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Palliative care focuses on living life fully, with meaning

By Jane Mather, MA, BCC

Despite the many impressive technological and pharmaceutical advances that modern medicine has enjoyed in the last century, there remain emotional barriers to the way these medical advances are or are not applied. These vary by individual patient and individual physician. Medical science strives for evidence and proof and yet it is also practiced as art – as subjective and based on the interpretation of personal values.

There is no field of medicine more impacted by this subjectivity than palliative medicine. In a recent survey done by the Center to Advance Palliative Care (CAPC), it was determined that 70% of consumers have no understanding of what palliative care is. This lack of understanding is one major barrier to care that is best described by the CAPC survey as follows:

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis.

The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment."

By definition, the word "palliative" refers to relieving symptoms (rather than intending cure) and thus improving quality of life. In that sense all medical care could be hoped to be palliative, at least from the patient's perspective! But too often, palliative medicine has come to be thought of as care for those with serious illness that is offered after everything else has "failed"!

The subjective and emotional connotation of "failure" – on the part of either the physician or the patient – is not perceived as a culturally acceptable response to any challenge, let alone to a serious illness. Therefore, palliative care is often the last resort – the final destination for partners on the medical journey who have already passed through "all else failed!" The sense of failure that commonly precedes the initiation of palliative care is a major barrier to engaging it sooner – resulting in poor symptom management and little or no attention being paid to the emotional, spiritual or social elements that help seriously ill patients cope with their illnesses.

If resistance to "failure" is one barrier, another is the cultural tendency to deny mortality as a part of the human condition. Medicine's great strides seem to have seduced our culture into the illusion that, with the right medical breakthrough, death will become optional!

It's no wonder that doctors feel compelled to offer treatments with slim-to-no-hope for cure and/or protracted ICU stays if failure is the alternative. And it's no wonder that patients and their families continue to accept these treatments and harbor (false) hope if acceptance of mortality and/or the limitations of medicine are never addressed as part of the equation. Together, these barriers result in many patients receiving unnecessary, painfully invasive, costly and sometimes futile treatments, after

which death comes anyhow – often accompanied by a sense of betrayal!

As a practice, palliative care is holistic. In its effort to relieve suffering (and simultaneously enhance quality of life) it embraces not just the patient's bio-physical condition, but their psycho-social, spiritual and relational conditions as well. (Prior to the burgeoning biomedical advances of our time, this holistic approach was more common. Now Western medicine is struggling to regain a better care for the whole person.) Palliative care intentionally prepares those in their care – the patient and all who are close to him or her – to explore how they can/want to live fully and as symptom free as possible for whatever time they have. For some patients, this time may be short, for others with chronic illnesses, it may be decades! In palliative care, time is not the issue; the quality of that time IS.

The Greeks had two ways of considering time: Chronos and Kairos. The Chronos version measures time with clocks and calendars in days, hours and years. The latter, Kairos, measures time in terms of what has meaning, is significant, beautiful or relevant. It could be a moment – like the birth of a child or a breathtaking sunrise – or it could take decades, like the struggle for freedom from oppression experienced by nations. Passage of time is not the standard of measure; the meaning of the time is.

Palliative medicine emphasizes and explores each patient's Kairos days. Seeing life through the lens of palliative care, each hour is vital, each significant event is precious, each decision is made to support the goals that are embraced (realistically) by patients, their families and the team of people supporting and providing for their care. Palliative care is not focused on failure but on what it means to live life fully, with meaning, in community and with full acceptance of our human capacities and limitations. Palliative care is usually intuitive for chaplains!

Jane Mather is director of Spiritual Care Services at Providence Sacred Heart Medical Center, Providence Children's Hospital and Providence Holy Family Hospital in Spokane, WA.

SOURCE: *Vision*, September/October 2011

Palliative care is interdisciplinary care

By Linda F. Piotrowski, MTS, BCC

It is 7:30 a.m. Staff pours into the Dartmouth-Hitchcock Medical Center in Lebanon, NH, for the start of another day. In the palliative care service area the murmur of voices can be heard in the conference room. In 30 minutes, morning rounds will begin. Our team consists of the attending physician for the week, the inpatient nurse practitioner, the outpatient nurse practitioner, the social worker, the volunteer coordinator, our healing arts practitioner, and our MD fellows. As the chaplain member of the team I am often called upon to lead morning rounds.

This morning, as per our usual format, we begin with introductions, as on any given day the staff may have grown by the addition of a third-year medical student, residents, guests from an outside medical facility or one or two peer observers from another institution. After introductions, we center ourselves by listening to a poem or some other type of reflective reading. On occasion we use a piece of music. Centered, we cover any patient deaths from the previous day, remembering each person with respect and care. From there our outpatient nurse practitioners introduce us to new patients and their families through a review of their previous day's new patient appointments. This could include referrals to the chaplain, social worker and/or volunteer coordinator.

Following the discussion of active new outpatients we discuss patients who are affectionately known as "outs who are in," i.e. outpatients who have been admitted due to a variety of reasons among which might be escalation of symptoms or return of disease. After that we review patients who have been discharged to make sure that there is continuity of care with the local nursing homes, rehab centers, hospices, primary care providers and local clergy.

We allow space in our morning meeting for "clinical challenges and opportunities." This is a time when any team member can raise a question for consideration. Challenges in the care of particular patients are lifted up. Advice is sought and given. It is in this space of time that our team becomes most transdisciplinary, as we step outside of our assigned roles to ask clarifying questions, share impressions, and offer suggestions.

From this point we move on to discussion of each inpatient. His or her diagnosis is discussed as well as recent changes in meds, social situation and spirituality. Representatives of each discipline report on his or her progress with the patients and offer insights and suggestions into the plan of care. Again the process of being interdisciplinary comes into play as specific roles are put aside to put into the plan everything that will help each patient along in the healing process.

The meeting completed, everyone rises and sets out on his or her day to meet the patients and put into place the plan discussed and agreed upon in the morning rounds.

In his article, "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life," Daniel Sulmasy puts forth that the biological, the psychological, the social, and the spiritual are distinct dimensions of the human person. Each aspect of the person can be affected differently by a person's history and illness. Each aspect interacts and affects other aspects of a person and helps or hinders a



patient's healing process.

In the same article, Daniel Sulmasy refers to Bernard Lonergan, who has argued that when one knows (literally) any "thing," what one is really grasping is a complex set of relationships, whether that thing is a quark, a virus, a galaxy, or a patient.

Sickness, rightly understood, is a disruption of right relationships. It is not "looking at a bad body inside an otherwise healthy body." (Sulmasy, 2002)

Working from this understanding of the human person, on the palliative care team each member must:

- Remain open to learning from other team members.
- Keep patient's needs and interests foremost.
- Hold sincere appreciation for one's team members.
- Respect the patient's knowledge of his or her own needs and resources.
- Pay attention to all aspects of the patient.
- Make referrals to the staff member most skilled in addressing a specific need.

The chaplain member of the palliative care team brings awareness of spiritual needs, resources, characteristics and inclinations to the table. Chaplains must possess the ability to listen at many levels to the various patient needs as put forth by other team members. The chaplain must also contribute from his or her field of expertise related to spirituality and religion. At the same time the chaplain member of the palliative care team must do what his or her training and expertise require: complete a spiritual assessment and based upon that information to serve as advocate, educator and coordinator.

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Reference:

Sulmasy, D. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist* 42, Special Issue III, 24-33.

SOURCE: *Vision*, September/October 2011

Palliative care or palliative medicine?

Setting up a hospital-wide palliative services program

By Patricia Duffield, MTS, BCC

The question of how to define ourselves was an early debate in the process of extending palliative care to medically appropriate patients throughout our Aspirus community-owned hospital facility in Wausau, WI. To those of us engaged in providing ongoing medical, social, emotional and spiritual support for patients with chronic and/or life-limiting illness, the need for correct terminology was important. To some, the term palliative “care” was more fitting to describe the nature of our approach. To others, more clinically oriented, the term palliative “medicine” would denote greater recognition of a valid field of treatment.



The question the task force initially grappled with was whether we were implementing a new department within the hospital, to stand along with Oncology, Orthopedics, Cardiac, etc., or whether we were offering an approach to care across medical disciplines by setting up a consulting team to be called when physicians recognized the need for palliative care for patients with a variety of chronic medical diagnoses. Was it possible to do one without the other? Did one consist of the other? Opinion varied on both sides of the question.

The need to extend palliative services to patients without necessarily admitting them to the Hospice/Palliative Care Unit, had slowly but surely evolved over the past couple of years, leading to the recognition of forming a collaborative team of professionals trained in the philosophy and mission of a palliative approach to patient care. It was determined that the team should consist of a medical director, a palliative physician, a social worker, a nurse practitioner, and a chaplain. All team members in the past had specific training for, and clearly understood the benefits of symptom management to enhance function, physical comfort, quality of life and psychosocial support for patients whose illness was manageable but not curable, and who were not necessarily close to death. The palliative chaplain would facilitate management of emotional and spiritual distress related to the illness, and the palliative social worker would ensure smooth transitions from the hospital to appropriate places of residence, with all support systems in place, along with psycho-social support for the patient and family.

The ultimate goal for the team, patient, and the hospital was to reduce frequent re-admission to the hospital, decrease length of stay, and reduce financial costs through successful symptom management before and after discharge. The hoped-for net effect would be an increase in levels of patient and family satisfaction.

In addition to the formation of the consulting team, policies were established to determine the referral process, advanced care planning, scope of service, pain and prescription management, palliative sedation, and spiritual and social service interventions. These policies were written and compiled by appropriate members of the team.

Once the team was established and policies written, discussion began around the question of how to educate in-house physicians to recognize the need for, and the benefits of palliative care, and how to make referrals to the team. The focus, it was decided, would be primarily on the hospitalist group of physicians.

In addition to face-to-face education sessions, and informative luncheons with the hospitalists, by the Palliative Medical Director and Palliative Physician, small laminated palliative referral guides were purchased and given to the hospitalists for easy reference. Other useful pocket references included a Family Goal Setting guide, Pain Management Guide, and Samples of Communication Phrases to use in conversations about the palliative approach.

During initial phases of the implementation process it had become clear there was need for clarification regarding differences between palliative care and hospice care among patients, families, and even physicians. To promote greater general visibility and education throughout the hospital and surrounding community about palliative care, the hospital Marketing Director provided input and suggestions that included hallway and elevator posters, lapel pins, FAQ sheets, business cards, community events, newsletters, newspaper articles, and brown bag lunches.

The input of various hospital personnel lending advice, assistance, ideas and strategies throughout our project was impressive; not least of which was evident in the next step of our proceedings. The Department of Information Technology designed and incorporated an additional dimension into the electronic medical record system, to give the consulting team a list of all current palliative patients, a means of communicating medical orders, physician dictation, and charting progress notes for patients admitted into palliative care. Electronic record-keeping had been utilized by our facility for several years. Physicians, RN's, dieticians, social workers and other hospital staff were accustomed to communicating their various reports and needs by this means.

To ensure successful outcomes, it was imperative that a smooth work flow among team members be designed and utilized correctly. The patient's hospital physician would write the initial order for a palliative consult. The order would be given to the palliative physician via page or phone call using the central hospital switchboard. Switchboard would have a list of appropriate names and numbers of all the team members. A call back to the referring physician would be made by the palliative physician, for purposes of clarification, gaining further information, and establishing a timeline. The referring physician would refer the patient to the palliative physician who would then set up a consult time with patient and family. After consultation with the patient and/or family members, the palliative physician would make referrals when necessary to other team members, and provide updates to other participating physicians involved in the patient's care. Upon a patient's discharge, all segments of ongoing palliative care would be established, and the community-based palliative staff would be asked to take over care of the patient.

In keeping with the palliative philosophy of holistic care, the palliative chaplain was asked to play a vital part in patient support in the hospital, and then facilitate transfer, with patient permission, to the community-based chaplain after discharge. A Spiritual Assessment tool was designed to be used by the attending chaplain, to discern the patient's spiritual and emotional needs. The tool was used to record any apparent spiritual, emotional, or relational distress that surfaced during the chaplain and patient conversation. Questions asked during the chaplain visit were specifically designed to reveal any evidence of alienation from God or others, anger, remorse, despair, loneliness, regret, and loss of purpose or meaning of life. Evidence of spiritual wellness would also be collected and used in affirmation and encouragement of the patient's ability to cope with his or her situation. Information gleaned from the assessment would be kept by the chaplain as a paper record, and transferred into electronic records for other team members to read and use as needed. Referrals to a patient's own clergy would also be done where the need indicated.

After several months of preparation, which included problem solving issues related to billing, weekend coverage, types of patients for referrals, and continued care after discharge, the palliative team felt ready to "go live." The first few requests for palliative consults asked for the "Palliative Medicine" Physician. Along with that came information-seeking about other aspects of our "department." Terminology resolved!

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For everything there is a season

By Michele Le Doux Sakurai, DMin, BCC

"...a time to heal; a time to tear down and a time to build up; a time to cry and a time to laugh." – Ecclesiastes 3: 3-4a

Palliative or supportive care is not new. I was introduced to it 20 years ago in Oregon while physician assisted suicide was being hotly debated. Palliative care has been deeply interdisciplinary and traditionally has centered on symptom management and enhancing quality of life. In its earlier days, the focus was



more on end-of-life needs; palliative care has grown to embrace chronic conditions with no specific end point in sight. As a discipline, it has developed clarity of purpose with the focus on the patient's and family's goals and wishes, what has meaning for the patient, and how to provide a quality of care that can meet the patient's agenda. Chaplaincy is attuned to palliative care, in part because our training has always been patient-centered – listening to the patient's story, his or her fears, hopes, dreams, and realities. In many ways palliative care serves as a bridge between the scientific-medical model and the more intuitive spiritual care model.

Palliative care is well established in urban areas; it has only been in the last year that a formal palliative care service has extended into the rural areas of Eastern Washington. Living in rural America carries its own challenges. In Critical Access Hospitals (CAH), there is a well-established pipeline for acute patients to tertiary hospitals; for patients with chronic conditions (especially those toward the last two years of life), the path is less directive. Many of these patients have frequent admissions, struggle with quality-of-life issues, and would welcome alternatives and additional resources.

Sharon, a pretty, petite, 30-something, lamented to me, "I will never have children, see my nieces or nephews marry; I will never live my dreams. My disease traps me and, as a result, I am not seen as an adult but as a child. I live with my parents who care for me. They try to dictate my life; I am not a child! For all of her struggles, Sharon did carry veto power for all her healthcare decisions, but the years of managing her illness weighed heavily on her.

Sharon's parents also had a lament. They found Sharon increasingly a challenge – her care was becoming more complicated. She was becoming more self-involved and unable to see how the stress was compromising her father's health. As conflict increased so did Sharon's ER visits, and Sharon had reached a point whereby she was being admitted every three to four weeks. Hospital staff viewed these admissions with growing disdain. They experienced Sharon as manipulating her disease as a way to lengthen her hospital stays. Her disease process did not make her appropriate for hospice, but when palliative care was explored, it was found to be a good fit. The system's regional Palliative Care Services program provided our hospital with an RN palliative care coordinator. She addressed Sharon's definition for quality of life as well as symptom management, clear boundaries for medical management, and identifying a setting in which Sharon could thrive. In collaboration with the interdisciplinary team (primary physician, ER physician, chaplain, pharmacist, acute care manager, PT, and discharge planner) and her parents, Sharon was provided a plan of care that focused on her wish to have autonomy, coordinated care, and an opportunity to develop meaningful relationships and a sense of service. The team commitment for resolution ran so deep that one physician traveled 200 miles to explore a residence that cared for a

younger population. When this proved to be less than a viable option, something closer to home was found. Initially, Sharon was prepared to veto this choice, but opted to try for a couple of weeks. It has been almost a year, and Sharon continues to thrive in this setting, and she has yet to be readmitted to the hospital.

In rural areas and elsewhere, chaplains wear a variety of hats as they collaborate as members of the palliative care team. Oftentimes, it is the chaplain who is the RN palliative care coordinator's first contact, "Michele, Mr. Smith is a full code, and has been admitted three times in two months as a result of falls. He is 89 and living with his wife at home. Does he have an advance directive, and do we know what his actual wishes and goals are?" And so, as chaplain, I invite the story of the patient to get a sense of meaning and what his values are – especially in terms of this admission. There are times the hat worn is that of advocate. By sharing the patient's story and his or her values, the chaplain makes the case for a change in code status or living conditions – as in the case of a patient who was receiving chemotherapy. When asked what she wanted, she replied, "I'm tired and ready to stop, but I don't want to disappoint my doctor." It was through the chaplain's intervention that her wishes could be honored.

Sometimes the hat of the chaplain is as ethics mediator. In all settings, chaplains are called upon to help resolve disputes among family members so that the patient might be heard. Most importantly, the hat that the chaplain wears most often is that of presence or witness. In Sharon's case, the chaplains acted as a witness to Sharon's story while at the same time inviting Sharon into a deeper understanding of her own wishes and needs through biblical allusions of lamentation, journey, and consolation. Because of the intensity of this case, chaplains were careful to hand off clear communication and were intentional about modeling good boundaries; it was vital that no one fall into family politics or blaming. The strength of the intervention came through the commitment of the interdisciplinary team to stay focused on collaboration. Sharon lives in a new season; she will never be cured, but she has experienced great healing over the past year. Her new course reflects the palliative care team members at their best; they take a time that tears down and transform it into a time of hope.

Michele Le Doux Sakurai is manager of pastoral care and mission for Providence Health Care, Stevens County, WA.

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Dying as they lived: A personal vote for palliative care

By Laurie Hansen Cardona
Vision editor

Four years ago, as I drove my 5-year-old daughter to gymnastics class, she belted out a ballad from her carseat detailing the last weeks of my father's life – his fall, his broken hip, the paramedics' arrival, visits to the hospital and later the hospice, and the final call from the hospice nurse. While she practiced her own brand of music therapy, I navigated the streets of Milwaukee with tears streaming down my cheeks.

When I came on board as editor of *Vision*, I was still reeling from my parents' deaths. Several years earlier, after a few months in home hospice, my mother had died of breast cancer that metastasized to the lungs. My husband and I then shared a duplex with my parents; I was managing editor of a Catholic weekly newspaper. My father, 83 at the time, was Mom's chief caregiver. My husband and I spelled him at night, sleeping on the floor of their flat to be there when help was needed for trips to the bathroom or just to provide a gentle hug at times of sleeplessness. I was the regular administrator of Mom's morphine patches, which kept much of the pain at bay.

Through the indignities of chemotherapy and the resultant losses, my mother demonstrated the same grace and aplomb she had throughout the rest of her 80 years, seldom complaining. There was time for gentle embraces, loving words, sunrises she still yearned to see. Our parish pastor came to provide the Sacrament of the Sick. Mom, my close confidante – in healthier times, a political junkie and nature enthusiast, who it seemed to me could name every tree and plant native to Wisconsin – faded away softly, wondering aloud how she would cope with the transition to the afterlife. When death came, it was I who was unprepared for the finality of it, loudly sobbing my grief in person and over the phone to friends and relatives.

My father spiraled into depression after Mom's death. My two young children brought him cheer, as did reading favorite authors and my sister's nightly phone calls. What kept Dad going for as long as he did were clearly his family and his desire to read and to learn.

In the face of his deep sorrow, Dad, a retired educator, did what he knew best. He studied, trying to understand his own plight and that of others. He re-read the psalms and Dostoevsky. He sought comfort in *Job* and *Scientific American*. He read *The Economist* and Stephen Hawking and *St. Anthony Messenger*. While this didn't solve all that ailed him, it did enable him to keep everyone he knew on their toes, passing on information he found fascinating on topics from technology to theology to science, from personal finance to the global economy and the war on Iraq.

His desire to fight depression through learning can be summed up in this quote from Merlyn the philosopher-wizard in one of Dad's favorite books, "The Once and Future King," by T.H. White:

"The best thing for being sad," replied Merlyn, beginning to puff and blow, "is to learn something. That is the only thing that never fails. You may grow old and trembling in your anatomies, you may lie awake at night listening to the disorder of your veins, you may miss your only love, you may see the world about you devastated by evil lunatics, or know your honour trampled in the

sewers of baser minds. There is only one thing for it then — to learn. Learn why the world wags and what wags it. That is the only thing which the mind can never exhaust, never alienate, never be tortured by, never fear or distrust, and never dream of regretting.”

Dad, who had prostate cancer and may have been the first person to introduce me to the term “palliative care,” reminded me regularly that he wanted to “go gentle into that good night” (contrary to poet Dylan Thomas’s plea), rather than be kept alive by a feeding tube or left to suffer for a lengthy period of time. A Lutheran-turned-Catholic, he had little patience for any theology that proclaimed the value of suffering. When he entered the hospital for the last time at age 91 and filled out a new advance directive, he reminded me once more of his pacific end-of-life expectations and asked me if I was sure I was up to the task of being his patient representative. Naively, I said I was. Despite Dad’s advanced age, I assumed he’d be returning home in short order with a hip replacement. After all, only a few days earlier he had been debating whether to buy a PC or a Mac and driving himself to the bookstore.

The surgery to repair the broken hip did not go well due to gastrointestinal complications. A second surgery was performed in hopes of repairing the problem, but to no avail. A nurse in post-surgery and the anesthesiologist who had witnessed the interior damage told my sister and me that we should be sure his DNR was in order.

After we moved Dad to the hospital’s hospice wing, Dad’s children and grandchildren came to see him regularly as did the surgeon who had operated on him. Kids’ drawings and a brightly colored quilt made by my sister adorned the room. Increased doses of morphine requested by my Dad and OK’d by me replaced his once nightly martinis, and he grew weaker and less coherent until death came, just one week after he had entered hospice.

One generation earlier, three of my four grandparents died in their 60s and 70s, two of them due to heart attacks. While today this may sound like lives cut short, the fact is these were natural deaths that were not prolonged with pain, suffering and struggle as so many are today.

When I attended my first NACC national conference less than a year after my father’s death, I recall tears welling in my eyes as I listened to plenary speaker Father Richard M. Gula talk of the importance of understanding patients’ life narratives. He said such narratives needed to be used to help to integrate patients’ sicknesses and the medical responses to those sicknesses with the patterns of life the patients had lived.

The emergence of new human life and the scourge of death – both of which seldom take place struggle-free – remain in the hands of God. The existence of palliative care, however, allowed my parents to die with a measure of the same dignity with which they had lived their lives.

SOURCE: *Vision*, September/October 2011

Preparing for approaching death

By Barbara Mulich, MSN, FNP-BC, ACHPN, and Ed Horvat, MA, BCC

This article was written by NACC chaplain Ed Horvat and nurse Barbara Mulich to provide to families in their respective West Virginia hospitals when the death of a loved one is expected.

When a person enters the final stage of the dying process, two different processes are at work, which are closely interrelated and interdependent. On the physical plane the body begins the final process of shutting down, which will end when all the physical systems cease to function. Usually this is a progressive series of physical changes that are not medical emergencies requiring invasive interventions. These physical changes are a normal, natural way in which the body prepares itself to stop, and the most appropriate kinds of responses are comfort-enhancing measures.

The other part of the dying process is at work on the emotional-spiritual-mental plane, and is a different kind of process. The spirit of the dying person begins the final process of release from the body, its immediate environment, and all attachments. This release also tends to follow its own priorities, which may include the resolution of whatever is unfinished of a practical nature and reception of permission to "let go" from family members. These events are the normal and natural way in which the spirit prepares to move from this existence into the next dimension of life. The most appropriate kinds of responses to the emotional-spiritual-mental changes are those that support and encourage this release and transition.

When a person's body is ready and wanting to stop, but the person is still unresolved or unreconciled over some important issue or with some significant relationship, he/she may tend to linger even though uncomfortable or debilitated in order to finish whatever needs finishing. On the other hand, when a person is emotionally-spiritually-mentally resolved and ready for this release, but his/her body has not completed its final physical process, the person will continue to live until the physical shutdown is completed.

The experience we call death occurs when the body completes its natural process of shutting down, and when the "spirit" completes its natural process of reconciling and finishing. These two processes need to happen in a way appropriate and unique to the values, beliefs and lifestyle of the dying person.

Therefore, as you seek to prepare yourself as death approaches, we want you to know what to expect and how to respond in ways that will help your loved one to accomplish this transition with support, understanding and ease. This is the great gift of love you have to offer your loved one as this moment approaches.

The physical and emotional-spiritual-mental signs and symptoms of approaching death that follow are offered to you to help you understand the natural kinds of things that may happen and how you can respond appropriately. Not all of these signs and symptoms will occur with every person, nor will they occur in this particular sequence. Each person is unique and needs to do things in his/her own way. This is not the time to try to change your loved one, but the time to give full acceptance, support, and comfort.

Normal physical signs and symptoms with suggested responses

Coolness. The person's hands, arms, feet, and legs may be increasingly cool to the touch, and at the same time the color of the skin may change. The underside of the body may become darker and the skin may

become mottled. This is a normal indication that the circulation of blood is decreasing to the body's extremities and being reserved for the most vital organs. Keep the person warm with a blanket but do not use an electric one.

Sleeping. The person may spend an increasing amount of time sleeping and appear to be uncommunicative or unresponsive and at times be difficult to arouse. This normal change is due in part to changes in the metabolism of the body. Sit with your loved one, hold his or her hand, do not shake or speak loudly, but speak softly and naturally. Plan to spend time with him or her during those times when he or she seems most alert and awake. Do not talk about the person in the person's presence. Speak to him or her directly as you normally would even though there may be no response. Never assume the person cannot hear, as hearing is the last of the senses to be lost.

Disorientation. The person may seem to be confused about the time, place, and identity of people surrounding him or her including close and familiar people. This is also due in part to changes in metabolism. Identify yourself by name before you speak rather than asking the person to guess who you are. Speak softly, clearly and truthfully when you need to communicate something important for the person's comfort, such as, "It is time to take your medication," and explain the reason for the communication, such as, "So you won't begin to hurt." Do not use this method to try to manipulate the person to meet your needs.

Incontinence. The person may lose control of urine and/or bowel matter as the muscles in that area begin to relax. Discuss with the staff what can be done to keep your loved one clean and comfortable.

Congestion. The person may have gurgling sounds coming from his or her chest as though marbles were rolling around inside. These sounds may become very loud. This normal change is due to the decrease of fluid intake and an inability to cough up normal secretions. Suctioning may only increase the secretions and cause discomfort. Gently turn the person's head to the side and allow gravity to drain the secretions. You may also gently wipe the mouth with a moist cloth. The sound of the congestion does not indicate the onset of severe or new pain.

Restlessness. The person may make restless and repetitive motions such as pulling at bed linen or clothing. This often happens and is due in part to the decrease in oxygen circulation to the brain and to changes in metabolism. To have a calming effect, speak in a quiet natural way, lightly massage the forehead, read to the person, or play some soothing music.

Fluid and Food Decrease. The person may have a decrease in appetite and thirst, wanting little or no food or fluid. The body will naturally begin to conserve energy that is expended on these tasks. Do not try to force food or drink into the person, or try to use guilt to manipulate them into eating or drinking something. To do this only makes the person much more uncomfortable. Small chips of ice may be refreshing in the mouth. A cool, moist washcloth on the forehead may also increase physical comfort.

Urine Decrease. The person's urine output normally decreases and may become "tea" colored, which is referred to as concentrated urine. This is due to the decreased fluid intake as well as the decrease in circulation through the kidneys.

Breathing Pattern Change. The person's regular breathing pattern may change with the onset of a different breathing pace. A particular pattern consists of breathing irregularly, for example, shallow breaths with no breathing for five to 30 seconds or up to a full minute. The person may also experience periods of rapid, shallow, pant-like breathing. These patterns are very common and indicate a decrease in circulation in the internal organs. Elevating the head, and/or turning the person on his or her side may

bring comfort. Hold his or her hand. Speak gently.

Normal emotional-spiritual-mental signs and symptoms with suggested responses

Withdrawal. The person may seem unresponsive, withdrawn, or in a comatose-like state. This indicates preparation for release, a detaching from surroundings and relationships, and a beginning of "letting go." Since hearing remains all the way to the end, speak to your loved one in your normal tone of voice, identify yourself by name when you speak, hold his/her hand, and say whatever you need to say that will help the person "let go."

Vision-like Experiences. The person may speak or claim to have spoken to persons who have already died or to see or have seen places not presently accessible or visible to you. This does not, necessarily, indicate a hallucination or drug reaction. The person is beginning to detach from this life and is being prepared for the transition so it will not be frightening. Do not contradict, explain away, belittle or argue about what the person claims to have seen or heard. Just because you cannot see or hear it does not mean it is not real to your loved one. Affirm his or her experiences. They are normal and common. If they frighten your loved one, explain to him or her that they are normal.

Restlessness. The person may perform repetitive and restless tasks. This may in part indicate that something is still unresolved or unfinished that is disturbing him or her, and preventing him or her from letting go. Our staff may be able to assist you in identifying what is happening, and help you to find ways to help the person find release from the tension or fear. Other things which may be helpful in calming the person are to recall a favorite place the person enjoyed, a favorite experience, read something comforting, play music, and give assurance that it is OK to let go.

Fluid and Food Decrease. When the person wants little or no fluid or food, this may indicate that the person is ready for the final shut down. Do not try to force food or fluid. You may help your loved one by giving them permission to let go whenever he or she is ready. At the same time, affirm the person's on-going value to you and the good you will carry forward into your life that you received from him or her.

Decreased Socialization. The person may only want to be with a very few or even just one person. This is a sign of preparation for release and an affirming of whose support is most needed in order to make the appropriate transition. If you are not part of this "inner circle" at the end, it does not mean you are not loved or are unimportant. It means you have already fulfilled your task with him or her and it is the time for you to say "good-bye." If you are part of the final "inner circle" of support, the person needs your affirmation, support and permission.

Unusual Communication. The person may make a seemingly "out of character" statement, gesture or request. This indicates that he or she is ready to say "good-bye" and is "testing" to see if you are ready to let him or her go. Accept the moment as a beautiful gift when it is offered. Kiss, hug, hold, cry, and say whatever you most need to say.

Giving Permission. Giving permission to your loved one to let go without making him or her feel guilty for leaving or trying to keep him or her with you can be difficult. A dying person will normally try to hold on, even though it brings prolonged discomfort, in order to be sure that those who are going to be left behind will be all right. Therefore, your ability to release the dying person from this concern and give him or her assurances that it is all right to let go whenever he or she is ready is one of the greatest gifts you have to give your loved one at this time.

Saying Good-bye. When the person is ready to die and you are able to let go, then is the time to say,

"good-bye." Saying good-bye is your final gift of love to the person, for it achieves closure and makes the final release possible. It may be helpful to lie in bed with the person and hold him or her or to take the hand and then say everything you need to say. It may be as simple as saying, "I love you." It may include recounting favorite memories, places and activities you shared. It may include saying, "I'm sorry for whatever I contributed to any tension or difficulties in our relationship." It may also include saying, "Thank you for...." Tears are a normal and natural part of saying good-bye. Tears do not need to be hidden from your loved one or apologized for. Tears express your love and help you to let go.

How will you know when death has occurred?

Although you may be prepared for the death process you may not be prepared for the actual death moment. It may be helpful for you and your family to think about and discuss what you would do if you were the one present at the death moment. The death of a terminally ill loved one is not an emergency. The signs of death may include such things as: no breathing, no heartbeat, release of bowel and bladder, no response, eyelids slightly open, pupils enlarged, eyes fixed on a certain spot, no blinking, jaw relaxed and mouth slightly open. As you already know, staff are nearby for support. Let us know when we can help.

Thank you.

We thank you for the privilege of assisting you and your loved one at this time. You have given your loved one the gift of yourself. There is no right or wrong way to deal with separating from a loved one. It is a difficult process. It is our hope that this article has helped prepare you for what to expect and has provided you with some suggestions to ease the transition to new life.

Barbara Mulich is an advanced practice nurse working in palliative care medicine for WV University Hospitals in Morgantown, WV. Ed Horvat is a chaplain in the Pastoral and Spiritual Care Department of Monongalia General Hospital in Morgantown, WV.

References:

Ferrell, B. R. & Coyle N. (2001) *Textbook of Palliative Nursing*. New York: Oxford University Press.

Callanan, M. & Kelley, P. (1997) *Final Gifts: Understanding the special awareness, needs, and communications of the dying*. New York: Bantam Books.

Related link:

The main website of the West Virginia Center for End-of-Life Care: www.wvendoflife.org

SOURCE: *Vision*, September/October 2011

For Noah's Children, intentional, cultivated relationships are key

By Sallye A. Hardy, MDiv, BCC

At the May 2011 NACC National Conference, Bon Secours Richmond Health System sponsored a poster presentation entitled "Pathways to Pediatric Palliative Care." The poster depicted the work of Noah's Children as a garden with various pathways to care that involve the larger community. Noah's Children www.noahschildren.com is a ministry of Bon Secours Richmond Health System and is Central Virginia's only pediatric hospice and palliative care program. It is a specialized program of comprehensive care serving infants, children and adolescents who have been diagnosed with a life-threatening illness. While taking an interdisciplinary, team-based approach to pediatric palliative care, the program also involves the larger community in its work. The article below is an explanation of the poster that was presented at the conference.

Know your roots

Noah's Children was inspired by children who simply thought sick children should have someone to care for them. That inspiration was heard by Bob Archuleta, a pediatrician who had spent his life caring for children in Richmond, VA. Its roots are in the children of Richmond and it has grown there since its founding in 1997.

This caring for children with life-threatening, limiting and/or terminal illness begins with these strong roots – good soil if you will. It is pediatric palliative and hospice care, not adult palliative and hospice care applied to children. This program has transitioned through changes in ownership, economic climates and staff within its interdisciplinary teams because its roots were strong.

Ninety-five percent of children who die do so in a hospital leaving only 5 percent to die at home. Noah's Children stays true to its roots by allowing children to live and die in the comfort of their home with those they love. This choice to remain at home and maintain some control of their now chaotic lives is the powerful nutrient that sustains this community garden. The home is the natural, holy ground where Noah's patients and their families grow during this difficult journey.



Know the families

It is imperative that those who work with pediatric palliative and hospice care recognize that emotional, physical, financial and psychological loss is the beginning of the journey. Parents report that they "knew" something was deeply wrong with their child before the doctor ever provided a diagnosis. One parent stated, "I knew it was more than an ear ache and it was." From the moment that thought enters the mind, loss becomes the key dynamic to attend to. It is not the weed to be gotten rid of because that is impossible, it is instead the flower that has to be attended to and taken care of.

Constant, growing loss is the core of the suffering that occurs when a child is diagnosed with a life-threatening/limiting illness. Naming those losses accurately is very important and how to attend to those losses is crucial. The patient will lose normal physical capacities that are the conduit for social, mental and

spiritual growth. Traditional connections to hope and innate connections to the transcendent can be shattered. A child's normal way of life is lost and the social roles that child and his or her family have within the home and community are modified significantly. Psychologically, how one perceives and thinks and makes decisions is radically challenged.

An active soccer player spends his or her afternoon in the oncology clinic. A popular junior in high school becomes an isolated teen in a recliner. A father who led the church vestry cannot physically tolerate even the sound of the church's organ. A household – respected and welcoming to its neighborhood – now keeps its front door closed. Loss within the patient and family must be recognized, honored and cared for intentionally. Naming these losses well and using all the tools of all the disciplines validate pain and suffering. Doing so can also create pathways that care and assist in the final memories to be made in a family's life together.

Crucial to this care is a functioning, healthy interdisciplinary team. This must be a team of experts in their own disciplines who respect the services that each discipline can provide.

Know Your Community

At its best, that team is integrated with its colleagues in the community. The effective pediatric palliative and hospice program will always be dependent on other community service providers. This is not driven solely by budgetary concerns (Who has enough money to be all things to all people?), or scope of services (Who wants to be all things to all people?) but by a recognition that a wide consortium of people and services are required to meet the needs of a patient and family. Crucial to Noah's Children is its embrace of community service providers, not just as colleagues, but also as a response to the family's core right and need to make choices. These services become creative acts of collaboration, not competition. Healthy relationships within the pediatric service community increase choices for patients and their families.

The freedom to make choices restores a family's sense of control and reinforces its abilities to trust itself again. Noah's is intentional about honoring those choices, while offering new choices that might be available. A young patient needed dental surgery, but his own dentist believed it to be life threatening, and his guardian grandmother was devastated that her grandson would have to be either in pain or risk dying in surgery. Noah's referred her to another dental oral surgeon whose work was devoted to special needs clients. Within weeks, the surgery was done on an outpatient basis and the patient was pain free and the grandmother was worry free.

Pediatric palliative caregivers must be committed to knowing their community's resources and developing those relationships through all disciplines. A social worker connects a family to a waiver; a chaplain connects with a Buddhist priest; a nurse connects with a new home care agency; a medical director connects to a colleague who remains the primary care physician. Volunteers connect to hundreds of opportunities that enhance the life of the family from art museums to zoos.

Intentional, cultivated, cared-for relationships allow this "unthinkable time" in a family's life to be lived with respect and some sense of control. The pathways are neither always clear nor easy, but best walked when shared through the seasons of these families' lives. So at any given moment, it can honestly be known, "All that love could do was done."

Sallye A. Hardy is chaplain for Noah's Children in Richmond, VA. For questions about this article or Noah's Children, contact the author at Noah's Children, 5855 Bremond Road, Suite 409, North Medical Office Building, Richmond, VA 23226 or by phone at (804) 287-7686, or by email at noahschildren@bshsi.org.

Poetry acts as bridge of love, solidarity

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

In his message for the World Day of the Sick this year, Pope Benedict XVI repeated his invitation “to create bridges of love and solidarity so that nobody feels alone but near to God and part of the great family of his children.” This got me thinking about what bridges of love and solidarity I might be able to create in my own clinical practice as a palliative care chaplain, especially for those patients who are at greatest risk for social isolation near the end of life.

As Patrick Clary (2010), a palliative care physician in New England, reminds us, poetry and metaphors can connect us to the seriously ill, and such connection is a central determinant of healing at the end of life.

One elderly palliative care patient I met a few months ago suggested that poetry was a prime spiritual strength for her. In response, I supplied her with a variety of pens and paper to write her poems. After a few weeks went by without any evidence of her poetry, the team and I began to wonder if we had misunderstood her. This patient spoke only Spanish and, even with a Spanish-speaking physiotherapist on our team, communication with her was extremely difficult. Only rarely would family members visit and be able to translate for us.

And then the poetry began to tumble out of her. She began to compose dozens of poems that were very rich in metaphors and symbols. Her poetry was extraordinary in its evocative mystical language.

Take, for example, these two poems she gave to me, “Más Allá” and “La gran plegaria.”

Más Allá

Más allá del Silencio, la Armonía.
Más allá de las Formas, la Presencia.
Más allá de la Vida, la Existencia.
Más allá de los Gozos, la Alegría.

Más allá de la Fuerza, la Energía.
Más allá de lo Puro, la Inocencia.
Más allá de la Luz, la Transparencia.

Más allá, más allá, siempre adelante.
Más allá, en lo Absoluto, en lo distante,
Donde la llama se apartó del leño.

A fulgir, por si misma, en la figura
De un Infinito, va sin amargura.
Y más allá de lo infinito, el Sueño.

Beyond

Beyond Silence, Harmony.
Beyond Forms, Presence.

Beyond Life, Existence.
Beyond Pleasure, Happiness.

Beyond Force, Energy.
Beyond Purity, Innocence.
Beyond Light, Transparency.

Beyond, beyond, always forth.
Beyond, in the absolute, in what is distant.
Where the flame departed from the wood.

O, to glow, by itself, in the figure,
Of an infinite, now without bitterness.
And beyond the infinite, the Dream.

(Translation by Ingrid Waisgluss)

La Gran Plegaria

El tiempo es hambre y el espacio es frío
Orad, orad, que solo la plegaria
Puede saciar las ansias del vacío.

El sueño es una roca solitaria
En donde el águila del alma anida:
Sonad, sonad, entre la vida diaria.

The grand prayer

Time is hunger, and space is cold
Pray, pray, for only prayer
can fill the anxiety of the void.

Dreaming is a solitary rock
where the eagle of the soul nests:
Dream, dream, in everyday life.

(Translation by Ingrid Waisgluss)

In addition to what deeper meanings poems and stories might hold for patients, sociologist Arthur Frank (2010) focuses also on what stories do – how they hail or call us into relationships, for example. In this way, with her poetry, my patient called me into a special relationship with her that crossed language borders. From her isolation, she created a bridge of love and solidarity with me that I was then able to communicate to the team via my unique role as chaplain. This bridge raised her from anonymity to reveal to us one of the most extraordinary patients for whom we have cared.

Robert Mundle is a chaplain at St. Mary's of the Lake, Providence Care, in Kingston, Ontario.

References

Clary, P. (2010) Poetry and healing at the end of life. *Journal of Pain and Symptom Management*. 40(5), pp. 796-800.

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

Frank, A. W. (2010). *Letting stories breathe: A socio-narratology*. Chicago: University of Chicago Press.

SOURCE: *Vision*, September/October 2011

Symposium participants wish to advance excellence in lay ecclesial ministry

Representatives of 43 organizations, associations, federations, institutions of higher learning and other ministries gathered on the campus of Saint John's University School of Theology Seminary in Collegeville, MN, Aug. 2-5 for the 2011 Collegeville National Symposium on Lay Ecclesial Ministry.

These 43 symposium co-sponsors, which included the NACC, share a common goal: to advance excellence in lay ecclesial ministry by increasing the church's theological and pastoral understanding of the vocation and authorization of lay ecclesial ministers. (See NACC Executive Director David Lichter's column in this issue of Vision in which he discusses the symposium and the evolving Catholic landscape regarding lay ecclesial ministry.) [LINK](#)

But why do symposium participants make this commitment? What motivates them to promote lay ecclesial ministry within the church? Their motives are as varied as their missions.

Sister Sharon Euart, RSM, executive coordinator of the Washington, DC-based Canon Law Society of America (CLSA), says that excellent formation for lay ecclesial ministry is essential, including formation in canon law. A primary purpose of the CLSA, according to its constitution, is to promote the pastoral ministry of the church.

"Canonical formation for lay ecclesial ministers, including knowledge of church structures and the law, is a vital component of the CLSA's educational efforts," she says. "It is our hope that the society will become a more visible and effective resource for pastoral ministers, particularly pastoral associates and parish life coordinators."

Peter Noll, executive director of the Minnesota Catholic Education Association (MCEA), is on that same page of promoting excellence in ministry.

"MCEA has designed and implemented a certification process for lay ecclesial ministers because it is our belief that a rigorous, relevant and comprehensive professional review process by a qualified evaluative team is an effective method of ensuring competency in the field," Mr. Noll says.

"The promotion of lay ecclesial ministry at Franciscan University of Steubenville is vital both for the university and for our students," says Stephen Hildebrand, associate professor of theology at the Ohio-based university. "We see the formation of students in theology and catechetics as an integral part of a larger mission to the church and the world. ... Lay ecclesial ministry lies near the heart of our mission as a university and as individuals called by God to his service."

Jean Marie Weber, president of the Association of Graduate Programs in Ministry (AGPIM), based in Milwaukee, WI, praised the U.S. bishops' 2005 document, "Co-Workers in the Vineyard of the Lord: A Resource for Guiding the Development of Lay Ecclesial Ministry," which is also the guiding document of the Collegeville National Symposium.

"It is indeed a ground-breaking document that is shaping lay ecclesial ministry in the U.S. church," she says. The document has "articulated the key role of lay ecclesial ministers in the church on the U.S. and beyond, reaffirms the call of the laity and invites all to redefine the vocation of the Catholic Christian in

the world," Ms. Weber adds.

Fr. Richard Vega, president of the Chicago-based National Federation of Priests' Councils (NFPC), and NFPC public liaison Alan Szafraniec view lay ecclesial ministry, understandably, from the perspective of the clergy.

"One cannot deny the shortage and graying of clergy in our country," the two NFPC representatives say. "Bishops have sought to strengthen the number of priests within dioceses with the assistance of international clergy. A burgeoning Catholic immigrant population means more ministers are needed so that parish communities remain vibrant." A single priest in a parish is now normative, they note, or a number of parishes share a priest under the title of pastor.

"To maintain one's own sanity and sense of balance, priests will need to rely on the assistance and collaboration of lay ecclesial ministers to respond to the varying needs of God's people. Alone, a priest will be unable to feed the flock that has been entrusted to his care," they add.

But the church has hope and confidence, according to Father Vega and Mr. Szafraniec, that in the face of this challenge lay ecclesial ministers "will truly become 'co-workers in the vineyard of the Lord.'"

Linda Stryker, director of religious education for St. Margaret Mary Parish in Omaha, NE, serves as a publicity liaison between the symposium and the National Catholic Young Adult Ministry Association, with offices in Washington, DC, and Chicago. The promotion of lay ecclesial ministry is necessary so that the best possible candidates are selected for roles in parish catechetical leadership, she says.

"Also, it is essential we have charismatic and well-formed catechetical leaders to help people to develop a relationship with Jesus," Ms. Stryker adds. "Our church is going to decrease if we can't keep up with the secular world."

Related links:

David Lichter's column in Aug. 8, 2011, NACC Now: www.nacc.org/resources/e-news/nn_issue_102.asp#1

www.LEMsymposium.org

SOURCE: *Vision*, September/October 2011

Prayer Service for the 10th Anniversary of 9/11

September 11, 2011, marks the 10th anniversary of 9/11, a tragic day that resulted in 2,977 deaths, tremendous grieving, altered international relations, U.S. troop deployment to Afghanistan, and increased concern over the fragility of life. Tim Serban, volunteer partner lead for the Spiritual Care Response Team of the American Red Cross, Washington, DC, coordinated and provided spiritual care on 9/11 as part of the American Red Cross Spiritual Care Response Team at the World Trade Center in New York City. At the request of the NACC, he has prepared a 10th anniversary prayer service that can be adapted by chaplains for their own use. This prayer service was first published in the Aug. 8, 2011, NACC Now so that member chaplains could use it to plan a ritual for Sunday, Sept. 11, 2011; however, it could be adapted for use anytime during this month of September.

September 11 occurs on Sunday this year. Most chaplains will participate in rituals in their home parishes or faith communities. Those who will be on duty may be responsible for incorporating this anniversary into their homilies. Still others will desire to create a meaningful ritual in their centers or hospitals. This prayer service is designed to help to provide a starting point for creating a meaningful ritual on this and future anniversaries of this date in history. Chaplains may wish to create a group email prayer to be sent to all employees across their ministries. Never underestimate the gift of prayer.

This article aims to apply to the many varied settings in which our chaplains serve. It includes ways in which chaplains can create a meaningful ritual that both honors the setting as well as its proximity to the places where loved ones lost in the 9/11 attacks last lived. The ritual should be designed or adapted with sensitivity to the population served and the setting. Keep in mind the details that four airliners were involved, including all three locations of this tragedy: New York City, the Pentagon in Washington, DC, and Flight 93 in Shanksville, PA. No one fully knows how others may have been impacted by the tragic events 10 years ago so sensitivity is paramount. If time allows, it would be important to issue an open invitation to the ritual for anyone in our facilities who has directly or indirectly lost a loved one on September 11. It is important to expect that there may be at least one person who has a direct connection to someone who died on September 11 in our ministries. With that in mind, expect to include families in the prayer service.

When I reflect on the days following September 11 and our work with the American Red Cross Spiritual Care Response Team at the World Trade Center site in New York, I remember a powerful ritual that was created in the silence of a darkened chapel. It was Sunday evening when a firefighter came to me there in a panic and said, "Chaplain, I don't think I'm gonna make it to Mass today!" We tried to find a parish before realizing that St. Patrick's was the only one with an evening Mass and it was simply too far away.

I invited him to join me in the cafeteria at a table beside the comfort dogs and stacks of cards from children everywhere. I asked him if he knew how many Masses were being celebrated around the world every day? He replied that he did not, and I said, "I think it's like over 300,000 masses every day." And I asked him, "What do you think is on the minds of every person who went to Mass today?" He said, "The people and families lost here in this tragedy?" I said, "Yes! And where do you think they would want to be if they were able to?" He said, "Right here!" And I continued, "If we are truly a community of faith, then you need to let them be the ones who attend Mass for you today, and you need to be the one who stands here on their behalf. Does that make sense?" I asked, and he agreed that it did. And we finished our soup and bread and I don't think I ever saw him again.

Planning the Gathering:

When family members from the event are present, find a way to include them into the prayer without having them stand apart from the rest of the group.

- Invite into the center of the circle all who have lost a loved one, family member or friend and ask them to stand together with their families. (Create the circle in such a way that family and friends are not isolated, but supported.) Invite them to link arms to help them feel strengthened. Next you may surround them with each group that is called forward.
- To the second circle, invite all who were First Responders or volunteers who served in New York, Pennsylvania, Washington, DC, New Jersey or any departure/destination airports. Invite them to encircle the families as they did 10 years ago.
- The third group of people to be invited to form a circle will be all current or past service members, including police, fire, rescue and military. They will surround the First Responders of 9/11.
- Fourth, invite nurses, physicians, chaplains, caregivers, families and friends and all others present to surround the entire group in a tight circle of support.

One may limit the number of prayers and reflections or the length of the homily in order to honor the spirit of quiet simplicity and reverence. Remember to ask who may be missing from this prayer. If the prayer service is at night, candles may be used as a symbol of light and hope in darkness. If music is played, try to choose original instrumental pieces, rather than popular or traditional songs. A familiar song may trigger negative emotions in family members. Below are prayers of intercession that may be used in the service:

Prayers of Intercession:

God of all creation, comforter of the afflicted, hear the prayer of those gathered here who know so well the depth of the tragic loss of their loved ones on Sept. 11, 2001. Help us be your arms that surround them on this 10th anniversary of this moment that changed our lives. We pray:

All respond: ***God our Comforter, hear our prayer.***

We lift those who courageously reached out to people in need – our firefighters, police, emergency services and rescue personnel. Let us also surround them with our strength and prayer as we pray for your protection over them in the face of unknown dangers. We pray:

All respond: ***God our Protector, hear our prayer.***

On this 10th anniversary, we ask you Lord to surround our caregivers and volunteers who responded through their role in relief organizations such as the American Red Cross, Catholic Relief Services and Catholic Charities. Heal their memories and comfort them as they serve those in need. We pray:

All respond: ***God our Provider, hear our prayer.***

We lift to you our prayer for each young woman and man who has responded to the call to bring peace into the world. We pray for those who seek peace with their presence and those who protect peace against aggressors in other lands. Be with them when they are far from home and hold them when they hurt. We pray:

All respond: ***God our Redeemer, hear our prayer.***

DfUmYf`cZF Ya Ya VfUbW.

God of comfort we lift to you our prayer this day on the 10th anniversary of September 11. We ask you to surround us with comfort, protection and your Divine Providence. September 11 was a day when we as a nation lost so many. May we take this time to honor the women and men, and the boys and girls who lost their lives. When we struggle with the questions behind these events, help us to know that we are never alone. Guide us with the courage to know that when we stretch out our hands to you, we feel your embrace in the arms of our neighbor. May we always remember that we are one family in this world. Help us to know that our pain is yours; and the tears of our family fall on your heart. Guide us as a nation, and help your people to never forget how so many laid down their lives for their friends. Bring us your grace to hear the small voice of the one crying in the wilderness. Bring those who are suffering your comfort in our embrace. We ask this through Christ our Lord, who lives and reigns with you and the Holy Spirit, one God forever and ever.

Amen.

Gathering at the Flag:

A gathering may be planned outside at the base of a flagpole and the flag may be flown at half-mast for the day.

The Sounding of the Bell:

It may be appropriate to invite a representative from a local fire department to bring their Brass Memorial Bell and ring it three times in honor of those who died on September 11.

In the past, as firefighters began their tour of duty, it was the bell that signaled the beginning of that day's shift. Throughout the day and night, each alarm was sounded by a bell, which summoned these brave souls to fight fires and to place their lives in jeopardy for the good of their fellow citizens. And when the fire was out and the alarm had come to an end, it was the bell that signaled to all the completion of that call. When a firefighter died in the line of duty, paying the supreme sacrifice, it was the mournful toll of the bell that solemnly announced a comrade's passing.

We utilize these traditions as symbols, which reflect honor and respect on those who have given so much and who have served so well. To symbolize the devotion that these brave souls had for their duty, a special signal of three rings, three times each, represents the end of our comrades' duties and that they will be returning to quarters. And so, the bell is rung for those who have selflessly given their lives for the good of others – their tasks completed, their duties well done, their last alarm; they are going home.

9/11 Memorial Sites for Newsletters or Electronic Resources:

Depending on the size and scope of the gathering one may feature key links to the new 9/11 Memorial site in New York that is scheduled to officially open Sept. 11, 2011, to the memorial honoring those aboard Flight 93, and to the Pentagon 9/11 memorial.

www.911memorial.org

www.honorflight93.org

pentagonmemorial.org

SOURCE: *Vision*, September/October 2011

What relaxes and refreshes you?

By James Castello, MBA, MA, BCC

Before training to be a professional chaplain, I took a two-year course to prepare me for this career change from a corporate marketing executive to a minister of God's caring presence. In this course, the head of the school would meet each afternoon with the six to eight students. She would always begin every session with the same question – "What have you done for yourself today?" We knew it was coming, so we did our best to have a good answer for her.

At first, I thought it was a rather silly question but over time – 12 years working as a chaplain – I have come to appreciate both the power of the question and the logic behind it. Surprisingly, the power in the question is the logic behind it. Being a caregiver and working with many caregivers over the years, I have noticed that almost all caregivers are very good at giving care to others but downright awful at taking the initiative of caring for themselves.

Caregivers are notorious for giving and giving and giving to others until they run out of "gasoline," but they keep on trying to give because that's who they are. In contrast, a car's engine will automatically shut down as soon as it runs out of gasoline. Caregivers who run out of gas need to remember that "you cannot give what you do not have." It might be good for caregivers to remember that the gas tank of a car has a meaningful application to them.

Within the past year, I have started to ask this question of selected caregivers where I volunteer my services. About seven months ago, I was listening to a nurse manager named Ben tell me how stressed out he and his staff of nurses were. As he was talking, I remembered the simple question and so I asked him, "What have you done for yourself today?" He was a bit stunned at first but, after some thought, finally came up with a fair answer, "I ride around in my Jeep with the top off!" Not a bad answer, but maybe he could develop a better one.

I didn't see Ben for about six months as I was recovering from bilateral knee surgery, meaning both knees were replaced at the same time. When I finally finished with physical therapy, I returned to the hospital, covered my units and sought out Ben just to see how he was doing. He still sounded a bit stressed so I asked him "the question" again.

Without any hesitation, he immediately responded with, "I am playing ice hockey twice a week with two different groups of guys (different skill/age levels) and I am really happy." Now there's a keeper of an answer! Ben went on to say that he had "stolen" this question from me and used it with his nursing staff with success. I think that is a demonstration of the power of a simple question. It doesn't always work as I tried it on Ben's unit manager, who admitted that while she and her staff were stressed at times, they have been able to effectively deal with stress via other means.

Even though it is not foolproof, I would like to suggest that you consider using this question in your ministry with your staff and yourself. It is a simple and potentially powerful question that is short, easy to use and remember, and absolutely free. If you are wondering what I do for myself to relieve stress, I try to do at least one thing for myself daily – read, play the piano, listen to music, dance, swim, walk with my wife or drive my car (25,000 mile/year). Yes, I actually like to drive. It relaxes me, as do all of my self-care activities.

What do you like to do that relaxes and refreshes you?

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

SOURCE: *Vision*, September/October 2011

Executive Director's Column

Evolving landscapes: Planning, partners, and palliative care

As you read this column, we will be past Labor Day and heading into a full fall of ministry, events, and new programming. While chaplaincy does not live by the academic calendar, it still seems that our work settings have planned for a scintillating sprint until Christmas!

It is no different for the NACC, as we have many [local events](#) that will be taking place, along with audio conferences, and other offerings. I want to devote this column to three areas where the NACC is involved.

Planning

If you recall, my July-August 2011 *Vision* column shared some key areas identified by our members at the NACC National Conference business meeting that the NACC Board of Directors should focus on as they review and refine the [2007-2012 Strategic Plan](#). At their October 2011 board meeting our NACC Board of Directors will devote time to decide how best to map out a strategic plan to carry NACC into the coming years.

Feedback from you, our members, has highlighted many good NACC initiatives for our members over the past four years, including: NACC Now, local events, audio conferences, special ministry conference calls, state liaisons, *Vision*, special resources (e.g. SCC 2008 and 2011 Salary Surveys), and engagement with other partners like Catholic Health Association and members of the Spiritual Care Collaborative on special projects. However, your recent feedback to us also asks NACC to continue its work to support the professional foundations of our ministry as chaplains will be required to: respond to the shift in healthcare delivery from acute care to multiple delivery channels outside of the hospital setting; evidence more and more its productivity, effectiveness, quality, and value to healthcare leaders; and identify and prepare the coming generations of chaplains while feeling anxious at times for their own positions.

The NACC Board of Directors will consider this feedback, as well as determine ways to listen to our members in the months ahead. Please continue to contact me on areas that you believe the NACC needs to focus on in the future.

Partners

As the NACC Board of Directors reflects on the present and future of NACC, we see around us an evolving landscape among our partners that also will continue to impact NACC. In our [2007-2012 Strategic Plan](#), both goals No. 3 and No. 5 addressed the importance of our partners. Goal No. 3 emphasized strengthening our relationships with the Catholic Church, and goal No. 5 spoke of collaborating with strategic partners.

Catholic Church

Over the past four years, our relationships within the Catholic Church have strengthened as we have worked closely with our episcopal liaisons (Bishops Dale Melczek and Randolph Calvo, and now Archbishop Coakley), and the [Episcopal Advisory Council](#) to help the bishops understand better the mission of NACC, the changing profile of our members, the required preparation to become a board certified chaplain, and the purpose and importance of their endorsement. However, we are aware that the certification landscape with the Catholic Church is evolving as the [USCCB Commission on Accreditation and Certification](#)

(USCCB/CCA) plans to close its Milwaukee office this fall, and the bishops' oversight of ministry certification will shift to a subcommittee on certification within the USCCB Secretariat of Catholic Education in Washington, DC. Even though plans are not yet clear as to how this will evolve, we know our certification standards and procedures remain approved and we continue to certify our members.

The Catholic landscape regarding lay ecclesial ministry is also evolving. A handful of us from NACC witnessed this as we participated in the [2011 Collegeville Symposium on Lay Ecclesial Ministry](#). NACC was one of 43 co-sponsors. I wrote about this in the [August 8 NACC Now](#).

As you know, the bishops, especially with Bishop Dale Melczek's leadership, decided in 2004 that NACC begin to ask bishops to endorse our lay men and women as lay ecclesial health care ministers. The bishops adopted this "lay ecclesial ministry" language as a way to express their understanding of how our lay members, who are professionally certified as board certified chaplains, minister in the name of the church. "Co-Workers in the Vineyard of the Lord," approved by the USCCB in 2005, elaborated on the meaning of, and the preparation and authorization for lay ecclesial ministry.

Now six years later, at that Collegeville Symposium of 225 lay ecclesial ministers from around the country, it was evident that the understanding of what it means to be a lay ecclesial minister, whether one is a pastoral associate, parish life director, director of religious education, or a chaplain, continues to evolve through theological and pastoral reflection. This is good for NACC because we are a dialogue partner in this important evolution. Zeni Fox, on our October audio conferences, will further reflect on this topic.

Other professional spiritual care partners

This truly is an evolving landscape! Last fall the [Association of Professional Chaplains](#) (APC) decided to withdraw from the [Spiritual Care Collaborative](#) (SCC). The remaining five members of the SCC continued to oversee the task force that was charged with revising the Common Standards for Professional Chaplains, and received and endorsed these revisions. However, the SCC Steering Committee is in an evaluative process on the future direction of the SCC. Our biggest concern is the central importance for the spiritual care profession of the common standards and code of ethics agreed upon jointly in 2004.

You may have read that the boards of the APC and the [Association for Clinical Pastoral Education](#) (ACPE) are in dialogue to explore ways of collaborating and consolidating. Both board chairs, Sally Schwab of ACPE and David Johnston of APC, shared with their memberships the historic precedence and value of such a dialogue. NACC leaders remain in close communication with APC on projects, such as the 2011 Salary Survey, and ACPE on the future of the USCCB/CCA accredited centers and CPE supervisors.

We are excited about our growing relationship with the [Catholic Health Association](#) (CHA). Over the past year, Brian Yanofchick, senior director, mission integration and leadership development at CHA, and I have convened quarterly a Pastoral Care Advisory Group. CHA has now made this group a CHA administrative committee. Our common efforts will result in better identification and accessibility to our members of the best practices in pastoral care, collaboration on critical pastoral care areas of chaplaincy ministry outside of acute care, productivity and evidence-based practices, and other areas. We look forward to this growing partnership.

Palliative Care

Finally, this issue of *Vision* is devoted to palliative care, which is a remarkable evolving field. I appreciate those who contributed to this volume.

I am also grateful to our members who have over the past two years participated in monthly conference calls on palliative and hospice care. Those involved have often expressed the value of being able to

network with others working in the special area, to exchange resources, and to share their experience and insights. We have a growing number of [member-contributed resources now available on our website](#).

We appreciate the work of [HealthCare Chaplaincy](#) (HCC) to advance this palliative care specialty. The HCC mission is now specifically devoted to palliative care, and the HCC is refining the competencies for a palliative care specialty certification and developing a specified curriculum for the education/preparation of those pursuing this certification. HCC has partnered with NACC in the vetting of these competencies by inviting our members who participate in our monthly palliative care calls to give their feedback on the competencies and by including NACC members on its panel of experts who are working on this project.

We are also appreciative of our ongoing dialogue with Tina Picchi of the [Supportive Care Coalition](#) and our mutual commitment to strengthen the chaplain's role in providing spiritual care in palliative care, especially the chaplain's competency on interdisciplinary and transdisciplinary palliative care teams. More will be coming on this.

I hope these few thoughts give you some glimpses into the evolving landscapes that our NACC board leaders and I need to remain attentive to as we refine the future plans of NACC so that we can continue our mission:

The National Association of Catholic Chaplains advocates for the profession of spiritual care and educates, certifies, and supports chaplains, clinical pastoral educators, and all members who continue the healing ministry of Jesus in the name of the Church.

Please share with me your reflections on the above. dlichter@nacc.org

David A. Lichter, DMin.
Executive Director

SOURCE: *Vision*, September/October 2011

Certification Commission meets quarterly to cover issues

By Sr. Geraldine Krautkramer, OSF, BCC

Q How often does the Certification Commission meet and what is on the meeting agenda?

A The Certification Commission of the NACC meets quarterly. We plan one of our meetings around the annual conference, and in order to be fiscally responsible, we have begun to hold one of our meetings via a conference phone call. Our meetings are held from Thursday evening through all day on Saturday. This past July meeting, we met with the Interview Team Educators (ITE's). We listen to their summary report and engage with them with any items that arise through their participation in certification interviews. Since we had some new ITE members we gave them a warm welcome.

Each time, we meet with our executive director who presents a report including the financials and the quarterly certification activities. We discuss with him any items that involve the future of CPE within the NACC.

Other reports that we hear and discuss include one from Rose Mary Blanco-Alvarado, who is administrative specialist/certification, and Jeanine Annunziato, who is administrative specialist/renewal of certification. Susanne Chawszczewski, who is certification and education coordinator, reports on the items related to those areas. In particular she consults with the commission when there are questions about situations that surface through the educational and certification areas.



The liaison member of the Standards Commission gives another report. Two areas we discussed this time were the Ethics Accountability Statement requirement and English as a second language. These reports can be time-consuming as we seek clarification, discuss alternatives and how to respond to applicants in specific cases.

Each time the commission meets we review and vote for applications from chaplains with endorsements and pending endorsements. We also review and vote for chaplain and supervisor certification renewals.

Each year we look ahead to planning succession since members may serve two terms. Members of the Certification Commission are listed with their email addresses on our NACC website if you should have any questions or concerns you would like to direct to a member of the commission. Please go to www.nacc.org/certification/commission.asp.

Sister Geraldine Krautkramer is vice-chair of the NACC Certification Commission.

SOURCE: *Vision*, September/October 2011

Q&A with Betty Skonieczny, BCC, MPS

By Laurie Hansen Cardona
Vision editor

Betty Skonieczny, coordinator chaplain at St. Alexius Medical Center in Hoffman Estates, IL, doesn't shy away from challenges. At age 64, as a chaplain new to an acute care hospital, she set out to change its corporate culture, especially as it applied to palliative care. Why did she feel the need to do so? Her own life journey with multiple sclerosis revealed to her how important good palliative care could be. In addition, she was shocked to see hospital patients subjected to unnecessary exams and forced to stay alive because loved ones weren't ready to say good-bye.

Q Please tell us a little about your background.

A I am celebrating 35 years in ministry and have been a board certified chaplain since 1983. I have a bachelor's degree in religious studies and a master's of pastoral studies. I have worked as director of pastoral care in a for-profit skilled nursing home, a continuing care retirement community, and an acute care hospital. I have served as a director of mission integration and pastoral care for a continuing care retirement community. I am married 46 years, have three children and seven grandchildren.

Q I understand it was your own serious chronic illness that drew you to the field of palliative care. Can you explain?

A At the age of 28, I was diagnosed with multiple sclerosis. It was in my desire to "live" with multiple sclerosis that I tumbled into and felt called to be a chaplain. Interestingly enough, once I began my studies, the disease went into remission. I know what it's like to live with pain and a serious chronic illness. I would have loved to have palliative care available to me as I was living with this disease and aging.

Q What is the value of palliative care to the dying?

A As a chaplain, I have witnessed many deaths over the past 35 years of ministry. I was appalled at the way people died. Watching and journeying with people who were dying in long-term care facilities made me aware of why people are afraid of the dying process. Now working in an acute care hospital, I have become more aware of why we are a death-denying society. Over and over I've heard people say "let me die." And we don't let them die. In the nursing home we put nasal gastric tubes in them to feed them, even as they were dying. When they pulled them out, the nurses poseyed (tied) the patient to the bed and put the tube in again and again and again, until the person gave up in despair. After an experience with my own Aunt Sophie, I vowed to try to bring about change and have devoted my life to finding better ways for people to die.

Q What, in your opinion, is a "good death?"

A During these years I have also witnessed "beautiful" deaths -- deaths where the person was surrounded by family, or alone, if they so chose, not gasping for their breath, slowly and peacefully, sometimes even smiling, as they left this life on earth and began a new life in eternity. My own father's death was beautiful. He died at home, surrounded by his wife of 56 years and his three children. He had cancer of the liver and pancreas. As he breathed his last breath, a glow came over him and all the yellow-

orange coloring left his skin. My Mom, holding her husband of 56 years in her arms, said, "Oh Ed, you're so happy." Death is not our enemy. If we are a Resurrection people and have faith and trust in God, heaven and a new life with God is our ultimate goal.

Q What are your current struggles in the field of palliative care?

A When I left long-term care ministry and came to the acute care hospital, the first three months I had difficulty sleeping. I had worked so hard in the long-term care facility to bring in palliative care. The director of nurses and I built a model program of palliative care in our facility. Now, as a chaplain in an acute care hospital, I was again witnessing people being forced to live instead of allowed to die. Too many people were subjected to unnecessary tests and procedures, placed on ventilators, unable to experience and feel the love of their family members. Oftentimes this was not because physicians wanted to continue all these tests and procedures; instead the family wasn't ready to "let go" of their loved one.

One day as I was reading Vision, I came across an article by Linda Piotrowski, in which she shared her experience as a participant in the ACE (Advocating for Clinical Excellence) Project, sponsored by the National Cancer Institute at the City of Hope in Pasadena, CA. Through a grant, the City of Hope was offering leadership training for chaplains, social workers, and psychologists to become advocates within their institution for bringing about palliative care. I could feel my heart pounding. With approval from my employer, I applied and was accepted. Then I got scared. What had I gotten myself into? I was 64 years old, I'd only been at this hospital five months, and I was going to try to change its culture? I prayed and reflected for days. Never one to fear life's challenges, I began planning and awaiting my opportunity to attend the City of Hope Conference in October 2008.

Q Did your involvement in the ACE Project turn out to be beneficial?

A First and foremost, it set in motion a process to bring palliative care to St. Alexius Medical Center. Once an interdisciplinary team was formed, progress began toward making palliative care a reality. Evidence of the culture change was apparent when the new DNR Order and Pre-Arrest Form was taken to the Medical Executive committee for approval. At first, when Dr. Jenny Kang brought the form to the committee, there was a tie vote, broken by the medical director. In three short months, after meeting with various physicians and educating them on the value and importance of these changes, the vote changed: 12 affirmative and four negative. The education was making a difference. In the fall of 2010, the committee recommended hiring a palliative nurse practitioner and this was approved by the CEO and Medical Executive Team.

The palliative care nurse practitioner began Jan. 1, 2011. In the first eight months she has received over 120 palliative care consult requests from primary care physicians. The numbers of requests grow daily. It is now mandatory that any patient in the ICU for five days has a patient/family care conference. Budget plans for 2012 include hiring an additional palliative care nurse practitioner with experience in infant and child palliative care.

Q Have you achieved all your goals?

A Our program has a way to go. Physicians are still waiting until the person is critically ill or dying to call for hospice consults. Occasionally, we get what is a true palliative care consult – a person who has one or more serious, chronic illnesses that are causing pain and lessening the person's quality of life. Persons with advanced diabetes, strokes, various forms of arthritis, cancer, congestive heart failure, chronic pulmonary disease, sickle cell anemia, multiple sclerosis, Parkinson's disease, who are not actively dying can benefit from palliative care.

Palliative is actually not new; it is old. It began centuries ago, when "care" for persons who were ill were all medicine had to offer. Now that cures have been found, we've placed unrealistic expectations on physicians and medicine to heal all illness. God is master and creator of life. Enabling people to live more quality filled lives with their chronic illness is the goal of palliative care.

Related links:

Ms. Skonieczny's PowerPoint project for ACE: [www.nacc.org/docs/resources/ACE PROJECT POWER POINT.ppt](http://www.nacc.org/docs/resources/ACE_PROJECT_POWER_POINT.ppt)

Ms. Skonieczny's poster on her participation in the ACE Project, which was featured at the 2011 NACC National Conference: www.nacc.org/docs/resources/ACE Project POSTER-2.ppt

SOURCE: *Vision*, September/October 2011

Spiritual strength stories in end-of-life care create valuable dialogue

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

Introduction

Medical sociologist Arthur Frank (2004) said that what distinguishes palliative care is not expertise in pain control, as crucial as this skill is, but that it is dialogical insofar as "it seeks to expand not only what patients say about themselves but also the capacity of caregivers to hear what their patients say" (p. 111). One way to help this process flourish, I would suggest, is to adopt the latest developments in narrative inquiry from the perspective of spiritual and religious care.



Whereas previous studies have illuminated how palliative care patients responded to singular open-ended questions such as, "What is most important for you to achieve?" (Quill et al., 2006), and "What bothers you the most?" (Shah et al., 2008), I begin with the spiritual assessment question: "What spiritual strengths does the patient draw upon to address his or her spiritual needs/distresses?" Common spiritual strengths might include rituals, participation in faith-based communities, and knowing that one is loved unconditionally and that there is a deeper spiritual purpose to life.

Moreover, I propose that patients oftentimes express spiritual strengths as a kind of a brief ontological meta-narrative – a "spiritual strength story" – that clinicians can learn to listen for in casual conversations, which can then become the narrative source for expanding the dialogical aspects of patient-centered care.

A "spiritual strength story" has five defining characteristics: (1) it is brief; (2) it is ontological; (3) it uses symbols and metaphors; (4) it is a "big story" or meta-narrative with a positive spiritual and/or religious focus; and, most conspicuously of all, (5) it repeats. To illustrate my definition of this narrative type I will present examples of the "spiritual strength story" in two case studies, one drawn from my own practice as a palliative care chaplain, and the other from the work of Dr. Richard Coaten, a dance movement psychotherapist who uses embodied practices in his work with older people with dementia.

Case 1: I am the tree of life

The first time I met James Oak (a pseudonym) he introduced himself to me in good humor by saying, "I am the tree of life." He intended this to be an obvious pun on his name. This 91-year-old palliative care patient repeated this pun to me in subsequent conversations, which piqued my curiosity and interest, and I soon suspected that it represented a "spiritual strength story" for him that was worthy of further exploration. Thus I reflected my interpretation back to him later on in our developing clinical relationship in the manner of what Savage (1999) called a "story check" and as a means to open up a discussion about the potential meaning of this metaphor for him and how it could be used to enhance the quality of his care. However, he denied any deeper meaning or significance to it at all. "Oh, that was just a joke!" he said, dismissively. Nonetheless, as he reviewed his life with me over the course of many conversations, his "tree of life" metaphor did indeed appear to be a significant overarching theme that became more and more apparent to me, if not to him.

Mr. Oak would talk to me about how oak trees are characteristically large, full, and strong trees that provide much needed food, shelter, and protection to many small animals. I perceived this to be a significant metaphor for him in reference to his own life story, particularly with respect to his enduring focus on his love and care for his family, which was a topic that dominated his conversations with me and with other clinicians as well. "My philosophy in life is love," he said to me, and his eyes would well up with tears whenever he would talk about his devotion to his family. "Without family, you've got nothing," he would say.

The life review Mr. Oak conducted over many conversations with me included various vignettes that corresponded to the theme, "I am the tree of life." Embedded in his perspective of life lived fully over 91 years with much love and devotion to family was the enduring pain of the loss of his father when he was a young boy. Oak thus extended this "tree of life" metaphor to his life when he was a child, and to his father's life by saying that his father was abruptly and prematurely "cut down in the crash," by which he explained that the stress of the stock market crash in 1929 caused the sudden heart attack that killed him.

When I asked him once if he regarded himself as a "spiritual person," he said, "I try to be." This positive stance towards spiritual growth especially at the end of a long and full life corresponds also to the "I am tree of life" story that is indeed the summary expression of spiritual strength embodied in life lived deeply and broadly out of love for family.

Case 2: An extraordinary little rhyme

Richard Coaten is a dance movement psychotherapist with the National Health Service in Yorkshire, England. One of his therapeutic relationships with an 86-year-old client in the later stages of a dementing illness, whom, he said, had very little language left, revealed an "extraordinary little rhyme." His interest was piqued by this rhyme or mantra that this client had apparently composed herself and repeated to herself regularly throughout the day and to anyone else who would listen: "I'm Doris Sarah Loxley (a pseudonym) and I'm lost in a fog, so we sent Willy, a St. Bernard's dog who found me and brought me safely home, so we gave him a big juicy bone" (p. 28). As Coaten explained, "here is metaphor, symbolism and meaning . . . [and] the rhyme is supportive of, and connected to her sense of identity and observed well-being." Moreover, his analysis indicates a very strong spiritual component, as follows,

Metaphorically Doris is lost in a fog, the fog of dementing illness. There is a dog in her psyche that knows the way home and can bring her home in spite of the fog of a dementing illness. This is not just any dog but a St. Bernard, traditionally associated with monks who regard it as their spiritual duty to look after the dogs that save lost souls in the Swiss mountains. Doris can give the dog a name and thank it for bringing her home by giving it a big juicy bone as a reward (pp. 28-29).

All told, I think that this "extraordinary little rhyme" is indeed a "spiritual strength story," according to my five criteria. Moreover, the impact and meaning of the story does not end with Doris. Rather, Coaten explained that he felt compelled to learn this important rhyme himself and that he found it helpful within his therapeutic time with Doris to say it with her when she struggled to remember it herself. In this way, Coaten was able to "give these words back to her" in order to help her remain in contact with them – words that he would argue were essential to her own sense of self and personhood. Also, in his intersubjective position and witnessing the response to this giving back of her own words, Coaten gained an immediate validation from her by either a warm and affectionate smile or often by her saying, "you are my friend, my dear, dear friend, I love you and I have always loved you." Therefore, following the interaction that Coaten said had been repeated on many occasions, he was left with a profound sense of the importance to Doris of the rhyme and this communication held between them. As he put it, "In the process my informant has been able to communicate emotionally, verbally, and non-verbally (by holding my hand at the same time) matters of great significance to her." Coaten used this opportunity to open up

new insights and possibilities for therapy as embodied relationship.

Discussion

Discerning the deeper meanings of a "spiritual strength story" begins with curiosity. For example, in my relationship with Oak I was struck at first by how his story "I am the tree of life" repeated. As Savage (1999) indicated, "A theme can be detected by the recurring use of a single significant word or phrase" (pp. 98-99), and "through themes it is possible to discern the deeper truth" (p. 79). Likewise, Coaten asked, "What aspects of Doris's life and experience were crystallized in the form of that rhyme?" Moreover, listening to Doris raised some significant reflective questions for Coaten himself that he captured in his "scratch notes," including: "Why did I as a dance movement psychotherapist choose these words to focus on, and not her movements? Why was I drawn to them?" In this way, Frank (2010) argued that stories interpellate – hail or call – listeners to respond to them in a certain way according to a particular identity (p. 49) that can be expanded beyond one's own "narrative habitus" (pp. 52ff.). Thus, Frank (2010) asked, "Which call of stories do people answer, among all the stories that call, each day?" (p. 54).

There are at least three important points to consider and bear in mind when working with a "spiritual strength story." First, Coaten recognized that whereas Doris's life and experience might have been "crystallized" in the form of her rhyme, in no way did it "finalize" her in his therapeutic relationship with her.

Second, listeners who take the stories they hear and reflect them back to the storytellers in an attempt to open up metaphors and explore deeper meanings, must also be prepared for resistance and denial. Without appropriate rapport, people may consider it an invasion of privacy and become resentful and emotionally distant from you. But when you have built strength in the relationship, this is perceived as caring and helpful. For example, Doris responded most favorably to Coaten by saying, "you are my friend, my dear, dear friend, I love you and I have always loved you," whereas when I reflected Oak's pun "I am the tree of life" back to him, he perhaps perceived it to be an intrusion into his privacy and rebuked me, saying, "Oh that was just a joke!"

Third, listeners must respect boundaries in therapeutic relationships, especially the "otherness" or alterity of patients. In this way the other's story does not become my own, but as a listener I strive to develop sufficient resonance with that story so that I can feel its nuances and appreciate the story being told as embodied.

Conclusion

Like other researchers, I have argued that narrative inquiry is helpful to improving the quality of palliative care. More specifically, I have tried to show that narrative analysis of spiritual assessment data can help inter-professional healthcare teams enhance the quality of patient-centered care by providing an innovative theoretical framework. This framework can help clinicians understand better how spiritual strengths can be expressed in a kind of compact story that potentially holds deeper meanings worthy of expansion, which can contribute not only to what patients have to say about themselves but also to the capacity of caregivers to hear what they are saying.

Robert Mundle is a chaplain at St. Mary's of the Lake, Providence Care, in Kingston, Ontario.

References

Coaten, R. B. (2009). Building bridges of understanding: The use of embodied practices with older people with dementia and their care staff as mediated by dance movement psychotherapy. PhD thesis. Roehampton University,

U. K. At: roehampton.openrepository.com/roehampton/handle/10142/90376

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

Frank, A. W. (2010). *Letting stories breathe: A socio-narratology*. Chicago: University of Chicago Press.

Quill, T., Norton, S., Shah, M., Lam, Y., Fridd, C., & Buckley, M. (2006). What is most important for you to achieve?: An analysis of patient responses when receiving palliative care consultation. *Journal of Palliative Medicine*, 9(2), 382-388.

Savage, John. (1996). *Listening and caring skills: A guide for groups and leaders*. Nashville: Abingdon Press.

Shah, M., Quill, T., Norton, S., Sada, Y., Buckley, M., & Fridd, C. (2008). "What bothers you the most?" Initial responses from patients receiving palliative care consultation. *American Journal of Hospice and Palliative Medicine*, 25(2), 88-92.

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How parents of children receiving pediatric palliative care cope in tough times

By Kari R. Hexem, MPH, Cynthia J. Mollen, MD, MSCE, Karen Carroll, BS, Dexter A. Lanctot, MDiv, and Chris Feudtner, MD, PhD, MPH



Be sure to read Sister Maria Theresa Hronec's response, ["Applying this research to our ministry"](#), below this article.

Introduction

Improving our understanding of how parents of children with life-threatening conditions draw upon their religious and spiritual beliefs and practices when coping with their children's illnesses can help improve the care children and parents receive (Davies, Brenner, Orloff, Sumner, & Worden, 2002; Himmelstein, Hilden, Boldt, & Weissman, 2004; Kang, et al., 2005). In general, religion is thought to provide an orienting system through which many people cope with the consequences of stressful life events and address larger life questions (Kenneth I. Pargament, 1997). Previous studies in diverse populations have demonstrated a large variation in how ill individuals and their families think about, practice, and experience religion and spirituality. However, only a handful of research addresses, in a focused manner, religion and spirituality in the setting of serious childhood illness and pediatric palliative care. We therefore sought to clarify and illustrate the role of religion, spirituality, or life philosophy (RSLP) in the lives of parents of children with life-threatening conditions.

Participants in this study were parents of children who had enrolled in the Decision Making in Pediatric Palliative Care Study, a prospective cohort study conducted at the Children's Hospital of Philadelphia (CHOP) and funded by the National Institute of Nursing Research. In total, 73 parents of 50 patients consented to participate. To identify the role of RSLP in these parents' lives, 64 (88%) of the 73 parents interviewed, representing 41 (82%) families, were asked the following open-ended question: "Many people have a religion, spirituality, or life philosophy that helps to guide them through tough times. Do you have anything like that in your life?" Responses were coded and organized thematically.

Religious affiliation

Most parents identified themselves as members of a particular religious faith (mainly Christian, although one family identified as Muslim and one as Wiccan). Many parents described their affiliations very positively, such as one parent who said, "We're Presbyterian and we have a church that we're very involved in, and that's been a wonderful support." Parents who described themselves as not regular church attendees still often felt a connection to God or sense of spirituality. As one parent said, "If I want to talk to God, I just will." Another parent said, "I haven't been drifting toward any type of spirituality; I don't know what kind of spirituality it would be, but it would probably be my own." While most parents reported some level of religious, spiritual, or other beliefs or observances, some answered the inquiry with a quick "No," "No, not really," or "Umm, no" that did not invite further questioning.

Common aphorisms

In discussing their RSLP further, many parents offered aphorisms pertaining to an overall outlook, goodness, human capacity, and belief that there is “a reason for everything.” Some of these phrases referenced the sacred (i.e., “It’s in God’s hands”), other phrases (such as “What’s going to happen is going to happen,” “That’s just life”) did not. As one parent said, “God is always good.” Additionally, some parents described their children’s presence in the world as a gift. For example, one parent said, “Every day is a gift, because she was only given three days (to live). So every other day with her is a gift.” Parents also often expressed a sense of human capacity. For example, one parent said, “We’re not given more than we can handle.” The sense that “Everything happens for a reason” was also often expressed.

Just because parents believed there were reasons, however, did not mean they always found those reasons easy to accept. As one parent said, “I think there’s a reason for everything. I’m not always happy about it.” Further research is warranted to understand parents’ frequent use of aphorisms that perhaps function as heuristics or “rules of thumb” (Gigerenzer, Todd, & ABC Research Group, 1999) to explain their RSLP and allow them to make effective decisions with a minimum of time, knowledge, and cognitive effort. While such phrases may appear cliché or superficial, the importance of the words people use when framing both their understanding of a situation, and their actions within a situational framework, should not be overlooked (Lakoff, 1996).

Relating to the child

Certain qualities of RSLP pertained directly to the parents’ beliefs in the child’s value in the world and in an afterlife for the child. For example, one parent spoke about “where (our child) fits in God’s plan and why children like her may be born and, actually, their very special significance.” Another parent stressed that, because Jesus always paid attention to children, all children, including her child, were important. Other parents saw their children as having a role on earth to help bring people together spiritually. One parent said, “(Our child is) like Mother Teresa; she would walk into a room, and everybody would be around her, you know? And so I say that she’s brought down here to bring all these people together and to show (them) something.” In describing life for their children after their deaths, parents used many different words including “afterlife,” “a life after this life,” “golden gate,” “a better place,” “a happy place,” and “heaven.” Parents said that belief in an afterlife was “reassuring,” providing “peace” and “acceptance,” and helped them to be “not afraid” of their children’s deaths and “trust in God to take care of (our child).”

Practices

Studies of religiosity attempting to measure the level of intensity of religious and spiritual beliefs and practices by asking questions about religious behaviors have failed to find a constant direction of association between behaviors and either mental health (Ellison & Flannelly, 2009) or decision making (Lam, et al., 2009). In our study, parents primarily identified their RSLP practices as prayer (alone and in prayer groups) and reading the Bible. One important aspect of prayer was that it could happen anywhere. Parents also mentioned reading the Bible in response to stressful life events. For example, one parent chose to read the Bible stories of Job and of Abraham, saying, “All the trials they went through in life and how their faith in God brought them through – that helps me a lot.” Our findings suggest that, while specific religious practices are important to families, these may not be associated with end-of-life care beliefs or behaviors but rather a more general sense of peace and calm.

Coping

Studies of religious coping, which consider how religious beliefs and behaviors inform a stressful life situation, have successfully identified associations between religious coping and mental health over time (Hebert, Zdaniuk, Schulz, & Scheier, 2009; K. I. Pargament, Koenig, Tarakeshwar, & Hahn, 2004; Trevino, et al.). In two small studies of parents of children with cancer, parents reported strong religious beliefs and increased religious behaviors following their children’s diagnosis, and the positive influence of

religious beliefs on coping behaviors (Elkin, et al., 2007; Schneider & Mannell, 2006). While most investigations of religious coping in parents of critically ill children have studied bereaved parents, (Anderson, Marwit, Vandenberg, & Chibnall, 2005; Maton, 1989; Robinson, Thiel, Backus, & Meyer, 2006) our findings, gathered from parents whose children had life-threatening illnesses but had not died, nevertheless support the association between religion and coping.

In respect to coping, religion and spirituality impacted parents' perspectives on medical circumstances, decision making, and locus of control. Sometimes a pastor was seen as being able to mediate between the parents and the doctors. As one parent said, "(Our pastor) can understand a lot of the things that the doctors need him to process (for) us on our belief level." Parents reported that decisions were less difficult when they felt as if they knew or accepted God's will. Other parents sought the formal guidelines of their religion; as one parent said, "I want to know what the church teaches on extraordinary measures as to ordinary measures, to give you comfort about DNRs and how far do we go, and just something to really be at peace about." One parent contrasted "wanting to plan things, to control things" with her religion's teachings, which she said helped give her patience and gave her the ability to "think things through."

Additionally, most parents felt that their RSLP was very important in providing support, peace, comfort, and moral guidance. "Without it," one parent declared, "I wouldn't be standing here." Participating in a particular religious community resulted in parents receiving support from a large number of fellow congregants in the form of phone calls, e-cards, meals, and prayer for the child and family. Parents also benefited from prayer groups, and saw the church as providing "a network" and a source of "unconditional support and love." Pastors were occasionally referred to as "good friends." Parents also felt supported by God. As one parent said, "Casting all your care to (God) gives you the feeling that you're not alone." Parents also reported that trust in God resulted in feelings of peace and comfort. As one parent said, "It comforts us as parents spiritually to think that hopefully, when she passes, she'll have an opportunity (in Heaven) to do (normal) things and it's just a happy place." Other parents found religion helpful in coping with their anger. For example, one mother remarked on the need to keep her "Christian cool" when communicating with a doctor, and another said, "Every time I'm mad or upset, I start writing to (God)."

Difficulties

Even among parents who reported some level of RSLP, many also reported questioning their faith, experiencing feelings of anger and blame toward God, and rejecting specific religious beliefs and communities. Even those who remained strong in their faith experienced difficulties. One parent said, "No matter what, it's hard. There is pain. You don't want to let go." Even while expressing anger at God, parents said that their anger was not incompatible with their faith. As one mother said, "I do believe in God, but I'm kind of angry at him right now." Some parents moved away from their faith as a result of a child being seriously ill. One parent said, "I used to be a lot more religious, and I've had a really hard time with it." Another parent, in describing his move away from his faith, said, "I'm not going to sit and pray and hope that (my child) gets better. We're going to bring her to the hospital."

Conclusion

We hope that this study, documenting a RSLP catalog of common concerns expressed by this group of parents, assists those who care for similar families to approach them with an informed but minimalist agenda: namely, to gently explore the religion and spirituality resources and needs of patients and families; to effectively facilitate the coordination of appropriate supports and services; and to be fully present and engaged during their journey.

Kari R. Hexem, Cynthia J. Mollen, Karen Carroll, Dexter A. Lanctot, and Chris Feudtner are members of the Pediatric Advanced Care Team at Children's Hospital of Philadelphia, Philadelphia, PA.

References

- Anderson, M. J., Marwit, S. J., Vandenberg, B., & Chibnall, J. T. (2005). Psychological and religious coping strategies of mothers bereaved by the sudden death of a child. *Death Studies, 29*(9), 811-826.
- Davies, B., Brenner, P., Orloff, S., Sumner, L., & Worden, W. (2002). Addressing spirituality in pediatric hospice and palliative care. *Journal of Palliative Care, 18*(1), 59-67.
- Elkin, T. D., Jensen, S. A., McNeil, L., Gilbert, M. E., Pullen, J., & McComb, L. (2007). Religiosity and coping in mothers of children diagnosed with cancer: an exploratory analysis. *Journal of Pediatric Oncology Nursing, 24*(5), 274-278.
- Ellison, C. G., & Flannelly, K. J. (2009). Religious involvement and risk of major depression in a prospective nationwide study of African American adults. *The Journal of Nervous and Mental Disease, 197*(8), 568-573.
- Gigerenzer, G., Todd, P. M., & ABC Research Group. (1999). *Simple heuristics that make us smart*. New York: Oxford University Press.
- Hebert, R., Zdaniuk, B., Schulz, R., & Scheier, M. (2009). Positive and negative religious coping and well-being in women with breast cancer. *Journey of Palliative Medicine, 12*(6), 537-545.
- Himmelstein, B. P., Hilden, J. M., Boldt, A. M., & Weissman, D. (2004). Pediatric palliative care. *New England Journal of Medicine, 350*(17), 1752-1762.
- Kang, T., Hoehn, K. S., Licht, D. J., Mayer, O. H., Santucci, G., Carroll, J. M., et al. (2005). Pediatric palliative, end-of-life, and bereavement care. *Pediatric Clinics of North America, 52*(4), 1029-1046, viii.
- Lakoff, G. (1996). *Moral politics: what conservatives know that liberals don't*. Chicago: University of Chicago Press.
- Lam, H. S., Wong, S. P., Liu, F. Y., Wong, H. L., Fok, T. F., & Ng, P. C. (2009). Attitudes toward neonatal intensive care treatment of preterm infants with a high risk of developing long-term disabilities. *Pediatrics, 123*(6), 1501-1508.
- Maton, K. (1989). The Stress-Buffering Role of Spiritual Support: Cross-Sectional and Prospective Investigations. *Journal for the Scientific Study of Religion, 28*(3), 310-323.
- Pargament, K. I. (1997). *The psychology of religion and coping : theory, research, practice*. New York: Guilford Press.
- Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: a two-year longitudinal study. *Journal of Health Psychology, 9*(6), 713-730.
- Robinson, M. R., Thiel, M. M., Backus, M. M., & Meyer, E. C. (2006). Matters of spirituality at the end of life in the pediatric intensive care unit. *Pediatrics, 118*(3), e719-729.
- Schneider, M. A., & Mannell, R. C. (2006). Beacon in the storm: an exploration of the spirituality and faith of parents whose children have cancer. *Issues in Comprehensive Pediatric Nursing, 29*(1), 3-24.
- Trevino, K. M., Pargament, K. I., Cotton, S., Leonard, A. C., Hahn, J., Caprini-Faigin, C. A., et al. Religious coping and physiological, psychological, social, and spiritual outcomes in patients with HIV/AIDS: cross-sectional and longitudinal findings. *AIDS and Behavior, 14*(2), 379-389.

Applying this research to our ministry

This study reviewed well the varied parental responses/motivations – religious, spiritual, or life philosophy (RSLP), when their child is terminally ill. Appropriately, the majority of the surveys were from the past decade. This created an ideal spectrum that imaged the shifting levels of religion and spirituality today. Yet, where a child with its innate innocence is the focal point, hope centers on the lovable child and the goodness of a Supreme Being. The responses ranged from belief in Jesus and God, to an afterlife, happy place, heaven, peace, and included prayers alone, in groups or in reading the Bible. Thus, religion and spirituality provide conclusive impacts on parents' perspectives in medical circumstances and decisions.

When I am with parents and their terminally ill child, my first impression is one of intense helplessness. It is important that I remain present with a deep hope and belief in the God-presence I bring. By the strength of my own faith, I can invite them to pray for their child and themselves, trusting and grateful for the abundant, gentle love of a compassionate God. To call forth their own strength, I would remind them of the supportive power of a parent's love. To facilitate their coping, I could ask, "Where do you see God in this illness? What is helping you to cope through this difficult time? How do you find or claim the greater strength you need?" I appreciate this RSLP study as a reminder to listen more intently to the pain, grief and needs of the parents and child, to empower them in sharing their love and to support them by loving the God-presence I see in them.

*Sister Maria Theresa Hronec, SSCM, BS – Nursing
Bereavement Counselor
Chaplain at Geisinger Medical Center, Danville, PA*

SOURCE: *Vision*, September/October 2011

He stays with NACC, seeking signs of generosity, justice

Name: Bruce Aguilar, BCC

Work: Interfaith chaplain, Spaulding Hospital Cambridge, Cambridge, MA

Member since: 1992

Volunteer service: NACC certification interviewer, Vision contributor: book reviews and coverage of the 2010 NACC national conference.

Book on your nightstand: "The Girl with the Dragon Tattoo," by Stieg Larsson

Book you recommend most often: 11 CD set – "Great Themes of Paul," "Life as Participation," by Richard Rohr, OFM (especially Disc 4 "Flesh and Spirit as False Self and True Self"!)

Favorite spiritual resources: Centering prayer

Favorite fun self-care activity: Walking the dog (especially with others)

Favorite movies:

Favorite retreat spot: The "backyard ecology" in our garden (to borrow from Sara Stein, who wrote "Noah's Garden").

Personal mentor or role model: My father

Famous/historic mentor or role model: Oscar Romero

Why did you become a chaplain? A field ed requirement for my MA degree in pastoral counseling at Emmanuel College in Boston led me to (then) Boston City Hospital in 1992. I loved the direct involvement in a diverse setting.

What do you get from NACC? The certification process is first; also, the networking and continuing education (both at the national conferences in particular).

Why do you stay in the NACC? To be honest, I have considered membership in other associations when I have felt alienated from certain church positions. I have decided to stay with NACC, looking always for signs of generosity and justice within our association.

Why do you volunteer? To contribute to this ongoing certification effort, which depends on its already certified members. While the preparation time (reading materials, drafting reports) can be tremendous for a volunteer activity, could I say that I do not learn much from each interview about what matters most in being a chaplain today?

What volunteer activity has been most rewarding? I have especially enjoyed reviewing new books for Vision; a favorite – which continues to be one I use almost daily – is "Seven Sacred Pauses," by Macrina Wiederkehr, OSB.



In NACC, he finds life-giving passion for ministry

Name: Fr. Steve LaCanne, MDiv, BCC

Work: Director of spiritual care at St. Joseph's Hospital/HealthEast Care System in St. Paul, MN, and pastor, St. Leonard of Port Maurice, Minneapolis, MN. (Back in 1985, helped to start Archdiocesan AIDS Ministry and write Archbishop John Roach's letter on compassionate treatment for those with AIDS.)

Member since: 2007

Volunteer service: Co-chaired/hosted the local NACC National Conference planning committee for St. Paul 2010; Minnesota State Liaison for past two years; planned and hosted chaplain retreat/reflection day with Fr. Jim Lynch; Archdiocesan Presbyteral Council (dean), representing chaplains and healthcare and prison ministries; mentor for those seeking certification; will host statewide gathering with Bishop Lee

Piche this September with Catholic Chaplains; St. Joseph's liaison to the Catholic Health Association; assist in legislative support for healthcare locally, especially for needy and mentally ill, disabled and chemically dependent

Book on your nightstand: Richard Rohr's "Falling Upward"

Book you recommend most often: "How Big is Your God?" by Paul Coutinho, SJ

Favorite spiritual resource: The Sacred Scriptures

Favorite fun self-care activity: Motorcycling, cooking and gardening

Favorite movie: "The King's Speech"

Favorite retreat spot: Franciscan Retreat Center, Prior Lake, MN

Personal mentor: Dick Rice

Historic mentor: Mahatma Gandhi

Why did you become a chaplain? I have felt the call of God and privilege to be present at the times of illness and great transitions to the other side and the need for the church to be present to listen, bless, love and care. I have been a pastor and served in parish ministry half of my 35 years of priesthood while serving in healthcare in the other half. I find this ministry is less politicized in serving the poor in our midst.

What do you get from NACC? I get encouragement for the ministry to the sick and dying; I get challenged to do excellent work, which does not happen in the larger church. I find the support for lay ministry that is part of the dream of Vatican II and offers a vision for church that is not supported anywhere else. I feel a passion for ministry here that is life-giving in every way!

Why do you stay in the NACC? Because this is the most positive and non-divisive group of ministers in the church today who service the poor and those most in need. NACC has vision and hope! NACC offers challenges to excellence and greatness.

Why do/did you volunteer? Because it is fun and I enjoy the staff of NACC who are wonderful and full of joy and laughter! Also, NACC supports the vision of church and healing that I have a passion for.

What volunteer activity has been most rewarding? Working with lay chaplains and promoting this wonderful group of givers!

What have you learned? Transformative change takes much time and all of us need to "hang in for the long haul" with our church, which seems to be retreating from Vatican II and the best we can be. With the help of NACC and other circles of love, I can use my passion for constructive work in the church that truly makes a difference for so many others. Too many in our culture and church are acting out of anger and destructive judgmentalism. As Gandhi once said, "We need to be the change we want to see."



SOURCE: *Vision*, September/October 2011

Book is rich compendium of meditations, prayer, conversations

By John Gillman, PhD, BCC

The Last Adventure of Life: Sacred Resources for Living and Dying from a Hospice Counselor. 2nd edition. By Maria Dancing Heart. Findhorn Press, Scotland, 2008. Paperback, 263 pp. \$19.95.

A daughter of Lutheran missionaries to Japan, author Maria Hoaglund was in search of a Native American name like so many of the participants in the light-worker circle she regularly attended. "Dancing Heart" popped into her head. Working on healing from "a series of betrayals" in the first half of her life, she finds that her new name helps her open "the heart that's been closed" (p. 219). In this fine resource for both caregivers and care receivers, the author shares a multitude of interfaith resources. In her words, it is a guide for "letting go" at the end of life for all those who enter this sacred time of transition.

Drawing upon 10 years of experience as a spiritual counselor, Ms. Dancing Heart assembles a vast array of reflections from colleagues, survivors, and patients that she briefly introduces with her own reflections. The style is open, informal and engaging. She names the first four chapters after what she calls spiritual virtues: truth, beauty, love and joy. The next four are on the "spiritual processes" of trust, reflection, awareness and hope.

The next two chapters present an array of prayers, rituals, and songs as well as reflections on the transforming power of grief. The last chapter provides a summary of 30 healing modalities, ranging from aromatherapy to Reiki to kangen water. Based on technology developed in Japan, kangen water is alkaline, ionized water that serves as an antioxidant. The author also includes a highly useful 27-page annotated bibliography.

This rich compendium of guided meditations and prayers, conversations and reflections, makes accessible in one volume the wisdom of many from diverse cultures, traditions and spiritualities.

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

SOURCE: *Vision*, September/October 2011

World Day of the Sick February 11, 2012



Prayer Card Order Form

Item	Quantity*	Cost (each)	Total
Card 1 - Prayer of the Caregiver		15¢	
Card 2 - Prayer for Sick Persons		15¢	

*A minimum of 25 cards must be ordered.

Grand Total _____
(Includes shipping & handling)

The World Day of the Sick is sponsored by the Vatican's Pontifical Council for Health Pastoral Care and has been celebrated since 1992 on the feast of Our Lady of Lourdes. This celebration is a reminder to pray for all those who are sick and to recognize and honor those who work in healthcare and those who serve as caregivers.

Over the last several years, the NACC has provided support materials for this celebration such as an ecumenical service, reflection notes and homily hints, prayer of the faithful, and so forth. These materials are available on the NACC website; go to www.nacc.org/resources/wds/default.asp.

For 2012, the National Association of Catholic Chaplains will offer two separate prayer cards for World Day of the Sick: Prayer for the Caregiver and Prayer for the Sick. On both cards, the prayer appears in English on one side of the card and in Spanish on the reverse.

Name _____
 Title _____
 Institution _____
 Street address _____
 City & state _____ Zip code _____
 Phone number _____ Email _____

Mail the check and order form to:
National Association of Catholic Chaplains
4915 S. Howell Ave. Suite 501
Milwaukee, WI 53207-5939
(414) 483-4898

- **The number of prayer cards ordered will be based on all orders received by November 30, 2011.**
 - **Any special orders received after December 1, 2011 will require additional cost.**
 - **Additional fee for credit card purchases**
- DO NOT SEND PAYMENT – INVOICE WILL ACCOMPANY SHIPMENT**

BCH9. Hc VmM' gMj Yh cgY |bMYgIX| b'ci fB 577 '88%K cf X8 Urc Zh YQW WfXgzk YUFYg |b| Zf cfXfVm
 Bcj Ya VY" Sz88%zg kY\Uj YUVm Wl bh: cf ei Yg|cbgd YgY WbHm7 |bXn6f|X Yg fWf|X Yg4 bUWcf| E'