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Diversity in Spiritual Care: Across Religions and Cultures

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Online resources help chaplains learn cultural humility

By David Lichter
Executive Director

This issue of *Vision* is dedicated to ministering to diverse cultures and religious traditions. I was pleased to read the contributions to this issue.

I would like to call our readers' attention to two documents that I think can be very helpful in considering this professional competence, if you have not already encountered them.

The first is by James W. Green, "Cultural Diversity, Spirituality, and End-of-Life Care," in *Reflective Practice, Vol. 29, Forming Religious Leaders in and for a Diverse World, 2009, 74-90* (<http://journals.sfu.ca/rpfs/index.php/rpfs/article/view/221/220>). In this article Green provides a very helpful overview of how to respect the diversity of one's patients. He offers a perspective on the movement within healthcare to prepare providers from cultural competence to cultural humility. He provides a perspective on the evolution of preparation from the 1980s, when the focus was on being attentive to one's own attitudes, having basic knowledge of other cultures, and learning some general communication style. This was often too general to help.

He further discusses the 2005 AAMC *Cultural Competence Education* (<https://www.aamc.org/download/54338/data/culturalcomped.pdf>), which provided additional guidelines on knowing how ethnic groups perceive illness and symptoms, and how the health system might be a challenge to them. It emphasized the need for a cross-cultural competency that can be taught and assessed in terms of attitudes (Has the student learned the particular importance of curiosity, empathy, and respect in cross-cultural encounters?), knowledge (Has the student learned the key core cross-cultural issues, such as the styles of communication, mistrust/prejudice, autonomy vs. family decision-making, the role of biomedicine for the patient, traditions and customs relevant to health care, sexual/gender issues, etc.), and skills (Has the student learned how to explore core cross-cultural issues and the explanatory model? Has the student learned how to effectively negotiate with a patient?).

Green also provides some interesting questions to express the “cultural humility” approach of wanting to come to know the person one is serving. I appreciated their simple, exploratory nature. What do you think of them?

1. Some people want to know everything about their medical condition, others do not. Do you have a preference?
2. Do you usually make your own medical decisions or does someone help you with that? Is there someone you would like to have here to help you now?
3. Would you be more comfortable if I spoke with your spouse, sibling, son, daughter, etc., alone?
4. Is there anything you want me to know about your family, religious faith, or community that might be helpful for us both?
5. Sometimes people are uncomfortable discussing these things with someone of a different race or background. Do you have any feelings that would be helpful for me to know?

Green notes in *Footnote 16*, on p.90 of the article: “The questions quoted here are adapted from H. Russell Searight and Jennifer Gafford, ‘Cultural Diversity at the End of Life: Issues and Guidelines for Families and Physicians,’ *American Family Physician* 71 (2005): 515–522. See also S.J. Farber and others, ‘Issues in End-of-Life Care: Patient, Caregiver, and Clinician Perceptions,’ *Journal of Palliative Medicine* 6 (2003): 19–31. The latter reported that patients identified four areas that were significant to them: awareness of the approach of death, coping with everyday routines while keeping up necessary care, changes in personal relationships, and personal experiences that were new and, obviously, challenging.”

I appreciated Green’s definition of spirituality as “a way human beings create meaning, something they are prone to do at times of existential reflection or of threatening crisis. They respond with the resources they have on hand, making sense if they can of events that seem arbitrary, hurtful, and meaningless.” I also appreciate his description of cultural competence as “the capacity to enter into the experience and suffering of others, surely with empathy but also as a critical, analytical exploration of all that everyone brings to the encounter. It is a way of looking through a glass darkly, finding there the astonishing diversity of ways

humans salvage what they can from the inevitable presence of death. What could be more spiritual than that?"

The second document is *Advancing Effective Communication, Cultural Competency, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook, IL: The Joint Commission, 2010 (<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>).

We appreciate the work of Sue Wintz, editor of HealthCare Chaplaincy's *PlainViews*, and one of the Expert Advisory Panel members.

This roadmap provides the practical, yet assessable, elements for effectiveness. As you read through this document, you will notice the specific reference to recognizing cultural- and religious-based sensitivities. For instance, at *Admissions* it recommends a general question, such as, "Is there anything else the hospital should be aware of to improve your experience?" Such issues could include modesty, garments, or religiously important items. At the time of *Assessment* (15), one needs to identify the patient's cultural, religious, or spiritual beliefs that influence care. That assessment might include such items as: the welcoming nature of the hospital (Do images conflict?); needs/preferences (modesty, touch, distance); place of complementary/alternative medicine; and space to accommodate prayer. Of course, this assessment of the needs that influence care must be documented in the patient's record. The document recommends that a professional chaplain, if available, complete the spiritual assessment.

Similar attention to these issues is noted in *Treatment* (21), and in the end-of-life care where one should ask if there any cultural, religious, or spiritual beliefs or practices that may ease end-of-life care. *Discharge and Transfer* (31) advises to "create a list of follow-up providers that offer the appropriate services and accommodations to meet the patient's communication, cultural, religious or spiritual, mobility, or other needs." Under *Organizational Readiness*, they provide an expectation of "cultural humility" as "self-awareness and a respectful attitude toward diverse points of view — not expect to understand everything, but engage patients/families to gather info." (42)

Finally, you will find, "Include professional chaplains in care delivery whenever possible, as a valuable resource for cultural, religious, and spiritual information.

Consult the chaplain when addressing and accommodating patient's cultural, religious, and spiritual needs, beliefs, and practices." (42-43).

I offer this cursory review of these two documents in order to highlight their value as we navigate the unfathomable and rich diversity of the people we serve, and the people with whom we work. I am deeply grateful for your ministry to the people of our world in a time of estrangement as they face aging, suffering, and death.

Native American father gets chance to die with the sun on his face

By Bob Barnes

The patient, an elderly Native American man, was dying. He was lying in an ICU bed, being kept alive by a ventilator, his life slowly ebbing away. As the unit chaplain, I had spoken briefly with his daughter, Ann (not her real name), a few times as she wrestled with difficult life-and-death decisions. She hadn't wanted anything.

On this particular day I was paged to his bedside. Unlike the previous times, Ann was not alone. Several siblings and nieces were also present. Ann told me she had finally decided to withdraw the ventilator. As we sat together contemplating the enormity of this moment for her, a cousin spoke up. "Did you ask him yet?" Ann shook her head.

"Ask me what?" I inquired.

"Oh, nothing. It will never be allowed. Never mind."

"Well, I can't possibility know if it's allowable unless I know what it is."

Ann took a long, deep breath. She proceeded to talk in great detail about her father's life, his values, how he spent all of his time outdoors, and how he would never want to die indoors lying in a bed. "If we could just get him outside for even a few minutes, so he could feel the sun on his face. It wouldn't have to be long, and then we could remove the life support. I know it would mean so much to him, even if he's not awake."

I told Ann that I did not know if this would be possible, but that it was worth asking. I knew that we had a rooftop patio for staff, and that the weather this day was unseasonably warm for springtime in the North. The difficulty was the ventilator and fact that such a thing had never been tried. "Let me see what I can do."

I asked the patient's nurse and the charge nurse if they could move the patient to the roof on the vent and withdraw it there. Knowing the patient's values, both were very excited by the plan but feared that it would not be allowed. Nonetheless, they wanted to try. Together we talked to the family.

The charge nurse literally took charge at this point. She proceeded to get all the necessary permissions, including from the physicians involved, the unit manager, administration, and the legal department. She arranged to have two nurses accompany the patient, and to have a respiratory therapist present for the transfer

and extubation. Security asked all staff to vacate the patio so the family could have privacy. The arrangements came together incredibly fast considering their complexity.

At the appointed hour, a very strange-looking caravan moved through the corridors and up the elevator: the patient in his bed, a respiratory therapist at his side blowing air through the vent tube, two nurses, 15 family members and me. The weather was warm and pleasant as we emerged onto the patio, with the sun shining brightly overhead. Someone shouted, "Look, an eagle" and pointed straight up. We all imagined that we could see this important symbol for their culture.

After prayers at the bedside with the family and staff, the ventilator tube was removed. The family members crowded close, holding the patient and talking to him until he died very peacefully about 10 minutes later, the sun still shining brightly on his face.

We all lingered on the patio with the patient and family for some time afterward. Many commented that the patient would never have wanted to die in a hospital, but if he had to do so, that was the way he would have wanted to go. Ann and her family thanked the staff profusely for showing such respect for their culture and for giving them, and her father, what they felt was an incredible final gift. "You can't possibly know how important this was to us."

Bob Barnes, BCC, is a staff chaplain at St. Mary's Medical Center in Duluth, MN.

Jewish patients: Overcoming the barrier of self-protection

By H. Rafael Goldstein

I have worked in a formerly Catholic hospital and a major hospice as a Jewish chaplain, and have had the pleasure of working with very dedicated nuns and priests who did amazing work with Jewish patients. And I also worked in a 500-bed community hospital at which one of the admission questions was, “Would you like to see a chaplain?” In the year that I was there, not one Jewish patient ever said yes to that question. Is there a problem with accessing and providing spiritual support to Jewish patients when you are an interfaith chaplain, or serving in an interfaith capacity?

Jewish patients, like most patients, are afraid when they are in the hospital. Are they going to get better? Will a procedure lead to even more pain and suffering? Will the doctors come in with even more bad news? But Jewish patients face an additional fear when someone from a different faith comes into their room and offers spiritual support: “Is this person going to try to convert me, or threaten my religious beliefs?” This is probably the No. 1 barrier for non-Jewish chaplains who are offering spiritual support. I am not sure why this comes up as a basic fear from Jewish patients. I suspect it comes from darker times, when vulnerable people were indeed imposed upon for conversion by well-meaning religious professionals.

To overcome this fear, the chaplain needs to add to his/her introduction something to put the patient’s fears at rest. Those first few seconds at the doorway can make a huge difference. “I am Sr. Helen from the Department of Spiritual Care and I am here to check on how you are doing spiritually and emotionally. I know you are Jewish, and as an interfaith chaplain I respect and honor your religious beliefs.” Putting the patient at ease about who you are and that you are not a threat is essential if you want to get past the “No thanks, Sister.”

The other thing to remember is that there is no typical Jewish patient, just as there is no typical Catholic patient. Catholic patients may go to church and receive Communion daily, or once a month on a Sunday, or only on holidays — or maybe last saw the inside of a church for a funeral 20 years ago. The same is true for Jewish patients, who might be very observant, or non-observant, and everything

in between. For some Jewish patients, an opportunity to see “a rabbi” might mean a man in a black hat and untrimmed beard, which they would not want — or which they absolutely would want. There’s no way to know what the perception of the Jewish patient might be. But there are hints.

If you see anything in the room or on the patient that says “observant Jewish person” (e.g. kippah on the patient’s head, a Hebrew prayer book, anything in Hebrew), pick up on the cues. If you don’t, don’t assume — please ask! The vast majority of people will minimize the importance of their religion, which is an opportunity for you to help them with their spiritual awareness. Ask for permission to ask questions, and provide the spiritual care we are trained to provide by asking questions and active listening, and you will have a receptive patient.

As chaplains, we share the common belief that spiritual care can make a huge difference in living with illness and in recovery. We know it also increases patient satisfaction scores in a hospital (see Marin et al., “Relationship Between Chaplain Visits and Patient Satisfaction.” I am in the et al.!).* Jewish patients need spiritual care as much as any other patient, and breaking through the barriers they might put up can really help them access the help they need from their inner spirit, from universal energy, from their Higher Power, from the Holy One.

May the Holy One continue to bless you in your work, and, together, may we bring healing to the world, one patient at a time.

Rabbi Dr. H. Rafael Goldstein, BCC, is the Executive Director of Neshama: Association of Jewish Chaplains.

* <http://www.ncbi.nlm.nih.gov/pubmed/25569779>

Muslims are likely to welcome a Catholic chaplain

By Ty Crowe

Chaplains sometimes attempt to find common ground with patients to build rapport in the first few minutes. But many patients either do not need to have something in common in order to trust the chaplain, or don't feel like small talk. And in many cases, chaplains who visit patients of different faith backgrounds are more nervous about making a mistake or saying the wrong thing. This, of course, makes those visits more likely to increase the chaplain's anxiety and cautiousness, especially early in a visit.

However, most Muslims appreciate and respect the focus on a shared theological connection that indicates that, "God is the direction for all my prayers." This simple understanding is both unifying and gratifying, especially when clergy from the Jewish or Christian faiths arrive for a visit.

As a Sufi, and as a person who provides ministry in an urban medical center, my perspective is informed by my experience and my context. As we know, religious differences can lead to lengthy debates. Also, I can only skim the surface of culture, which is often embedded within religious frameworks and is an important influence on how patients perceive their situation and care.

However, I'd like to focus on three specific points that may be helpful to Catholic chaplains as they work to reach and support Muslim patients. I hope that these points will lessen anxiety and cautiousness when these visits occur.

1. World news takes its toll.

As small talk emerges and anxiety is managed, keep in mind that much of the world news that is shown in the United States contains negative impressions of Islam and focuses on radicalized people and terror. We cannot say enough that terror of any kind does not belong in Islam, nor does it represent the millions of faithful followers. But it is also a touchy topic, especially to a patient who is already suffering with a medical condition.

Do not assume that patients and family members have an interest in talking about world events. Only a few will want to, and, if so, they will initiate that kind of discussion. More often, the present experience of suffering and faith exploration will provide enough conversation for a meaningful chaplain visit.

Many practicing Muslims are noticing an increase of Islamophobia. Because Muslims are often recognizable, given their clothing or head coverings, they may feel guarded, especially around those who could pose a threat to them. You will find this dilemma present for patients, and also for medical staff who notice subtle mistrust and, sometimes, overt prejudice. Such prejudice needs to be discussed and explored. Without acknowledgment, the work environment for Muslim medical (and other) staff will feel at best unsupportive, and at worst unsafe. It is within the chaplain's role to bring up issues of injustice and religious prejudice so they can be acknowledged and addressed appropriately, often with support from diversity officers and HR experts.

2. Theological differences matter, too.

Many chaplains explore the inner, perhaps unacknowledged feelings that patients have about God, especially in light of both negative events that have occurred in their lives and their current hospitalization. It is somewhat common for chaplains to pursue this line of questioning, and as patients are willing, deeper feelings can be touched, shared, and explored.

But theologically, this line of questioning will not make any sense to a Muslim. In fact, it is likely that a chaplain will get a blank look followed by a defensive response, something along the lines of, "Why would I do that?" It doesn't make sense to question God's plan, even if it has led to suffering. Suffering is not something to be avoided, but rather embraced as part of a larger, more sophisticated and mysterious plan. A more specific question from the chaplain could be, "How are you working with God's plan for you?"

While God has a plan for every Muslim, every Muslim may not understand it or follow it. It could be interpreted that each time a deviation from God's plan occurs, it is a sin. Muslims believe that they were born pure and later develop the ability to choose right or wrong, to sin or not. When visiting adult patients in the hospital, many may reflect on their choices and their desire to return to God's path. Some Muslims will equate their suffering with poor choices and others will not, acknowledging the mystery of the unknown as the cause. Chaplains can be very helpful in unearthing this understanding of suffering from their Muslim patients in the hopes that healthy coping is occurring and adequate support is derived from their faith.

3. Expect to be invited in.

Begin each visit with the expectation that you will be invited in. While no one can guarantee this will occur, the way the chaplain enters the room often does make a difference. A Catholic chaplain can wear a cross or collar, which should not be a cause of anxiety or cautiousness. Most Muslims will automatically welcome a visit from clergy from the Abrahamic faiths.

Any attempt to connect using Arabic when you enter a room will likely be met with appreciation, although it is not required. To say, “As-Salam Alaykum” (Peace be upon you), a common Muslim greeting, would likely give a Catholic chaplain instant credibility and trust. Also, referring to God in Arabic as “Allah” would also help build rapport quickly. Again, this is not required.

Prayer is also most welcome and should be offered. Prayers concluding “In Jesus’ name” will not land well, obviously. However, a prayer concluding in the name of God will be perfect. Be prepared for more observant Muslims to begin some recitation of the Qu’ran after the chaplain’s prayer. It would be appropriate to stay in prayerful posture until the recitation concludes.

In conclusion, be mindful of the toll that prejudice takes on today’s Muslims in the United States. An awareness of the theological differences around God’s plan will help Catholic chaplains navigate conversations with those they visit. And chaplains should enter the rooms of Muslims with the expectation that they will be welcomed and that any use of general Arabic terms will be well received.

Ty Crowe, BCC, is an ACPE supervisor and director of spiritual care and chaplaincy at The Johns Hopkins Hospital in Baltimore.

Ministry to atheists or agnostics is meaningful in a different way

By Marcia Marino

Some of the patients for whom chaplains offer spiritual care are atheist, agnostic, or humanist (secular). Chaplains who have lived most or all of their personal and professional lives within a Christian community might feel hesitant or uncomfortable offering spiritual care to patients from diverse groups.

First, for clarity's sake, a few definitions. An atheist believes that God does not exist; an agnostic does not have a definite belief whether God exists or not; a humanist has values and beliefs based on the idea that people are basically good and that problems can be solved using reason rather than religion.

Here are a few basic reflections based on my experiences of serving as a Unitarian Universalist chaplain (who is a Buddhist) in a hospital system serving a predominantly Christian patient population. Of course, some of these suggestions are ones used by effective chaplains daily.

- Do not assume that the atheist/agnostic/humanist patient was previously part of an organized religious tradition. Their families may be atheist, agnostic, or humanist. Or not. It might help to encourage family members to share their stories so that the dynamics present in the room are clear.
- Do not assume that an atheist/agnostic/humanist patient is angry at God. These patients have come to their spiritual beliefs through their own unique journeys. Their spiritual choices may have much more to do with what they chose to walk toward than what they chose to walk away from.
- Do not be afraid to engage the patient in conversation. If she or he is feeling well enough, feel free to ask about their spiritual journey. If you understand their journey as an atheist/agnostic/humanist, it will be easier to be a more effective chaplain for them.
- Do not assume that a patient who is an atheist/agnostic/humanist will change her mind and have a huge spiritual metamorphosis during the process of dying. It will likely be offensive to the patient if you or anyone

else asks about such a thing. It may be important to also work with the nursing staff to help them understand and respect the spiritual beliefs of the patient.

Those are some of the Do Nots. How about some Dos?

- If there is time during these days of short inpatient stays, ask the patient to tell you some stories about himself (much as you would with any patient). If possible, ask: What has brought the deepest meaning to your life? This response may help you understand the patient's spiritual beliefs from a new perspective.
- Be your effective chaplain self: Offer your open-hearted, open-minded, deep listening self to these special patients, just as you do with others. Patients — no matter who they are — recognize authentic caring.
- Know that there is a higher than usual chance that these patients will want no visit from you. They may have had previous experiences with a chaplain or clergy member that left them dissatisfied or worse. They may also fear proselytizing or judgment from a chaplain.

Once I was called to see an atheist who had been out to dinner with two of her best friends from her apartment complex. She had suddenly collapsed at the restaurant, and her friends called 911. Scans at the local hospital revealed that she had a brain tumor, and she had emergency surgery. I stopped to see her the next morning. She was groggy, but awake.

I asked her if I could do anything to support her as a chaplain. She asked me to please do two things: To seek permission for her two good friends to come visit her in the ICU; she had no family. And secondly, to find new batteries for her hearing aids. I asked her for an empty package of her batteries and set off.

I spoke with the patient care manager of the ICU, who cleared the patient's friends for visiting right away. They had waited downstairs all night, and I went to the lobby to give them an update. I witnessed a poignant reunion of close friends before leaving the ICU that day.

The next day the patient was completely awake. Her first words when I stopped in were, “You’re not going to pray for me, are you?” I smiled and said, “Actually, that thought had not crossed my mind.” I asked how she was feeling and whether the batteries had arrived. They had, but she was frustrated. She had trouble inserting them; one of her neighbors always did it for her.

“Would you mind if I did it?” I asked. She looked a bit hesitant, but handed me her aids and the batteries, and I inserted them.

She looked at me with a funny smile. “I know that they don’t teach hearing aid battery classes at seminaries.” I nodded, and told her that I had worked as a speech pathologist for 10 years before going to seminary, and had worked with many people with hearing aids. I needed to get going, and asked if I could do anything for her as a chaplain today. She smiled, and said, “You already did. Thank you.”

Ministry with atheists/agnostics/humanists happens within our relationships of caring without prayer or ritual. It is still richly meaningful — just in a different way from other ministries.

Chaplain Marcia Marino, D.Min., BCC, teaches pastoral care online for the Church of the Larger Fellowship (Unitarian Universalist) and for the Oates Institute. She lives in Milwaukee, WI, where the Brewers are in another rebuilding season, and she may need a chaplain if the rebuilding continues.

A perfect Buddhist stranger in a different country

By Donald Stikeleather

I looked down at my census and saw the patient's religious status. Islam. Will I be accepted? Will the person have the patience to see I'm not there to convert him? Will he understand enough English to understand my role? These questions and others go through my mind. Chaplains have an individual pastoral formation and are also expected to be able to provide spiritual resources to all.

I am an APC board-certified chaplain serving newborn and cardiac ICUs of a pediatric hospital in Indianapolis. I also visit adult patients when I serve on-call. I am a white American male, raised United Methodist, now an ordained Buddhist in the lineage of Tibetan Siddha Chögyam Trungpa. I witness suffering and provide compassion, comfort, and reflection. I often pray with Christian patients, having inherited a prayer language passed down from pastors on both sides of the family. I enjoy the diversity of our patients, who travel great distances for specialized care.

My CPE journey included studying at a Catholic hospital, working at busy adult and pediatric trauma centers, and completing an ethics fellowship. I have an M.Div. from Naropa University, a Buddhist-inspired hotbed of contemplative education in Boulder, CO, where I met my spiritual teacher, Reginald Ray.

How does one minister to a patient from another religious tradition? I ask the patient what would be spiritually helpful. When I start *there*, I get much closer to helping their own spiritual coping meet their emotional experience as a result of medical experience. For example, with Hindu patients, I ask if there is a particular deity that they worship, and if it feels appropriate, I ask permission to pray to that deity. It is always helpful to ask if there is someone in their community to call. It takes a little practice to be a "perfect stranger" in someone else's religion (go to https://www.amazon.com/How-Perfect-Stranger-Essential-Religious/dp/159473593X/ref=sr_1_2?s=books&ie=UTF8&qid=1471362763&sr=1-2&keywords=How+to+Be+a+Perfect+Stranger+The+Essential+Religious+Etiquette+Handbook for a valuable resource). Practice leads to confidence.

How does one minister to a Buddhist patient? There are as many different kinds of Buddhists as there are Christians, and I'm not talking about denominations. For example, there is the Asian Buddhist patient who doesn't speak English, or speaks

English but is actually a Christian convert. There is the American patient who struggles with the idea of leaving Christianity, has read some books, has meditated, but is deep down a practicing Christian. I believe that spirituality is in our very cells, and an intellectual journey may be shorter than the convert's somatic journey to renegotiate and reconcile long-held beliefs. In cities such as New York, Los Angeles, Seattle, and Boulder, you will find Buddhist communities of converts. There are also householder (non-monastic) Asians who are cultural Buddhists but don't practice meditation (the monks do the practicing), and there are monks with an extensive support system of followers.

What about the visit? First, I let the patient know that I am aware that she is Buddhist. Having this acknowledged may be disarming. She may or may not want to talk much about feelings. What!? Thoughts and feelings, which lead to stories, are not valued the same way as in other religions, since Buddhism focuses on training the mind. It may help to ask a patient how her mind is doing. This tells her that you understand something about what she values. "How is your heart?" is another good question.

I'm not saying to avoid talk about feelings and thoughts or stories, but wait for the patient to initiate that. "How is this story helpful to you?" "How does your practice work with these feelings?"

Does the patient have a community to contact? It may not be local. I am part of an international community, but am the only one in my city. Does she have a meditation practice? If so, ask if she can do this practice while in the hospital. For some, the hospital is a perfect place to meditate, given the long periods of waiting among the chaotic sounds and interruptions. We meditate not to make the chaos go away (and we don't need the room to be completely quiet), but to BE with the chaos of life. Some Buddhists do formal prostrations, and while in the hospital, could be encouraged to visualize doing them if they are physically unable. It is important for them to count these prostrations/chants or other practices, so they might need a mala (beaded bracelet), or paper and pen. If they are Christian with Buddhist leanings, they may want to process that journey.

If they have a meditation practice, and you feel comfortable (or not), ask them to teach you the practice (you might already know it) and go ahead and do it with them right there in the room. That helps them know that you are joining them. What you learn, you can teach another patient!

There will probably not be a reason to offer prayer, since prayer is not a Buddhist practice, if you define it as speaking to God, since Buddhists don't speak of God and eschew the idea of dualism, of human AND Supreme Being.

When I have taught Asian monks about chaplaincy, they have asked eagerly if I chant with patients. I mention this to help you understand that there is a commonality of "this is what I do" when it comes to meeting someone outside of your belief system, with the trepidation of asking yourself to be open to what your patients actually need.

The very first time I prayed with a Christian patient, I felt the patient holding space during this important moment. Thousands of prayers later, I have gained more confidence, knowledge and skill. The same is true of the ministry to patients of other religions I have met. We start to build a reservoir of knowledge and confidence that we can be great spiritual resources. It begins with openness.

Donald Stikeleather, BCC, is a chaplain at Riley Hospital for Children in Indianapolis.

Respect the unique spirituality of the nonreligious

By Kathy Ponce

One need only search the web for “spiritual care of the nonreligious” to discover the many articles on this topic in the past several years. We Catholic chaplains need to think about how we minister to atheists, agnostics, those who consider themselves spiritual but not religious, and those who identify with no particular religious tradition. But perhaps the most important part of our personal reflection on our ministry involves our own attitudes toward those who may be very different from us from the standpoints of faith and belief.

I’d like to draw your attention to some great information currently available to all chaplains. An excellent introduction to and description of spiritual care of the nonreligious comes in the first and second parts of a three-part series by Rev. Mary Martha Thiel and Rev. Mary Redner Robinson, (both of whom are United Church of Christ ministers with strong involvement in chaplain education), and published in *PlainViews* in recent months.¹ They also provide very concrete and practical tips for chaplain ministry within these populations. I would urge all chaplains, regardless of their denominational affiliation, to read these articles by clicking the links above.

Rev. Thiel has also presented a webinar sponsored by the ACPE Academy (<https://www.acpe.edu/pdf/SpiritualCareOfTheNonreligious.pdf>). It, too, is an excellent resource for all chaplains in clinical practice. The audio as well as the PowerPoint slides of Rev. Thiel’s webinar are available on YouTube at <https://www.youtube.com/watch?v=uelSjCwnCAY>.

One of the most striking aspects of Rev. Thiel’s message, in my view, was her admonition to work continually to develop a cultural humility and a deep respect for the spiritual complexity of those we encounter in our ministries. This calls for a critical examination of our attitudes toward the “nonreligious.”

For those of us raised in a particular religious tradition, it may be difficult to imagine NOT having a belief in God steeped in a tradition that also provides a community of those who share our beliefs. For many of us who are Catholic

chaplains, our religious tradition may have been a part of our formal education anywhere from eight to 16 or more years. We may have come of age when the attitude of our church was somewhat triumphal and even contemptuous of those who were not part of our tradition. Our Catholicism, both the admirable aspects and the less admirable ones, may be far more a part of who we are than we might realize at first blush.

Developing humility as Catholic chaplains also entails understanding and appreciating why some people leave their traditions. It does not necessarily mean rejection of belief in God. Sometimes leaving is a result of hurts caused by exclusion — a feeling of not belonging because of disability (think of the many worship spaces that even today, are physically inaccessible); differences in culture or race (think of resistance by some to worship services in other languages); differences in age (think of young people who feel excluded if they show up in denim or with unique hairstyles); or differences in sexual orientation (think of the alienation experienced by gay members of a congregation, regardless of whether they are out or still stuck in “don’t ask, don’t tell”).

But aside from those reasons, there are those who truly cannot conceive of a higher power. Persons who espouse agnosticism or atheism have often moved beyond a “synthetic/conventional” faith stage to an “individual/reflective” faith stage or possibly to a unique variation on the “conjunctive” stage of faith in which an alternative community of like-minded thinkers becomes important. (For more on this topic, see *Stages of Faith* by James Fowler.) Because they often reflect much thought and study, the stances of atheists and agnostics are not to be dismissed by providers of spiritual care. People’s highest values and meaning in life are not necessarily tied to belief in God, but they are important and worthy of our investigation and our respect.

The times, they are a-changin’. As more and more people have abandoned organized religion or have difficulty with a belief in a deity (or deities), we Catholic chaplains need to take a very close look at ourselves to recognize our own biases and blind spots. (If you doubt that you might be very conditioned/ingrained in your tradition as a believer, just think of how often, when concluding a spiritual visit, you automatically say “God bless you,” “May you feel God’s presence in your illness,” or “I’ll keep you in my prayers.”)

As we Catholic chaplains explore the very real world of SBNRs (those who are “spiritual but not religious”), agnostics, atheists, and those who have abandoned organized religion, it is important to strive continually not just for tolerance, but for understanding through profound self-examination, personal reflection, and perhaps a careful rereading of James Fowler. As Catholic chaplains, humility is our best asset in providing spiritual care that meets the needs of all people of all cultures, faith traditions, and degrees of belief or non-belief.

Kathy Ponce, BBC, is an adjunct instructor at the Institute of Pastoral Studies of Loyola University in Chicago.

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- ¹ http://plainviews.healthcarechaplaincy.org/articles/Spiritual_Care_of_the_Nonreligious?

Chaplaincy and Hinduism: Two helpful links

To commission articles for this issue of *Vision* that concentrates on other religions and cultures, we approached our colleagues at the Association of Professional Chaplains for introductions to chaplains of other faiths who would be willing to write for us.

Through that connection, we contacted Swami Sarvaananda, a certified Hindu chaplain. She provided links to two previously published articles that may be useful to our members. See below for an overview of the role of a Hindu chaplain and a discussion of yogic preparation for death.

<http://www.hinduismtoday.com/modules/smartsection/item.php?itemid=3088>

http://iyta.org/wp-content/uploads/2016/03/IYMag.Winter2016_4.pdf

Caring across cultures: Programs and projects to promote diversity

By Beth Lenegan

“The first task is approaching another people, another culture is to take off our shoes. For the place we are approaching is holy ground. Else we find ourselves treading on another’s dream. More serious still, we may forget that God was there upon our arrival.”

— Author unknown

Caring for patients and families from a variety of ethnic backgrounds and belief systems can be challenging for healthcare professionals and chaplains. Practices and beliefs that center on illness, suffering, death, and bereavement are varied and can greatly influence important decisions regarding the health and treatment of an individual. These diverse practices and beliefs also influence the perception of the quality of care. It is well documented that caregivers who are sensitive to patients’ cultural and belief systems can reduce stress at very difficult times and increase patient satisfaction.

As a director of pastoral care in collaboration with the director of diversity and inclusion, I have come to understand that diversity means differing from one another, so any group of two or more people is a diverse group. Our focus at Roswell Park is inclusion. An individual’s race, ethnicity, nationality, language, gender, sexual orientation, physical capability, and spiritual beliefs need to be respected. It is important for institutions to understand and reflect the communities they serve. Chaplains are instrumental in creating an inclusive environment that fosters teamwork, nurtures innovation, relies on integrity and creates a culture of compassion and respect for each other.

For the past 17 years, I have tried to continually educate and foster the environment of respect for the employees and staff at my institution, as well as those we serve.

One of my first steps was to assess the spiritual, religious, and cultural makeup of the community that surrounds our organization — the community that our employees, staff, and patients reflect and return to. As a comprehensive cancer center focusing on research, education, and treatment, Roswell Park attracts

students, researchers, and patients from around the world. The city of Buffalo has a very strong Catholic presence, with pockets of refugees from distant countries. Therefore the first question is how we come to understand and respect one another's beliefs.

One early project was to develop a resource guide for healthcare professionals in an interfaith world. This resource guide reflects communities of faith and cultures in our area (see https://www.roswellpark.org/sites/default/files/21946_caring_across_cultures_final.pdf). This project accomplished three things: It introduced local spiritual leaders to Roswell Park's concern for the members of their community; the resource book educated employees and staff about the beliefs and values of their colleagues; and it became a tool that the institute staff could use as a guide to better understand the patients they were caring for.

I set aside a summer to visit men and women of different faiths and cultural backgrounds. I went with an open mind and asked each of them to teach me about the tenets of their faith; their sacred stories; the days they set aside as holy; the symbols and rituals of their tradition, and so on. Other questions included: What is your community's view of illness, end-of-life issues, withholding and withdrawing treatment, and bereavement? How do your culture and religion communicate with one another? What is the understanding of family? Male and female relationships?

The result of meeting with 32 individuals was the publication of *Caring Across Cultures and Belief Systems*, which reflected various communities that surround the institute as well as the diverse work force within Roswell Park. This past winter we added four additional communities and published the second edition. The 36 individuals that I reached out to now serve Roswell Park as community consultants.

To better understand the diverse community within, I formed an interfaith employee networking resource group. Our mission is to promote an understanding and tolerant work environment by creating awareness of various religious beliefs, practices, and social structures that our employees embrace. The goals of the committee are for all religions to express their faith in an appropriate and meaningful way in the workplace and to establish an awareness of holy day and religious observances practiced by different religions. The committee meets

every other month to plan the worship calendar for the year, as well as educational and social events that will increase religious and cultural awareness.

Also, the committee sponsors educational luncheons for the staff. A member of a faith tradition is invited to speak about his/her beliefs and values, and a caterer from that tradition provides lunch. One year, we invited staff to a Thanksgiving dinner and gave thanks for the diversity of Roswell Park. Last December, we sponsored a celebration of light and recognized those traditions that use light as a symbol during the winter and learned about their customs while sharing in their foods.

Pastoral Care Week offers an opportunity for chaplains to promote the work and ministry of spiritual care and to thank all who support our ministry. Patients and families are the best teachers of what is important to them during the time of illness, suffering and at the end of life. Each year, I invite five patients from different backgrounds to talk to our staff, pastoral care team, and area consultants about what their spirituality, religion, and culture mean to them and how their beliefs helped and challenged them as cancer patients.

Other ways I have promoted diversity and inclusion are: speakers, readings and choirs for patient remembrance services; website materials; and materials written for and distributed to patients and families.

Chaplains in all areas of ministry can be the leaders of tolerance, understanding and respect for all of God's people. Creating a culturally sensitive workplace environment will help us respect our colleagues as well as care for each person with a deeper understanding.

For more information about any of the programs or projects or about future programs, you can contact me at (716) 845-8051.

Beth Lenegan, BCC, is director of pastoral care at Roswell Park Cancer Institute in Buffalo, NY.

Culture must be studied and learned, Gittins says

By David Lewellen

***Vision* editor**

A different culture must be studied and learned just like a different language, according to Fr. Anthony Gittins.

“Good will is simply not enough,” said Fr. Gittins, CSSp, a professor of theology and culture at Chicago Theological Union. “You need serious skills and habits. ... Take lessons. Be willing. It’s scary, but believe that it’s possible.”

Fr. Gittins began to form those conclusions as a young missionary in Sierra Leone while he was also working on his doctorate in anthropology. As a white cleric from Great Britain he brought a particular faith, which he initially assumed that the African laypeople he worked among would assimilate. But he quickly realized that not only couldn’t they do so, but he didn’t want them to.

In his new book, *Living Mission Interculturally*, Fr. Gittins distinguishes between “multicultural,” in which cultures live side by side with little interaction, and the more difficult but rewarding idea of “intercultural,” in which two people or cultures are changed by their encounters.

Theology has lagged behind anthropology in this idea, Fr. Gittins said, but faith can only be lived through culture — meaning that people of a different culture will experience faith differently.

That leads to the possibility of syncretism, which “get a bad rap in Catholic theology,” Fr. Gittins said. But one must be careful to assess and discriminate between good and bad syncretism; if others “live out their Christianity in a different way, it becomes enriching to both of us. We need to be enriched reciprocally.”

Understanding another culture does not just mean a nation or an ethnic group; it can also extend down to the level of a particular parish. And not all encounters with other cultures are positive, of course; Westerners may well feel confused or disgusted by the practice of female genital mutilation, and Gittins pointed out that as a Catholic priest, if he encounters a patient with a sexually transmitted

disease, “there’s going to be a degree of disgust. I’ve got to deal with that and go beyond that to empathize with this person. We come up against our prejudices, our likes and dislikes. We have to note our personal response and disavow our own tendency to offload our response, legitimate or illegitimate.”

In interreligious interactions generally, and for chaplains in particular, he said, “Be very careful not to try to convert or coerce.” Gittins himself spent many summers working as a hospital chaplain, “assimilating my own authentic way of operating into the way I related to doctors and families and patients.” From the experience, he learned that “hospital chaplains need to be very careful listeners, and very slow to judgment, and very willing to take advice from people who know better.”

Literature from other disciplines addresses cultural competency

By Marilyn Williams

Although the Certification Standards and CPE programs address diversity and cultural competency, few research studies or academic articles by chaplains address the delivery of spiritual care to diverse populations. An early exception is a February 2004 article that introduced and demonstrated a five-step process of competency assessment in two clinical cases by Robert G. Anderson, a chaplain with New York Presbyterian Hospital. This article was also included in a book, *Ministry in the Spiritual and Cultural Diversity of Health Care*, edited by Anderson and Mary A. Fukuyama.

However, many articles on this topic in the nursing, medical, and public health literature could be useful to the healthcare chaplain. One frequently cited source is Dr. Josepha Campinha-Bacote's *Cultural Competence in the Delivery of Healthcare Services Model* first described in a January 31, 2003, article in *The Online Journal of Issues in Nursing* (<http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume82003/No1Jan2003/AddressingDiversityinHealthCare.aspx>). This model identifies five constructs of cultural competence: cultural awareness (a self-reflection of one's own biases), cultural knowledge (of other cultures), cultural skill (or assessment regarding the patient's culture), cultural encounters (personal experiences with patients of different backgrounds), and cultural desire (the process of wanting to be culturally competent). In addition, Campinha-Bacote emphasizes that cultural competence is a process whereby the provider should continually strive to effectively work within the cultural context of each client.

While Campinha-Bacote's model deals with the cultural competency of individual clinicians, also during 2003 Betancourt et al. (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf>) published in *Public Health Reports* a framework and conceptual model based on a literature search that also addressed organizational and structural barriers to cultural competency. They found strong evidence that there is a need for organizational and structural as well as clinical interventions. Their model may be particularly applicable to mission leaders' efforts to address diversity and cultural competency throughout their healthcare systems.

One practical checklist for looking at clinical, organizational, and structural issues regarding diversity and cultural competency in healthcare settings is included in a Mather Lifeways Orange Paper by Dawn Lehman, Ph.D; Paula Fenza, MA; and Linda Hollinger-Smith, PhD, RN, FAAN, entitled *Diversity & Cultural Competency in Health Care Settings* (<http://www.matherlifewaysinstituteonaging.com/wp-content/uploads/2012/03/Diversity-and-Cultural-Competency-in-Health-Care-Settings.pdf>) available at www.matherlifeways.com. This paper also included a good literature review.

The journal *Theological Education* based an entire issue in 2013 on a project funded by the Luce Foundation: “Christian Hospitality and Pastoral Practices in a Multi-faith Society,” which could potentially enhance cultural competency models in healthcare, especially for Catholic and other faith-based systems (see <http://www.ats.edu/uploads/resources/publications-presentations/theological-education/2013-theological-education-v47-n2.pdf#page=47>). The project that started in 2010 brought together faculty members, scholar practitioners representing world faiths, and chaplains from hospitals, correctional facilities, and the U.S. military to explore pastoral practices of preaching, teaching, pastoral care, marrying, burying, and others. The project was structured around the three ecclesial families with the Association of Theological Schools: evangelical Protestant, mainline Protestant, and Roman Catholic/Orthodox. As such the first three essays provide each group’s perspective regarding Christian hospitality and pastoral practices.

Adeney, Bidwell, and Walker suggested in one article that in the coming decade, theological education’s primary task may be cultivating a capacity for dialogical heart based on a relational stance toward the Religious Other of receiving hospitality as much as providing it. The dialogical heart involves a capacity to recognize the Imago Dei among believers of other faiths, a trust that God is the agent of conversion and therefore proselytization becomes an unnecessary practice (p.41). In addition, Amos Yong claims that “it is the very nature of the triune God to be a guest in the presence of Others” in suggesting that theological education should require visiting those in other faiths in their sacred space (p.79). Perhaps the quality and experience of healthcare for all cultures and religions would be enhanced if healthcare professionals saw themselves as giving and receiving hospitality. Indeed, the term *hospital* derives from the root word for *hospitality*.

A 2016 article (<http://www.mdpi.com/2077-1444/7/5/53>) that would interest especially chaplains in palliative or hospice care is from a 2015 Spirituality in Healthcare “Sowing the Seeds” conference by Hamilton Inbadas at the University of Glasgow, published in *Religions* (7(5), 53. Inbadas asserts that most studies regarding spirituality and end-of-life care often represent an individualistic understanding of spirituality. He cites a number of references noting that understandings of and attitudes to death are deeply rooted in cultural, historical and contextual factors. He concludes that “further research is needed to understand how spirituality is shaped by history and culture and maintained through traditions in particular contexts.” Also, this research can inform effective spiritual care at the end of life. Another study related to culture and end-of-life care is one studying the impact of physicians’ religion and ethnicity on ethical decisions. (*Journal Medical Ethics*. 2010; 36 (11):677-82)

In another very interesting recent study regarding culture and healthcare, Lucchetti et al. studied physicians’ perspectives on the influence of spirituality and religion on health from three different cultures: Brazil, India, and Indonesia. (*International Journal of Behavioral Medicine*, February 2016, 23:1, pp 63-70 – at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf>) This was a cross-sectional, cross-cultural, multi-center study from 2010 to 2012 of 611 physicians. Lucchetti concluded that ethnicity and culture have an important influence on how spirituality is addressed in medical practice and that these cultural differences must be considered in developing curricula for physicians on how to address spirituality in clinical practice.

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Welcoming the stranger: Engaging diversity toward the beloved community

By Maggie Finley

Culture shapes all encounters. Much of how we gain access and move through culture depends on perception, understanding, and meaning. As people of faith, we come from a place of humility, knowing we tread sacred ground. It's already in our chaplain DNA to bridge gaps, so in spite of our differences, relationships always starts with conveying genuine concern as we plumb patient stories for their hopes, dreams, and expectations for good care. To enter into another's pain is to approach humbly, for where we tread is sacred ground.

Fortunately, post-Vatican II, we've inherited the wisdom born of the revolutionary interface between social science and theological inquiry — a first step toward deconstructing the heritage of colonialism in favor of more liberating local theologies. Animated by a new sense of Shalom, incarnating the God who pitched a tent to reconcile all of creation, paradigms for pastoral ministry shifted. We were encouraged to recognize, accept, and celebrate the unbounded creativity of a Spirit already at work in all people, places, and circumstances.

I've been privileged throughout my chaplaincy to study multicultural and cross-cultural communication. I felt compelled to learn as much as possible, not only to become a better chaplain to a diverse population, but to come to a deeper knowledge of myself as a multiracial woman in ministry. Working at University of Washington/Harborview Medical Center's Community House Calls and Interpretive Services in Seattle, and later at Harborview's International Women's Clinic, I learned about Berlin and Fowkes' LEARN Model for cross-cultural communication. It's simple and not unlike what we already do:

- Listen** to patient/family story, perceptions, concerns
- Explain** your perspective [role], ask them to explain as well (reframe, assess understanding)
- Acknowledge**, discuss differences and similarities
- Recommend** a plan (e.g. plan of care or referral)
- Negotiate** agreement (explore ways to serve)

A word about interpreters: I highly recommend using them whenever appropriate. I know some hospitals prefer telephone “language lines,” and I know we tend to be constrained by time, short staffing, and large caseloads. But they can be wonderful allies in furthering our work.

Whether or not you make interpreter-assisted visits often, you can learn contextually during visits. If possible, speak privately with the interpreter for a few minutes before and after the visit. Ask for thumbnails on the environment you’re about to enter, then at the end try to process briefly. This way you are not one more member of IDT to overwhelm with or repeat questions. Try to find practitioners actually trained as cultural brokers, recognized members of communities served. Besides language and custom, a good broker may be fluent in diverse belief systems related to health, healing, and wellness; cultural variations in the perception of illness/disease and cause; help-seeking behaviors and attitudes toward healthcare providers; and indigenous/traditional health practice.

Transcultural bridge-building is painstaking and precious. These questions have implications for how well you provide spiritual care:

How do the patient and family see my role? What, if anything, do I offer?

Is there concept and/or language equivalency? Do I need an interpreter? Are shamans, medicine (wo)men or other spiritual leaders involved in care and healing? What are some ethical pieces in the patient’s particular religious context? What rituals are there for sickness, healing, and dying? Is syncretic practice present (e.g. Native Americans who may practice both natural and Catholic religions)? If so, is it still kept secret (i.e. clandestine rituals forbidden or unlawful in the past)?

What’s the concept of family? Who are mediators or contact persons? What are customs and language for delivering bad news? What must you understand about a patient’s right to know? Are interactions gender-specific (e.g. care for Muslims)? Are family dynamics intergenerational (e.g., do Gen Xers and millennials embrace the dominant culture)?

As you probably know, many of those seeking care are from diaspora

communities challenged to find footing in the dominant culture. So there may be unspoken concerns about racism, finance, immigration status, or language skill that need sensitive intervention.

Chaplain interventions can enhance cultural communication because of what's uniquely ours to give — listening deeply to a particular narrative for what has personal meaning, connection, and congruence. Competent and compassionate presence has the potential to build relationship and beloved community — an ideal that we cannot overlook, especially when cultural divides are daily drawing attention to an urgent need for better understanding.

So questions of how we navigate culturo-religious difference may be always with us. The good news, as Okokon Udo tells us, is that “none of us can be an authority on the values and beliefs of every culture.” Competence comes from hearts “opening to and holding cultural difference with deep respect, with eagerness and willingness to learn and accept that there are many ways of looking at the world.”

Maggie Finley, BCC, is a retired chaplain from Providence Hospice of Seattle.

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Our road to Emmaus leads through Albuquerque

By Beth Lenegan
Conference Task Force Chair

“I paused on the journey and looked back at where I had come from. I saw the spots where I had stumbled and gotten up again. And I was able to see just how far I had come and what an incredible traveler I had become.”

— Author unknown

In April, Catholic chaplains and chaplains of other faith traditions from across the nation, Canada and beyond will travel to New Mexico to be energized, supported, challenged, and transformed personally and professionally. The conference theme, “Hearts on Fire, Our Own Emmaus Journey,” will offer an opportunity for each person to reflect on his or her own journey as a follower of Christ.

Our time together in New Mexico will be about our individual and communal journeys and reflecting upon the companions we encounter along the way. Those companions will include men and women in sacred scripture as well as contemporary figures who have laid the foundation for our Catholic Christian faith.

On the road we travel, we are continually developing our own story while we engage in the stories of those we minister to, as well as a global story. These stories are filled with challenges, struggles, brokenness, and strife, as well as joy, grace, peace, and reconciliation. As we encounter the roads of life, how do we — as individuals, as a church and as an organization — continue the living tradition through these sacred stories?

Our road and our ministry are not done in isolation. As we continue toward our own Emmaus, we are constantly reminded that God is always present — ahead of us and beside us. This God is one of faithfulness who calls us to continue the work of his saving action.

As we discover the meaning of our own Emmaus, we are transformed every step of the way. With the presence of God and burning hearts, we grow personally,

professionally, and as followers of Christ. We continue the mission of a Church with a living tradition and sacred stories, always in the presence of a living God.

I am proud and humbled to serve as this year's conference chair. As we are well aware, this conference cannot be planned by one person. I would like to thank the task force members: Tom Chirido (plenary chair); Alex Chamtcheu-Tchamtcheu (workshop chair); Fr. Rich Bartoszek (liturgy chair); Eve Kelly Corcoran and Mary Catherine Casey (local arrangement co-chairs) and Michael Saxton (board liaison). Also, this conference would not be possible without the incredible support in the national office from David Lichter, Jeanine Annunziato, and Andris Kursietis.

I invite each of you to journey with us to the beautiful and culturally rich state of New Mexico to look at our rich tradition, share stories as fellow companions, re-discover the God before us and with us, and continue the journey with burning hearts.

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Chaplaincy and the Cry for Mercy

Christine M. Bochen (ed), *The Way of Mercy*. Maryknoll, NY: Orbis, 2016. 143 pp. \$18.00

By Anne M. Windholz

Worldwide, we have experienced a violent, divisive summer. Respect for human dignity and compassion for the outcast seem to be crumbling. Innocents die. Afraid, we choose sides, claim righteousness, and judge anyone who is “other” or thinks “otherwise” as misguided at best, evil at worst. Too often we thank God that we are on the side of “right,” that our insight is the gold standard by which all things ought to be judged, making it a duty to sacrifice our neighbor on the altar of our rectitude.

But then, through the din of disillusion and grief, the cry of Hosea rises: *I desire mercy, not sacrifice.*

The contributors to Christine Bochen’s *The Way of Mercy* offer prophetic indictment of a society wedded to what Thomas Merton calls “the demonic falsification of mercy.” The slimness of Bochen’s volume is deceptive: She gathers spiritual heavyweights to take up Pope Francis’ Jubilee call. Jim Forest quotes Flannery O’Connor’s warning against a tenderness “detached from [its] source” in God, leading to “forced labor camps and the fumes of the gas chamber.” Jon Sobrino decries “sheer sentiment” shorn of praxis. Elaine Prevallet insists that authentic mercy “sees things as they are, sees the cruelty, the pain, looks the brokenness right in the face, takes it all in.” Their messages resonate with a central lesson of chaplaincy training: that avoiding conflict, offering pious platitudes, and looking away from injury is not ministry but self-indulgence. It can cost people their physical as well as their spiritual lives.

While directed toward a wide audience, this book might be a guidebook to our profession. Francis’ documents set the tone, extolling mercy as key to the psalms, wisdom literature, Gospel parables, and the Beatitudes. He appeals to an ecumenical, interreligious, and *active* mercy that “eliminate[s] every form of close-mindedness and disrespect, and drive[s] out every form of violence and discrimination.” Other writers underscore his counter-cultural emphasis on forgiveness, unconditional love, and openness to neighbor. Leonardo Boff speaks of an “ethic of urgency” and a “potency of service” that could constitute a chaplain’s job description: “always opening oneself to others, letting them be, listening to them, welcoming them, and if they fall, reaching out

to them.” To adapt Prevallet’s argument, our call is to create a space for mercy where healing can occur.

This is no passive, comfortable vocation. Boff describes mercy as transfiguring, a “colliding meteor.” Mercy “loves to the point of folly,” Dorothy Day reminds us, dares rejection and heart-crushing sorrow. Willingness to suffer — and to suffer with — becomes, Joan Chittister maintains, “the measure of the God-life in us.” That alone must be the gold standard against which we measure our competence, the core of Pope John XXIII’s “medicine of mercy” (quoted by Bochen, ix).

During what remains of this Jubilee year and beyond, may we have the courage to bear this elixir to those sick in body and heart. May we receive the grace to share mercy with each other when we falter from pain or stumble over injustice. And, as we move ahead, let’s keep *The Way of Mercy* in our pocket to remind us why we do what we do, and for whom.

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