways to take “time out” for reflection or prayer, linking the flow of work with sacred days or liturgical seasons, for example, celebrating the institution’s religious “Founder’s Day,” or honoring the dead as many Christians do in the month of November (Marek, 2006).

3. Education/Training in Caring for the Spirit

Those who have been trained have a responsibility to train others in care of the spirit. They cannot hold it unto themselves as a specialized professional competency that they alone can deliver. Integrated delivery of body-mind-spirit care means that anyone who delivers care to the body – doctor, nurse, CNA, pharmacist, dietician – touches that person’s spirit. All caregivers need to learn how to be attentive to the care they deliver and its impact on the patient’s spirit and attitude. Lessons in attentive listening and responding are skills that the professional chaplain can share and teach to all the staff.

Chaplains are also well qualified to mentor developing ministers who are learning the craft, from eucharistic ministers to visiting clergy to pastoral visitors and volunteers. They can provide standards of ministry, clear expectations and ongoing support. Those who have been mentored well can draw others into their ministry and have a responsibility to do so. Some chaplains have adapted ministry educational models, drawing from the insights of Clinical Pastoral Education and seminary pastoral training programs, to ensure that those who share in their ministry have a basic introduction to spiritual care practice and the essential work of reflection upon care.

4. Healthcare/Professional Advocacy

With healthcare reform – and the contested role of the church in this political environment – chaplains and other religious leaders cannot allow themselves to retreat into the role of “the spiritual.” Chaplains have
learned to advocate for their profession within their own institutions. But it is not enough simply to protect one’s own domain, even if it sometimes feels that it is under assault. The issues of healthcare reform and the future of Catholic healthcare are too critical.

Notably, NACC chaplains are increasingly sought out to clarify church teaching and to comment on more nuanced responses of various church leaders to increasingly complex ethical and political challenges within healthcare. In many institutions chaplains are invited to serve on ethics or institutional review boards. Chaplains need to be well-informed and articulate on the issues of healthcare reform in order to support their system’s political advocates who are seeking to preserve and advance the ministry of Catholic healthcare. The Catholic Health Association has abundant resources to keep current with healthcare issues (www.chausa.org).

Conclusion

My (Paul’s) reflection on this all began eight years ago with a comment by Bridget Deegan-Krause that: “We are now called to expand our healing ministry to include spiritual leadership. We must move beyond the bedside.” I have witnessed professional chaplaincy make great strides in the past eight years. There are many changes that sought to improve patient care and institutional service. There are other challenges that were not sought (economic, political and organizational) and the profession has learned to be flexible and nimble in addressing these opportunities. Careful listening allows the chaplain to meet the patient at critical moments of need; the same skills at “reading the signs of the times” have helped chaplains meet organizations and institutions at the places of greatest need, hence moving the profession beyond the bedside into new territory. And as organizational needs are better defined and professional roles evolve, new positions will be created that draw on a wide variety of expertise and require more chaplains to expand their roles beyond the bedside.

Paul Marceau is retired from his position at Trinity Health, where he was vice president for mission, spirituality and ethics. He lives in South Bend, IN, where he volunteers in the areas of healthcare, hospice, homeless shelter, immigration and tutoring as well as travels when he can. Bridget Deegan-Krause is an NACC chaplain who is currently a stay-at-home mom. She works extensively in local political efforts and consults on ministry formation in healthcare, education and congregational settings. She resides in Ferndale, MI.

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SOURCE: Vision, March/April 2011

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

Vision is a serial publication of the National Association of Catholic Chaplains.
Author sees amazing future in store for church

By Sheila Hammond RSCJ, BCC

At the July 2010 meeting of the Certification Commission and Interview Team Educators (ITES), there was a good deal of discussion about John Allen’s book “The Future Church: How Ten Trends Are Revolutionizing the Catholic Church.” The discussion centered on how these trends might impact our membership, our certification, and our standards. As a result of that discussion, the Certification Commission submitted this review for Vision in the hope that our members will also read and share in the discussion of this book.


“Perceptive, even-handed, thought-provoking, horizon-expanding, remarkably well informed” are words that John W. O’Malley used in a review for the National Catholic Reporter (www.ncronline.org) to describe John L. Allen’s book, “The Future Church: How Ten Trends Are Revolutionizing the Catholic Church.” To that list, I would add “engaging” and, strangely, “hopeful.”

Allen is the Catholic reporter and Vatican analyst for CNN and NPR as well as NCR’s “man in Rome.” Here he writes as a journalist with the disclaimer that he does not write as “a priest, theologian or academic.” His aim is a descriptive analysis of trends that he has identified, thought over, discussed, and honed over time. He does not claim to make judgments about the trends, but he does see their vitality as a call to the church. He is unabashed about his hopes. “I want to see the Church harness its resources to respond to the perils and promise of the twenty-first century, because I believe Catholicism has a potentially transformative contribution to offer that no other global actor can replicate.” (p. 6 Introduction)

It is precisely this point that I find engaging and hopeful. As Allen pursues each of the trends, he puts it in a perspective that requires imagination and suspension of the habitual North Atlantic view of the current situation. His choice of trends may surprise those whose experience has been assimilating the sexual abuse crisis, the ever increasing desire of women for inclusive language and a less hierarchical and male-dominated structure, or who have been involved in recovering or squelching Vatican II, or introducing new or reviving old forms of liturgy or music in worship. These do not meet his criteria for the trends that will inevitably affect the development of the church, which must be global, grass root, acknowledged by the official leadership, have an impact on the church as a whole, have predictive power, and not be driven by a particular ideology. The 10 mega-trends he identifies have a quasi-seismic impact, and will impact the Church in a significant way – although the precise nature of the impact cannot be foreseen, as the variables involved are too great and the trends themselves are impacting each other. Those he names, as a descriptive journalist, are a World Church, Evangelical Catholicism, Islam, the New Demography, Expanding Lay Roles, The Biotech Revolution, Globalization, Ecology, Multipolarism, and Pentecostalism. He cautions, however, that the church moves slowly, often taking centuries to adapt to external change – and then cites a paradigm shift that took place in “the blink of an eye,” namely the doctrine on the death penalty in the late 1990s.

Each of the trends begins with a discussion of “what’s happening.” This is engaging especially because Allen uses an imaginative story or a real narrative about someone who is impacted by or living the trend.
He then moves into more speculative thought on “what it means” for the life of the world and the church in the time to come. Development rather than prediction is the theme of this section and it allows the reader to wonder about present reality as well as future possibility. (As I write this review, the situation in Egypt continues to rivet all of us, especially the shifts in power and the unpredictability of what is to come. Thanks to Allen’s discussion of the role of Islam and the future church, some of the players in the negotiations in Egypt are more clearly identified if not understood. What is clear is that what is happening in Egypt is happening to all of us on many levels, which seems to be an aspect of Allen’s trends.)

His analysis of global shifts is that the church may include African, Latin American and Asian leadership, possibly even a non-white Pope, but the global North will continue to use more resources and have more influence than other parts of the church. But because of the Southern influence it will be morally conservative, liberal on social justice, and rely on biblical authority rather than canon law. It will be concerned with competing religious entities rather than secularism. The young majority of the South will give the church a younger “feel,” of being dynamic, innovative and hopeful. The Europeans and Americans may feel left out if debates about polygamy replace their concerns about gay marriage.

Evangelical Catholics will wish to distinguish themselves from others by their traditions and may be perceived as “far right” politically and religiously, with a return to Eucharistic adoration and Marian devotion. Apologetics may outweigh ecumenical dialogue.

Allen posits that with Pentecostalism being the fastest growing religious movement in the world representing as much as a quarter of all Christians, Catholicism will incorporate more of the supernatural, including miracles, healings and exorcisms. It will be prosperity oriented and entrepreneurial, supporting material prosperity and engendering small, competitive groups for worship, many of which will be lay-led – by women.

These trends in turn will cause the church to engage more with the world at large as evangelicals preach, the Southern Catholics concentrate on poverty and war rather than power in the church or doctrine, and the biotech revolution and the rise of Islam demand a response from the church.

As Allen engages further with the great questions of the 21st century: its role vis-à-vis Islam (a rival, but also an enemy of secularism), the problem of the globally aging population, the politics of biotechnology, global warming and ecology, water wars (rather than oil wars), he ascends into dizzying clouds of futurism. And here he allows himself to become prescriptive: the church must strengthen its own identity and moral weight, give up internal squabbling over doctrine, and recognize that no one perspective enjoys a monopoly on wisdom.

It must also recognize that its power lies not in its hierarchy, but in its people at large – in the creative energies of its religious orders, lay movements, and a variety of grassroots coalitions. He ends by calling on the church to give sociological expression to its theological claim to be the “sacrament of the unity of the human family,” by fostering holiness.

Whatever the impact of the trends, or others that might emerge, the church of the future requires the “the courage to be globally Catholic, moving out of the parochialism of a given language, ethnicity, geographical region, or ideology, and embracing membership in a truly “catholic” church. With that courage there can be an amazing future for all.

Sheila Hammond is the director of pastoral care and CPE supervisor at Saint Louis University Hospital in Saint Louis, MO, and a member of the NACC Certification Commission.
Lenten Reflection: BELOVED JESUS

Beloved Jesus, please,
    bless me with your healing and peace;
By your redeeming pain—
    salvation now I obtain.
O good, kind Jesus, exhausted Jesus, O Jesus!

You did not think of self,
    left heaven with us to dwell;
A bitter death endured—
    my soul’s new life procured.
Obedient Jesus, beloved Jesus, O Jesus!

For me your blood was sweat,
    your patient love was spent;
I see this world’s great hate—
    harsh justice was your fate.
O suff’ring Jesus, my gracious Jesus, O Jesus!

Lo! bound with cruel ropes,
    Jesus my love and hope,
Is dragged across the ground—
    as laughter and scorn abound.
Downtrodden Jesus, dear gentle Jesus, O Jesus!
Such massive wounds, fierce blows,

great agony, painful woes;

No mercy, justice shown—

so helpless and alone.

My wounded Jesus, beloved Jesus, O Jesus!

This Lenten reflection is the translation of a traditional Slovak hymn, “Moj Mily Jezisu,” by Sister Maria Theresa Hronec, SS. C.M., chaplain at Geisinger Medical Center in Danville, PA. According to Sister Maria Theresa, there is no record of a composer. She has always loved to sing this hymn, she said. She noted that she has completed translations of several traditional Slovak songs to help Slovak-Americans who can no longer interpret their meaning. Sisters in her community who are English teachers, poets and writers review her translations, which she strives to make singable in the original melodies.

SOURCE: Vision, March/April 2011

Visit www.nacc.org/vision
Milwaukee known for its architecture, beer baron history, ‘gemütlichkeit’

By Kathy Ponce, BCC, MAPS

As you prepare to attend the NACC National Conference in Milwaukee, the members of the Conference Planning Task Force would like to provide some practical information about the conference site, the Hilton Milwaukee Center, located on the main street in one of the Midwest’s most charming cities. The meeting rooms in which our conference events will take place are named for the founders and the historical figures of Milwaukee’s 19th and early 20th centuries: Solomon Juneau, a French Canadian explorer who became the first mayor of Milwaukee; architect Frank Lloyd Wright, whose Annunciation Greek Orthodox Church is a local treasure; and beer baron Frederick Miller. Our conference hotel is located in an area that has easy access to some of Milwaukee’s most popular attractions.

Within walking distance of the hotel (about five city blocks away) is the Milwaukee Public Museum, one of the largest in the United States, a museum of human and natural history providing something to excite and challenge visitors with a diversity of interests. Permanent exhibits are contained in three-and-one-half floors of exhibit area. Tour the Museum’s exhibit space to visit Africa, Asia, Europe, the Arctic, South and Middle America, the Pacific Islands and a Costa Rican rain forest. Take a small step back in time to the turn-of-the-century Streets of Old Milwaukee and European Village and to ancient Mediterranean civilizations. Or, take a giant leap back more than 65 million years to The Third Planet, to see the world’s largest-known dinosaur skull and a life-sized replica of Tyrannosaurus Rex. Stroll amid free-flying butterflies from around the world in The Puelicher Butterfly Wing.

Near and dear to the heart of many Milwaukeeans, gemütlichkeit is a sort of cozy, warm state-of-being created by the presence of good friends, close family, a relaxing environment, and often, top quality beer.

About one mile west on the same street on which the Hilton Milwaukee Center is located is the Flemish Renaissance Revival Mansion of Captain Frederick Pabst, another world famous beer baron. The Pabst Mansion is a stunning example of the skills of the European craftsmen who settled in Milwaukee and whose arts included intricate ironwork, exquisite woodwork, and stained glass. En route to the Pabst Mansion, also on Wisconsin Avenue, is the Marquette University campus.

The Shops of Grand Avenue, several blocks east of the hotel, encompass three city blocks of indoor stores and reflect the diverse cultural heritage of Milwaukee. “Old World Third Street,” also within walking distance of the hotel, is a quaint collection of shops anchored by Mader’s German Restaurant, Usinger’s Famous Sausage Company, and the Milwaukee Spice House.

The Milwaukee Riverwalk, located on Wisconsin Avenue at North Water Street, slightly more than one-half mile east of the hotel, spans nearly three miles along the Milwaukee River through the heart of the city’s downtown and features restaurants, clubs and other attractions. On the shore of Lake Michigan at the very east end of Wisconsin Avenue is the renowned Milwaukee Art Museum that includes the Quadracci Pavilion, designed by Spanish architect Santiago Calatrava.
The character of Milwaukee, past and present, is embodied in something that the Germans call gemütlichkeit. Near and dear to the heart of many Milwaukeeans, gemütlichkeit is a sort of cozy, warm state-of-being created by the presence of good friends, close family, a relaxing environment, and often, top quality beer. Currently Milwaukee boasting a number of microbreweries including the Lakefront Brewery, whose “Eastside Dark” brew is currently enjoying the No. 2 spot in “Beers of the NY Times Dunkel-Style Lagers.”

Those of us who treasure Milwaukee’s flavor and spirit hope that you’ll be able to enjoy some time exploring the city before, during or after our conference days. For more information about some of Milwaukee’s attractions, you may want to google “Milwaukee Sightseeing” and spend some time browsing the web for information on the city’s most popular treasures as well as information on many hidden gems.

*Kathy Ponce, a chaplain at Resurrection Health Care in Chicago, IL, is plenary speakers chair for the 2011 NACC National Conference in Milwaukee.*

**Related links**

- Milwaukee Art Museum: www.mam.org
- Milwaukee Public Museum: www.mpm.edu
- Shops of Grand Avenue: www.grandavenueshops.com
- The Pabst Mansion: www.pabstmansion.com
- Lakefront Brewery: www.lakefrontbrewery.com
- Marquette University: www.marquette.edu

*SOURCE: Vision, March/April 2011*
Planning is everything as NACC moves forward

It’s hard to believe that the timeframe for our 2007-2012 Strategic Plan will soon be concluding! I am first tempted to ask, “So what have we accomplished toward meeting our goals?” However, I am reminded of a quote on planning attributed to President Dwight D. Eisenhower that was used by my former company, Growth Design Corporation: plans are nothing; planning is everything. The emphasis was on the importance of developing and implementing some form of ongoing strategic thinking and planning with all the key stakeholders so that the organization is always assessing and responding to the external and internal influences on its ability to respond well to its members, clients, customers, etc.

While we have been guided by the 2007-2012 Strategic Plan, I have come to appreciate both the process that was used to engage members in the planning, such as the Vision and Action Committee that helped guide the process, the member focus groups, and the other various ways members were listened to and enabled to contribute to the process and the plan finalization. It was a good process; it helped bring life and direction to the NACC – gifts I inherited. Thank you! The NACC Board of Directors will devote a good portion of its May 2011 board meeting to discussing and identifying the next planning process.

The products of the planning were also good. As in so many cases, the work on developing the mission, vision, and value statements was the foundational and most important work. I remain impressed and motivated by these statements. They ground and guide our efforts. Have you visited them lately?

As I noted in my column in the January-February 2011 Vision issue, I continue to find the opening words of the mission statement, The National Association of Catholic Chaplains advocates for the profession of spiritual care, inspiring and motivating as they did not focus on the NACC nor on us as members but on the profession we live. This direction continues to help us focus our attention first on developing strategies to strengthen our profession’s value through partnering with many other associations and organizations, such as the Spiritual Care Collaborative, Catholic Health Association, and so many Catholic system leaders. These efforts are ongoing. Over the past three years, Vision issues have been dedicated to themes, such as the current issue on charting and spiritual assessments, that highlight the need for chaplaincy to develop as a profession. I appreciate the guidance of the NACC Editorial Advisory Panel, under the leadership of Laurie Hansen Cardona, for their exceptional work in identifying Vision themes and writers.

As for this issue’s topic, let me point to the work of Christina M. Puchalski, MD, and Betty Ferrell, RN, PhD, Making Health Care Whole: Integrating Spirituality into Patient Care. They distinguish between spiritual screening, spiritual history, and spiritual assessments. They note that all three of these are “formal parts of the medical history during which a patient or family is asked about their spiritual or religious beliefs.” Non-chaplain clinicians who have been trained to do so can do the first two. However, as to spiritual assessments, they emphasize that: “Because of the complex nature of these assessments and the special clinical training necessary to engage in them, they should be done only by board-certified chaplains” (p.93-95). Such a statement by nationally recognized clinicians shows the advancement in recognizing the distinctive professional training and role of a board certified chaplain.
The assertions above also raise accountability questions for me. Is NACC up to the task of ensuring that every board certified chaplain is capable and competent in providing such spiritual assessments and the charting they require? Does NACC provide enough resources and training on spiritual assessments and charting, and/or partner with other professional associations to provide these resources? Has every NACC board certified chaplain embraced the responsibility of ongoing professional development in spiritual assessments and charting so that he/she is looked to for high quality service? What is the role/opportunity for board certified chaplains to train other clinicians to provide spiritual screenings and spiritual histories? Who of our members are already providing such training and education? How can they help other members learn of these training/education skills as well?

I began this column with a reference to the approaching time horizon on our 2007-2012 strategic plan. As we look to the future and determine the next planning process, I would also make a case for keeping the focus of our mission where it is! What do you think?

Please provide me your thoughts and responses to these questions, at dlichter@nacc.org.

Thank you for your ministry!

Appreciatively,

David A. Lichter
NACC Executive Director

SOURCE: Vision, March/April 2011

www.nacc.org/vision
Greetings,

In serving as the new Board chair, I have been invited to address the membership in Vision. As I look out my window at the blowing snowstorm here in Denver, CO, and consider the freezing 3-degree temperature outside, I am thankful for the warmth inside. I am also thankful for the more than 100 people who joined together this morning as we celebrated those who care for the sick and suffering in our World Day of the Sick prayer gathering.

In our prayer this day we turned to the Gospel of Mark, chapter 2 verses 3-5, where the Gospel author recounts the powerful story of faith and subsequent healing as the four friends removed the roof of the dwelling where Jesus was ministering to the crowds and they lowered the man who was paralyzed down on a pallet before Jesus. And as you may recall “when Jesus saw their faith,” Jesus proclaimed, “My son, your sins are forgiven,” (verse 5) and with those words the man was healed.

In our prayer gathering this day we not only celebrated caregivers and prayed for those who are sick and suffering, but we also invited all who serve in our healing ministry to reflect upon the question: “What does it mean to me to ‘carry a corner of the bed’ of someone who has come to our healthcare ministry in need of healing?” After a brief time of silent reflection the room became energized with lively discussion as people turned to the person next to them to discuss this question and the passage from Mark’s Gospel.

The professional executive assistant next to me reflected upon how all of us, no matter our specific role in the organization, are called upon to carry our part of the bed and in doing so we become a part of the healing ministry today. In turn this question and passage took me back to an experience in the summer of 1984 when I was serving as a chaplain intern at Saint Joseph’s Regional Medical Center in South Bend, IN. As the chaplain on call I was paged to visit a “non-compliant” patient who was refusing to go to his physical therapy appointment. I quickly learned that the patient had experienced a traumatic injury to his leg resulting in an above-the-knee amputation. He had been fitted with a prosthesis that he refused to wear. He confided in me that he had been a successful athlete and coach and now his life lacked meaning and purpose. He suggested that he was now without worth and furthermore he did not need a chaplain, and he then told me in very explicit and vulgar terms that I should leave.

Respecting his wishes, I quickly retreated from the room only to be caught by the arm by a member of the housekeeping staff who announced that she could help me assist this patient. She told me that I was only one of many whom he had successfully dismissed from his room, and, oh, by the way, she noted that he took it easy on me, probably because I looked like a rookie chaplain, which I was. She briefly recounted to me that she had a friend who suffered amputations of both of his legs and he was now fully recovered into a new and meaningful life and career. In short order we arranged for a visit, and as the patient began to curse at the three of us, the housekeeper’s friend sat down, yanked off both his prostheses, and then

As your new board chair, I invite you to share your stories in ways that will invite others to join us in this great privilege of serving God’s people in the healing ministry of healthcare.
respectfully asked the patient if they could talk alone. He not only consented to dialogue with the man who had journeyed through deep suffering, but he started his therapy that very day. In my journey as a chaplain and educator in Catholic healthcare, I have enjoyed the privilege of witnessing God’s healing presence within the person of many patients, their significant others and the diversity of caregivers who are called to serve them.

I am guessing that those of you who may be reading this also have been blessed to witness the healing presence of our Creator on so many occasions. As your new board chair, I invite you to share your stories in ways that will invite others to join us in this great privilege of serving God’s people in the healing ministry of healthcare. As other board chairs have expressed before me, I invite you to visit the NACC website, to attend the national conference and to gather with other chaplains to learn from and with one another as we continue this sacred ministry into the future. I pledge my prayers to support you in your ministry and I invite you to pray for your board members, commission, and committee and task force leaders, and for all who serve in the healing ministry of NACC and the church. May God continue to bless each of you in your respective ministries and I express my gratitude to you for being a part of NACC.

Alan E. Bowman
NACC Board Chair

SOURCE: Vision, March/April 2010
Q&A with Sr. Sheila Hammond, RSCJ, BCC

By Marika Hanushevsky Hull, MDiv, BCC

Sr. Sheila Hammond is the director of pastoral care and CPE supervisor at Saint Louis University Hospital in Saint Louis, MO. Saint Louis University Hospital is a 356-bed, Level 1 Trauma Center in Midtown Saint Louis serving the surrounding metropolitan area. It is also a Regional Referral Center for hospitals throughout Missouri and Illinois.

Sr. Sheila has had much experience training chaplains as part of the healthcare interdisciplinary team. Her hospital uses electronic charting and is beginning the process of transition to a completely electronic record. Here are some of her insights into the process of charting for chaplains.

Q How do you think about the process of charting in terms of spiritual care of the patient?

A The process of charting is essential in terms of the care of the patient from a holistic perspective. In our hospital, if it is not recorded, it did not occur. Also, over the years the interdisciplinary team has grown accustomed to the progress notes and spiritual assessment information that chaplains offer in their electronic charting. Some of the areas of spiritual assessment have to deal with: concept of God, significant relationships, meaning of hospitalization, spiritual resources, and spiritual concerns. The information helps everyone know the patient and the needs more fully.

Q How do you address resistance to charting from chaplains because of confidentiality or other concerns?

A The issue for us is not resistance so much as knowing what is appropriate for the chaplain to chart. This involves not charting negative information about another staff person, placing in quotes specific statements verbalized by the patient, or medical staff, or the patient’s family, etc. It also requires careful negotiation and permission of the patient if there is sensitive information verbalized by a patient that the chaplain feels is vital to the patient’s care.

Q What are your thoughts regarding balancing privacy with providing appropriate information for the interdisciplinary team?

A Interdisciplinary communication is vital to the healing process of the patient. It is important to place in the patient’s chart only what will benefit the healing process of the patient. The kind of information we put in should benefit the physical, spiritual or emotional healing of the patient. Sometimes that requires careful discernment on the part of the chaplain. Often “less is more.”

Q What are some of the difficulties of electronic charting for chaplains that you have experienced?

A Electronic charting takes time. At our hospital we follow a specific format for a Progress Note: “Need,” “Intervention,” and “Response.” This requires a mental review of the visit, a distillation that gives these...
categories real importance, and communication that has meaning. Logistically, finding an open computer can be a challenge.

Q What guidelines do you use for progress notes?

A There is a template in our Meditech system for the format of the Progress Note, which I just mentioned. In the future we anticipate more "drop down" items. We are required to write Progress Notes for all referrals. An electronic "Death Note" is written for all deaths. We’re moving towards an expectation that every visit will have a Progress Note.

Q Are there any policies in place in your department regarding a common understanding of charting?

A Yes. We have a Pastoral Care Policy binder that includes the Pastoral Care policy about charting. There is a dedicated section on our policy concerning charting in the Clinical Pastoral Education Handbook, and in the PRN (evening, night shift, and weekend) Chaplain manual.

Q Do you feel that charting makes chaplains more effective?

A I think charting definitely increases the effectiveness of the chaplain. Doctors, nurses and other members of the interdisciplinary team regularly read chaplains’ notes to gain information about the patient and the relationships, and/or concerns, as well as supports in their lives that can be a strength or a hindrance to the patient’s healing and treatment process. Charting also adds to the total flow of information needed during the patient’s admission. For example, chaplains often discover the names of next of kin and contact information, especially in trauma situations. I think charting also helps the chaplain to focus the needs of the patient, and to develop an effective plan of care.

Q Do you favor a particular format, or a particular set of questions for charting?

A We use the spiritual assessment format that I mentioned earlier. In the assessment we also add “Care Plan,” and "Referrals,” which would pull in other disciplines to address areas of concern that the chaplain recognizes, but is not qualified to address.

The “Progress Notes” has the categories that I referred to that are part of our Meditech template: Need – what was the referral or the need of the patient; Intervention – what did the chaplain do, what went on with the chaplain and patient, and or family; what next; Response – what response did the patient or family have.

Q Does your interdisciplinary team read your chart notes regularly?

A More and more disciplines find the chaplain notes helpful. Some services more than others have doctors, nurses, and, especially, social workers reading the chaplain notes on a regular basis. This is certainly an ongoing educational opportunity for us as chaplains.

Marika Hanushevsky Hull, a chaplain at Saint Anne’s Hospital in Fall River, MA, is a member of the NACC’s Editorial Advisory Panel.

SOURCE: Vision, March/April 2011
Mayo Clinic survey reveals patient response to ‘our wildly important ministry’

By Katherine M. Piderman, PhD, BCC

I met Mr. Olsen when I was in the third quarter of my CPE residency almost 20 years ago. He was a 74-year-old Minnesota farmer with a serious hematological disease. He talked quite readily about the toll his illness had taken on him and his concerns about his family and the future. His faith was a foundational part of his life and I offered to pray with him. His rather gruff response is one that I have never forgotten. He said, “Well, you’re a chaplain, aren’t you? If you don’t pray with me, what good are you?”

Much of the work of a hospital chaplain is done, one by one, patient by patient. We know well that not everyone would have the expectation or opinion that Mr. Olsen voiced, but it can be very instructive to discover what patients want from us. With this in mind, we conducted a systematic investigation to learn more about patients’ expectations of the ministry that chaplains provide. Our study is not intended to diminish the vital importance of honoring the uniqueness of each person and assessing and responding to specific and individual needs, but it does offer some interesting information.1,2

Three weeks after their discharge, surveys were mailed to 4,500 eligible medical and surgical patients in Mayo Clinic hospitals in Minnesota, Arizona, and Florida. This gave us a large group to study, from varying geographic areas. Approximately one-third responded from each site. The majority were male, married, 56 years of age or older, and either Protestant or Catholic.

Of those who responded, nearly 70% reported wanting a chaplain to visit them, and 39% expected a chaplain to visit without having to request it. Forty-three percent were visited and of these, 81% indicated that the chaplain’s ministry was important to them. About 31% expected regular follow-up.

From the menu of responses we gave them, we learned that those who wanted to be visited by a chaplain were most likely to value us as a reminder of God’s care and presence and as someone to pray or read Scripture with them. The majority also endorsed being with them during times of anxiety and uncertainty and providing support for family and friends as important aspects of our ministry. In addition, Catholics endorsed sacramental ministry very highly.

We found that neither length of stay, time in the ICU, or an emergent or unexpected hospitalization was a help in determining which patients would like to be seen by a chaplain. Rather, the greatest predictor of wanting ministry from a chaplain was being denominationally affiliated. Interestingly, those who were contacted by their pastor or representative from their home congregation were more likely to want a chaplain to visit than those who were not.

The take-home message of our data is something that we know intuitively. Patients appreciate our ministry! They expect us to show up! They want us to be with them when they are in the hospital...
The take-home message of our data is something that we know intuitively. Patients appreciate our ministry! They expect us to show up! They want us to be with them when they are in the hospital, and to provide religious and supportive care for them and for their loved ones. While this is affirming, it is also very challenging, as it seems that there are many more needs awaiting us than we can manage, even with the best of intentions and/or work ethic.

One of the questions that I have found helpful in my own reflection on patients' expectations of me as a hospital chaplain, is guided by Stephen Covey's work\textsuperscript{3}, "What is wildly important today?" Despite the piles that await me on my desk and the ideas that are begging to be born, I know that the answer is, "Mr. Olsen," and others like or unlike him. I know that I can't see them all, and I know that there is value in processing piles and ideas, but on a weekday or a weekend, and in the daylight and in the night, I can expect that many people are hoping for, and even expecting, a reminder of God's immanent love for them. My expectations of myself and what I can accomplish must be realistic, but considering the question, "What is wildly important today?" helps me to affirm the vital spirit inherent in my call and helps me to focus my efforts at the bedside, in the waiting rooms, and even at my desk.

Katherine M. Piderman is staff chaplain and coordinator of research in the Department of Chaplain Services at Mayo Clinic in Rochester, MN. In addition, she is assistant professor of psychiatry at Mayo College of Medicine.

References:


Related link

www.mayoclinicproceedings.com/content/85/11.toc

Applying this research to our ministry

What are patients’ expectations of hospital chaplains? A simple but significant question to be sure, but with no firm answers in the research literature. This study is among the first to not only begin to answer that question from a relatively large and broad-based sample, but also to raise awareness of other relevant issues for hospital chaplains and administrators.

It was not surprising that having a denominational affiliation was the greatest predictor of wanting a chaplain to visit. What struck me as I read the expanded article\textsuperscript{1} was the resultant challenge to hospital chaplains as many communities become increasingly diverse, with more patients having no religious affiliation or more varied religious affiliations. I don't expect that most patients, regardless of religious
affiliation, know the breadth of training that chaplains receive or the ways a chaplain may be supportive of their spiritual needs. I agree with the authors that it is important for hospitals to assess the visibility of their chaplain services and evaluate efforts to improve access and to assure that patients are aware of the range of ways that chaplains may be supportive of them.

Another significant finding was the gap between the percentage of patients who wanted a chaplain visit (69.5%) and the percentage of patients who received one (43.5%). Future research is needed to expand upon the findings of this study, exploring new ways to identify patients desiring chaplain visitation so that hospital chaplains may “provide the right spiritual care, to the right patient, at the right time.”

Terry Albanese, PhD
Research Associate
Health Services Research and Education Institute
Summa Health System
Akron, OH

SOURCE: Vision, March/April 2011
A liturgy of pastoral care celebrated in Trauma 1 Room

By Marcia Thaeler

It was noon when I was paged to the Trauma 1 Room on Friday, Aug. 27. There was a 65-year-old, white female, who had arrived via ambulance just 20 minutes earlier. I was informed that the patient had had an episode at home causing her husband to call 911, but by the time she arrived at the hospital her vital signs were normal. Still it was clear she was not well. Since her arrival she had been transferred to Trauma 1, had been intubated, and was surrounded by a sea of doctors, nurses, paramedics, and her husband. When I entered the room (hopeful that God would initiate the dialogue through me), I introduced myself to her husband as Marcy from pastoral care. The husband’s immediate response was, “I don’t need you,” to which I responded, “If I were you, I’d be scared.” He replied, “I am scared. Sit down.”

For the next hour we participated in a beautiful, sad, paschal, liturgical event together. My primary role was to be a silent presence to the husband and a few minutes later to the husband and only child, a daughter. I would tell the family if a new face entered the room, the person’s name and what role he or she would play. Occasionally I would offer words of compassion.

Why did I choose this case to discuss liturgy? In the small room it was almost as if the staff were at Mass. There was complete unity (despite many different religious traditions being present) and coordination among staff members – almost as if they were the one body of Christ (Philibert, 2005, p. 49). Only necessary talking was done, voices were very soft, the cadence of the speech was slow, and if the doctor made a request of the medical staff, he always followed the request with a genuine “please” (Collins, 1991, p. 44). If one member of the medical staff needed to move – several members of the team also needed to move to open a path. All movements in the small room were done slowly and deliberately. About once every 10 minutes one of the three doctors would come over to the family, squat down to be at eye level, and bring the family up to date. At one of these updates, the doctor gave the family a choice: “We can continue what we are doing and she will die. We can also administer a large dose of blood thinning medications, which will have major side effects and still she might die. What would you like us to do?” The family opted for the last option. Ten minutes after the medication had been administered, the doctor did an ultrasound and told the family, “The left side of her heart is not functioning at all. We can continue CPR, but her heart will never pump on its own again. Would you like us to continue the CPR?” The family opted to stop the CPR, and the patient died immediately.

To me, but not to the husband and daughter, the unified symbolism and reverence of trying to save the patient’s life was a graced sign of her birth into eternal life, which indeed is a mystery (Philibert, 2005, p. 49). For the family, life was the end instead of the means to eternal life. This family only knew the horizontal plan. The family’s perspective, hope, joy, and experience of God were limited. The patient’s death was not an act of faith.

But the family realized grace was present in the last moments of her life through the reverence and unity of staff members throughout the medical care (Philibert, 2005, p. 52). Symbolic matter had been evident in the professional work, care and compassion in that Trauma 1 Room. The Holy Spirit abundantly answered my silent prayers. Everyone in the room had been transformed (Cooke, 1990, p. 1116). “Sacramental grace,” even though the family would deny the use of such a term, was present in the work,
the reverence and the unity of the staff. Just as Jesus died and rose to eternal life, my experience was this patient also had entered eternal life through Christ’s passion.

My role was one of presence and silent gestures of one person caring for other people. This presence was a symbol for God’s presence even if the family could not grasp that reality (Cooke, 1990, p. 1122). As Irwin states, “All reality is potentially or in fact the bearer of God’s presence and the instrument of God’s saving activity” (Irwin, 2002, p. 198).

God had spoken through the actions of the staff that day in Trauma Room 1. It remains to be seen what the long-term response of the family will be (Empereur, 1987, p. 129).

Marcia Thaeler, of Ogden, UT, is a student member of NACC having completed 4 units of CPE and having only 1 1/2 courses left to complete her MACHM at Aquinas Institute of Theology. Several of her peers at Aquinas and at Ogden Regional Hospital, where she is a chaplain, have encouraged her to tell them this story over and over again. She believes it presents a broad, comprehensive view of pastoral care.

References


SOURCE: *Vision*, March/April 2011
Featured Volunteers

She loves meeting fellow NACC members, sharing insights

Name: Sr. Eileen Buckley, RSHM
Work: Chaplain at Mayo Clinic Chaplains Department
Member since: 1990
Volunteer service: I have been a volunteer since 1990 for what was then NACC Region VIII, organizing annual gatherings and being the photographer. In the years that followed, we continued our annual meetings for NACC members in Minnesota, North and South Dakota. I have been on the planning committee for these annual gatherings. I generally sent out registration materials and kept members aware of upcoming meeting dates and times. I felt very strongly about the importance of keeping these meetings going for chaplains who often did not have easy access to professional gatherings.

Book on your nightstand: Walter Wangerin’s "Letters from the Land of Cancer," which is my book club selection for January. I love reading the classics and books related to women from various cultures, and their struggles. I find reading is the best way to relax at the end of a day.

Books you recommend most often: I usually do not recommend a book, rather let the person select what helps as he or she is able and well enough to read. I recommend our Mayo-prepared CDs based on our "Peace Booklet" and "Finding Peace in Difficult Times."

Favorite spiritual resource: The Psalms and Gospel passages.
Favorite fun activity: Reading and listening to good music, walking and exercise at our Dan Abraham Healthy Living Center.
Favorite movies: I am not a regular moviegoer, but I have two all-time favorites, "The Secret of Roan Inish" and the "Sound of Music."
Favorite retreat spot: Cormaria Retreat House in Sag Harbor, NY.
Personal mentor or role model: The inspiring women of my own religious community whom I have known and loved.

Famous/historic mentor or role model: I had wonderful parents and teachers growing up in Ireland and, of course, they taught me to be involved with helping others. Since being here I have been inspired by the Franciscan sisters who, together with the Drs. Will and Charlie Mayo, began an incredible adventure in the field of healing.

Why did you become a chaplain? I genuinely felt a call to this form of ministry.

What do you get from NACC? NACC offers professional expertise and encouragement to me. I believe strongly in what our organization stands for, and I gladly support our leadership and visionary expertise.

Why do you stay in the NACC? I am very happy as a chaplain and as a member of NACC. Twenty years of membership is its own testament.

Why do you volunteer? I enjoy being involved and appreciate being able to provide valuable educational opportunities for other chaplains in more isolated areas in our part of the country. I love meeting the members and sharing insights and resources.

What volunteer activity has been most rewarding? Being a member of the planning team for the North Central Prairies and Lakes Chaplains has been a rewarding experience as I have heard much appreciation from our annual conference participants.

What have you learned from volunteering? The joy of service and developing a giving heart mean lifelong learning to me.
Learning from peers makes him a better chaplain

Name: Michael John Doyle
Work: Board Certified Chaplain, Resurrection Medical Center, Chicago, IL
Member since: 2004
Volunteer service: Many parish committees and projects including the Adult Education Committee, soup kitchen, youth ministry, and most importantly for me, I play cello at liturgies on a regular basis.
Books on your nightstand: "The Space Between Us," by Thrity Umrigar
Book you recommend most often: "The Grace in Dying," by Kathleen Dowling Singh
Favorite spiritual resource: Taize Prayer
Favorite fun self-care activity: Playing golf with my wife, playing my cello
Favorite movie: "Wit"
Favorite retreat spot: Christ in the Desert Monastery in Abiquiu, NM
Personal mentor or role model: Jerry Kaelin, friend and CPE supervisor at Loyola Hospital in Maywood, IL

Historic role model: Julian of Norwich
Why did you become a chaplain? During a CPE residency in 2003-04 it became very clear to me that God was inviting me to companion sick and dying patients and their families.
What do you get from NACC? Great mentoring, rewarding volunteer opportunities, lots of good food, fun and laughter while working on a variety of projects together over the years.
Why do you stay in the NACC? Collaboration and growing our profession are critical to me and to our success as a ministry in the Catholic Church of today and tomorrow.
Why do/did you volunteer? Susanne keeps calling me!
What volunteer activity has been most rewarding? Certification interviewing is the most humble and uplifting and sacred work I do next to patient care. Getting to know and discover what our peers are up to is truly a gift to me and makes me a better chaplain.
What have you learned from volunteering? It pays better, in some ways, than my day job in terms of the reward and the camaraderie.

SOURCE: Vision, March/April 2011
In Memoriam:
Fr. Lawrence G. Dunklee

Please remember in your prayers:

NACC member Fr. Lawrence G. Dunklee, who was director of ethics for the Hospital Sisters Health System. He died Jan. 7 at Sacred Heart Hospital in Eau Claire, WI, where he was director of the Center for Spiritual Care.

Fr. Dunklee, a priest of the Diocese of La Crosse, WI, died of esophageal cancer after a brief illness. He was 58.

The priest provided ethical and theological expertise to all members of the 13-hospital Hospital Sisters Health Systems, which has hospitals in 12 communities in Illinois and Wisconsin. He was a member of the Catholic Health Association’s National Theologian/Ethicist Committee and was an author of “Now and at the Hour of Our Death,” a 2002 pastoral letter of the Wisconsin Catholic bishops on end-of-life decisions that was reissued in 2006.

Fr. Dunklee was born in Hillsboro, WI, in 1952 to Lawrence and Kathleen Dunklee. He attended Edgewood College in Madison, WI, and received a bachelor’s degree in 1974. He then entered Saint Francis Seminary in Milwaukee, WI, and received his Master’s of Divinity in 1978. He was ordained a priest for the Diocese of La Crosse by Bishop Frederick Freking on May 28, 1978.

His first assignment was as associate pastor of St. Michael Parish in Wausau, WI. Fr. Dunklee ministered as director of pastoral care at St. Michael's Hospital in Stevens Point, WI, from 1981 until 1988. During that time, he attended St. Louis University and received a master's degree in religious studies with a concentration in medical ethics. He was named bishop's liaison for health affairs for the Diocese of La Crosse in 1988.

During his 32 years of priestly ministry, in addition to being diocesan vicar for priests for nine years, Fr. Dunklee served the Diocese of La Crosse as pastor of several parishes as well as chair of the Presbyteral Council, member of the Personnel Council, moderator of the Diocesan Council of Catholic Women, and chair of the Diocesan Healthcare Advisory Council. He was also vice president of mission and pastoral services for the Hospital Sisters Health System (Western Wisconsin).

In September 2010, Fr. Dunklee was honored by his alma mater, Saint Francis Seminary, when he was awarded the seminary's highest honor, the "Sal Terrae" award. This award, granted by Milwaukee Archbishop Jerome Listecki, is given to an alumnus who has exemplified "heroic and extraordinary service to the church." In September 2010, Fr. Dunklee received a national award, the Dorland People Health Award, in the category of ethicist.

SOURCE: Vision, March/April 2011
Priest finds movement of grace in work with gangs

By Larry Ehren, MDiv, MBA, BCC


How do you fight despair and learn to meet the world with a loving heart? Whether within yourself, or in colleagues, patients in dire circumstances, or families at their wits’ end – the question is the same.

Father Greg Boyle, SJ, (warmly referred to as “G” by the “homies” he has lived among and ministered to for more than 20 years in Los Angeles) has nurtured a gift within that we as chaplains also need to cultivate. In the midst of overwhelming sorrow and despair, he has listened for the movement of grace in the ordinary. What he has heard in this contemplative stance is often humorous, many times surprising, and always life giving.

Like Scripture, the core of this book existed for years as “oral tradition.” These stories have been told in numerous talks, countless sermons, multitudes of encounters with the young men and women he is engaged with at Homeboy Industries. Homeboy is the largest gang intervention program in the United States. Its core truth – Nothing stops a bullet like a job – has carried it through good and challenging times (like now).

Through these wonderful stories (you will laugh … and remember them) the mystery of a God who is there “no matter what” is revealed and experienced. They will transform you and the way you look at your ministry. One testimony of this reality is that the principal of my daughter’s school found reading this book changed her image of God. High praise indeed!

One of the major threats to chaplains and their colleagues in healthcare ministry is burnout. “Tattoos on the Heart” offers an alternative stance towards the truly tragic and sometimes horrible events we encounter in our ministry. Whether you deal with the results of gang life in your setting or not, Greg’s stories and hard-earned wisdom will provide you with the simple invitation to listen to your pastoral encounters with a renewed heart. It is a must-read (and yes, buy, proceeds go to Homeboy Industries) for chaplains yearning to continue to grow theologically while reflecting on the harder aspects of our ministry.

_Larry Ehren is the director of spiritual health services at Truman Medical Center in Kansas City, MO._

SOURCE: _Vision_, March/April 2011
‘Come and see!’ chaplains invite questioners

In response to the gentle challenge of James J. Castello's article in the January/February 2011 Vision, "How do you make the case for chaplaincy?" I would like to offer the following few thoughts for consideration.

Like most of us involved in chaplaincy, I, too, have had to face the challenge of answering the question, "so what is it that you chaplains do?" This has come from the hospital president/CEO, vice presidents, all levels of management, administrative staff and their assistants, members of the sponsoring congregation, mission directors, physicians, medical residents, nurses – you get the picture.

With a creative team of chaplains, we devised a multi-layered educational approach. What follows is a list and description of some of our efforts. We were fortunate to have earned a place as presenters in the following educational areas, which gave us exposure to a large number of associates at one time:

**New Hire Orientation:** Chaplains prepared a PowerPoint presentation and have the opportunity to introduce the chaplains highlighting their education, experience and areas of expertise. The presentation continues with a conversation with the New Hires on the meaning of spirituality and spirituality in the workplace and ends with a list of ways chaplains can be of service to associates, including spiritual and emotional support, the completion of advance directives (in our first year we helped some 300 associates complete DPAs), mindfulness stress reduction training, a weekly drop-in twilight retreat, an annual dream workshop and monthly dream work opportunities, emotional support when departments and individuals experience losses, daily Mass, chapel services as needed and appropriate, and the like.

**New Hire Commissioning:** Chaplains prepared and administer the New Hire Commissioning with participation of the senior management team, which again offers an opportunity to remind both New Hires and senior management of the mission and values, and the role of chaplains in promoting the mission and values in the institution as a whole. Associate feedback indicates that through these first two presentations, the chaplains take on the added role of embodying (simply by their presence around the institution) the mission and values that drive the hospital.

**Annual Compliance Education:** Chaplains play a part in this educational opportunity to once again inform associates about what chaplaincy is about and what chaplains do. Chaplains begin the education day with an audiovisual meditation to set the tone and during the day have a 30-minute slot to present on a variety of themes, including spirituality, the value of an advance directive, and end-of-life issues.

Of course, none of the above educational opportunities fully addresses the chaplain's role in patient care – how does one explain in 100 words the complex roles a chaplain plays at the bedside?
Well, there once was a wise man who, in answer to his quest to help others understand what it was that he was doing in Israel some 2,000 years ago, invited them with the following three words, "Come follow me!" (transliteration: “Come and See!”) He left it to his followers to add the other 97 words in years to come!

I am told that Blessed Teresa of Calcutta used the same clever idea when inviting young Indian women to join her in her work. She, too, said, "Come and See!" So, without waiting to be asked again what it is that chaplains do, we launched a campaign to invite everyone involved in the care of the patients to "Come and See!"

I suggest, therefore, that we chaplains would be in good company when even on the shortest elevator ride between one floor and the next, we invite anyone who may ask what it is that chaplains do to "Come and See!" then make a follow-up call to set a date and time.

But be warned, there will be challenges. The first is being available at any moment to meet the CNO, CMO, a medical intern, a floor manager, the executive assistant to the CEO, a bedside nurse, a security guard, the dietitian, and welcome him or her into the world of the chaplain: at the patient's bedside; at a patient-family meeting being a voice for the voiceless, helping to ask the right questions, and building bridges between three worlds (the hospital, the patient and family, and the spiritual worlds); an ethics consult; preparing a memorial service, homily, or a grief support meeting; accompanying a patient and family as death approaches; support parents who have experienced a fetal demise; and you fill in the blanks! The second and unforeseen challenge is trying to balance and complete one’s daily ministry with someone in tow.

Some unexpected outcomes include wonderful developing relationships built on all levels with hospital associates; creating vocal champions for the chaplains and the value of the ministry they perform; and an increase in referrals for chaplain involvement from expected and unexpected quarters.

The burning question remains how would this personal invitation to "Come and See" work given the busy schedules of all in the hospital setting. Well, give it a try, we did and were astounded with the responses – tears, verbal handwritten expressions of appreciation, mention at various meetings, and many saying, "Wow! I do not know how you guys do what you do every day!" But most heartening of all was the decrease in the number of times we heard the question, "So what is it that you chaplains do?" And, this made us feel really proud.

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SOURCE: Vision, March/April 2011

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

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