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## As we strive to hold each other "accountable"

How do we reflect upon and examine our practice, and hold one another accountable in our profession of chaplaincy in acute care beyond our own NACC standards for certification and our Common Standards? The Association of Professional Chaplains with the assistance of other groups of pastoral care givers, including NACC, joined together to create the Standards of Practice for Professional Chaplains in Acute Care (SOP-AC) to use as an important sounding board that we all need to become more closely familiar and conversant with.

You may recall that in our November-December 2011 *Vision*, we focused on long-term care ministry. In my column in that issue, I offered reflections on the Association of Professional Chaplains' (APC) Standards of Practice for Professional Chaplains in Long-Term Care (SOP-LTC). I noted that the SOP-LTC were for the most part identical in structure and content with the Standards of Practice for Professional Chaplains in Acute Care (SOP-AC), except for some very important points of distinction offered in the introduction and in the designation of those served. [www.nacc.org/vision/Nov\\_Dec\\_2011/ed.asp](http://www.nacc.org/vision/Nov_Dec_2011/ed.asp).

This issue of *Vision* is dedicated to exploring the SOP-AC themselves. Several excellent articles have been prepared. We believed it was appropriate and timely to do so as the NACC has also partnered with Catholic Health East (CHE) and other Catholic health systems that helped plan the Spiritual Care Champions webinars to prepare 2012-2013 webinars based on the SOP-AC. The NACC can be proud of its dedication to preparing and certifying members to meet these standards, as well as to providing ongoing educational opportunities with several partners to help our members further develop their competencies in these standards. Let me offer a few introductory thoughts about these SOP-AC's, their preparation, development, and endorsement.

We applaud the initiative of the APC's Commission on Quality in Pastoral Services in assembling an inclusive work team (members of APC, Association for Clinical Pastoral Education (ACPE), and NACC) to draft the SOP-AC's. They used the standards of practice for social work and nursing as models, as well as the prior work on chaplain standards done by our Australian and Canadian confreres. Their primary goal was "to reach consensus about what standards of practice are most important at this time and to set those standards in front of the profession for further discussion." The drafts were vetted through our respective organizations. There was also the realization and humble acceptance that SOP-AC's are not written in stone, but are expressions of our practice at this point in time and so "will be adjusted as the profession moves forward." [www.professionalchaplains.org/index.aspx?id=1210](http://www.professionalchaplains.org/index.aspx?id=1210)

The endorsement/affirmation process of the SOP-AC included the Spiritual Care Collaborative (SCC) cognate groups as the SCC formally affirmed the SOP-AC in fall 2009. On the SCC website you can read: "Building on the work of the Council on Collaboration, which established common standards for professional certification, education and a common code of ethics, the Spiritual Care Collaborative Steering Committee affirms the Standards of Practice for Professional Chaplains in Acute Care Settings that were recently developed by the APC Commission on Quality in Pastoral Services that included representatives from other SCC participating associations." [www.spiritualcarecollaborative.org/standards\\_of\\_practice.asp](http://www.spiritualcarecollaborative.org/standards_of_practice.asp)

The rationale for the development of the SOP-AC included the professional peer importance of articulating and holding ourselves to our own professional standards since "others with whom chaplains serve and communicate, such as doctors, nurses and those from other disciplines in healthcare settings, have standards of practice." When announcing the SOP-AC in Hospital and Health Networks, Sue Wintz, then

president of the APC Board, in making this point, said: "We want to be recognized as leading the clinical team in cultural competency and for our contributions to patient outcomes and quality issues." [Chaplains Launch New Standards of Practice](#)

The other important rationale was to foster greater professional growth among ourselves, as the introduction states: "Having standards of practice can help chaplains communicate with others about chaplaincy and assist chaplains in discussions with other chaplains."

[www.professionalchaplains.org/index.aspx?id=1210](http://www.professionalchaplains.org/index.aspx?id=1210)

Ultimately, this last rationale is foundational and essential, and makes the first reason credible and persuasive. How do we reflect upon and examine our practice, and hold one another accountable in light of the SOP-AC? Thus the purpose and importance of this issue of *Vision* and the 2012-2013 CHE Spiritual Care Champions webinar series.

We are deeply grateful to our members who wrote the articles on specific SOP-AC in this *Vision* as an invitation to have each of us articulate his or her experience of practicing these standards. Here are the SOP-AC's we are examining together.

**The Preamble:** Chaplaincy care is grounded in initiating, developing and deepening, and bringing to an appropriate close, a mutual and empathic relationship with the patient, family, and/or staff. The development of a genuine relationship is at the core of chaplaincy care and underpins, even enables all the other dimensions of chaplaincy care to occur. It is assumed that all of the standards are addressed within the context of such relationships.

### **Section 1: Chaplaincy Care with Patients and Families**

**Standard 1, Assessment:** The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

**Standard 2, Delivery of Care:** The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

**Standard 3, Documentation of Care:** The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

**Standard 4, Teamwork and Collaboration:** The chaplain collaborates with the organization's interdisciplinary care team.

**Standard 5, Ethical Practice:** The chaplain adheres to the Common Code of Ethics, which guides decision making and professional behavior.

**Standard 6, Confidentiality:** The chaplain respects the confidentiality of information from all sources, including the patient, medical record, other team members, and family members in accordance with federal and state laws, regulations, and rules.

**Standard 7, Respect for Diversity:** The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.

### **Section 2: Chaplaincy Care for Staff and Organization**

**Standard 8, Care for Staff:** The chaplain provides timely and sensitive chaplaincy care to the organization's staff via individual and group interactions.

**Standard 9, Care for the Organization:** The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and mission statement.

**Standard 10, Chaplain as Leader:** The chaplain provides leadership in the professional practice setting and the profession.

### **Section 3: Maintaining Competent Chaplaincy Care**

**Standard 11, Continuous Quality Improvement:** The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.

**Standard 12, Research:** The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.

**Standard 13, Knowledge and Continuing Education:** The chaplain assumes responsibility for continued professional development, demonstrates a working and current knowledge of current theory and practice, and integrates such information into practice.

We look forward to our ongoing dialogue on these standards with one another, while holding sacred the blessed and reverential relationships with patients, families and staff members within which these practices are lived out.

I welcome your reflections at [dlichter@nacc.org](mailto:dlichter@nacc.org).

Appreciatively,  
David A. Lichter, DMin  
Executive Director

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## Standards 1 and 2: Assessment and plan seen as tandem aspects of chaplaincy art

By Gordon J. Hillsman, DMin, BCC

### **Standard 1. Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.**

Three essential components hold up quality assessment like the proverbial three-legged stool: 1) a profound reverence for the process of assessment; 2) competence in establishing rapport; and 3) a conceptual framework for understanding and communicating issues that affect holistic well-being. Assessment fails to find much usefulness when any of them is missing.

1. Reverence: Every spiritual assessment is a work of art and needs to be approached with the utmost reverence. Anybody seeking to appraise your financial situation would be immediately suspected. Assessing a person's spirit and soul is far more intricate and intimate. Nobody ought to encroach on that territory without constant self-vigilance against distractions, interface issues, and impulses to trivialize and generalize from inattention or fatigue. Assessment is sacred ground.

2. Rapport: The etymology of the word "assessment" combines the Latin prefix *ad* meaning "next to," and *sedere* meaning "to sit." "Assess" means "to sit beside." Unless you're willing and able to sit beside someone in personal listening, rather than diagnostic listening, to hear him or her deeply to establish the elusive interpersonal trusting engagement called rapport, your assessment will be superficial at best and spiritually brutal at worst.

Learning to establish rapport with as wide a diversity of people as possible is much of the goal of formative Clinical Pastoral Education. Refining such fundamental skills as lingering, gentle query, reflecting emotion, supportive validating, astute interpretation, attention to detail, minimal self-disclosure, and prescriptive physical touch constitutes the primary work of maintaining quality chaplaincy practice. Assessment quality largely depends on rapport, with patient, family members and interdisciplinary staff.

3. Conceptual Framework: In order for a spiritual caregiver to find the best direction for her care in any given pastoral situation she constantly invests in shaping and deepening a concise and useable framework of concepts with which to communicate assessments. The highly complex data of spiritual assessment, from the subject's physical situation, current cognition, human relationships and ways of coping with and enjoying Transcendence, need a lively intuitive assimilation to make assessment useable to interdisciplinary teams.

A brief description of one conceptual framework developed and used for six years by a West Coast Franciscan spiritual care department can exemplify how a chaplaincy team can function together in providing spiritual assessment as a valued part of interdisciplinary staffing throughout a healthcare system.

Four questions guide this unique multi-faceted assessment. The questions themselves are not asked of people. They prompt identifying issues from careful listening, along four axes: emotional support, major loss, religious/spiritual care, and referral concerns. The framework is sparse enough to allow considerable unique description by very different chaplains, and full enough to broadly apply to many common spiritual issues of hospitalized people, their families and care of the staff who attend to them. The questions are:

1. What does this person need from me emotionally right now?
2. What major losses, recent or historical, continue to occasionally cause some level of pain to this person?
3. What religious and spiritual needs currently assail this person?
4. What are this person's painful needs that I can't meet but somebody else may?

Each question opens the chaplain's thinking to five or six specific spiritual needs. Twenty-one identified chaplain functions have been designed by the staff to address the 21 needs that result. The staff also collaborated on describing several spiritual care outcomes that an experienced chaplain is likely to hope for when engaging in any of the functions.

**Standard 2. Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.**

This standard requires fashioning a spiritual care strategy, answering succinctly, "What will the chaplain do to meet the identified needs of this patient or family?"

Care plans can be some of the most difficult aspects of reporting for chaplains. Before about the year 2000, CPE didn't prepare ministers well for articulating either assessments or plans. Some brief, human-oriented chart writing, however, helps to preserve and promote interdisciplinary teams' impressions of patients and families as real people in the sometimes sterile and strident healthcare arena.

An assessment and plan together blend the color of human description with the brevity of clinical communication. An imaginative narrative conveys the humanness of a patient and situation, while summary points (previously called "bullet points") summarize issues and plans to be easily grasped by busy MDs and RNs. Fashioning no more than two or three summary points constitutes an art all its own.

Summary points flow naturally from identified spiritual needs. Any of the five categories of major loss needs (at Franciscan Health System, Tacoma, WA, these are recent, previous, major adjustment, dying, and estrangement) suggest a grief care summary point.

Emotional support needs (stabilizing, verbal processing, empowering, waiting/networking, and informing/interpreting) suggest summary points about caring for the patient's unique and problematic emotions of sadness, anger, hurt, fear, or guilt/shame.

Referral issue needs (medical ethics, addiction/mental illness assessment, advocacy, or love/life pain) indicate a summary point on engaging in a quality, motivating referral process, preferably naming the caregiver the chaplain suggests is needed for further care of identified issues.

Each spiritual and religious need (FHS names religious support, spiritual support, spiritual counseling, facilitating self-forgiveness, and instructing) may call for a summary point on what the chaplain did and intends to do regarding the person's current religious or spiritual struggle.

If a chaplain can't identify any plans that fit the patient's situation, she documents that common eventuality so that staff members know she saw no need for follow-up.

*NACC and ACPE Supervisor Gordon J. Hilsman will speak on this process in June at a four-hour pre-conference workshop titled "Summary Point Charting for Interdisciplinary Effectiveness" at the APC annual meeting in Schaumburg, IL. Graphics and descriptions of the assessment process outlined here can be obtained from St. Joseph Medical Center, Tacoma, WA, or by contacting Hilsman at [ghilsman@gmail.com](mailto:ghilsman@gmail.com).*

## Standard 3: Charting can allow meaningful stories to shape patient care

By Jane Mather MA, BCC

**Standard 3. Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.**

For most chaplains, discussions regarding documentation are unexciting and over-rated. Mention documentation.... Have you done it? Were you careful with your words? Did you check all the right boxes? Did you write something on every patient visit?... and watch for the eye-rolls at chaplaincy staff meetings!

And yet, it is the No. 3 Standard of Practice for acute care chaplains and considered essential to their professional practice.

The word "document" can be both a noun and a verb – a thing or an action, depending on its use. In healthcare, chaplains are involved in both forms of the word. The word refers to "a form that gives evidence or proof" (n) or "providing evidence or proof" (v). There used to be a saying in healthcare that "If you didn't chart it, it didn't happen (even if you did it)."

Chaplains are sometimes compelled by the need to prove their presence and officially note it somewhere in the chart, should there be an audit, a complaint or a probing Joint Commission surveyor. Chart notes used primarily to validate the chaplain's workload often read something like, "Provided spiritual and emotional support" – dated, signed with the chaplain's name and either handwritten or on a sticker (perhaps with some additional check-boxes) and placed in the progress note section for all – who take the time to look – to see.

This method of charting is minimal, safe and often used in new chaplaincy departments as chaplains develop trust with the medical team, proving not only that they will visit when asked but that they are not likely to write something potentially troubling in a chart that might have legal repercussions for the hospital. This form of charting is used more to focus on how chaplains use their time than on the meaning or value of the time itself. The "I was there" note reveals nothing pertinent to the interdisciplinary team's care for or knowledge of the patient, whether the chaplain's visit was meaningful to the patient/family or how the chaplain's professional expertise might add to the overall care plan. Chaplains have covered themselves, but have not necessarily given evidence or proof that the visit contributes anything useful to the healing process for which the patient entered the hospital!

Some hospitals give chaplains their own page or tab in the chart. Depending on whether the interdisciplinary team reads the page, what information is contained on the chaplains' page and how relevant the contents are to other members of the team, "documenting" on that "document" may have relative value. Many Spiritual Care chart pages that I have seen are focused on religious identification, practices and affiliation. While this history may be highly relevant to the patient's experience and some of the practices may impact or potentially conflict with the care team's plans, unless there is a note somewhere else in the chart that is more visible to interdisciplinary team members, that page is seldom seen – except by other chaplains.

Sometimes chaplains themselves are concerned that their visits carry the sanctity of the confessional and are therefore not chartable. In that case, those chaplains avoid charting altogether. And some patients may also presume that what they tell a chaplain will be held in total confidence. Whenever chaplains are

privity to extremely sensitive information that might have an influence on a patient's care, it is best to ask the patient's permission to share a mutually agreed upon version of the information in order for the team to provide more effective care.

No matter what form of documentation is used, chaplains are privileged to hear meaningful insights and stories involving each patient – information that is likely to or should influence their plan of care, impact their compliance with treatment or set the tone for their hospitalization. The most valuable documentation chaplains can provide is that which reveals the psycho-social-spiritual aspects of the patient to the rest of the healthcare team. This information should be accessible – obvious, even – in order to help shape holistic care.

While it is true that physical, medical crises bring people into the hospital, it is also a fact that it's the human spirit and the way patients make meaning that will determine their ability to adapt and heal. As words and as concepts, "healing" and "wholeness" share a common root. Our current systems of medicine, however, are inclined to analyze (separate into parts) rather than synthesize (put the parts together to make a whole) in their effort to heal. Chaplains are trained to view patients through the lens of their wholeness, and not just as the sum of their biophysical parts. So, wherever and however the chaplain charts, the key is to ensure that our charting reflects that perspective. The value of having a professional chaplain on the care team is sharing (with discretion) what can be seen through that lens and ensuring that the care team has evidence of its relevance to their healing efforts.

*Jane Mather is director of Spiritual Care Services for Providence Spokane Urban Hospitals in Spokane, WA.*

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## Standard 4: Claiming a place at the table, contributing to the plan of care

By Linda F. Piotrowski, MTS, BCC

### **Standard 4. Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.**

For me, interdisciplinary is both a noun and a verb. Interdisciplinary is not a listing of representatives from various disciplines or a group of people who gather in a room with the medical members of the team doing nearly all the speaking.

As a noun, "interdisciplinary" in the medical setting describes a group of people who gather for the purpose of planning for a patient's care. "Interdisciplinary" is a verb when it is a process that involves listening and sharing one's expertise, while respecting the expertise of others.

It is not enough to sit in a room or occasionally gather with colleagues from other disciplines and sit mute at a meeting table. It is something active requiring involvement at many levels.

"Interdisciplinary" implies listening, one of our great areas of expertise, and then offering input regarding each patient's\* spiritual needs. It means documenting in such a way that significant information about a patient's spiritual resources and needs can contribute to informing and improving the care provided by all members of the team. We can communicate our plan of care designed to meet a patient's spiritual and/or religious needs. It is an opportunity to educate team members regarding theological, cultural, and spiritual considerations that affect the patient's healing.

What does one process of interdisciplinary care look like? I welcome you into an interdisciplinary team meeting at Dartmouth Hitchcock Medical Center, where I am a member of the Palliative Care Service Interdisciplinary Team.

Our team gathers Monday through Friday mornings from 8-9 a.m. Ira Byock, MD, our director, reminds us that this is one of the most expensive meetings that takes place. Expensive in terms of the salaries of the clinicians gathered in the room, but also expensive in the amount of time it takes away from the inpatient and outpatient clinical arenas. However, he also reminds us, the team meeting is the heart and soul of what we do. It is where our work becomes interdisciplinary. (Just as an aside, how often do we as chaplains consider the expense associated with our time when we gather for chaplaincy meetings or chat in our offices? How does that weigh out related to the time we spend with patients and our clinical colleagues on the floors or in patient homes?)

Facilitation of the meeting is shared by all the members of the team composed of physicians, nurse practitioners, social workers, healing arts practitioners, a volunteer coordinator, me, the chaplain, and occasional medical students, our fellows, and often visitors from other hospitals – social workers, chaplains, nurses, etc. We take turns facilitating the meeting to provide each team member the opportunity to facilitate the meeting in a way that is comfortable to them, yet efficient and productive.

The meeting begins promptly at 8 a.m. with a poem or reflection. We take that time to center ourselves and prepare for the sacred work ahead.

We then hold sacred the lives and deaths of patients that occurred in the hospital during the past 24 hours

or deaths that occurred in patients' home within the past week. Team members who knew a patient well share information about each person. We decide at this point whether or not the death involves the likelihood of complicated grief in which case a clinician member of the team will make the call. If it appears to be what we have termed a "standard bereavement," a trained bereavement volunteer will make the call. It also provides an opportunity for us to hold sacred the memory of each deceased patient.

Next, the Outpatient Practitioners share information about outpatients who are a part of our service. Here time is provided for discussion of any particular challenges occurring in the outpatient setting. It is important to note that this is not a time for those of us serving the inpatient population to check out. We are expected to listen carefully and contribute any thoughts, ideas, and suggestions that might help the presenting provider to care for our patients who are outpatients. We all listen attentively and contribute when possible, asking questions or making suggestions.

The next section, Outs Who Are In, names former outpatients who have been admitted to the hospital. Here our Outpatient Clinicians alert us to specific needs of outpatients who are now in the hospital.

Following this section of the meeting is the part named: Clinical Challenges and Opportunities. Once again, any team member from any discipline is able to present particular challenges they are facing in assisting patients. Each member listens carefully and offers suggestions for consideration.

Next comes Inpatients. In this section we report on each inpatient. Again, we report anything that will be of significance or make a difference to the care of each patient.

After each in-patient is discussed the final section of the meeting is Announcements and Opportunities. At this time any team member can remind us of learning opportunities, special events, upcoming vacation days, ideas we want to present, etc.

The danger in interdisciplinary meetings, I believe, is the temptation to take a back seat believing that the medical members of the team have more important information to share than we do as chaplains. Standard 4 and its measurement criteria remind us that we are required to have knowledge of the service areas represented on the interdisciplinary care team. We are to participate as fully as possible as well as contribute to the plan of care. Implicit in this is that we have developed a plan of care of our own with measurable objectives. Within the team process is the opportunity to receive and respond to referrals. It provides an opportunity beyond clinical charting to fully expand and report on our clinical interventions. The meeting is the appropriate place to educate team members on various theological, religious, spiritual and cultural aspects of patient care.

It is not easy to speak up in the face of multiple medical practitioners whose input may appear infinitely more critical to patient care than ours. However, this is the place to remind ourselves and our colleagues that the very best care is holistic involving the entire person, body, mind and spirit. Standard 4 reminds us in concrete ways that we have a place at the interdisciplinary table. It is up to us not to squander that place.

\* The word patient includes the unit of care surrounding a patient, i.e., family members, significant others, friends, etc.

*Linda F. Piotrowski is pastoral care coordinator/ chaplain palliative care at Dartmouth Hitchcock Medical Center, Norris Cotton Cancer Center in Lebanon, NH.*

## Standards 5 and 6: Concerning ethics, confidentiality, what seems obvious is often complex

By Rev. T. Patrick Bradley, MA, BCC

### **Standard 5. Ethical Practice: The chaplain adheres to the Common Code of Ethics, which guides decision making and professional behavior.**

After several years of chairing the NACC Ethics Commission I find that what seems obvious is often much more complex. Take Standard 5: Ethical Practice, "The chaplain will adhere to the Common Code of Ethics, which guides decision-making and professional behavior." The measurement criteria says that a chaplain "Maintains clear boundaries for sexual, spiritual/religious, financial, and/or cultural values."

It should be obvious to anyone in our profession that we maintain these boundaries. However, it is easy for these boundaries to blur. Patients become attached and we don't notice it. Staff members tend to cling to our casual advice. Patients inquire as to what church we are affiliated with and when we preach. Staffers want advice on cultural values of certain ethnic or religious groups. In all these situations, we have to be careful to evaluate how the recipient perceives us. Are our comments being taken as Gospel? Are they taken as directions on what to do? Are our biases being transmitted in our comments? We must remember that some people ascribe an authority, a cloak of infallibility, to us just because we are chaplains.

What are we to do when folks ask if something is morally acceptable when our Catholic religious views differ from the views of that person's religion? If we are mindful of our boundaries we can navigate these dangerous trails. We can keep on track by being mindful of the authority we are perceived to have.

Although the measurement criteria also remind us that we protect confidential relationships, we develop with patients, confidentiality is a separate standard, Standard 6.

### **Standard 6. Confidentiality: The chaplain respects the confidentiality of information from all sources, including the patient, medical record, other team members, and family members in accordance with federal and state laws, regulations, and rules.**

Just how confidential is our relationship? If a patient reveals to us that he uses street drugs, can we share that information with the medical and nursing staffs? Do we have to inform the patient of our intent and obtain his permission first? Since the revelation was not in the course of a sacramental confession, we can and perhaps should share the information. If the revelation is not pertinent to the treatment plan for the patient, is it necessary to share the information?

State law varies on the question of confidentiality. Some states limit it to clergy; others will have a more inclusive view. As I researched the question in my state, Wyoming, I found that confidentiality is not codified in the state statutes. A friend in the Wyoming Attorney General's office advised me that I really don't want to be the first one to take the matter to court. Common law tends to favor the seal of the confessional; however, general clergy privilege varies with the situation and the particular state.

That said, the question of privacy laws is quite different. HIPAA allows for the exchange of medical information among providers. It is my perception that most chaplains tend to maintain confidentiality sometimes to the extreme. Some take the attitude that charting only what is appropriate for the care being received means charting innocuous comments like, "Prayed with patient." In reality, charting such

items as the nature of family dynamics, comments by elderly patients about who comes to visit them and related information can be important to the patient's recovery.

The only real way to address ethical issues and issues of confidentiality is to make sure we attend continuing education events at which ethical issues are discussed. We also need to keep open lines of communication with medical and nursing staffs. Participating in case conferences and multidisciplinary rounds – and that means participating, not just listening – is another way to share appropriate information with others.

*Rev. T. Patrick Bradley is director of pastoral care at Cheyenne Regional Medical Center in Cheyenne, WY.*

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## Standard 7: Respecting diversity means being cognizant of multiple traditions, calling in others when needed

By Elaine Chan, MSW, MDiv, BCC

**Standard 7. Respect for Diversity: The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.**

For the past nine years I have served as a staff chaplain at Beth Israel Brooklyn. The hospital is under Jewish auspices and serves an ethnically and religiously diverse population. In my work I seek to model what a Roman Catholic or Christian is, someone who ministers to whoever is in need. I do so while “respecting and providing culturally competent patient-centered care” as noted in this Standard. I will share a few of my experiences.

In the first situation I ministered to a Chinese-speaking woman whose husband had had a severe heart attack. I was asked to attend an ethics meeting to discuss taking him off life support. My official role was interpreter, but what I ended up doing was advocating for the wife and serving as a cultural broker between the wife and the hospital staff. The wife wanted to know what his chances of recovery were before she made the decision. Since the attending physician spoke Chinese, I encouraged her to ask him directly but she felt awkward about doing this. The meeting was conducted solely in English. I interpreted what the doctor said but then asked her to speak to him directly. She then questioned the doctor and he responded directly to her in Chinese. Hearing directly from the doctor gave the wife the peace of mind that she was making the right decision to take the husband off life support. The patient was taken off life support. I stayed with the wife and son and supported them throughout.

Another time I had an Orthodox Jewish patient who was a Holocaust survivor. He had been in and out of the hospital and was discouraged because he was not getting better. He expressed a desire to die at home. His wife was also a Holocaust survivor and did not feel she could physically take care of him in his weakened state. She was very stressed by his illness. Their only son had died a few years earlier, so she was going to be alone when he died. Whenever she saw me in the hallway she would ask me to come in. We hardly spoke about her faith or the Holocaust. Rather my visits pertained to his condition and her feelings about what was happening. Despite religious, cultural and age differences, we developed a strong connection. One time I wanted to say goodbye but she asked, “Where are you going, my little chaplain?” After three times of my trying to leave and her asking this question, she finally let me go.

I was making my rounds one morning when I learned that the patient had died. In the Jewish tradition a person who has died is not to be left alone. The wife was outside speaking to staff when I found her. I stayed with the body until the Chevra Kadisha or the Jewish burial society came to wrap the body and say the prayers.

Patients and their family and friends appreciate that I am cognizant and attentive to specific religious practices for their tradition, such as calling the Chevra Kadisha. Once a month I participate in orientation for new nursing staff and share some thoughts regarding cultural and spiritual/religious diversity. When I am on the floors, I also answer questions from staff regarding different faith practices.

In my work, I seek out volunteers of various cultures and faiths to minister to patients of diverse

backgrounds. For instance, I have had Muslim student volunteers as well as imams visit with Muslim patients. Priests and rabbis should take heart that they are not the only ones whom I persistently call to see patients! I greet Muslim patients with the Arabic salutation of "peace be with you." One time I gave a Muslim patient a Koran that he had asked for. In a subsequent visit he told me that seeing me gave him encouragement. Sadly, he died unexpectedly shortly thereafter.

Roman Catholic patients are culturally diverse. Once I had an elderly Haitian patient who was upset about being in the hospital and was creating quite a stir. The staff, which included Haitians, did not know what to do. Haitians usually have close-knit families. I called the patient's family whom I had met previously. A grandson answered and said his mother was going to the hospital later on. I told him that later was no good. Someone had to come "now!" I put the patient on the telephone to speak to the grandson. She was comforted by a familiar voice. The nurse let the patient sit by her side, until the daughter came shortly thereafter. A crisis was averted!

As a chaplain I minister to and am respectful of other faith traditions and cultures. When I started I often heard staff say that I was unlike any other chaplain they had encountered. One said chaplains were male and taller. Others said they did not know there were Chinese Catholics. Still others said that Catholic chaplains do not see non-Catholics. While this is not true of my predecessor, I have heard this in other situations. Some also are taken by my prayers. When I pray I do not use only the Our Father or Hail Mary, I will say an extemporaneous prayer which is tailored to what the patient or family member has told me. For my part, I am most grateful for the opportunity to minister to folks at a critical moment in their lives, to interact with folks of various faiths and walks of life, and to demonstrate my faith through my actions.

*Elaine Chan is chaplain at Beth Israel Brooklyn in Brooklyn, NY.*

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## Standards 8 and 9: Chaplain often viewed as organization's pastor

By Mary Lou O'Gorman, MDiv, BCC

### **Standard 8. Care for Staff: The chaplain provides timely and sensitive chaplaincy care to the organization's staff via individual and group interactions.**

A primary aspect of the chaplain's ministry is his or her care of the staff. The chaplain is often viewed as the organization's pastor and plays a pivotal role in addressing staff's spiritual and emotional needs. Daily rounding often produces multiple opportunities to engage with employees on personal and professional sources of celebration or concerns that are challenging, even threatening. Those concerns may range from stress related to family issues, health or financial crises, or specific work-related problems. Some staff are seeking a "safe place" to talk. Others request prayer or reassurance, while others may make an appointment for individual counseling. As a chaplain, I limit counseling sessions to two and make referrals to EAP or other community resources, given time constraints and the specific skill set needed to address the issues at hand.

The current healthcare environment contributes to a ripe climate for a range of work place syndromes. These include, but are not limited to, compassion fatigue, burnout, grieve-out, and moral distress. Chaplains provide education as well as individual and group support to address these debilitating experiences and the impact of the accumulation of such experiences. Chaplains have collaborated with other members of the interdisciplinary team to develop proactive interventions at the time of a potentially troublesome "code" or death. Group huddles at the end of a shift or individual conversations following a traumatic event seem to diffuse the toxicity of an adverse experience. Staff chaplains at Saint Thomas Hospital engaged in a pilot study for one year in which a follow-up was made after every death in critical care with the nurse(s) caring for the patient. This was an incredible opportunity to identify potential problems as well as to support those negatively impacted by a situation. Staff expressed both relief and gratitude for this ministry.

An interdisciplinary team including chaplains provides CISM (Critical Incident Stress Management) for staff affected by a major event. At Saint Thomas, we have utilized this type of intervention to address staff distress following the death of infants and children in the Emergency Room. At another hospital in our system, similar teams engage situations following complicated fetal or maternal deaths. On another occasion, chaplains led a large team's outreach to traumatized, devastated visitors, hospital and medical office staff who witnessed a public suicide. This latter event required several weeks of follow-up individual and group ministry to diffuse the overwhelming emotions associated with that experience.

At Saint Thomas Hospital, chaplains provide prayer and rituals weekly for staff in their patient care areas, offer prayers of blessing during the state designated day/week for each discipline (such as nurses, environmental services and health information management weeks, etc.) and rituals for groups when a colleague or family member has died. These interactions acknowledge and affirm the spiritual lives of employees and recognize the impact of life-changing events on those individuals/teams. Recently, the Saint Thomas Hospital Transplant Chaplain led a worship service for the conclusion of that program, honoring the team's 25-year commitment of the medical and nursing staff and the patients that had been served during the program's tenure. The focus of the service, through prayer and symbol, was to recognize the contributions of the team, their grief at losing a significant ministry vital to them and re-commitment to the VAD (ventricular assist device), which has become their future. Over the last several months, during two separate rifts, chaplains were contacted to offer staff support. In the first incident,

several chaplains met with individual staff following their being notified of a dramatic downsizing of their department. In the latter, a chaplain met with HR staff over lunch as they reflected on the meanings of the upcoming departure of the majority of their team and the loss of community they had shared.

**Standard 9. Care for the Organization: The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and mission statement.**

Chaplains develop effective working relationships with an organization's leaders in order to enhance role and function within the institution served. Periodic meetings with the chaplains and key members of the senior leadership team provide a rich opportunity to communicate the current activities of the chaplaincy program and key department initiatives. Further, this dialogue may explore the pastoral care team's involvement in and commitment to key organizational initiatives, such as activities that sustain quality, safety, the expanding outpatient ministry and other components of the organization's long range plan. Rich story-telling gives life to the narratives that capture the heart of ministry and are provocative conduits of the chaplain's experience and vital role in the organization. In one of the hospitals in our system, chaplains round weekly in the administration suite and meet with organizational leaders to provide support for their ministry and to enhance relationships.

Chaplains create relevant worship opportunities that celebrate community events, embedding such rituals and celebrations in the organizational culture. They also offer blessings of new areas and spaces that connect such activities to the organizational purpose and healing mission. Recent blessings at this hospital include: the hybrid OR, the new Unity System, (an integrated diagnostic imaging and surgical treatment center to treat brain tumors) and re-dedication of the treatment rooms in the Breast Center. These rituals serve to frame and reframe the significance of the work and align that with the organization's stated purpose and mission. Chaplains name and claim, affirm and bless, the holy embedded in these events as well as in the daily, seemingly routine work performed at every level of the organization.

Ministry that respects the diverse spiritual, religious and cultural beliefs and practices of individuals and groups is the purview of chaplains, who are trained in understanding, supporting and facilitating care that addresses those needs. The growth in multicultural populations in many of our communities and The Joint Commission's recent emphasis on addressing communication barriers in order to provide safe, effective care have highlighted the obligation to honor cross-cultural needs and values. Chaplains are pivotal in the drafting of policies and developing guidelines to reverence the diverse needs of constituents, from the provision of holistic care across the continuum to addressing the specific needs and challenges at the end of life.

*Mary Lou O'Gorman is director of pastoral care and CPE at Saint Thomas Hospital in Nashville, TN.*

## Standard 10: Chaplain leaders promote chaplaincy, provide education, support colleagues

By Gary Weisbrich, BCC

### **Standard 10. Chaplain as Leader: The chaplain provides leadership in the professional practice setting and the profession.**

A decade ago, I was attaching radio transmitters on canvasback ducks and tracking their movements in the Gulf of Mexico region. Now, I find myself tracking our chaplaincy department's initiatives, goals and projects. However, the common thread that has remained is that as a leader, I have been afforded excellent mentors along the way in each area in which I have worked and ministered.

As a "chaplain leader," I work closely with my colleagues. Periodically we look at what is working and what is not and what we can let go of in our processes, in order to embrace a new way of doing things. Hopefully, the result is better, more effective, quality spiritual care.

From an organizational standpoint, chaplaincy always has been supported and valued by our administration; however, that doesn't give us a free ticket or exempt us from the changes that all departments face. Rather, it puts us in a position to all be leaders – leaders in accepting, promoting and supporting the growth and change that the entire hospital is experiencing.

My participation and leadership on different committees (Ethics, Institutional Review Board, Problem Resolution and Grievance, Bereavement, Perinatal Palliative Care, Donor Resource and Professional Advisory Group for our CPE Program) have given me the opportunity to be present to other leaders, work together and to build a relationship of trust. It also fosters a mutual respect for each one's profession and person. I have enjoyed being the NACC state liaison for the past 10 months. The conference calls, networking and support from NACC is priceless. I find it demanding, but very rewarding to write articles for the NACC Vision as well as other publications. I also enjoy speaking and take advantage of opportunities to guest speak whenever possible. It is one way that I can promote the profession of chaplaincy and to clarify some of the misconceptions.

The most recent request by our hospital CEO and medical director was to speak to fourth-year medical students during their Spirituality in Medicine Program. It reminded me of the challenge Dr. Christina Puchalski presented to all of us chaplains at the NACC annual conference last year: "Get involved at all levels of your organization and get to know the medical students and future physicians that you will be serving."

One of the most rewarding areas for me as a chaplain leader is in the area of education. I make it a priority to routinely attend staff meetings of all frontline nursing units as well as other areas, such as housekeeping, maintenance, financial services and human resources. I explain the role of chaplaincy, what we do, why we do it, what we do not do, and how we can support others in their daily work and ministry.

Avera-McKenna Hospital provides Mission Leadership Development (MLD) to all formal leaders. I have been fortunate to facilitate these monthly sessions for the past three to four years. The goal is to bring this information focusing on mission leadership back to our own departments and share it with our fellow staff members, to know it and live it out. The other unique privilege that I have had is to be a mentor for one of my colleagues, currently in our Emerging Leaders program. This program looks at leaders within

our own healthcare facility.

How ironic, as I write this letter, that we are in the midst of budget season. Budgets will always challenge our chaplaincy department just as it challenges all other departments in our hospital. The key, I believe, as a leader, is to help support our entire hospital and the different departments, as we together face challenges.

All chaplains of all levels – be it PRN (as needed), contract, part time, full time, board certified or not – are called to be leaders by the nature of the ministry and service we provide. As a department director that “chaplain as leader” entails additional leadership opportunities. My goal as a chaplain leader in this role is to provide each of my staff members with the resources and ability to grow daily in their call to ministry. I do that by encouraging reading of professional articles and books, staff role-playing and discussion with case scenarios and sharing of best practices. My focus is on promoting and achieving board certification for all chaplains as well as providing ample time and opportunity so they can obtain their continuing education credits. We talk often about monitoring self-care and life/work balance, and I am able to provide them with a quarterly time of debriefing with our Employee Assistance Program. I value their convictions in their own faiths and belief systems, which allow them to be confident and better able to minister to people of all faiths and circumstances. I am among leaders most richly blessed.

*Gary Weisbrich is director of the Chaplaincy Services Department at Avera-McKenna Hospital in Sioux Falls, SD.*

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## Standard 11: Assumptions on care delivery

By Nancy Cook, MDiv, MSW, BCC

### **Standard 11. Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.**

Continuous quality improvement is essential in all acute care settings for patient safety and satisfaction. While this standard has always been vital it becomes increasingly so for Accountable Care Organizations subject to Value Based Purchasing commencing in 2013.

Continuous quality improvement is rooted in the work of W. Edwards Deming (d. 1993). He challenged the traditional U.S. manufacturing method of quality inspection done solely at the stage of finished product. Deming's method was more holistic assessing the relationship between the worker, the product and the customer, beginning in the product design phase and continually assessed and addressed through completion. Being rejected in the States, Deming took his method to Japan and there transformed their manufacturing with innovation and high quality, thereby significantly boosting the Japanese economy. Consequently, he was recognized in the United States and methods for measuring quality here were greatly improved. His method can be recognized in current quality systems and methods as: 1) plan, 2) do, 3) check, and 4) act. Deming's holistic method should be recognizable to chaplains. In the delivery of spiritual care the chaplain is continually assessing, addressing and responding to the patient's needs. This is later followed by reflection in which the chaplain again assesses the patient encounter, "What went well? What could I have done better?" "What can I learn from this experience that will help me in my next patient encounter?"

### **Quality System**

Chandler Regional Medical Center (CRMC) is a member of the Dignity Health system (formerly Catholic Healthcare West) and follows the Studer principles of service and organizational excellence. The hospital also is influenced by the pillars of Patient Family Centered Care. Outcome measures are based upon various metric tools, the most important being the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), patient satisfaction and employee satisfaction – all of which are administered by an outside healthcare quality organization, Avatar International. Studer's principles assist organizations in meeting service excellence goals. The sequential principles are: 1) commitment to excellence, 2) measure the important things, 3) build a culture around service, 4) create and develop leaders, 5) focus on employee satisfaction, 6) build individual accountability, 7) align behaviors with goals and values, 8) communicate at all levels, 9) recognize and reward success. Along with these principles, CRMC also incorporates the pillars of Patient Family Centered Care: 1) communication, 2) dignity and respect, 3) participation, and 4) collaboration. Monthly reporting tools from Avatar measures patient satisfaction by unit, department, values, etc. "The hospital staff honored my faith, beliefs and values" metric is associated with spiritual care service delivery.

### **Process Improvement**

*Spiritual care service delivery within 24 hours of admission at a rate of 85%.*

The improvement was conceived and implemented within CRMC and is not a systemwide practice at this time. CRMC's Spiritual Care Department envisioned an improved and innovative method for the delivery of spiritual care services to increase its reach and care to patients and families as well as to align with the larger goals of the institution (pain and satisfaction).

Before the improvement, chaplains were involved in case finding and a form of pastoral counseling with repeated patient sessions. Their services also included codes, deaths and referrals, triaged in that order, which are also incorporated in the improved 24-hours of admission method.

The improved method was considered and implemented for the hospital and patients as a whole. In other words, no specific units or patient mix was specifically targeted. The goal of the chaplain was to provide service delivery to patients within 24 hours of admission at a rate of 85%. Chaplains use AIDET (acknowledge, introduce, duration, explain, thank) and while assessing for spiritual needs also assess for pain ("Are you comfortable?") and for needs met ("Are we doing a good job for you? Do you have everything you need?").

The improved method proved efficacious in that patients and families received initial spiritual care services without the need for inquiry or a referral at the top of their stay. While some patients declined services they were satisfied in learning of spiritual care services available and knowing these services were at their demand. Additionally, service linkage and/or service recovery was able to occur again, at the top of the patient stay, so that the patient received the remedy at the beginning of their admission.

The industry standard for the delivery of spiritual care services in an acute setting is 16 patients per chaplain per eight-hour shift. With an average length of stay of three days, the interventions of pastoral counseling and repeated patient sessions were ineffective. Chaplains focused their services and time on a limited number of patients using these modalities at the expense of a greater number of encounters for a shorter duration. Additionally, chaplains possessed a mindset of a direct relationship between length of visit and quality. So then the fallacy – the longer the service delivery per patient, the better the service; which consequently means dedicated and concentrated time on a few patients at the expense of the majority.

The improvement of service delivery within 24 hours of admission allows for more patients to be seen by the chaplain and therefore, the assessment of true needs and the triaging of those needs. The improvement method also aligns with an average length of stay of three days. Again, as mentioned above, the patient will have a better experience if comfort and needs met are assessed at the beginning of admission.

## **Outcomes/measures**

Chaplains learned to adjust their thinking about the delivery of their care. They came to see that reaching out to more patients in initial visits with an average of 10-15 minutes in duration versus 30-45 minute patient visits allowed them to more fully identify the spiritual needs of the hospital at large (again, allowing for triage). They also learned there can be efficacy in a 10-minute encounter, or that efficacy is not measured in length of service delivery as previously assumed. While reaching out to more patients, chaplains were then able to champion organizational goals of comfort and needs met. Avatar metrics showed, on average, a score improvement of "faith, beliefs, and values" (FY10/FY11) of 1.5% as a whole. Notably higher scores were seen in CVICU and ICU respectively, 8.9% and 6.7%.

The improvement was measured and assessed monthly and again on an annual basis with the spiritual care team to evaluate its merits and demerits. It was consensus that the method should continue and that the team can deliver spiritual care within 24 hours at an increased rate of 90%.

*Nancy Cook, of Phoenix, AZ, has served the Catholic Church in professional leadership for 20 years. Her experience includes the parish setting, higher education and acute care. She worked as a pastoral associate for the Archdiocese of Seattle and as a rector at the University of Notre Dame. For the past 10 years Nancy has worked in acute care in both the hospice and hospital setting, most recently having served as the director of spiritual care for Dignity Health (formerly Catholic Healthcare West).*

## Standard 12: Chaplains can take measured steps toward research expertise

By Robert Mundle, MDiv, STM, ThM, BCC

**Standard 12. Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.**

Exhorting chaplains to do research is like being told to “eat our vegetables” – it might be vital to our health, but it doesn’t seem very palatable to many of us most of the time. And there are good reasons for us to feel this way: Our “presence” to the spiritual mystery of human relationships in times of crisis defies quantification; formal training in research methodology is lacking in typical MDiv and CPE curricula; and time-consuming research projects distract us from our primary focus, which is, after all, to provide expert patient-centered care. Surely we can leave research for the professional researchers and experts in other disciplines.

Yet we have significant practical strengths to draw upon to widen our outlook. Every time we ask our patients open-ended questions that invite reflective answers, and each time we report those answers in chart notes or at interdisciplinary rounds, we are doing a kind of qualitative research. And every time we take stock of the diversity of religious traditions among our patient populations and report this data in our statistics, we are gathering quantitative data. In this way we are able to report key findings to others from our own unique perspective on patient-centered care. Furthermore, when we ask for feedback from patients, families and staff we are intentionally beginning to think about the effectiveness of our practice with a critical evidence-based focus.

Yet as telling as our findings might be to us, without the rigor of formal research methods, their impact on healthcare will be sorely lacking. Anecdotes and workload measurement are not hard data. Therefore, how can we continue to build upon our strengths to demonstrate that we, too, practice out of a research base and can make a contribution to healthcare?

What I like most about Standard 12 on research is its gradation – we needn’t become expert researchers all at once. That would be impossible. Rather, we can take measured steps toward developing greater interest and expertise in research, from basic, to intermediate, to advanced levels of proficiency.

In my own case, I search such terms as “chaplain” and “spiritual” on search engines like Pubmed.com once a month to see what new articles I might find that will be of interest and use to me and my colleagues. Then I collect the articles I like best in an ever-expanding bibliography complete with brief notes about why I think each one is important. This also helps me to see gaps in the literature, which suggest opportunities for new research. Sometimes I correspond with researchers via email and on professional-social media sites, which has fostered my interest in research and built my professional network. One of my goals has been to collaborate with researchers in other related disciplines. In this way I’ve been fortunate in my career to have had some expert researchers mentor me in my projects and ambitions.

One article that grabbed my attention early on in my career in acute care was Iler, Obenshain, & Carmac’s “The impact of daily visits from chaplains on patients with Chronic Obstructive Pulmonary Disease: A pilot study,” published in *Chaplaincy Today* (2001; 17:1). This article is a gem. It is clear; easy to read and to understand; and it opens a window on the spiritual health issues of a previously unexamined patient group. The findings support the effectiveness of pastoral visits for improving the emotional and physical

well-being of COPD patients, which allowed these patients to feel more satisfied with their care, less anxious on discharge, and even to stay fewer days in the hospital than patients in the control group. All told, these findings are a gift to our profession and can have an impact beyond its borders.

But that is not all. Remarkably, this study demonstrates that “research can be completed within the structure of a one-person pastoral care department operating within a medium-size community hospital ... balanced between patient visitation, worship services, psychiatric spirituality groups, supervision of a 20-member volunteer chaplain program, consultations with staff, and the administrative work of the chaplain” (p. 10). It did, however, require two-and-one-half years to complete, which is itself a study in faith and determination. My only quibble with this study is that it and others like it are not published more often in interdisciplinary journals.

As chaplains we might not like the idea of research very much, at least generally speaking. But we do have a responsibility to take the steps necessary toward greater competency as research-informed professionals. Standard 12 on research guides us towards this goal. As Iler, Obenshain & Carmac put it, “The future of healthcare chaplaincy will continue to be dependent upon research which assesses not only the fiscal benefits of pastoral services, but also the outcomes in emotional and spiritual health of the patients and family members who are served.” Surely this is something we can all buy into. And, who knows, we might even like it. Really!

*Robert Mundle works in spiritual health at St. Mary's of the Lake Hospital site, Providence Care, in Kingston, ON, Canada.*

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## Of human bonds: A trip to China, Mr. Loy, and the silent treatment

By Sister Frances Smalkowski, CSFN, BCC

Last year, while enjoying a two-week tour of the cultural capitals of China, I was amazed by how at home I felt. Searching my memory for the reasons behind this unexpected state of mind, I suddenly remembered Mr. Loy.

We met more than 40 years ago. I was in my third year as a nursing student, doing a semester-long rotation in a large psychiatric hospital. Each student was assigned a patient for the semester, and Mr. Loy was mine.

We were expected to forge a therapeutic relationship with our patients. This was a tall order; most of our patients were diagnosed with some form of persistent schizophrenia, and few spoke in any coherent fashion, if they spoke at all.

Mr. Loy was no exception. A short man in his late 60s with raggedly balding hair, he made frequent references to "the machine on my head." His bald spots marked his attempts to remove the machine. The machine, he said, had commanded him to kill his son. Because he'd actually tried to do so, using a large knife, he'd been hospitalized as criminally insane.

Before our first meeting, I read Mr. Loy's medical history. Thanks to the psychiatric nursing education I'd received, I understood about hallucinations and delusions, and on a basic level I felt prepared to talk with him. I made a tentative plan to ask him about his life story while accepting in some way his regular references to the machine. In this fashion, I hoped that I could uncover and affirm some positive aspects of his life and make our time together a beneficial experience for him.

But I wasn't prepared for the fear that struck me during our first encounter – not fear of someone who'd been labeled as criminally insane but fear of a Chinese person. The neighborhood I'd grown up in, Jamaica, NY, was fairly diverse in race, color and creed, but no Asian people lived there. My images of Asians came from the television shows I'd seen, in which they were depicted, in the usual stereotypical way, as sinister bad guys.

This fear made it hard for me to relate to my new patient, although this probably wouldn't have been noticeable to anyone else. Someone looking at us would have seen Mr. Loy and me sitting side by side in silence. Occasionally I'd make attempts at conversation. Most of the topics I broached – his work, his home and family – sparked barely any response.

These long periods of silence, as it turned out, were therapeutic – for me.

Being outgoing by nature, I found sitting with Mr. Loy difficult, even painful. But, sitting beside him, I could see how irrational my fears were. Unlike the Asians on TV, Mr. Loy projected nothing sinister at all. (I viewed his psychiatric diagnosis as a separate issue entirely.)

I took comfort that he seemed quite accepting of my presence. Even early on, when I would come to the unit for a session, he would stay seated next to me instead of getting up and pacing, and soon he began to smile when he saw me come in.

His acceptance of me, and my self-awareness, combined to allow me to see what my issues were. Little by little, I felt my fear peel away.

Then, one day when we were planning a St. Patrick's Day party for the patients, I had a major breakthrough with Mr. Loy.

"Do you have a favorite song?" I asked him.

To my surprise and delight, he answered!

"Yes," he said.

"What is it?" I asked.

"How Much Is That Doggie In The Window?" he replied. (I was so pleased that he'd spoken that I didn't think to ask him how this particular tune had become his favorite.)

The day of the party arrived.

Strumming my guitar, I led the singing, beginning with Mr. Loy's favorite. He beamed from ear to ear, and I marveled at how little it took to touch his heart.

This seemingly small connection made all the difference. From that time forward, Mr. Loy began to talk more in our one-on-one sessions. He also became noticeably protective of me. During fire drills, for instance, if he saw another patient acting disrespectfully to me, or anywhere nearby, he would frown at the person or point in the time-honored "get lost" gesture.

For me, the highlight of our relationship occurred when my turn came to lead the small-group session.

We students dreaded this experience. Under our teacher's eye, we'd sit in a circle with seven or eight patients and do our best to get them to speak about their thoughts and feelings – a nerve-wracking challenge. Halting initiatives by the student were met with awkward silences; and after a few minutes, one by one, our patients would get up and wander off.

Soon after I opened the session, Mr. Loy stood up. Going to each patient in turn, he pointed and said, "You!"

To my thrilled astonishment, many of them responded, in words ranging from "You" or "My baby" to "Leave me alone," "Get out of here" and "Shut up." The exchanges were brief – and yet, it was the most active group I'd seen in all of my time at the hospital.

Afterwards, my psychiatric nursing professor was very congratulatory – and at semester's end, she recommended me for a National Institute of Mental Health traineeship.

It was a sad day for me when, after weeks of preparation, I had to terminate my therapeutic relationship with Mr. Loy.

I approached him gingerly.

"As I've told you before," I said, "I'm only a student so I only get to stay here a short time, and today is my last day."

He looked at me and I looked at him, not knowing what else to say – sensing our bond, knowing that he had so little company, if any, and feeling guilty that I was deserting an old friend.

To this day, I have him to thank for helping me through the opening stages of my successful 35-year psychiatric nursing career as a clinical specialist and private-practice therapist.

Visiting Mr. Loy's homeland, I felt his spirit with me in a special way, and I had a sense that he understood the gratitude I've felt to him all these years.

It made me realize that we didn't say goodbye, only so long. Such treasured encounters are never really forgotten. Their imprints in our hearts and minds remain, a testament to the powerful – and mutual – bonds that form between ourselves and our patients whenever healing takes place.

*Sister Frances Smalkowski is director of pastoral care at Pope John Paul II Care and Rehabilitation Center in Danbury, CT, and maintains a part-time private practice in Monroe, CT. This article was first published in Pulse – voices from the heart of medicine ([www.pulsemagazine.org](http://www.pulsemagazine.org)).*

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## Q&A with Marie Coglianese, BCC, and Sister Cyrilla Zarek, OP, BCC

By Deirdre Manning, BCC

The position of director of pastoral care in an acute care hospital brings with it many challenges these days. Among the tall orders is making sure patients are seen by a chaplain. This simple and important goal was one that motivated Marie Coglianese, director of Loyola University Medical Center's Pastoral Care Department, to create a program whose sole focus was striving to meet this aim.

Officially named the Initial Visitor Program, it was born of Ms. Coglianese's hope in 1999 that every inpatient would be seen at least once before leaving LUMC. Thirteen years later, with the help of Sister Cyrilla Zarek, OP, this program has developed and grown, making the vision a reality as more LUMC patients are being welcomed, supported and informed that pastoral care services are available to them. Seeing every patient before he or she leaves remains a departmental goal of LUMC.

From 1999 until March of 2008, Sister Cyrilla was the primary Initial Visitor chaplain. In March 2008, Grace Gentle was handpicked by Ms. Coglianese for having the "heart" of a chaplain. Coglianese's requirement for the role was that the person would have an innate ability to listen, support and be present to patients. By not requiring the Initial Visitor chaplains to be board certified, Marie was able to expand and creatively pursue her search for the "right" person.

Since joining the team, Ms. Gentle has helped the program expand, allowing for CPE students to shadow initial visitors as part of their training. In spring 2011, another initial visitor, Diana Durkin, joined the duo to further extend coverage in a hospital whose census is increasing.

Recently Ms. Coglianese and Sister Cyrilla, who was one of the first women chaplains to be certified through the NACC and a former CPE supervisor, agreed to an interview with Vision about Loyola's Initial Visitor Program.

**Q Marie, When did you begin dreaming and scheming about a way that every inpatient could be seen by a chaplain before leaving the hospital?**

**A** Ms. Coglianese: It was in the spring of 1999. My staff and I had discussed in our department meetings the challenge of seeing every patient before they were discharged. We set this as a departmental goal. In my mind, I knew we needed a program beyond the role of the board certified staff chaplain to help us reach this aim.

**Q Then, in the summer of 1999, Sr. Cyrilla was hired to work part time, four days a week and to visit all new patients. Is that correct?**

**A** Ms. Coglianese: Working alongside her certified chaplain colleagues who also made sure every new patient on their unit was seen at least once, Sr. Cyrilla initiated what has become the Initial Visitor Program.

The main goal of the program was to welcome and greet patients to the hospital on behalf of pastoral care. Representing the face and heart of the department, Sr. Cyrilla would bring her smile and warmth to every encounter. After asking permission to enter the room and to sit down, Sr. Cyrilla would inform the patient about pastoral care services, giving him or her a brochure and a prayer booklet. After this brief

welcome and introduction, what would follow would be as different and varied as each patient.

**Q Sister Cyrilla, How did patients react to your presence?**

**A** Sister Cyrilla: Occasionally, patients would open up, sharing a loss or a life stressor, welcoming a listening presence. In these instances, I would be sure to make referrals to my fellow chaplains for follow-up visits.

Sometimes the response would be, "Sister, I'm not Catholic." I would tell them: "This doesn't make any difference. We're all in this together." I would try to clarify the patient's religious status, as some patients were listed as "None" or "Other" which might have been an error. I asked Catholic patients if they would like to receive daily Communion from the volunteer eucharistic ministers. If a patient was not in the room or asleep, I would leave a "Sorry I missed you" card and the brochure and prayer booklet.

**Q Did a patient ever refuse your visit?**

**A** Sister Cyrilla: One man, who after hearing my introduction proceeded to tell me about his own grief and gripes with his Catholic upbringing, worked himself up so much so that he asked me to leave his room. I prayed for this man, and when he returned as an inpatient some time later, I paid him another visit. This time, he welcomed me to his room and was quite receptive to my visit.

**Q Now that your initiative has expanded to include Grace and Diane, how do the three of you coordinate with the rest of the department?**

**A** Sister Cyrilla: We participate in the staff's daily huddles, sharing and receiving pertinent information about patients. These twice-daily team meetings are additional ways to ensure that the needs of patients and families are being met by the pastoral care department. We play a key role in these discussions, as we are the frontline of many patient and family encounters.

**Q How have your own gifts contributed to your ministry?**

**A** Sr. Cyrilla: Playfulness is one of my primary gifts. I feel I am able to activate this gift when visiting patients for the first time. I try to find an in with them. I also love the spontaneity of the program and the God of surprises!

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Since this interview, Sr. Cyrilla retired from Loyola, leaving a strongly established Initial Visitor program in place. Diane Durkin has completed two units of CPE with plans to pursue certification. Loyola University Medical Center was welcomed to the Trinity Health Systems family.

*NACC member Deirdre Manning is a board certified chaplain working as a full-time chaplain at a long-term acute care hospital as a Loyola/Trinity Health Systems employee in the Chicago area.*

**More information**

Read about the Initial Visitor Program at Loyola University Medical Center at [www.nacc.org/vision/May\\_June\\_2012/LUMC-IVP.asp](http://www.nacc.org/vision/May_June_2012/LUMC-IVP.asp).

## Research abstracts: Examining standards of practice in acute care

By Austine Duru, MDiv, MA, BCC

In this issue of *Vision*, in lieu of publishing a research article, we present eight research resources in hopes of assisting readers to sample a broad range of research by chaplains and non-chaplain collaborators. Each research resource is related to our current Vision theme, "Accountable in Acute Care: Examining Standards of Practice." A link to a safe open access site has been included to aid in further detailed reading.

**Meg Orton.** "Emerging Best Practice Pastoral Care in the UK, USA and Australia." *Australian Journal of Pastoral Care and Health* 2, No. 2 (2008): 1-28. (44 references)

Link: [www.pastoraljournal.findaus.com/pdfs/Emerging.pdf](http://www.pastoraljournal.findaus.com/pdfs/Emerging.pdf)

This interesting project by Meg Orton draws on a number of sources to examine the emerging views around best practices in pastoral care across three continents, thus giving the reader a global snapshot of the principles that inform existing standards of care in the countries examined – The United Kingdom, the United States and Australia. This ongoing global project suggests consistent progress in the growth and advancement of professional pastoral practice in healthcare and related fields. Meg Orton observed that in each country there is a movement towards professionalizing pastoral care. Some of the factors cited ring true, yet newer developments, especially in the United States and Australia, call for a revision of this work. Nevertheless, much can be learned by reviewing the cited models and findings. One important lesson to take home is that, in the current global framework, professional chaplaincy cannot survive in isolation in any of these countries. This work invites readers/professional chaplains to continue to add to the available data by contacting the author, through an e-mail address provided to the reader, as things continue to evolve and improve in the professional practices in these countries or elsewhere in the world.

**Katherine M. Piderman, Dean V. Marek, Sarah M. Jenkins, Mary E. Johnson, James F. Buryska, Tait D. Shanafelt, Floyd G. O'Bryan, Patrick D. Hansen, Priscilla H. Howick, Heidi L. Durland, Kandace A. Lackore, Laura A. Lovejoy, and Paul S. Mueller.** "Predicting Patients' Expectations of Hospital Chaplains: A Multisite Survey." *Mayo Clinic Proceedings* 85, No.11 (2010): 1002-1010. (15 references)

Link: [www.ncbi.nlm.nih.gov/pmc/articles/PMC2966363/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2966363/)

In this survey, Katherine M. Piderman and her colleagues set out to identify what patients would expect from chaplains during their stay in the hospital, which patients would most likely seek chaplain visits, and what these patients would consider important elements of a pastoral visit. Some 4,500 medical surgical patients across three hospitals in Minnesota, Arizona and Florida were surveyed by mail. The data were analyzed using multiple tools. The results suggest that medical and surgical patients value chaplain visits during their hospital stay. Patients are more likely to desire chaplain visits because it is a reminder of God's care and presence. In addition, those patients who are affiliated with religious institutions are more likely to seek chaplain visitation. This study provides some insight into the unique role of professional chaplains who provide care for patients. However, the authors caution against using this survey as a justification for providing pastoral care to every patient without considering patient's preferences. "These findings can guide institutions in responding to patients' expectations and implementing best practices in providing spiritual care for their patients.... It cannot be used to overshadow the vital importance of honoring the uniqueness of each person." Each person, the authors conclude, must be assessed individually, with care and respect. *An article by Katherine M. Piderman on this study was published in the*

March-April 2011 issue of Vision.

**Judith R. Ragsdale.** *Educating Clinical Pastoral Education Supervisors: A Grounded Theory Study of Supervisory Wisdom.* Antioch University, 2008: 198 pages. (109 references) Note: this work is the author's doctoral dissertation. The full text of the electronic version of the dissertation could be accessed at the Ohiolink ETD center:

Link: [etd.ohiolink.edu/view.cgi?acc\\_num=antioch1205193710](http://etd.ohiolink.edu/view.cgi?acc_num=antioch1205193710)

In this groundbreaking 198-page work on supervisory education, Judith Ragsdale explores the wisdom and practices of competent CPE supervisors to determine what they are doing right and to develop a theory of CPE supervisory education based on her findings. The author used grounded theory methodology (based on studying experience, what Anton Boisen referred to as the living human document. This theory was developed by Anselm Strauss and Barney Glaser [1967]) to interview 11 CPE supervisors to identify the themes that may emerge. The data for this qualitative study were gathered primarily by interview, each interview lasting about 75-100 minutes. Data were analyzed/coded by a multidisciplinary coding team. Four primary dimensions emerged, including: selecting supervisory education students (SES), helping SES develop supervisory practices, guiding SES toward integration, and blessing SES to develop independently. Supervisory wisdom was the core dimension that weaves all the others together. Continuing education and professional development were seen as significant aspects of the supervisors' standards of practice that enhance their ministry. The author concludes that the theory of reciprocal wisdom – the wisdom of the CPE process, reflects the best of CPE practices. This work, although lengthy, is a must-read for serious supervisory education students and CPE supervisors. The extensive bibliography offers a wealth of resources for further reading. A shorter, more organized version of this work was also published in the *Journal of Pastoral Care and Counseling*, Vol. 63, No. 3. 4 (2009).

**George Fitchett.** "Making our Case(s)." *Journal of Health Care Chaplaincy* 17, Nos. 1-2 (2011): 3-18. (43 references)

Link: [www.tandfonline.com/toc/whcc20/17/1-2](http://www.tandfonline.com/toc/whcc20/17/1-2)

In this insightful article, George Fitchett makes the case that healthcare chaplaincy and professional chaplains must remain engaged with research and the production of excellent body of evidence-based qualitative research work, such as case studies. Fitchett acknowledges that case studies, informed by daily chaplain interventions, play a significant role in "training new chaplains and in continuing education for experienced chaplains, not to mention educating health care colleagues and the public about the work of health care chaplains." This work is an important introduction to qualitative research; it simplifies this process for professional chaplains and also outlines the steps to get case studies published. It is significant to note that the guidelines presented in this work have been adopted and implemented by the editorial board of the *Journal of Health Care Chaplaincy* as a standard for future case studies in chaplaincy research and practice (see the editorial from the *Journal of Health Care Chaplaincy* in the link above.) This call for research literacy has become necessary as new thinking on the delivery of healthcare is currently under way in the United States and worldwide. *An excerpt of this article was published in the September/October 2010 issue of Vision.*

**Kevin J. Flannelly, Katherine R. B. Jankowski & George F. Handzo.** "Testing the Efficacy of Chaplaincy Care." *Journal of Health Care Chaplaincy* 17, Nos. 3-4 (2011): 100-125. (131 references)

Link: [www.tandfonline.com/doi/abs/10.1080/08854726.2011.616166](http://www.tandfonline.com/doi/abs/10.1080/08854726.2011.616166)

This article, funded by a grant from the John Templeton Foundation, gives a detailed review of clinical practice of chaplains as contained in published studies conducted in the United States. It takes a balanced look at the literature on the efficacy of "chaplain interventions," "patient satisfaction with chaplaincy services," and "clinical practices of chaplains with patients and family members." The authors identify three important factors that are likely to shape the future of chaplaincy services based on emerging trends. These include: a) growth in the demand for palliative care services; b) significant rise in the

number of individuals who do not fit into any current religious classifications; c) the convergence of electronic documentation, pastoral interventions and spiritual outcomes. To best position chaplaincy to meet these changing demands, the authors recommend that "chaplains generate research-based definitions of spirituality, spiritual care, and chaplaincy practice; and that more research be conducted to describe the unique contributions of chaplains to spiritual care, identify best chaplaincy practices to optimize patient and family health outcomes, and test the efficacy of chaplaincy care." The extensive bibliography also offers opportunities for further reading on this subject. Also on this subject see, K. Galek, K. J. Flannelly, K. R. Jankowski, & George F. Handzo. "A Methodological Analysis of Chaplaincy Research: 2000-2009." *Journal of Health Care Chaplaincy* 17, Nos. 3-4 (2011): 126-145. (64 references)  
Link: [www.tandfonline.com/doi/abs/10.1080/08854726.2011.616167](http://www.tandfonline.com/doi/abs/10.1080/08854726.2011.616167)

**Shane Sinclair.** "Impact of Death and Dying on the Personal Lives of Palliative and Hospice Care Professionals." *Canadian Medical Association Journal* 183, No. 2 (2011): 180-187. (35 references)  
Link: [www.cmaj.ca/content/183/2/180.full](http://www.cmaj.ca/content/183/2/180.full)

Burnout and Secondary Traumatic Stress (STS) pose significant challenges for chaplains. This study by Shane Sinclair focuses on an important aspect of ministry for chaplains and healthcare professionals who encounter the death of their patients. The author was specific in focusing his ethnographic research on the impact of death and dying on palliative and hospice care professionals, which he identified as a limitation to the scope of the work. The study surveyed 11 specific themes that were organized into three categories of past, present, and future. Early life experience of death was discovered to play a significant role in the career path of participants in the study. "Participants reported that their work provided a unique opportunity for them to discover meaning in life through the lessons of their patients, and an opportunity to incorporate these teachings in their own lives." The conclusions are somewhat tentative. The study comes at the issue from the vantage point of a privileged observer. The study finds that the challenges of end-of-life care pale in comparison to the benefits of gleaning valuable wisdom from the dying experiences of others. "They had the opportunity to incorporate these truths into their everyday lives, integrating end-of-life wisdom from the vantage of foresight, in contrast to the perspective of dying patients looking back on their lives." While this study sheds some light on this issue, it fails to raise important questions of self-care and disenfranchised grief known to affect healthcare chaplains and other healthcare professionals. The next article discusses some of these issues in detail. This article, nonetheless, makes for interesting reading on the subject.

**Tyler Lee Kruger.** "Keys to Resilient Practice in Contemporary Chaplaincy." Lancaster Theological Seminary, 2010: 83 pages. (39 references)  
Link: [gradworks.umi.com/3416822.pdf](http://gradworks.umi.com/3416822.pdf)

This work by Tyler Kruger offers fresh perspectives on how professional chaplains could remain resilient in the face of overwhelming emotional work demand and provides some helpful suggestions on dealing with burnout and grief as they arise in ministry. Kruger's study was done as part of his graduate work, where his focus was to learn about resilience and "its key characteristics that enable chaplains to remain healthy, emotionally, spiritually and physically." Tyler also looked at the main theologies of resilience and what constituted enemies of reliance – what chaplains should watch for in ministry. This study was framed to explore three primary concerns: "1) to learn what stressors reduce the chaplain's ability to live abundantly? Are there environmental risks or other possible 'enemies' of resilience? 2) To find ways of incorporating self-care practices into the daily life of chaplains by identifying habits that prevent them from experiencing physical, emotional and spiritual depletion. 3) To discover ways for restoring chaplains to a place of wholeness, when physical, emotional and spiritual emptiness has occurred." This study led Tyler to offer three important conclusions that should not be ignored by professional chaplains: "1) Take the Life Stress Test and Quality of Work Satisfaction annually as part of one's yearly review and evaluation. 2) Develop a simple self-care plan "Living with Resilience Action Plan," termed L-Wrap, that will assist chaplains in the intentional development of resilience practices/thriving strategies that nurture the body, mind and spirit. 3) Develop and implement group rituals around grief and celebration – and

incorporate these into the daily life of the department." This is a recommended reading for chaplains, students and chaplain educators.

**Otto C. Scharmer.** *"The Blind Spot of Institutional Leadership: How To Create Deep Innovation Through Moving from Egosystem to Ecosystem Awareness."* Paper prepared for: World Economic Forum, Annual Meeting of the New Champions, Tianjin, People's Republic of China, September 2010. (2 references)  
Link: [www.ottoscharmer.com/docs/articles/2010\\_DeepInnovation\\_Tianjin.pdf](http://www.ottoscharmer.com/docs/articles/2010_DeepInnovation_Tianjin.pdf)

Otto Scharmer is a significant voice on the subject of individual, groups, organizational/organizational and systems leadership. This paper, presented at an international conference, is built on years of research in contemporary leadership and thought. Scharmer identifies the "blind spot" present in our current "institutional design and intellectual frames about leadership." The inherent blind spot, Scharmer believes, lies in the fact that current leaders are seldom aware of the "source level... the inner place or the state of awareness from which leaders and social system operate." An example of this would be the interior work demanded in Clinical Pastoral Education (CPE) training and the relational qualities of "Leadership from behind that demands deep listening and authentic care" (see Margaret B. Clark, *Vision*, March/April, 2010.) Scharmer argues that success of any particular leadership model must depend on the degree of awareness of this "source dimension." This concept was introduced in his "Theory-U" process (Scharmer, 2007), and was deepened in "U.School" (Scharmer, Cunningham, and Kaufer, 2011). As one moves through the "U" process, one learns to connect to one's inner self through "presencing" (presence+sensing) or the source dimension. Scharmer advocates a radical departure from the existing fragmented framework of leadership training.

He proposed a paradigm shift in our thinking and training of future leaders, which includes: "(1) Close all business schools, schools of public policy, and departments of urban studies – and reopen them in the form of tri-sector leadership schools that bring together students and mid-career executives from all three sectors (business, government, civil society), that teach them in the language and the logic of all three sectors.... Such new leadership schools would equip students with an effective set of listening, management, and reflection tools that help them to be effective social entrepreneurs and change agents in the societal renewal processes. (2) Bring together key younger leaders across institutions in specific and deeply broken ecosystems and give them the process, methods, and tools that help them to see, sense, reinvent, and reshape their system."

This proposed collaborative model has significant implications for CPE training, healthcare chaplaincy and healthcare administration and management. The references cited in this work are not exhaustive, yet the ideas posed here are innovative and touch on important themes in the training of a professional chaplain. I believe CPE training already gives chaplain leaders a significant edge in this area. As the author concludes, "The transformational leadership must involve all key stakeholders in a journey of profound innovation and renewal."

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Involved in research on a topic related to chaplaincy? Looking for a venue to publish? *Vision* would be interested in learning about your research effort. Contact Austine Duru at [gusduru@yahoo.com](mailto:gusduru@yahoo.com) or Laurie Hansen Cardona at [Lcardona@nacc.org](mailto:Lcardona@nacc.org).

## No proselytizing, please: One chaplain's reflection on his quiet evangelization

By George Reed, MA, BCC

As a Catholic lay ecclesial minister, I realize my priority is first as a follower of Jesus Christ and as a husband before I am a hospice chaplain. My faith has taught me to sincerely hold to these priorities.

In hospice chaplaincy, I often need to hold my beliefs silently to support others of different beliefs. Does this mean that I am a lukewarm Catholic? This question has troubled me.

As a board certified chaplain I am supposed to refrain from proselytizing. I find, especially out of respect for the imbalance of power between a vulnerable patient and myself, that there is much more to living faith and growing in holiness than a nominal profession of loyalty to the church and to our Savior.

"Then Peter proceeded to speak and said, "In truth, I see that God shows no partiality. Rather, in every nation whoever fears him and acts uprightly is acceptable to him" (Acts 10:34-35).

Recently, in Eucharistic adoration, I read in the Liturgy of the Hours an excerpt from *Lumen Gentium*: "Those who have not yet received the Gospel are in their different ways related to God's people." It clarifies these as Jews, Muslims, agnostics, and others who seek God with a sincere heart. "Whatever goodness and truth found among them is seen by the Church as a preparation for the Gospel and as given by Him who shines on all men so that they may at last have life."

This reflection from the Office of Readings in the Liturgy of the Hours tells me that there is hope even for those who have not yet received the Gospel or who live by another faith. I am in continual formation as a chaplain who supports people of all faith backgrounds including Protestants, Buddhists, Muslims, Hindus, Native Americans, agnostics, and atheists. It is essential for me to remain rooted in my faith and to honor the diversity of beliefs and practices of the dying whom I encounter in hospice.

Kneeling before the humble, courageous, and compassionate presence of our risen Lord as the small consecrated host held in the monstrance, my faith grows stronger in hope for the dying. "His mercy is endless and his treasury of compassion is inexhaustible."

The dying have so much to teach me, just as Christ teaches so much to his disciples through his dying. The dying help me in the ongoing spiritual battle I have with my pride and how difficult it can be for me to be small.

So often, I need to get out of the way and let our Lord do what he wills. What I do and say is important, but more important is faith in the blood of Christ. "And without faith it is impossible to please him. For whoever would draw near to God must believe that he exists and that he rewards those who seek him" (Heb 11:6).

And this faith is to lead me to love my neighbor as Christ loves them. Unfortunately, I often fall short and need to recharge in prayer before the Eucharist and in Confession. There I find the grace to see the face of Christ in those with whom I serve and those whom we have the privilege to serve together. The fruit of listening with faith is a quiet evangelization.

In the Eucharist we have the compassionate presence of One who suffers with those he loves. Jesus,

though he could have prevented his passion and death on the cross, surrendered to his Father's will. And in doing this he reveals the undying love of God ... the love that is better than life (Ps 63:4), stronger than death (Song of Songs 8:6b) , and surpasses all expectation (Eph 3:20).

"Now to him who is able to accomplish far more than all we ask or imagine, by the power at work within us, to him be glory in the church and in Christ Jesus to all generations, forever and ever. Amen." (Eph 3:20)

In hospice chaplaincy, I often need to hold my faith silently. Even this silent act of holding faith bears fruit. The fruit of listening with faith is a quiet evangelization by the Holy Spirit for those to whom I listen and for me (Acts 15:9). It is faith that cleanses the heart.(Acts 15:9).

There are times I avoid conflict. I don't find it necessary to always make my disagreements known. I discover that by listening with faith, our God cleanses my heart and invites me to grow into a better teammate in this quiet evangelization.

I can help prepare the way for others to receive the Gospel by listening to and honoring what is true and good in their lives. While this is not as exciting as preaching the Gospel to all of the world, it is in line with what Saint Francis taught while working to rebuild the church in the world. "Preach the Gospel always. Use words only when necessary."

But isn't hospice chaplaincy different? What about unbelievers who are near death or actively dying? This question has troubled me. I am thankful for a humble Polish nun named Faustina Kowalska. She received in a vision from our Lord the chaplet of Divine Mercy with an invitation to trust in the infinite ocean of mercy that is our God. Praying the chaplet of Divine Mercy has strengthened my identity as a lay Catholic chaplain for the dying.

I pray that when I am dying, someone will be praying with faith in Jesus for me also (Mt 25:40). "And the king will say to them in reply, 'Amen, I say to you, whatever you did for one of these least brothers of mine, you did for me'"(Mt 25:40). So that in joyful love, I, too, may embrace our merciful Savior.

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## Award-winning history book examines how society has wrestled with cancer

By Marilyn Williams, BCC

*The Emperor of All Maladies: A Biography of Cancer.* By Siddhartha Mukherjee. Scribner, New York, NY, 2010. Paperback, 571 pp. \$18.

The author, oncologist and researcher Siddhartha Mukherjee, calls his history of cancer a “biography” because in his own words, it is an “attempt to enter the *mind* of this immortal illness, to understand its personality, (and) to demystify its behavior.” Yet, in many ways his book may tell us more about the *mind* and behavior of cancer researchers, oncologists, political activists and policymakers, and indeed all of society. Even Mr. Mukherjee’s personification of cancer is reflective of how cancer is perceived as a cruel and relentless enemy to be defeated regardless of cost or casualties. Mr. Mukherjee also refers to his book, winner of the 2011 Pulitzer Prize for non-fiction, as a military history quoting a 19th-century surgeon who called cancer “the emperor of all maladies, the king of terrors.”

As a child in the 1950s and 1960s I can remember no illness strike more terror than cancer. Indeed even today despite the fact that many learn to live with cancer as a chronic disease with remissions and recurrences, few diagnoses terrify people more than cancer. Mr. Mukherjee’s history of cancer tells of the terror, citing historical and literary examples as well as noting the stories of patients he has treated.

Also, Mr. Mukherjee tells the story of the “war” on cancer from the perspectives of cancer researchers such as Mr. Sidney Farber, who started his work on childhood leukemia in the late 1940s, and political activists, like Ms. Mary Lasker, of the 1950s and 1960s. Mr. Mukherjee describes how this militaristic mindset led to the mindset that “cancer could be conquered just as the moon had been conquered” (p.179) and how this led to an emphasis and funding for treatments for cancer versus basic research on understanding the basic biology of the disease process. In addition, Mr. Mukherjee tells of how the politics of cancer impacted the political activism surrounding AIDS. Yet Mr. Mukherjee’s story is not only of the 20th century, for he weaves into his book earlier scientific findings and cultural understanding from throughout the ages since the earliest time that cancer was described and named. Mr. Mukherjee tells us, “karkinos,” the Greek word for “crab,” first appeared around 400 BC in the time of Hippocrates because a tumor with its swollen blood vessels reminded him of a crab dug in the sand with its legs spread in a circle.

In addition to being a fascinating historical and political account of cancer, Mr. Mukherjee’s book is a scientific history and treatise of the research that has led to our current understanding and treatment options for cancer. This science is explained in terms the educated layperson, such as a chaplain, can understand. This scientific background would especially be helpful to any chaplain who participates in Tumor Rounds and work with oncologists. In telling this scientific history of cancer, the reader gains a greater understanding that cancer is not one disease, but a family of diseases related or linked at a fundamental biological level. One begins to understand that cancer is a “flaw in our growth,” in our physiological processes of aging, regeneration, healing, and reproduction.

In reading this history, I believe many chaplains will question as I do the cost of this research, not the financial cost, but the cost in terms of physical and emotional pain or quality of life considerations for those receiving experimental treatments. The question that may be asked were these people heroes who made progress possible or victims – the same question that might be asked of all wars. And as for all wars, could the goals or progress of this war been achieved by other means?

Moreover, while it is apparent from his book that Mukherjee cares deeply about his patients and what they and others with cancer have endured, it seems to this reviewer that the telling of their stories is the weakest aspect of his book. Despite this shortcoming, "The Emperor of All Maladies" would provide valuable insights regarding the science and politics of cancer to chaplains, all of whom work with cancer patients sooner or later.

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