

How are we perceived in the workplace?

Over the past couple of years, I have participated on the CHA Pastoral Care Advisory Council (PCAC) whose membership consists of representatives of several Catholic healthcare systems, and whose charge is to act as a resource to CHA and NACC in their efforts to: identify and address significant issues in pastoral care within the Catholic health ministry; provide a forum for key pastoral care leaders within the Catholic health ministry to discuss important issues and how to share leading practices; and to offer guidance for CHA and NACC in their planning and development of resources and programs that support pastoral care.

Last year the PCAC identified three issues it planned to address: how to determine/measure quality in pastoral care, spiritual care staff structuring in these changing venues of delivering pastoral care, and communicating the value of spiritual care and chaplains within their settings. All three are critical to strengthening spiritual care within healthcare institutions. The first two issues align well with the NACC Strategic Goal I: to educate and support association members for the future of professional chaplaincy, as the PCAC members' concern and focus are for chaplains, and the spiritual care services being rendered, to be present and effective in the emerging service settings across the continuum of care. I wrote about Goal I in the September-October *Vision* issue and that issue along with this current issue provides articles on these non-acute care settings.

The third issue of communicating the value of spiritual care and chaplains within their settings matches the NACC Strategic Goal II: to increase awareness of the value of chaplaincy among key constituencies. What are the best ways to do this among our professional colleagues and the executive decision-makers? The PCAC decided that, in order to better communicate the value of spiritual care and chaplains to executives and clinician colleagues within their healthcare settings, it would be important first to learn how these constituencies perceived the value of spiritual care. So, over the summer the PCAC developed two survey tools for these two constituencies groups, and these surveys were made available in early September to CHA's email lists of executives (board member/trustee, CEO, CFO, COO, CMO, CNO) and clinical team members (physician, nurse, social worker, physical therapist, nutritionist, CNA). We were pleased by the percentage of participation from these groups and by the information we received. It will be helpful to us as we develop materials for these target audiences. Let me offer a couple of insights from the research.

One question the executives were asked was, "As we enter a new era of fiscal challenges and healthcare reform, professional chaplains are an important discipline in creating a better healthcare system. As a decision maker, what types of information regarding the role of chaplains do you want to have in your decision making?" They were offered seven examples, then space to write in others. The highest two examples noted were: integral role of spiritual care, especially in tending to the emotional needs of the clients we serve (80.7%) and positive influence on patient satisfaction (80.3%). The next two affirmed the importance of chaplains to the staff: support staff, especially during critical incidences (79.4%) and orientation, education and integration of staff in meeting spiritual care needs (75%). The item receiving the lowest percentage was impact/involvement in quality initiatives (60.4%). While this does not seem to lessen the importance of our role in such initiatives, it is not "top of mind" for the executives compared to the other ones noted. Learning these perceptions will be helpful to us. Hopefully, they confirm for you the importance of your profession and ministry.

One question the clinical team members were asked was: "When seeking assistance from spiritual care and professional chaplaincy, what are you asking for?" They were offered five examples, then space to write others. The highest two involved care for patients and families: supportive presence for patient and families (97.4%) and prayer or ritual for patient or family (83.9%). Again, for this group, staff care was

very important: supportive presence for staff (72.5%). "Ethical questions/concerns" received a lower percentage (58.7%). Could this indicate that we are perceived as less proficient in addressing ethical issues, or perhaps, more accurately, is it that ethical concerns are not viewed as part of our responsibilities? Either way, this is good for us to consider as we make plans to better communicate who we are and what we do.

We look forward in the coming months to continue this PCAC work, and other initiatives to increase awareness of the value of chaplaincy among key constituencies.

If you or your institution is involved in a project to increase the understanding and value of chaplaincy, please let me know.

I look forward to hearing from you!

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Chaplaincy services offered at subsidized housing communities

By Sandra Lucas, MDiv, BCC, and Sister Anne Marie Diederich, OSU

Laurel Lake Retirement Community in Hudson, OH, became part of the Humility of Mary Health Partners in 1994. Soon after, members of the various departments reached out to senior adults at Keys Towers in neighboring Stow, OH. Every month a social activity was shared with the residents. It was not long before the Laurel Lake staff began to identify additional unmet needs of the residents, particularly in the area of healthcare. Sister Marie Ruegg, HM, worked with Carol Telesman, RN, BSN, MSN, to develop a program that would address these needs.

The Personal Health Partner Program was created as part of the healing mission of Laurel Lake in the broader community. Since 2000, Laurel Lake has partnered with area agencies to offer free health and wellness services to older adults and vulnerable persons living in subsidized housing communities in northeast Ohio. By promoting proper preventative care and management of chronic illnesses, the PHP Program seeks to prevent expensive hospital emergency room visits and crisis hospitalizations, and increase access to wellness services for individuals in the community.

A registered nurse works on site to assess the individual healthcare needs and to help residents make healthy lifestyle choices, supported by free wellness screenings, referrals, continuing health education, individual counseling, monitoring, and fitness programs. The goal is simple – to prevent illness, create an individualized plan for health, and empower each resident to make personal choices that support the plan every day. The service is free to all residents.

While the program was initially begun in Stow, OH, it has since expanded to include Sutliff I in Cuyahoga Falls, and the Senior Apartments in Twinsburg, so that the health and wellness needs of more than 400 senior adults can be met. Additional wellness support has been provided by Laurel Lake through the provision of regular fitness programs at each site as well as distance learning opportunities.

As the nurses at the three sites shared their concerns about residents, several needs surfaced for which they sought assistance. These included opportunities for residents to: 1) work through times of grief and loss; 2) deal with chronic pain; and 3) address problems with interpersonal relationships with peers, with residents not of their generation, as well as residents with mental disabilities, etc.

In order to extend the healing ministry of Jesus to those who were suffering various forms of spiritual pain, the Mission/Community Benefits Department at Laurel Lake developed a part-time position for a spiritual care coordinator who would assess the needs, develop programs, and provide individual and group counseling as needed at each of the three sites.

The person hired was Chaplain Amir Darr. He holds a master's degree in bioethics from Case Western University and a master's of divinity from Yale Divinity School. He completed a residency in Clinical Pastoral Education at the Cleveland Clinic in 2011. Mr. Darr's particular strength in ministering to peoples of all walks of life is rooted in the fact that, although he grew up a Muslim, he is now in the process of ordination for the Disciples of Christ. He seeks to meet individuals where they are on their spiritual path, whatever particular religious expression that might take.

Chaplain Darr works closely with the nurses at each site who make referrals to him. He currently offers group sessions in meditation and guided imagery and meets one-on-one with residents to offer support and pastoral counseling. In the near future, he is planning to offer support groups for bereavement and chronic pain.

"In this setting, there is a real opportunity to develop relationships and see growth," he said. "It can be quite different from hospital ministry where there is often a one-time encounter followed by a hope or prayer that the spiritual intervention made a lasting impact upon a person's life outside of the facility. Here, I can help residents understand what spirituality is and offer spiritual interventions before their health is affected negatively. In this sense, I believe that a model of spiritual care interventions before hospitalization is the necessary parallel to the model of healthcare we'll hopefully see more of in the future: an emphasis on preventative care."

Mr. Darr works with residents to understand the value of their story. "I hear their stories and share their joys and their burdens," he said. "I help them to consciously reflect on meaning, purpose, values, and a relationship with not only the self, but transcendence outside of self, to not only neighbor but also a higher power. My hope is to bring to them an understanding of how spirituality relates to their physical bodies and overall well-being."

Mr. Darr is in a unique and emerging setting for spiritual care services, which are continually adapting themselves to new models of healthcare delivery. "Spiritual interventions, as taught to me in CPE, are naturally focused on persons who are already medically ill or in some situation of trauma," he said. "This newer model will focus on wellness in individuals before they are already bodily suffering. The goal is preventative health, which must include the spiritual along with the physical."

Anecdotally, he expounds upon the importance of these preventative measures by sharing the many encounters with residents that have ended with tangible beneficial effects for the residents' well-being. "Already, I've had numerous situations with residents who have spoken with me, session after session, exploring emotional trauma going back decades. After our sessions, they've reported a sense of freedom from burdens, a sense of healing from wounds they've been suppressing for so long."

Sandra Lucas is regional director of spiritual care for Humility of Mary Health Partners in Youngstown, OH. Sister Anne Marie Diederich is director of mission integration at Laurel Lake Retirement Community in Hudson, OH.

Outpatient ministry allows chance to build more relationships

By Sister Martha Donnelly, PBVM

As a chaplain in a hospital with a CPE center, I have never run out of challenges in my ministry. Mentoring students is as challenging and rewarding as the rest of my ministry.

One of my sites is the cancer center, which includes outpatient chemotherapy and radiation. Providing pastoral care to these patients is similar to seeing patients in the hospital. Many times the best referrals come from a nurse on the run who has noticed an issue that needs addressing. When I initiate a visit, my goal is to establish a relationship with the patient and, as that relationship grows, make a spiritual assessment.

When I began ministering with the palliative care team, I followed one of our supervisors who was working in this area with a resident. It was the resident who got me on board. I continue to learn how to be a part of this team as I work with residents in this assignment.

One of the pluses in this ministry is that when you are in the room with the provider and the patient, you are seen as part of the team. You listen to the patient's story and the interaction with the provider. Often previous notes by chaplains give you an idea of the patient's spiritual background. In conversation, with or without the provider present, you make a spiritual assessment. This conversation helps me determine my plan of care.

During these visits in the clinic I offer emotional and spiritual support by active listening and validation of feelings. One woman's family did not understand how hard dialysis was for her. She needed someone to listen and to affirm her. I encouraged her to be open to a visit from a chaplain while in dialysis. I saw her again and spent time listening and provided prayer for her and her family.

As a chaplain, I listen for values and beliefs and ways of coping that have worked in the past. A man who had lost his partner shared some of his story. The provider was working to help the physical pain. As I listened, I sensed he was grieving appropriately and was realistic about his grief. He then shared that his church community has been supportive of him. His concern was with how brushed aside he had felt the last time he had seen the pastor. At this point, the provider returned with a prescription. We both affirmed his love for his church family. We encouraged him to try church again and give the pastor another chance. And if he still felt "pushed away," to share those feelings with the pastor.

Ministering with palliative care in the outpatient setting is a wonderful way to offer ministry to patients we might never see in the hospital. At the same time it is an opportunity to build relationships with the providers and those persons who later do become patients in the hospital. As pastoral care grows into new areas, it is an exciting time to be a chaplain.

Sister Martha Donnelly is chaplain at Gunderson Lutheran in LaCrosse, WI.

Chaplaincy in long-term and short-term home care: Advantages, disadvantages and challenges

By Lauren Marsh, MAR

What a gift I have been given! As a staff chaplain, I have had years of offering spiritual care for patients and families in many settings; acute care, home care and currently long-term care. Most of my time has been between home care (10 years) and long-term care (seven years). My intent here is to give some examples of advantages and disadvantages of ministry in these two settings as well as to surface some of the challenges chaplains and patients may face along the way.

Clearly, in long-term care, there is the advantage of more time to spend with patients and residents. This ultimately allows for deeper, more personal pastoral relationships between the chaplain, patient and family members. Usually there are many spiritual and emotional issues for long-term residents upon their arrival to the facility. Issues dealing with fear, loss and anxiety are prevalent. The good news, though, is that the chaplain can journey with the residents as they process these emotions and feelings. In this setting, chaplains get to know each resident rather well – their interests, hobbies, life work, values and beliefs. The chaplain can encourage residents to reflect on their lives and redefine meaning and purpose for their future living in a long-term care senior living community. For example, residents participate in joint activities to accomplish a common community mission, such as raising a community garden or organizing a welcome wagon committee for new residents. Some of these activities are instrumental in the patient's adjustment to living in a new facility or senior living community.

The long-term care facility where I work also has a rehabilitation unit. Many patients are admitted for a short rehab stay, but sometimes they are admitted with terminal, chronic conditions that prohibit participation in the therapy required for rehab. Many insurance plans cover some or all cost associated with rehabilitation as long as the patient is making good progress. A good number of these patients are too sick to return home and yet too sick for rehab. This becomes a difficult situation as most patients and families do not have the funds to pay privately for their stay when insurance no longer covers the charges.

Many people receiving home care while living in their own homes have expressed to me their feelings of isolation and depression. Sometimes they exhibit anxiety if family members are not available to be present around the clock, especially as patients become more dependent on others. Of course, each patient's home life is unique, some with lots of family and socialization and others with less. In comparison, a patient's anxiety level in long-term care can be relatively high upon admission, but later subsides as they become familiar with staff members and come into a trusting relationship with them. It seems to me the social setting in which patients live has enormous impact upon the quality of their lives. In the long-term care setting, patients have many staff and other resources close at hand when needed, whereas in home care these resources are not as immediately available. Chaplains, social workers and other healthcare staff play significant roles in the spiritual and emotional well-being of patients and residents. Patients who find meaning and purpose in a safe environment, in the midst of their medical diagnosis, seem to have a relatively good quality of life and cope better with their illness.

In both settings, the consistent challenge I face with patients is that many do not seem to know or understand their diagnosis and prognosis. There may be various contributing causes. This lack of information creates challenges not only for chaplains, but for other healthcare staff members as well. The physician is the member of the healthcare team who gives patients their diagnosis; other healthcare staff members are prohibited from providing this information to the patient even though they have knowledge of the diagnosis via the medical record. Given this circumstance, the patients and families find themselves in quite a dilemma as they attempt to make future healthcare plans together with staff with rather limited

medical information. My hope is that physicians will have better, easier access to chaplaincy services in the future, even as they deliver healthcare in their medical offices and practices.

Chaplains are patient and family advocates who can be helpful in guiding patients through the sometimes overwhelming processes in our healthcare facilities and systems. It is truly an honor to journey with patients, residents and families during these vulnerable times in their lives.

Lauren Marsh is a chaplain at Mercy Health Schroder in Hamilton, OH. Mercy Health Schroder is a part of the Mercy Health System and Catholic Health Partners in southwest Ohio.

Life's graces: Those in assisted living minister to me

By Victoria Lucas, MA, BCC

I knock at the door of a new patient, Mrs. Fay. Her daughter answers, "Chaplain Victoria?" I show my badge to Mrs. Fay, letting her examine my name and title and face. She looks at me with a smile of welcome. She is a small woman with a halo of soft white curls, seated demurely in a wing back armchair.

Mrs. Fay lives in the assisted living wing of one of the continuing care communities I visit as a chaplain with Holy Cross Home Care and Hospice in Silver Spring, MD, a member of the Trinity Health System based in Michigan. Her apartment is small and beautifully appointed, with furniture, paintings and family pictures from her former home. She tells me about how she and her late husband acquired these artistic pieces while they traveled for his work with the government. She and her daughter describe their various homes across the country and globe, before settling down in this area. I enjoy hearing their family story, seeing these artifacts of her life. Those items she brought with her to this pared-down studio space illustrates how she sees herself, her life, and those values she holds dearest. Without a word, Mrs. Fay and her daughter are filling in the details of my initial assessment. Whenever possible, I try to meet with family members during this initial visit. I often minister to family as much or more than to the patient, and their presence usually puts my patient at ease.

Now, we turn to the events that led to her coming to hospice service. Mrs. Fay fell and was hospitalized for several days; she did not bounce back and her other medical issues were exacerbated. Mrs. Fay explained she fell while trying to get out of bed. "I did not want to bother anyone."

This is a typical scenario, especially for persons living in assisted living apartments. Having recognized to a greater or lesser degree their need for extra assistance, they have given up their residences and moved to a place where their medications are monitored and distributed, meals are prepared and served in congregate dining rooms, group activities are planned. Mrs. Fay, and many others to whom I minister, wants to do for herself and preserve as much of her independence as possible.

Because Mrs. Fay is alert and oriented, I visit with her for a few minutes alone to talk about her fears, concerns and joys. She tells me she understands that her death is likely to come "sooner than later" and that she is content with that, unafraid, "because God will be with me then as he is now." She tells me she finds solace in the Eucharist. She invites me to come again.

I then speak with Mrs. Fay's daughter about her own concerns and fears. She and her siblings are saddened by this turn, but grateful they have the support of hospice. She explains their arrangement for visits and care. She and her siblings are clearly loving and supportive of their mother and each other. We discuss timing and details for my next visit, and the daughter expresses how pleased she is that spiritual care will be part of their hospice journey.

Just as I was about to offer prayer and Communion, the eucharistic minister from the nearby parish enters to take Mrs. Fay to the weekly eucharistic service. I introduce myself to her and collect information on the parish and details about the sacrament and Mass schedule at the facility.

She invites me to join the service and I readily accept. What a blessing to receive the ministry of another and feel the graces of Eucharist flow over me! This is an unexpected joy in the middle of my day.

Before departing, I head for the nurses' room, make a note in Mrs. Fay's chart, and outline my assessment and probable care plan and orders for our computerized charts. I greet the nurse for Mrs. Fay's unit and

introduce myself to the social worker for the assisted living unit who shares this office area.

While driving to see my next patient I smile as I think about Mrs. Fay's gentleness, acceptance, innate politeness, and the obvious family love she enjoys.

Recently, I have been reflecting on Mrs. Fay and my other patients living in assisted living communities. I fell several weeks ago and shattered my arm. I am unable to drive, write, tie back my hair, and cut up my meat – so many little “activities of daily living.” A friend offered to drive me to a doctor’s appointment. I insisted that I could close the car door and fasten my seat belt. “Alright, Ms. Independence,” my friend chided. That struck a chord. I humbly recognized Mrs. Fay’s attempt to do for herself in my own “assisted living” situation.

It takes grace to recognize what we can and cannot do. It takes grace to let those who love us, help us. It is then that we become a conduit of grace to them. We have a model in Jesus, he who accepted the help of Simon and Veronica along his own final walk. So I have a broken arm, not a terminal diagnosis. Today, I have an opportunity to practice assisted living, and feel the graces of that life flow over me in the middle of my career as a chaplain.

Victoria Lucas works for Holy Cross Home Care and Hospice in Silver Spring, MD, ministering to patients in their own homes, in skilled nursing, assisted living and independent living facilities. She also ministers to hospital end-of-life patients.

For many, home hospice means life lived in a richer way

By Davlyn Duesterhaus, MRS

Home hospice brings, with the program, a team of professionals, but most importantly, it brings a multitude of possible blessings, insights, and healing for the patients, families/friends, and even staff. Currently I am journeying with a patient who is in his 90s, has a compromised heart, and shows signs of some senility and confusion. He had to move to north Texas, where his daughter Betty and her family live, because he needed a dryer climate. Jane, his wife, remained in south Texas with her family. This is a second marriage for each of them. They visited on the phone one or two times daily to keep in touch. Joe mourned the loss of not being with Jane and oftentimes, in my visits, he would talk about how they knew each other from school days and yet went separate ways, marrying someone else. After their spouses died and a few years passed, they joined their hearts and vows in marriage.

In the initial patient visit, Joe repeatedly referred to himself as a bad person because he left his wife. Guilt was an issue as well. His life of going to church, studying the Bible, and trying to be a witness to his religion were no consolation for him. After several visits with Joe and hearing his life review, he shared a sermon that he remembered helped him. It was that sermon that contained the seed that unlocked his guilt and his viewing of himself as bad. Together with God's grace and mercy, we threw all that out the window of his room. He said his neck pain lessened and his heart felt lighter. In subsequent visits, Joe referred to throwing those thoughts out the window if they came back and to thanking God for taking the burdens away.

Some visits later, Joe's daughter contacted me to say Jane was now a hospice patient and dying. If Joe were to travel to see her it might compromise his health. The home hospice nurse and I met with Betty before going into her dad's room at the assisted living complex. During the conversation, I suggested that she and Jane's family try to use Skype so they could see and talk to each other. That afternoon Joe and Jane did visit by using the technology available. A few days later, Jane died. The nurse and I met with Betty and her husband prior to giving her dad the news.

It took some time for the news of her death to sink in, and when it did, he cried, talked, or jabbered to be more exact, and cried some more. After Betty noticed my eye contact with her, she moved toward her dad, hugged him, held him, and they cried together. Ultimately, all the details were worked out for them to travel more than 500 miles. Meds, oxygen, tickets, etc. were all handled quickly so they could leave the next morning.

After his return from the funeral, I went to see Joe. He was beaming as he shared the events of the few days, including his gratefulness to his daughter and son-in-law for getting him there. By going to south Texas, Joe realized more deeply, the many blessings they did have in the few years of being married – memories, companionship, roots, and love. He also came to know how many folks remembered him, missed him, and wished him well. Joe had struggles with abandoning his wife, being selfish, and being resented. He learned otherwise from the visit. Assumed feelings on the part of each family were proven wrong. Betty experienced a healing of her anger and felt her stepmother's family had a similar response. That journey has become a forerunner of Joe's final journey – Heaven.

It is an honor to serve the patients and families in our hospice program. The stories, the vulnerability witnessed, the struggle between living and dying, the various stages that intertwine with the physical decline, all make for a lived human document that unfolds as long as time provides. The story of Joe illustrates, in a minute way, how home hospice can affect or change lives of patients, families, and staff. Hospice chaplains have the privilege to be part of the blessings, insights, and healing in the hearts of their

patients. Feedback from most families and friends of the patients also reveals their realizing a new vision for living life in a richer way. An additional blessing for Joe in the days surrounding Jane's death was that of a son resuming contact with his dad. He had not been in communication for quite some time. I witnessed a twinkle in Joe's eyes and grin from ear to ear the day he told me that he had heard from his son who lives in west Texas.

"May I Walk You Home?" by Sr. Joyce Rupp and Joyce Hutchison, "The Four Final Things That Matter Most," by Dr. Ira Byock, and "Olivia," by Sister Olivia Prendergast (foundress of the hospice where I serve) are resources containing experience, knowledge, and true hospice stories. Using what I have learned from these books and remembering what patients have taught and still teach me, I give thanks to God for the 12 years of ministering as a hospice chaplain, both in home care and for the in-patient unit. Blessings, insights, and healings abound!

Davlyn Duesterhaus is staff chaplain assigned to the hospice program for the in-patient unit and home care, a part of the Baptist St. Anthony's Health Care System (BSA), in Amarillo, TX.

Dying patients thrive on ‘own turf’

By Allison DeLaney, BCC

I have been a NACC certified chaplain for the past six years (five in hospice care) and a physical therapist for the past 13 (in acute, rehab, and outpatient settings). This strange combination of careers has taught me a simple fact: timely matching of patient needs and wishes with placement is crucial for achieving patient goals. For example, if patients are truly at the end of their lives, then sending them to rehab is probably not the best plan. In fact, it probably will be counterproductive because the patient (and family) will inevitably spend energy working toward impossible goals aimed at progress.

Emotionally, rehab sets one up for the possibility of getting better. The thought process is, “My doctor would not have sent me to rehab unless she thought I was going to get better.” In contrast, if individuals who are dying are informed of their limited prognosis, and encouraged and guided on how to prepare, then their limited energy can be spent in a more meaningful way.

There are so many variables to consider when trying to support someone at the end of life: the doctor’s own view of mortality, the patient and family’s willingness to hear, the disease process itself, the doctor-patient communication process, the insurance company, and the financial resources.

I feel that home-based care, in most cases, supports the greatest choice, autonomy, and dignity at the end of life. When one is losing control of so many things – bodily functions, mobility, memory, and more – the familiarity of home can be of utmost comfort. In one’s home there are a collection of familiar smells, textures, pictures, memories and pets. So when it is possible, the home setting is an ideal place to accompany patients. They seem to thrive “on their own turf.” However, even though a patient’s wish may be to die at home, their physical needs may require more help than can be had at home – perhaps there is not a caregiver that can handle the amount of care, perhaps the logistics of the home make it unsafe for the patient, or perhaps it is financially impossible for the family. In these cases, I find myself learning to navigate with the patient through their lost hopes and disappointment in addition to the guilt of caregivers who feel that they have “failed.” Then together, we try to navigate the new setting and recalibrate our hopes to what is possible.

I also want to acknowledge those who adamantly don’t want to die at home. Some need to die trying every medical intervention the body can accept because anything else would feel like “giving up.” Some decide that they want to die in a facility so that they are not “burdening” their family or “leaving a bad memory in the house.”

In summary, I feel that home hospice is a wonderful option that should be offered to everyone. The way that one finds meaning at the end of life varies (and doesn’t always match my own ideal). So my journey as chaplain has been to educate myself on the myriad aspects that the patients have to reconcile in the time and place they have been given, and to support them where they are. In a strange way, the process of preparing for the end of life reminds me of when I was giving birth to my first child. I tried to prepare myself through facts, conversations, and consultation with the experts. I had an ideal that I wanted to achieve – no pain meds, breast-feeding, etc. – but in the end I just had to wing it in the moment and trust those available in my time of need. May we as chaplains be truly present to those nearing the end of their lives with their unique needs and expect the Spirit to guide us wherever we need to go.

Allison DeLaney is chaplain and bereavement coordinator for Hospice House and Support Care of Williamsburg VA

Teamwork, interdisciplinary efforts especially important in hospice work

By Linda Schlafer, PhD, BCC

Hospice is a home care service in that we visit our patients wherever they live. This may on occasion be in a hospital or hospice house, slightly more frequently in an assisted living facility, and most often in a nursing facility or private home.

Most hospice workers I know visit in all of these venues except possibly the hospice house, since not all hospices have access to a hospice house, and sometimes staff are assigned just to a hospice house when there is one. Generally, we are just known as "hospice" as distinct from other healthcare workers who go to homes (again, wherever people live) but do not provide hospice services.

I don't see hospice as "the wave of the future." I hope that it will continue to grow in people's acceptance as a healthcare option that is available to them, but I think this will continue to happen relatively slowly, primarily by word of mouth from families of patients who have had a good hospice experience. It is definitely positive for more people to know about and accept hospice services, and it would also be wonderful if many more people were willing to go to hospice services much earlier in the end-of-life experience. This often does not happen until close to the time of death, when family members are desperate for support and skilled services and can no longer avoid the knowledge that their loved one will die soon, with or without hospice. Hospices can offer much more by way of support and services if individuals participate for extended periods of time (i.e., as soon as they qualify, not in the closing days or hours of a person's life). Of course, we are willing to provide whatever help we can at any point in the process.

I was a hospital chaplain before I began working for hospice. Some things that have changed, or at least have taken on greater emphasis in my ministry, are that I provide more of what we call "intentional presence and comfort measures" than previously, as many of my patients are not conscious or are not able to carry on a conversation. I have also learned that patient conditions can change quickly in hospice, so while I might naturally want to have a period of weeks or months to initiate and develop a relationship, it is not uncommon that my relationship with a patient begins, develops, and ends in one visit, even if the patient seems alert and coherent. I don't always get another visit if a person declines quickly after that.

There is usually an interdisciplinary component in hospital chaplaincy, but teamwork and the weekly interdisciplinary meetings take on a much greater importance in hospice. In the hospital, my team was primarily made up of other chaplains. In hospice, I am the only chaplain and my team is made up of support staff, nurses, social workers, hospice aides, and the volunteer coordinator. Strangely enough, I was called to almost every death in the hospital, but in hospice, it is usually the nurse who makes the death visit, and the chaplain goes only if invited by the nurse for specific reasons.

Hospice care requires 24/7 primary caregiving by a family member, friend, or hired caregiver. Hospice is present in a home for the sake of the patient, but also for caregivers and family members, or anyone else closely associated with the patient. Hospice provides the services of all the team members mentioned above, plus volunteers who go to patient homes to provide an additional variety of services. This gives patient and family a lot of professionals in different disciplines to keep close watch on the patient and caregiver and to be accessible to them on a daily basis to answer questions, provide education, social and spiritual services, and hands-on care.

Aides and volunteers will even style hair and paint fingernails! This gives families and patients a kind of skilled companionship that raises morale, troubleshoots, and gives confidence in caregiving and in

knowing what to do at the time of death. Especially for an elderly spouse who is caregiving without other family support, this kind of companionship is essential. In all of the things I've mentioned, of course, there are great individual and family differences as to what is needed, what is tolerated, and what special conditions may apply. I find this a very interesting job due to the variety of personalities and situations involved and find it a great privilege to share this sacred space with our patients and families.

Linda Schlafer is chaplain and bereavement coordinator at the Hospice of Southwest Iowa in Council Bluffs, IA.

A time of change, a season of thanks

By Judith A. Shemkovitz, LPC, BCC

As this article is written, autumn has arrived and as you read it we are approaching Thanksgiving. With autumn comes the transition from the warmth of summer days to the cool crisp air of fall. As the trees relinquish the green of their leaves, we enjoy the yellow, orange and red that exemplifies this time of change. And November draws us to that time when our awareness of all that we should be thankful for is heightened.

These thoughts are no less apparent with the membership of the Certification Commission and the Interview Team Educators. As 2012 comes to an end, three commissioners will conclude their terms of service – Rev. James Yeakel, OSFS, Sr. Geraldine Krautkramer, OSF, and Sr. Janet Biemann, RSM, have served on the Commission for six years. We are grateful to all of them for their commitment and faithfulness to this role of service. And we thank Jim and Gerri for their leadership as commission chair and vice-chair.

Current commissioners Judi Shemkovitz, spiritual care coordinator for VNA of Ohio – Hospice, and Joseph Bozzelli, director of pastoral care services at St. Elizabeth Medical Center in Edgewood, KY, will serve as Certification Commission chair and vice-chair respectively. Of note, this is the first time in NACC history that board certified chaplains will serve as commission officers.

In 2012, Linda Bronersky, vice president of mission services at Wheaton Franciscan Health Care and Mary Denise Davis, director of the Spiritual Care Department at CHRISTUS Santa Rosa Health Care were appointed to the commission. And in 2013, Dr. Jane W. Smith, who is completing her service as the lead ITE, Dr. Gordon Hilsman, a retired CPE supervisor and Rev. John Bucchino, OFM, a CPE supervisor, will join the Certification Commission. Additionally, Carolanne Hauck, of Lancaster General Hospital, will assume the role of lead ITE. We are grateful to these members for accepting to serve the NACC in these positions.

The efforts of the Certification Commission and Interview Team Educators over the years have made our certification process a model for others. Many thanks to all.

Judith A. Shemkovitz, a member of the NACC's Certification Commission, is spiritual care and volunteer coordinator at the Hospice Care Center for the Visiting Nurse Association of Ohio.

Furry feline visited lonely, comforted dying

By Sandra Lucas, MDiv, BCC

For many years, a furry creature has roamed the halls of Mount St. Joseph Holistic Care Center in Waterville, ME. The creature is Jessi, a 16-pound Maine Coon cat. Jessi's fur is sable brown with streaks of black. He has a pink nose, white cheeks and bib, and four white paws. Jessi's job is to visit the residents at the long-term care facility. Seven days a week, he saunters down the hallway, tail raised high like a flag, making his rounds.

Jessi's job is important. He is a companion and friend to the residents, many of whom left behind a beloved pet when they came to the facility. One resident, Beatrice, still misses her cat, Casey. On her bedside table is a photo album of the pewter-colored Himalayan cat.

"I had to give Casey away when I got too sick to care for him," she said. When she came to Mount St. Joseph, she was thrilled to meet the friendly feline. "Jessi visits me every Saturday," she said. "He comes when my son visits." At first, her son would look for Jessi and bring the cat to his mother's room. Now Jessi just comes by around 6 p.m. on Saturdays. "I don't know how he knows it's Saturday," she marveled.

Jessi chooses his own schedule and routine. He likes to play with strings in the morning, rest in the enclosed courtyard in the afternoon, and have his neck and ears rubbed anytime. One never knows when he might stroll into a room, looking for a sunny window, a soft bed or, better yet, an open closet to nap in. Being 10 years old, he naps a lot on the job.

There's another important aspect to Jessi's work. When someone is seriously ill or dying, he keeps a bedside vigil, stretching out next to the person or keeping watch at the foot of the bed. Somehow he senses this important change and, along with the family and staff, he cares for the resident.

Mr. Woodbury spoke about Jessi's bedside vigil when his mother was dying. "I was unable to be there through the night," he said. "But I knew Jessi was sleeping by my mother's side. I could go home at night in peace, knowing Jessi was there in my place." For three days and nights, Jessi kept vigil. He never left Mr. Woodbury's mother's side, even when the nurse's aides would change the bedding or turn the resident. When Mrs. Woodbury passed away on the fourth day, as the morning rays broke through the darkness, Jessi jumped off the bed and left the room. His work was done.

Jessi's job description is multi-dimensional. He visits the lonely and comforts the dying. He lifts the spirits of residents and staff. He knows when residents are allergic or not cat-friendly; he never imposes himself on others. He takes a lot of naps. In exchange for his work, he receives room, board and medical coverage. He doesn't receive a salary. But Jessi has what money can't buy – friends who love him, meaningful work, and plenty of time for rest and play.

This article, originally published in The Town Line, South China, ME, was written by Sandra Lucas in beloved memory of Jessi, who died in 2006 after bringing joy to countless residents, families, and staff. Ms. Lucas is a member of the NACC's Editorial Advisory Panel.

Therapy dog Henrietta a favorite

Please join us in recognizing Henrietta, our therapy dog, for her 13 years of service at the Hudner Oncology Clinic at Saint Anne's Hospital in Fall River, MA. Henrietta died last year. Henrietta, together with Sister Thomas More, a Dominican Sister of the Presentation of the Blessed Virgin Mary, greeted many of our patients and families during their visits to the clinic.

The story began when Henrietta was literally born in our parking lot on the day her owner, a patient at the clinic, came for treatment. Thanks to the generosity of one of our oncology physicians she became our waiting room dog, and was named Henrietta by Sister Thomas More.

Henrietta was ultimately adopted by an oncology nurse. The nurse and her family provided a loving home for Henrietta and brought her to the clinic where, under the supervision of Sister Thomas More, Henrietta did her "ministry." Henrietta was a favorite of staff, visitors and patients. She will always be missed and fondly remembered.

Revised and reprinted with permission of "News You Can Use," Saint Anne's Hospital, Falls River, MA. March 26, 2012.

2013 NACC National Conference plenary speakers announced

By Susanne Chawszczewski, PhD

As the 2013 Conference Planning Task Force continues to work on bringing quality to your conference experience, they have identified and confirmed four plenary speakers who will bring the theme of "Three Rivers Converging: A Call to Faith, Identity, and Action" to fruition during the conference. As the image of the three rivers of faith, identity, and action converge in our call, we embrace the invitation to be ministers of the church, professional spiritual care providers, and people of hope. In keeping with the conference theme and issues, the committee is happy to present the roster of Plenary Speakers for the 2013 Conference in Pittsburgh, PA, April 13-16, 2013.

Saturday, April 13, 2013

Opening Plenary Speaker

Rev. Donald J. Goergen, OP, Ph.D.

Father Donald Goergen is a Dominican priest, teacher, lecturer, and author. He has taught, lectured and given retreats in Asia, Africa, and throughout North America. He was previously provincial for the Dominican Friars of the Central Province as well as president of the Dominican Leadership Conference. He co-founded the Dominican Ashram, a contemplative Dominican community and ministry of prayer, in which he lived for nine years. He previously taught and currently teaches at the Aquinas Institute of Theology in St. Louis, MO, where he is also prior of the formation community. Father Goergen's doctorate is in systematic theology, his dissertation on Pierre Teilhard de Chardin, and his current interests include contemplative traditions, East and West, the evolution of consciousness, and the thought of Thomas Aquinas as a spiritual master. He has published many articles and 10 books in the areas of Christology and Christian spirituality, including "Fire of Love, Encountering the Holy Spirit" (2006). Among other honors awarded him, he is the recipient of the 2010 Yves Congar Award from Barry University in Miami, FL.



For some recent MP3 homilies (Sept. 23, Sept. 9, Aug. 19, and July 15) by Father Goergen, please see the Saint Louis University Saint Francis Xavier College Church website at: www.slu.edu/college-church/quick-reference/homilies

Sunday, April 14, 2013

On the topic of Faith

We are a people of faith. It is this faith, propelled by our baptismal call, that is the grounding and source of who we become. Our faith is a river that moves and motivates us in our ministry.

Neomi DeAnda, Ph.D.

Neomi DeAnda, a Tejana, is a faculty member and director of the Oscar Romero Scholarship Program, the Hispanic Theology and Ministry Program at the Catholic Theological Union in Chicago, IL. She holds a doctorate in constructive theology from Loyola University Chicago, where she wrote a groundbreaking dissertation retrieving the writings of Sor María Anna Águeda de San Ignacio (Puebla, Mexico, 1695-1756) that focused on images of God and Imago Dei as understood through the image of Mary's breast milk. She received a Hispanic Theological Initiative Fellowship for this project. She also holds master's degrees in theology and educational leadership. Her research interests include religious history of 17th-19th centuries' Mexican convent nuns, religion and culture, feminist studies, religion and Latino/a theologies and pedagogies. Ms. DeAnda also serves as the treasurer for the Academy of Catholic Hispanic Theologians of the United States (ACHTUS) and co-chairs the Latino/a Religion, Culture and Society Group of the American Academy of Religion.

Recently, she was named by the *National Catholic Reporter* as one of 12 Catholic women under 40 making a difference in the church. For a copy of the article, you can go to: ncronline.org/news/people/12-catholic-women-under-40-making-difference.

Monday, April 15, 2013

On the topic of Identity

We are ministers of the church and compassionate listeners who provide a healing and caring presence. Our identity is a river that challenges us to claim our roles as Catholics, as professional chaplains and CPE supervisors, as members of the NACC, and as active participants in the broader society.

Rev. Myles N. Sheehan, SJ, M.D.

Father Myles Sheehan has served as the provincial of the New England Province of the Society of Jesus since 2009 and is responsible for the Jesuits and their ministries in the New England area. Prior to beginning this position, Father Sheehan served as senior associate dean for Loyola University Chicago's Stritch School of Medicine. He also directed the Ralph P. Leischner, Jr. Institute for Medical Education and served as professor in the Department of Medicine. He received a faculty fellowship from the Project on Death in America from 1999-2001 and developed the Recovering Our Traditions curriculum aimed at improving end-of-life care in the Catholic community. Prior to that he also served at Boston's Beth Israel Hospital and as an instructor in medicine at Harvard Medical School, where he developed a curriculum in geriatric medicine. Father Sheehan graduated from Dartmouth Medical School in 1981 and trained in internal medicine and geriatrics through the Harvard Geriatric Fellowship Program. In 1985, he entered the Society of Jesus, New England Province, and was ordained to the priesthood in 1994. He also holds a master's degree in philosophy/healthcare ethics from Loyola University Chicago and a master's of divinity from Weston Jesuit School of Theology. In 2006, he co-edited (with Kayhan Parsi) the book "Healing as Vocation: A Medical Professionalism Primer."

Father Sheehan is the co-host of "Aging Gracefully," a five-part miniseries addressing issues for the elderly on CatholicTV. Watch an episode on Fears, Health and Psychological Issues at www.catholicTV.com/Fears-health-psychological-issues-aging.aspx.

Tuesday, April 16, 2013

On the topic of Faith

Our faith and identity drive us to take what we have learned and use it in the service of our ministry. Action is a river that impels us to make an impact on our environment and to grow spiritually, to be ministers of the church, professional spiritual care providers, and people of hope.

Sister Carol Keehan, DC, RN, M.S.

Sister Carol Keehan has served as the ninth president and chief executive officer of the Catholic Health Association of the United States (CHA) since 2005 and is responsible for all association operations and leads CHA's staff at offices in Washington, DC, and St. Louis, MO. She has worked in administrative and governance positions at hospitals sponsored by the Daughters of Charity for more than 35 years, including Ascension Health's Sacred Heart Health System, Providence Hospital, Sacred Heart Hospital and Sacred Heart Children's Hospital/Regional Perinatal Intensive Care Center. She serves on numerous boards and committees, including health, labor, and domestic policy committees of the United States Conference of Catholic Bishops (USCCB). Among her many awards, Sister Carol Keehan has received the *Pro Ecclesia et Pontifice* (Cross for the Church and Pontiff) from Pope Benedict XVI and the Leadership Conference of Women Religious (LCWR) 2011 Outstanding Leadership Award. In 2010, she was named one of *Time* magazine's "100 Most Influential People in the World." She earned a bachelor's degree in nursing from St. Joseph's College and a master's degree in business administration from the University of South Carolina, Columbia.

For more information about Sister Carol Keehan including articles and videos, please visit www.chausa.org/Pages/About_CHA/Presidents_Page/Overview/.

Q&A with Sister Colleen Settles, OP

By Sandra Lucas, MDiv, BCC

Sister Colleen Settles, OP, chief mission integration officer for Providence Health and Services, Southern California Region, believes the current changing healthcare landscape requires chaplains to have courage, foresight, and creativity, and to pay attention to the building of relationships with physicians and other clinicians.

Sister Colleen oversees a mission team consisting of six mission directors, a regional ethicist and regional director of CPE. This mission team is responsible for the mission, spiritual care, and ethics of five acute care medical centers, palliative care, hospice, home care, and 352 physician practices at multiple care sites.

She holds a doctorate in ministry from McCormick Theological Seminary, Chicago, and a master's degree in religious studies from Loyola University Chicago. She is a board certified chaplain with the Association of Professional Chaplains. Sister Colleen recently took the time to answer questions for *Vision*.

Q Can you share with us a little about your background?

A As a Sinsinawa Dominican Sister for the past 44 years, I have had the chance to work in various ministry settings, beginning in the classroom and moving into youth and adult religious education in Catholic parishes in Madison, WI, and Minneapolis, MN. After CPE training in Minneapolis, I began my chaplaincy journey in South Bend, IN, moving to Mission Hills, CA, to become the director of spiritual care. From this setting I moved into the mission leadership role 14 years ago which allowed me to use my pastoral skills on an administrative level and within the larger community.

Q The traditional framework of spiritual care has been an acute care model. As healthcare moves into a new model that is based on wellness and outpatient care, how do you envision spiritual care services changing?

A Traditional spiritual care, provided within an acute care setting, has not required the chaplain to become a strategic partner with the physician. In acute care, the patient was seen by a member of the spiritual care team without the physician necessarily requesting this intervention and often not being aware of how the work of the chaplain contributed to the well-being and healing of the patient. The presence of a chaplain has at times been taken for granted as a part of the care team, especially within the faith-based hospitals. But if chaplains are to remain a vital part of the care team, it is important to find that new care team, and pay attention to the building of relationships with physicians.

I envision a spiritual care team located near or on the campus of a hospital with some of the staff specifically trained for and assigned to the acute care setting. I also envision a wider range of chaplaincy specialties within the team and available for ministry in various other venues. Some may be connected with home health and hospice and others with palliative care (whether the patient is in the home or hospital, these same chaplains would follow their care).

Chaplains would also be assigned to the various physician clinics, not to spend time visiting with the patients initially, but spending time building relationships of trust and understanding with the physicians and clinic staff. Physicians and their staff need help in identifying clients who may benefit from the ministry of a chaplain. The death of a spouse or the diagnosis of a life-altering illness may never bring this person to an acute care hospital yet they may clearly be in need of spiritual care. This visit may come in

the form of an initial phone call by the chaplain for an assessment and may proceed to an actual visit to the home or an appointment at the physician office.

Q What do you see as some of the challenges, or training needs, in this transition of spiritual care services?

A Chaplains have traditionally moved freely around the hospital with an open door to almost any patient. The initiative for the visit was generally from the chaplain and the setting was private or at least semi-private with the patient being fairly immobile. In working with patients from a physician's office, or any other outpatient setting, the patients are in transit and involved with day-to-day life. Finding a sacred time and space may be more challenging. Even more challenging may be meeting someone over the phone for a first encounter, or through e-mail, thus finding it more difficult to connect on a heart level. While those of us over 50 may find this intimidating, I need to remember that many younger people find making friends very easy over social media. My level of discomfort with new methods of connecting may not be as difficult with other generations.

Also, learning the community resources becomes more important, especially learning the resources available through the hospital for outpatients. Knowing how to access community resources as well as the more familiar resources of faith communities will be important for community-based spiritual care.

Q How does your role as chief mission integration officer drive your passion for developing and supporting spiritual care providers?

A As healthcare takes on its new forms and venues, I have a passion for moving into new directions for two reasons. First, there will be fewer and shorter in-patient stays and thus there will be a need for fewer in-patient chaplains. At the same time, those needing the ministry of a chaplain will not decrease but this community-based spiritual care may not be available to our patients unless we have enough courage and foresight to prepare now – and not turn away from the challenge and opportunity. Secondly, as physicians intentionally work with chaplains as strategic partners in the health of their patients, these physicians can see firsthand the power of spirit in the work of healing, thus enhancing their own skills as physicians in providing holistic care – body, mind and spirit. Excellent chaplains on their teams will help seed their practices in the mission and values of Catholic healthcare.

Q Any additional thoughts you would like to share?

A There are many challenges that are not addressed in this brief article but worthy of note. Payment structures for spiritual care are still based out of the acute care model. As healthcare financing evolves, it is important to speak up loudly for the healing presence of a chaplain in all of the settings which can actually reduce overall costs, especially within a palliative care setting.

As spiritual care is integrated into the various settings, it is important to have the electronic medical record reflect the presence and work of the chaplain within all settings as well as developing a referral method within the medical record as with all other disciplines. This interconnectivity can also be important for continuity of spiritual care across the continuum.

This can be a very exciting time for those in spiritual care and it calls for great creativity. The entire model for healthcare is transforming before our eyes. Yet while the locus of healthcare may change, the basic human needs of the heart and spirit do not go away – the need for community, for hope, for reconciliation, and for the touch of the sacred, remain. Therefore, I do not see the basic spiritual care service changing, rather the locus of that care and the naming of new partners in identification of need.

Sandra Lucas is regional director of spiritual care for Humility of Mary Health Partners in Youngstown, OH.

Dog ministry: Bringing together dogs, prayer, nursing home residents

By Jerilyn E. Felton

Introduction

It cannot be doubted that America is a land rich in dog-human relationships. As the population ages, the pets who had become a vital part of the lives of senior pet owners are often required to be left behind because they cannot accompany their ill or infirm owners to healthcare facilities. Though there are national organizations that prepare volunteers to visit these seniors (Delta Society, 2008), there appears to be a vital piece that is missing in this comfort and care. That piece is a comprehensive program for dog visitation that specifically addresses the spiritual/pastoral care needs of elder individuals, building on dogs' natural ability to draw people together "almost like ... a magnet" (Baun & Johnson, 2010).

See also:

Four-footed ministers in formation: A dog ministry prayer group gathering by Jerilyn E. Felton (pg. 27)

Furry feline visited lonely, comforted dying by Sandra Lucas, MDiv, BCC (pg. 17)

Therapy dog Henrietta a favorite from Saint Anne's Hospital, Falls River, Massachusetts (pg. 18)

Perhaps it was fortuitous then that a study on the use of dogs in ministry was undertaken in Beaverton, OR, a suburb of Portland, a city that at one time had been voted the dog-friendliest city in the country. Over the course of nine months, the author, with the assistance of the director of spiritual services at Maryville Nursing Home and a ministry volunteer at Maryville, conducted a qualitative study with long-term resident volunteers. The aim of the study was to discover how a preliminary "road-tested," safe, effective, and repeatable program could be designed to address the spiritual and pastoral-care needs of the long-term elder residents. What emerged was the Four-Footed Ministers Pastoral Care Program that sketched the outlines for the ministry with dogs.

Methodology

Study design presented several challenges beginning with the issue of defining and measuring spiritual and pastoral care. Johnson, Bell, Crowley, and Piderman pointed to the first difficulty – that of defining spirituality as well as how to determine "empirically measurable results" in pastoral care (Johnson, Bell, Crowley, Piderman, 2010). In a previous study (Felton, 2005), the researcher had drawn upon the work of Rabbi Dayle A. Friedman, where the story told by the person needing spiritual and pastoral care became the way for the pastoral care provider to access the inner life of that individual, much like unearthing the meaning of a scriptural story through interpretation on many different levels (Friedman, 2001). Not only were the outlines of the long-term care residents' stories captured in the researcher's notes from one-on-one visits, but also dog-ministry prayer-group interactions were analyzed, and a summary of these encounters was used to define the various templates for the program.

From September 2010 to May 2011, the researcher and ministry volunteer visited the study participants weekly during a two-hour window (10 a.m. to noon). These human ministers conducted one-on-one interactions, building a relationship with each person through the connections facilitated by their four-footed ministerial companions, Alya and Caterina. At approximately the halfway mark in the study, a dog-ministry prayer-group service was added and continued through to the conclusion of the study.

In May 2011, the study participants were given the opportunity to respond orally to questions in a survey administered by the researcher (Felton, 2012). Though the researcher realized that she had become well-liked, and impartial evaluation was difficult, the fact remains that program for dog ministry was affirmed as valuable to the spiritual life, as the following response illustrates. When asked to "tell why or why not 'dog

ministry' made a difference in your relationship to God," one resident said, "I never thought about having a relationship between dogs and God. I never made a connection of any kind. I have recently thought about the funny things I did with my dog because of the story of Merea" (Merea is the dog in "The Master's Companion: A Christian Midrash," a book written by the researcher and used in Maryville dog ministry prayer group gatherings. See author's note and sidebar.).

Results: Burdens and benefits revealed

Throughout the study, there were several challenges that had not become evident in the initial design. One of the first challenges encountered was the busy lifestyle of the long-term care residents. The original visitation day for one-on-one visits had to be changed because many study participants left on outings. The visitation day moved from Fridays to Thursdays. When the dog ministry prayer group services began in January 2011, it was difficult to find a consistent gathering location. With the help of the director of spiritual services, the teams were able to gather with the participants, though the location differed from week to week. Finally, though a volunteer moved out of the facility and death overtook two of the study participants during or shortly after the conclusion of the research, it was still possible to determine that spiritual and pastoral care interactions using the dogs appeared to be effective.

As challenges were encountered and surmounted, many strengths of a program for dog ministry were revealed. First and foremost was the chance to take advantage of a dog's social lubrication gifts, "strongly supported by empirical data" (Hart 2010), and use these gifts to create a bond to another person. This person could then enter the spiritual plane, a dimension noted but not extensively studied (Gammonley & Yates, 1991).

From the beginning, two of the integral qualities of a program, safety and liability, were defined and highlighted. While many in ministry have been using their dogs in ministerial interactions, these casual encounters have the potential for leaving the facility and the pastoral care provider in jeopardy of lawsuits if an accident should occur. Therefore, the protocols for safe interactions between humans and animals developed by Pet Partners® (Delta Society, 2008) provided the necessary foundation to ensure that the dogs used in the Four-Footed Ministers Pastoral Care Program were appropriately trained and registered. Further, it was evident to the researcher that if the owner/handler and dog had been tested for compatibility and predictability by an independent agency and were already covered by a general liability insurance policy, administration and infection control departments would more readily accept a comprehensive dog ministry program.

Other objections raised to a ministerial visitation program had easy solutions. It had been suggested that having a resident dog or using virtual pets would make a program unnecessary. While a resident dog would allow for continual care and comfort of the residents (Cusack & Smith, 1984), the care for the animal could create additional stress on staff. The researcher discovered that effective spiritual and pastoral care depended heavily on a foundation of an exclusive relationship of the dog with the pastoral care provider, a factor not possible if the dog did not have that exclusive relationship already established (Felton, 2012). As to the successful use of virtual pets to reduce stress or the use of stuffed animals (Wells, 2005), the researcher discovered that virtual pets appeared to isolate individuals rather than bring them into community and thus had the potential to increase loneliness and isolation.

Implications for future dog ministry programs

The most extensive discussion in refuting other solutions to the problem of integrating a canine companion into ministry revolved around the whole issue of dogs functioning as ministerial partners. There seems to exist an unwritten warrant that ministry is a service rendered from one human person to another (United States Conference of Catholic Bishops, 2005). The researcher argued that this stance needed to be re-examined in light of other theological voices from within the history of the church that sang a different hymn of creation. More often than not, these voices had been drowned out by the traditional theological giants of church history, e.g. Saint Augustine and Saint Thomas Aquinas. Recovering perspectives that

spoke of a theology that more adequately encapsulates the 21st-century worldview of the interconnection and salvation of all creation, the researcher discovered that using a system-sensitive lens for church history built upon a theory of the evolution of the human spirit (Armour & Browning, 2000; Graves, 1970) pointed to the need to re-examine ministerial activities. Discovering possibilities for dog ministry can be viewed as acknowledging that the Holy Spirit is constantly at work within the church creating new ministries and forming new ministers for service, whether they be of the two-legged or four-legged variety (United States Conference of Catholic Bishops, 2005).

Beyond the philosophical and theological discussions that happen within spiritual and pastoral care circles, responses from several of the participants in the Maryville program reveal a simple truth that dogs made a difference:

Respondent A: "I felt that touching and being touched by the dog was important."

Respondent B: "Well, from a personal standpoint, I never thought of any connection between the dogs and ministry; it just forms another channel that is beneficial."

Respondent C: "Well, we all love the dogs and care for them. And we get the sense that the dogs feel the same way about us."

Respondent D: "The way the dogs looks up to us gives us a lesson of how we should look up to God."

Conclusion: What's next?

Given the vision that all of creation is important to God and that human beings have been designated as stewards for that creation, this research and the researcher's experience with the dog ministry program at Maryville Nursing Home illustrates that dogs do have their place as ministers alongside their human counterparts. Participant responses confirm the value of dog-human interactions in a spiritual and pastoral care setting defined by a comprehensive dog ministry program. The structure for dog ministry developed at Maryville is a small step on a road of discovery investigating the ministerial role of four-footed ministers to various populations in various venues.

Author's Note:

Jerilyn E. Felton, Four-Footed Ministers Pastoral Care Program coordinator, Maryville Nursing Home, was assisted in her research by Sister Josephine Pelster, SSMO, director of spiritual services, Maryville Nursing Home, and Barbara Miller, Four-Footed Ministers Pastoral Care Program volunteer. This research was supported by a ministry grant from the Sisters of the Holy Names of Jesus and Mary.

The book titled "The Master's Companion," referred to in this article, offers readers a new look at the Gospel message through midrash, an ancient storytelling tradition that uses imagination to fill in the gaps within the biblical narrative. In the Judaic tradition, the rabbis, or teachers of Scripture, used these imaginative stories to draw out the meaning of God's word. The stories served as metaphors that pointed to the deeper truths of God's message. "The Master's Companion" is an imaginary tale about Jesus and the small black dog with a white foot that Jesus heals. The dog accompanies Jesus during critical moments in his life. At times, Jesus uses the dog as a springboard for telling a short story, or parable, in order to draw out meaning from familiar stories found in Scripture.

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Four-footed ministers in formation: A dog ministry prayer group gathering

By Jerilyn E. Felton

Research notes

Lesson on animal welfare

Chapter 5 ("The Master's Companion")

Note Date: 3/31/11- Quality of animal welfare

Thanks to Sister Josephine Pelster's efforts, providing the attendees with the Scripture for today and her gathering them together, we met in the community room in a space that was very comfortable for all concerned. Today, there were no interruptions, even though the space was an open one by the piano in the community gathering space.

The four of us (Barbara¹, Caterina, Alya and me) arrived early and visited briefly with individuals who were coming out of Mass who wanted to pet the dogs. It was difficult because of the traffic congestion that stopped residents caused. We tried to draw individuals aside in order to keep the area open.

We had a short meeting with Sister Josephine to discuss the unexpected passing of "L" that happened on the previous Sunday, as well as get a sense of improvements for our visits/prayer services. The residents who attended the prayer service commented on the memorial that will be conducted for the individual who had died.

We had a total of nine attendees come today and everyone appeared to enjoy the time we were together

See also:
 Dog ministry: Bringing together dogs, prayer, nursing home residents by *Jerilyn E. Felton* (pg. 23)

 Furry feline visited lonely, comforted dying by *Sandra Lucas, MDiv, BCC* (pg. 17)

 Therapy dog Henrietta a favorite from *Saint Anne's Hospital, Falls River, Massachusetts* (pg. 18)

Service as designed		Service as conducted
Call to prayer	With individuals seated in a circle: begin with "Let Us all be in God's Spirit, and we begin this time of prayer and meditation in the name of the Father, and the Son, and the Holy Spirit. ² "	I used the prayer to gather us into a community.
Silence	Time for centering and connecting to Spirit.	I paused only briefly here. I tend to think that this population will benefit from a short pause rather than a long break. A short break helps the group to center, whereas a long pause might hinder the sense of community and the

		attentiveness needed for prayer.
Welcome:	Welcome back to our circle of wisdom where we can share our stories of our canine companions and other beloved animals sharing the lessons they have taught us. Today's lesson is that of animal welfare. The question we should think about today is: How did my concern and care for my pet reflect God's loving concern and care for me now?	I followed this section's outline and feel that the placement of the question here, to be repeated after the story worked well.
Scriptural reading	Read Chapter 5 of The Master's Companion , pages 79-93 (whole chapter).	I actually read pages 79-88 where there seemed to be a natural break. Everyone seemed to enjoy the story, including a new resident who seemed to be very engaged in what was happening in it.
Silence	A period for reflection.	Silence will not work well here. I moved immediately into the reflection question.
Faith sharing time on animal welfare, a reflection of God's love and care for us.	Time for sharing of stories about past experiences related to animal welfare. The question we should think about today is: How did my concern and care for my pet reflect God's loving concern and care for me now?	I repeated the question and opened the floor for stories. Since no one was coming forward, I asked Joseph , who seemed to want to contribute, to tell us a story. He stated he had told his story previously, but Barbara encouraged him to tell it again as many had not heard his story the first time he told it. Thus, Joseph retold the story about his dog. A resident then shared a story about his dog, who ran with a pack of dogs and often returned to the family after absences of a few days.
Next session	"At the Foot of the Cross" (Chapter 6) – Jesus Reconciled All Creation – Including Animals – to the Father taken from Luke 23:	I mentioned the Scripture that was to be read for the next week.

	32-33; John 19: 38-40; Matt 27: 62-65.	
Conclusion: Sending forth	Let us now pray... "Almighty God, as we reflect on the beauty of your creation, let us go into our community to spread your joy, love and peace. Amen"	As there were retired members of the clergy present, I asked for a blessing. A member of this group provided us with another story, and after finishing, I concluded with the final prayer.

¹ Ministerial partner in the study and her dog, Caterina.

² After the Maryville study concluded, the wording of the gathering prayer was changed to reflect a more interreligious focus.

³ Jerilyn E. Felton, *The Master's Companion*, St. Mary's Press: Winona, MN, 2007.

⁴ In order to insure confidentiality, the individuals in the study were assigned biblical names.

⁵ The weekly gatherings now include a time for vocal prayer petitions before the concluding prayer is offered. This additional segment illustrates how the dog-ministry prayer-group gatherings continue to evolve.

Autumn, winter prepare us for the Fifth Season

By Isabelita Q Boquiren, BCC

“A changed heart you will not spurn.” – Psalm 51

Autumn or fall is a beautiful change from the scorching heat of the summer sun. It brings forth something kinder, softer – the embrace of a gentle breeze, mild mornings and a change in foliage.

Ah, the change in fall foliage is intriguing and captures one’s vision. Bright reds and purples burst forth across parks, woods, highways and even in gardens. Picking up leaves one day led me to ponder: Why do the leaves change color in the fall? This simple question, probed deeply, lends time for spiritual reflection. As the days grow shorter in the fall, light and dark are equal. This phenomenon allows trees to “know” to begin getting ready for winter. What does this message say to us?

As life’s shadows lengthen, we begin to prepare for our individual winters. The change in colors of the autumn leaves marks a movement of heart and spirit. We are nudged to look back gently, reflecting on how we lived out the other seasons of the year. Perhaps we spilled energy on many things of youth, some immediate wants, other essential and non-essential desires. We recall the seasons, not to beat ourselves up over mistaken priorities so much as to take inventory and place our hope in those things that have been running deep within us that are eternal. We shed any leaves of guilt, shame and regret. It is a time of letting go. The leaves turning brown and falling to the ground are a metaphor for “death” or abandoning our personal non-life-giving habits, lifestyle, or attitudes.

Our hearts, contrite and humbled, lead us to plead, “Create a clean heart for me, O God.” The surprise perhaps is that the colors of the leaves in the fall are already within them; they simply were covered by the green chlorophyll dominant during the warm seasons. Autumn is a “revelation of something already there.” We, too, have a foretaste of Heaven within us – the gifts of love, peace, goodness, kindness, beauty and holiness. All have been there all this while from birth when, out of silence, God uttered the word, and each one of us came to be. The time when we prepare to offer full response to God’s gifts is a spiritual autumn. It is a time to manifest the change running deep in the core of our hearts.

Winter comes like a quiet visitor, observing as it envelops the sacred stillness of hearts, only to unfold the mystery of the purity of love, humility and freedom – the beginning of the Fifth Season, when life will become full circle, and Heaven, home.

Isabelita Q Boquiren is chaplain and patient advocate at Carondelet Holy Cross Hospital in Nogales, AZ.

Featured Volunteer: Mary Ann Gorelczenko

Name: Mary Ann Gorelczenko

Work: Nurse manager for Homefront Health Care in Woonsocket, RI, and chaplain and parish nurse at St. Brigid Church, Johnston, RI

Member since: 1996

Volunteer service: NACC liaison for Rhode Island

Book on your nightstand: Rather than a book, on my nightstand is my radio, set to classical music selections.

Books you recommend most often: "Love, Medicine and Miracles" series, by Bernie S. Siegel, MD

Favorite spiritual resource: I often use the Sacred Scriptures in my personal prayer and beyond. Sacred Scripture offers me the best insights about love of God, self and others. My favorite quotes are Micah 6:8 and Romans 12:9-16. I am able to name my favorite spiritual themes of the Incarnation (God-With-Us), having a missionary Spirit in all things, and God's Triune Love as meaningful to me and my path of life.

Favorite fun self-care activity: Nature walks, swimming, boating, and listening to music

Favorite movies: "A Christmas Carol" (1951), with Alastair Sim.

Favorite retreat spot: Jesuit Center in Wernersville, PA.

Personal mentor or role model: Father Thomas Augustine Judge, CM, founder of the Missionary Cenacle Family. My ability to cherish and deepen my spirituality in love of God and neighbor can be attributed to my formative years as a Missionary Servant of the Most Blessed Trinity Religious Sisters, whose founder is Father Judge, a Vincentian priest from Boston. He also founded the Missionary Servants of the Most Holy Trinity Priests and Brothers, and the Missionary Cenacle Apostolate, a laity group.

Famous/historic mentor or role model: Henri J. Nouwen, who is best known for his book, "The Wounded Healer." Henri Nouwen presents a theology of service that begins with the realization of the fundamental woundedness in human nature, which can be a source of strength and healing for oneself and others. Ministers are called to recognize the suffering of their time in their own hearts and make that the starting point of their service to others. How fitting for a chaplain!

Why did you become a chaplain? To walk together with another on an Emmaus journey (Luke 24:13-35)

What do you get from NACC? It is a support in terms of chaplain identity, professionalism, accreditation, education, and peer support.

Why do you stay in the NACC? For strength and enlivenment.

Why do you volunteer? I volunteer to help to bring chaplains together and to help provide opportunities for NACC activities.

What volunteer activity has been most rewarding? Experiencing the Triune God's presence with the chaplains gathered together in a conference prayer setting. I am in awe of what is created at that time and am grateful to be part of the planning that makes the space for such an encounter.

What have you learned from volunteering? Volunteering is work! It is an intentional activity from the heart and soul of a person and a gift to others with the purpose of contributing to the good of one and all.

Biography tells amazing story of Sister Thea, who shared her gifts through song, word

By Bruce Aguilar, BCC

Thea's Song: The Life of Thea Bowman. By Charlene Smith and John Feister. Orbis Books, Maryknoll, NY, 2009. Hard-cover, 319 pp. \$28.

This biography reads like a novel – the story of young Bertha, a young black girl from Canton, MS, who at age 15 makes a decision to commit herself to a new life in a faraway place, leaving her beloved home and family. Along the way, she falls in love with the work of a fellow Southerner, William Faulkner, becomes a teacher, studies further in our nation's capital, and visits Europe.

Increasingly exhausted by terminal cancer, this woman perseveres to share her gifts through words and song with many, both in her church and across the land. Bertha became Sister Thea, (whose mother, a teacher, was Episcopalian and whose father, the town doctor, was Methodist), one of the most inspiring Roman Catholic nuns of the 20th century United States.

Two authors present the story: Charlene Smith, fellow Franciscan Sister of Perpetual Adoration (FSPA), one year ahead of Thea in the convent and later her friend; and John Feister, a religious journalist and editor of Saint Anthony Messenger Press. Their book contains various writings, speeches and quotes by, and about, Thea – gathered from interviews, the FSPA archives and elsewhere. These words are complemented by photographs that run the gamut from Thea's parents (before her birth) to Thea's memorial liturgy. One sees her singing, hugging Muhammad Ali, being interviewed for "60 Minutes," and, in a famous portrait while she underwent cancer treatment – dressed in African clothing with a beautiful smile, her head now bald, with Jesus on the cross behind her. The only media lacking, of course, is Thea in sound.

Consider this book if you feel curious about someone who could make, at an early age, a commitment that she kept for all her life; someone who became an expert communicator through song and word; someone who returned to her identity – as a black Southern woman – while called to conform to a curious white world up North and in many parts of the country during a time of racial struggle; someone whose life was put on pause in high school by a diagnosis of tuberculosis, and whose life ended while living with cancer; someone who managed to weave her life's song out of all of her experiences and deeply trust that her God would let "this little light of mine ... shine."

Perhaps one thing puzzled this reviewer. While some modern-day "saints" – Salvadoran Archbishop Oscar Romero comes to mind or perhaps Dorothy Day – express great inner struggle and transformation as they seek God's call, Thea seemed to live as a steady vessel through her illnesses, racial injustice, and decision to join the FSPA congregation as a teenager.

How did she decide to join the Roman Catholic church at age 9, then leave home for a motherhouse in the white North at age 15? Bertha's friend Flonzie called attention to the impact made by the nuns in their hometown of Canton, MI, "This is one of the things that Thea talked about: one of the things that won her to the Catholic faith was not the liturgy or the doctrine, it was that these nuns would walk the streets and find these children...." (p. 36).

Bruce Aguilar, BCC, works as a staff chaplain at Spaulding Hospital Cambridge (long-term acute care facility) and Spaulding West Roxbury (long-term nursing and therapy center) in Massachusetts. He lives in Belmont with his wife and son.