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Professional Practice

Chaplain Virgil Fry on allowing grieverers to grieve

A Reluctant Griever

To regard grief as somehow unworthy of a Christian who believes in the resurrection is to forget the example of Christ who was so often “moved with compassion,” who wept at his loss of Lazarus and prayed the longer in his agony. We cannot short-circuit human processes; we have to give the experience time to come home to us before it can become a motive for hope and a promise of fuller life...Grief is only unchristian if it is wholly self-centered or if we never emerge from it.

Maria Boudling, *Prayer: Our Journey Home*

I write these words from the raw side of fresh grief. Less than two months ago Caryl, my beloved wife of 33 years, died.* A tenacious, vibrant, faithful woman, she finally succumbed to death after two hard years of declining health, and fifty years of being a Type 1 diabetic. The battle for her has ended.

But for me, the battle is not over – it’s only beginning. Many a kindhearted person has tried to console me with the reality that she’s now better off, her suffering has ended, and she’s in a much better place.

The other side of that coin that isn’t acknowledged is this: *I’m still here*. My heart is broken. The security of a long and stable marriage is shattered. I’m busy trying to get through the fog of grief while finishing up legal papers and insurance forms. I feel like I’m slogging through molasses. My life is forever altered, and I miss her. No amount of joy over Caryl’s betterment removes that cold reality.

Someone I know objects when others refer to the death of her husband as a “loss,” as in “you’ve lost your husband.” She likes to say that he isn’t lost, but found by God.

But the truth is, it’s not his loss: it’s hers. And that kind of deeply significant relationship loss is excruciatingly painful.

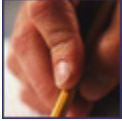
Grieving is a process, an energy-draining task. Those of us in the faith community should particularly know this, for our God is often presented as sorrowful, upset, dismayed, grieving. So let us allow grieverers to grieve, rather than trying to hurry them through their unfolding journey of sorrow. Call out the name of the one who died. Tell of special remembrances, of what you miss about that person. Or just allow the griever to tell, and often retell, stories that bring smiles and tears. A simple “I’m with you in prayer and spirit” is infinitely more refreshing to a lonely griever than, “Aren’t you glad she’s in a better place?”

For now, I grieve. In my head I know that such intense grief indicates how blessed I was to have had such a loving life partner. In time, with God’s promised faithful presence, I will rejoice in Caryl’s “graduation to heaven.”

But for now, I grieve.

* This article was written in January 2008.

Chaplain Virgil Fry has served 23 years as a denominational chaplain representing Churches of Christ for U.T. M.D. Anderson Cancer Center in Houston. He is Executive Director for Lifeline Chaplaincy, a non-profit organization providing pastoral and benevolent support for patients in Houston and Dallas. An Associate of APC, he is also adjunct professor for Pepperdine University in Malibu and Abilene Christian University in Texas.



Advocacy

Chaplain George A. Burn on chaplaincy without boundaries and borders

Respecting Differences While Celebrating Similarities

I recently returned from attending the European Network of Health Care Chaplaincy (ENHCC) meeting in Tartu Estonia and following the meeting, served as a member on the Certification Committee for chaplains in Latvia. I attended as a representative of the Association of Professional Chaplains as well as the Chair of the International Advocacy Committee. APC was officially represented by Josephine Schrader, the Executive Director, and Mary Whetstone, the President of APC.

Such high level dialogue has been growing between our two organizations over the past few years. We have come to respect the similarities in our respective missions as well as the difference in the way each of us practices pastoral care based upon the cultural, religious, and ethnic populations we serve. We have much to learn from each other.

In Tartu, 62 representatives from 23 European countries discussed the way end-of-life issues are faced within the context of their own countries and legal systems, including the practice of physician-assisted suicide in Holland. Chaplains provided presentations about their work with patients who faced those choices. Theological presentations from the Eastern Orthodox, Catholic, and Anglican perspectives about the sanctity of life contrasted markedly with the practices of chaplaincy in the trenches where "the rubber meets the road."

Our informal times gave ample opportunity to get to know each other and the issues we face in our own lives.

European chaplains are growing in numbers, and are penetrating into countries that were formerly a part of the Soviet Union. The European Union (EU) has offered a framework in which spiritual care can be promoted as a standard of care throughout the continent. Father Stavros Kofinas and others from the ENHCC have had high-level discussions with representatives of the EU regarding the need to legitimize and underline spiritual care within the context of that new political union while acknowledging the differences within each country. One cannot speak about European chaplaincy, therefore, without speaking of the way each country defines it and the issues within their borders.

In Latvia, for example, chaplaincy is a growing entity. There are currently 25 chaplains serving in Latvia in a variety of settings. While sitting on the Latvian committee, I began to realize how clearly issues in the practice of pastoral care are influenced by the past. One third of Latvia's population is Russian as a result of the post World War II occupation by that country. In the United States we talk about having good "boundaries." On the certification committee in Latvia this term was translated having good "borders." Pastoral Care in this setting means being multi-lingual, (Russian, Latvian, and German, and perhaps English as well) and having sensitivities to living with neighbors who were once the families of an occupying force).

This kind of understanding and the subtleties regarding the mix of people who have melted together as a result of conflict and the redefining of political boundaries is essential. Those who practice pastoral care in Europe have training via life experience that American chaplains have, fortunately, not had to deal with.

It is important that we continue our bridge-building efforts, to understand that the world we live in requires looking beyond our own borders, our own understanding of international relations, and the way we envision pastoral care to be practiced. I was deeply moved at the end of our certification committee process when I said, "I will send you the pictures I took of our meeting." One of the chaplains who sat on the committee responded, "No, BRING them back!"

Such affirmation of goodwill is really at the heart of what needs to be achieved between our organizations across the globe. It is my hope that there will continue to be exchanges of information, sharing of

experience, and an openness to learn from one another in the future. Having been to Europe for the second time at the ENHCC meeting, I cannot imagine that I could do it any differently. I look forward to seeing my friends in Europe again.

Chaplain George A. Burn, BCC, has been the Director of Pastoral Care at Mount Nittany Medical Center in State College, PA for 15 years. He has served as the State Certification Chair and the State Representative for the Association of Professional Chaplains in Pennsylvania. Currently he is a CPE equivalency reviewer for that organization. He is an ordained American Baptist, holds a BA from Eastern College and an M.Div. from Princeton Theological Seminary with a major in Ethics. He has written articles for The Caregiver, PlainViews, and the Consortium Ethics Program at the University of Pittsburgh.



Education & Research

Rabbi Dr. Sandra Katz on listening in a new way

Musician's Ears, Chaplain's Ears

Before I wanted to be a rabbi, I wanted to be a cantor. To achieve my goal, I went to music school. There I learned of my vocal limitations and my distinct lack of talent – and, thank goodness, other lessons that continue to inform my work.

I have mused on these ways that music and chaplaincy, two listening professions, interact:

1. Am I in the middle of the pitch? If I am singing sharp or flat, even by just a little bit, it makes it impossible for others to join me, and even untrained ears know that there is something a little off. Corollary questions: Am I staying true to the composer's intent, true to the music, true to the other aspects of the piece?

2. I felt a little sorry for the violin majors. They all had to be divas to succeed. I noticed that some of the other singers needed to be divas, too. The best singers in my school could step out when it was time to sing solo, and blend seamlessly when they rejoined the ensemble.

3. A favorite conductor used to rehearse us in sections unless we started to sound fatigued. Then he would scramble us, making sure that we stood next to no one from our voice part. I believe that this contributed to our phenomenal blend. Each singer had to know his or her part independently when we sang scrambled. More than that, hearing the other singers always gave me a sense of the richness of the music that reignited my passion for what we sang and inspired me with awe for my ensemble-mates.

4. My brother has the musical talent in the family. I play guitar to sing, but he plays to express himself. When we play together, I play rhythm and he makes music. I really climb out of myself, amazed at what we are able to do together and how my tiny contribution makes a difference. In choral singing, too, I often felt as if I stepped out of my body, losing myself in our shared creation.

5. The University of Oklahoma was (and is) a big football school. I noticed that the games felt very different from our concerts in this way: at the end of a game, there was a winner and a loser. When we sang, we felt the audience respond. This moved us to sing better. In turn, the audience responded more. This virtuous cycle continued, teaching me about the synergy of win/win. I really like that paradigm better than win/lose.

6. Music theory teachers like to baffle new students by telling them that they will develop a seeing ear and a hearing eye. That is, music students learn to hear a piece of music and know what it would look like on the page; they learn to read a page of music and hear it in the mind's ear. Such a stretch for the senses strengthens our powers of observation.

So it is that we chaplains can use skills from the world of music:

1. Am I in the middle of the pitch? Am I staying true to my "call"?

2. Have I developed my ability to play on the team, singing solo when needed and blending with the group egolessly at other times?

3. Do I know how to listen for blend in my environment? When I am with a client/patient/counselee, do I play my part in the sharing of his/her life's song?

4. Can I let myself feel the moments of transcendence? Do I grasp that this really is bigger than I am? Do I let those moments inspire and transport me?

5. Do I play for win/win in individual interactions, on the interdisciplinary team and in life?

6. Do I keep myself using all senses to be deeply present?

Musical training teaches students how to listen in a new way. I confess to forgetting what a French sixth chord sounds like. Yet my musical training, similar to my chaplaincy training, has given me tools that shape the way I hear the tone poems of my clients' lives, the way I lead worship, and the vision I have for our community.

Rabbi Dr. Sandra Katz, BCJC, lives in Rochester, NY and serves as chaplain for Jewish Senior Life, a continuum of care campus for seniors. She is immediate past chair of the National Association of Jewish Chaplains' Conference Commission. She took a hiatus from writing for PlainViews while working on her Doctor of Ministry degree, which she received in April 2008.



Spiritual Development

Chaplain Michele Monroe-Clark on wasted words

A Psalm of Lament

For day and nights
Weeks and months
I've prayed
Words of healing
For self and others
My words of pleading
Praise and hope
Fall upon deaf ears

Death comes
Unwelcomed
Unwanted
Anytime any place

Not only physical
But spiritual too
Life stolen
Consumed by disease
Darkness surrounds
Consuming my words

Words of hope and faith
Of love and compassion
Wasted on you
My God my Source

Bitterness grows
In the darkness
Consuming what is left
Of Grace

Bitterness grows
Feeding upon my spirit
Your spirit in me

And my words
Are no longer words
Of hope or praise
My words are words
Of rage; bitter and dark
Wasted upon you
My God my Source

You do what you want
When you want
Without my voice
My words my prayer

Now, I hold my tongue
No longer uttering words to you

My wasted words
Now are tears
Upon my cheek
Spilling out
Watering my hope

You alone will catch them
As they fall
Embrace them in love
Transform them in mercy
Fill them with grace
For life renewed

This lament is the result of living through a very difficult year of painful losses, both personally and professionally. In the past eighteen months, two patients and one nurse committed suicide, a nurse and my father died from cancer, the inpatient nursing directors were reassigned, the CEO was promoted, and the Chief Nursing Officer resigned. In the midst of these events, I struggled to provide spiritual care to a patient who was hospitalized for a depressive episode and was not responding to treatment. Hopelessness began seeping in. As I sat in a room with my chaplain colleagues, we began discussing the psalms of lament, trying to find peace in the hopelessness.

In a culture that preaches a “prosperity gospel,” the psalms of lament provide another view: a view that describes God as a deity who cares but does not always respond according to our wishes; and a view that describes God as faithful and present through trials and tribulations, but not necessarily the God who fixes life so that it meets humanity’s whims and wishes. It is a view that describes a complex relationship between God and God’s people. The psalms of lament witness to the reality that salvation and redemption are possible, even when life seems hopeless and God seems to have forgotten humanity.

Chaplain Michele Monroe-Clark is an ordained minister in the PC (USA) and a staff chaplain at Alexian Brothers Behavioral Health Hospital. She received her MSW from Loyola University of Chicago and her M.Div. from Western Theological Seminary. She and her children reside in Hoffman Estates, IL.



BioethicsWalk

BioethicsWalk addresses bioethical issues that chaplains face in their day-to-day work. *PlainViews* invites our readers to share their responses to each *BioethicsWalk* column, which will be published in the following issue. We also invite our readers to submit areas of concern/interest about which they would like Nancy to write.

If you'd like to respond to *BioethicsWalk*, please send a comment of no more than 100 words. You can use the e-form below (click on "hearing from you," link) or submit your commentary to the editors in the body of an e-mail (or as a Microsoft Word attachment) sent to Info@PlainViews.org. Please put the phrase "*BioethicsWalk*" in your subject line. Comments that are too late for the previous issue can be viewed in TalkBack.

We look forward to [hearing from you.](#)

Summer Reading

Sociologist Raymond de Vries taught me that the sociologist's goal is to observe a culture, then describe it so clearly that a member of that culture can say, yes, I recognize my life. Sharon R. Kaufman, a medical anthropologist, has done just this for anyone who counts themselves as a member of the culture called "end of life care." Her book, . . . *And a Time to Die: How American Hospitals Shape the End of Life* (University of Chicago, 2005) is a must-read for chaplains. Kaufman spent several years minutely observing the ICU, the ethics committee, and long-term care. Nothing escaped her notice, including the presence of chaplains, their role in the care of dying patients and their families, and their struggles with how end of life decisions may be framed or carried out under the cultural and economic pressure to make individual cases conform to established story lines: the "heroic" pathway of technology; the "revolving door" pathway of the chronically ill. She also describes two states – "waiting" for death, and "life with no end," when technology is life-saving but not life-restoring – that exist in tension with the drive to "move things along" toward resolution and reimbursement. Go find this book. It may not suggest itself as ideal vacation reading, but it is a page-turner.

More on sociologists and reading: I've just finished co-editing a set of six essays collected under the title, "Chaplains in health care: What is their role in improving quality?" This essay set is the final product of The Hastings Center's research collaboration with The HealthCare Chaplaincy, made possible by the Arthur Vining Davis Foundations, in which we explored the relationship between the "professionalizing" profession of chaplaincy and the quality improvement movement in health care. Authors include Ray de Vries and fellow sociologist Wendy Cadge, on what is gained – and lost – when an occupation decides to become a profession; medical educator and religious studies scholar Margaret E. Mohrmann, on the challenge of "ethical grounding" for a health care profession that is also a ministry; and clinical ethicist Martin L. Smith, on the parallels between chaplaincy and clinical ethics as professionalizing professions whose members may benefit from more frequent and conscious collaboration. Chaplains Martha R. Jacobs and George Fitchett, and other scholars who study chaplaincy, also contributed to this essay set. It will be published in the November-December issue of the *Hastings Center Report* and will be available online; watch this space for details.

Nancy Berlinger is Deputy Director and Research Associate at The Hastings Center. Her research interests focus on clinical ethics and include end of life care; ethics in health care chaplaincy; conscientious objection and moral distress in health care; and patient safety and the resolution of medical harm. Her broader interests include bioethics issues in cancer care, narrative ethics, and medical humanities. As Deputy Director, she manages the Center's organizational capacity-building initiative, Bioethics and the Public Interest, which has received major support from the Ford Foundation. Berlinger is the author of After Harm: Medical Error and the Ethics of Forgiveness (Johns Hopkins, 2005), which will be released in paperback in fall 2007. She serves on the ethics research group of the Joint Commission, the ethics faculty of the American Society of Healthcare Risk Managers (ASHRM), the bioethics committees at Montefiore Medical Center, Bronx, New York and at Richmond of New York, and the editorial board of Medical Ethics

Advisor. She is a frequent presenter at grand rounds and other ethics education programs for health care professionals. She volunteers on the Chaplaincy Service at Memorial Sloan-Kettering Cancer Center in New York City.

She is a graduate of Smith College and holds the Ph.D. in English Literature from the University of Glasgow and the M.Div. in Christian Ethics from Union Theological Seminary.



LongView

Chaplain Judy Seicho Fleischman on caring for persons living with HIV and recovering from trauma

Healing Community: Transforming Trauma in Relationship

A clue to the journey on which I was embarking arrived in the form of a question from a chaplaincy mentor.

While interviewing me for a chaplaincy position, he cautioned, "Whoever serves in this role will be a lightning rod for this community. Some people thrive on this energy and some people are depleted. You need to ask yourself, which type of person are you?"

That was two- and a half years ago. Since that time, I have been privileged and challenged to deepen my understanding of this question while providing professional chaplaincy services. The setting has been an adult day treatment center for people living with HIV who face increased health risks. During this time, I have become increasingly aware that healing manifests in relationship. I consequently sought an integrative approach, which led to developing a model of inter-relational, interdisciplinary care entitled, "*Healing Community*."

This model tailors treatment for individuals living with HIV and additional stressors including: homelessness, trauma, mental illness, drug addiction, alcoholism, domestic violence, and criminal activity. These factors contribute to their increased health risks, such as self-medication, self-isolation, and non-adherence to medical treatment.

Senior administrative staff and the substance use specialist estimate that 90% of clients report history of trauma and 90% report history of drug addiction and/or alcoholism. Over 50% are diagnosed with a mental illness.

The need for a compassionate container for caregiving is evident. This need led to an historic initiative, which in turn led to my hiring. The initiative was between Housing Works' West 13th Street Adult Day Health Treatment Center, the largest of four sites in NYC, and The Healthcare Chaplaincy (HCC). This effort marked a shift for the Center in defining spiritual care from pastoral counseling to professional chaplaincy.

The Center's then executive director wanted to integrate spirituality in an inclusive, broadly-defined manner. He saw this as a foundation for healing in an interdisciplinary context.

The resulting contract called for HCC to recruit a board-certified or certification-eligible, professional chaplain who would provide twenty-one hours of care per week to clients and notably to staff, which was a new concept for this facility. Also, HCC provided two documents: a "Best Practices for People Living with HIV/AIDS," and a "Spiritual Assessment" template tool.

Noteworthy demographics include: 76% of all clients identify as male, 56% as African American/Black (predominately African and Caribbean American) 39% Hispanic, 5% Other. 4% identify as Transgender. Many clients identify as Gay (same sex partnering) or Bisexual. These demographics indicate the role that sensitivity to racial, multi-cultural, sexual orientation, and gender identity issues plays in serving these clients.

Clients' religious demographics reveal inter-relational issues as well. The general intake census for religion, meaning what clients report during admission process is: 48% unknown, 7% none, 12% Protestant, 5% Roman Catholic, 4% Baptist, 3% Muslim, Buddhist 1%, and 19% Other. What they report in the chaplain's presence is quite different. Based on over one hundred spiritual assessments as well as hundreds of individual sessions, 85% of clients identify as Christian, primarily Protestant and Roman Catholic. Significantly, many also report feeling alienated from their religious communities and/or their "Higher Power" (in monotheistic terms, God as they understand God to be).

Facing multiple hardships and unable to resolve discrepancies between espoused and operational theologies, many clients verbalize feelings of self-loathing and/or ambivalence in relationship with their Higher Power. Furthermore, many report feelings of guilt and shame as well as fear of abandonment in relationship with their religious communities and/or Higher Power. The strategy many clients then employ is self-isolation.

Another important factor is the theme of loss in relationship. Individuals experience statistically higher deaths in their circles of loved ones. These likewise occur at an earlier age than in the population at large. Coping with a sense of loss is often less than adaptive. Self-isolation and self-medication with drugs and/or alcohol are common.

Recognizing these interwoven issues, the organization adheres to a 'harm reduction' rather than abstinence based model of treatment. The healthcare program assembles an impressively diverse interdisciplinary team, including full medical and social work services and many other disciplines such as creative arts therapies, vocational rehabilitation, and forensic (incarceration history) counseling. The Center also operates a targeted outreach program to transgender persons. Advocacy (local to international) is a primary mission.

Finding the treatment modality that serves best has been a personal journey. During my first year, the greatest challenge was the steep learning curve in providing clinically meaningful documentation including chart notes for my billable services. Constant vigilance to detail is crucial for coordination of care and to demonstrate compliance with care and funding guidelines to overseeing external agencies in a climate of changing political conversation over "appropriate use" of these funds. I struggled to offer care and to document within the twenty-one hours allotted per week.

During my second year, my focus shifted to larger issues of client safety and staff sustainability. A sense of urgency increased as we experienced a higher number of client deaths than in previous recent years, including several suspected suicides from drug overdose or neglect of medical treatment regimen.

Seeking to respond to the elevated stress, I began to frame challenges as inter-relational and to promote a spiritual foundation in terms of interdependence.

Healing Community integrates spirit-centered care, mindfulness meditation, and therapeutic play within an interdisciplinary context to promote healing in relationship.

Spirit-centered care is inter-disciplinary care in an integrative care setting, which is rooted in a person's experience of spirituality as the expression of what they value. Mindfulness meditation is a widely applied clinical method, which Jon Kabat-Zinn describes as "paying attention . . . nonjudgmentally." [1] Therapeutic play, from my perspective, is the experiencing of wholeness through creative expression, both verbal and non-verbal.

Inspiration for this inter-relational view of healing draws on two images from the spiritual traditions in which I practice. Buddhist cosmology offers Indra's net, which extends infinitely and contains a jewel in each of its vertices. Each jewel perfectly reflects all the others. This illustrates what Zen teacher Thich Nhat Hahn coins as "inter-being" or interdependence. Transformation manifests in the moment of directly realizing this interdependence. [2]

The second image is drawn from Jewish mysticism and depicts revelation at Sinai, the moment when the people assemble and as Rabbi Arthur Waskow states, "become a community" [engaged in] "a constantly unfolding process of revelation in which everyone in every generation is able to be present. . . to join in partnership with God." [3] This revelation is a covenant or contract in relationship.

These images frame *Healing Community* as an inter-relational practice, which in Zen terms could be called "direct realization" and in Jewish terms, "ongoing revelation." Significantly, it can be presented in a secular manner, hence accessible to everyone. Contract in relationship is not new to this setting. I simply applied it in a new way.

The contract began in me. Identity and community became major issues for me in this setting. I wondered how could I offer care, even while utilizing professional chaplaincy skills, to a largely Christian demographic when this is not my path of spiritual practice? Also, as a Caucasian woman from a middle class

background, how could I authentically engage with those for whom race, ethnicity, and poverty (to name a few issues) are daily challenges in relationship? Finally, how could I embody pastoral authority within a community, which tended to identify me as their pastor, a traditionally Christian, male authority figure?

This difficult process of introspection led me to embrace being different as an expression of being interdependent. Then, I could direct these differences to be of service.

Seeking to understand the purpose and scope of our contract in relationship, I began a research effort. My goal was to identify common values based on patterns emerging from individual sessions with clients and staff as well as spiritual assessments and groups. I utilized Non-Violent Communication (NVC), a model developed by psychologist Marshall Rosenberg, to formulate a needs assessment.

It is notable that clients and staff expressed differences in what they identified as paramount concerns. The primary needs stated by clients were: safety, trust, dignity, guidance, purpose, and belonging. Among staff, the primary needs stated were: sustainability, integrity, fulfillment, appreciation, and rest. To meet some of these needs, I advocated for a quiet, contemplative space, called the "Reflection Room," and for a bulletin board, which we named "Healing Community."

The room was decorated sparingly. Above the entrance, we posted a photograph taken in New York's Central Park of children of different races holding hands and lying on the ground to encircle one word in the center: "Imagine." Spiritual groups meet in the room as do other groups. The room also is available for general use consistent with guidelines posted on the door.

Inside the room, we placed a clear vase with vine cuttings growing roots. This was inspired by a verse from Psalm 80, "I took a vine cutting out of Egypt and planted it . . . and it struck root." These vines offered a poignant reflection for those reporting significant displacement and marginalization issues.

A large, framed print of abstract art that was hung on the wall became a powerful metaphor for making meaning of one's experience. During groups, I refer to the art as "what's happening" and the frame as "what it means to me." It focuses client's attention on intention.

For instance, I asked a client reporting panic attacks, trauma history, and a gambling addiction to visualize the abstract art as himself standing at the slot machine. I pointed to the frame and asked, "what's your fear?" He replied, "losing." I then asked, "what's the bigger picture?" He smiled and replied, "trusting the unknown." I guided him in a succinct, breath-centered prayer using his words. "Breathing in, trusting" and "Breathing out, fear." He has repeated this prayer often and reports it as an effective intervention when feeling panic arising.

The "Healing Community" board resides close to the Center's entrance and promotes a sense of purpose and belonging. We decorate it seasonally. We attached a mirror and above it, posted the phrase (in English and Spanish): "Look Closely." Below, we posted a monthly "reflection" such as November's "How am I generous?" Clients contributed succinct writings or drawings to a compilation entitled, "Stories of Generosity," which was presented to the assembled community on Thanksgiving.

Staff contribute as well. December's "what does peace mean to me?" resulted in a peace banner. The endeavor offered a bright antidote to despair and hopelessness. People were grieving deaths (some quite recent) of loved ones, some of whom were clients. Participants shared tears and laughter as they reported experiencing themselves as members of an extended family.

Recognizing the need for co-creative ritual, I reached out to clients and staff in preparing for then frequent memorial services. Clients participated in all aspects. This helped to contain and contextualize grief as a shared journey.

Entering my third year in the Center, I suggested and collaborated with several clients and the director of creative arts therapies to initiate a "Reflection Board." Its purpose is to hold participants' reflections on what had become our monthly "Healing Community" theme. The board has the appearance of a big mirror. The reflections have evolved. For instance, for this June's, "How do I feel about working together?," one client drew a big circle with a dot at a distance from it. Beside the circle, he wrote, "them" and beside the dot, "me." His contribution empowered peers to express inter-relational stressors as well as benefits.

I also initiated a *Healing Community* monthly outing, which connects with the monthly theme. Each trip is co-facilitated whenever possible with a colleague to link our disciplines. During our first outing, a psychiatric social worker joined to offer a trip to a museum whose artwork illustrates the interplay of spirituality and psychology with the theme of "Transformation." This June's trip was to a community garden with the theme of "Working Together."

Current spiritual groups reflect pressing issues, namely: "Living with Dying," "Moving On," "Spirituality and Recovery," "Spirituality and Health," and a monthly "TranSpirit" (for transgender persons and friends). Additionally, a minister from a nearby church offers a non-denominational, Christian Sunday service and Bible study.

I integrate mindfulness meditation, voice dialogue (a psychological method of integrating aspects of oneself, developed by Drs. Sal and Sidra Stone), breath-centered spontaneous prayer, and therapeutic play (especially music, movement, and touch).

During groups, rather than stating "group rules," I facilitate a process for clients to enter into a contract concerning guidelines for communicating. As we close, participants enter into a contract to take up a mindfulness practice, which we articulate together, during the week. This usually incorporates a form of breath-centered prayer. Simple repetitive phrases reflect meaning, such as "breathing in calm, breathing out fear." Many clients report this as a skillful intervention, which helps them to reduce self-harmful behaviors, promotes insight, and fosters healing friendships.

We celebrate interdependence as a community with an event in July called, "A Day of Unity: Celebrating Diversity, Expressing Who We Are." It incorporates a participatory music and art program. This month will mark our three-year anniversary.

These efforts have born fruit. While the issues appear to be complex, and there have been a number of coordinated organizational initiatives including *Healing Community* outreach, this endeavor has contributed to several tangible outcomes.

I see clients more engaged in treatment. Staff are more aware of self-care and client care as a collaborative and shared responsibility. Most of all, I see a more appreciative and pro-active community reshaping itself to simultaneously value differences and express these with a sense of common purpose.

Our next step might be to produce measurable data to quantify impact on specific clinical issues and outcomes.

A poignant portrait of the impact of these efforts arrived just before Father's Day this year. During "Moving On" group, an African American woman whose son had unexpectedly died in his early 20's, shared her rage: "I am angry with my Father [referring to her Higher Power] and don't understand." A Hispanic woman in her mid-20's said, "It makes me sad because I think of my kids [in foster care] who I haven't seen in years. My kids and my father. He's the reason I've got them. I don't want to think about that." As we went deeper, clients cried and reached out to one another. As our time together drew to a close, I said, "let's stand" and led the group in a breath-centered spontaneous prayer with everyone holding hands. This transformed into a group hug. While reflecting alone immediately afterwards in silence, a client returned to the room. He had forgotten his paper. Seeing me, he said, "this room finally served its purpose." I nodded silently.

I look forward to extending this vision widely, beginning with a website, www.sensingwonder.com. As our world grows larger and smaller, *Healing Community* is our shared purpose and awesome responsibility. Like a lightning rod, we can be energized when inconceivable power moves through us. Nothing to fear. Nothing to hold us back. How marvelous!

Footnotes:

[1] Jon Kabat-Zinn, *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*, Hyperion, 1994, 4.

[2] Thich Nhat Hahn, *Being Peace*, Parallax Press, 1987, 87.

[3] Rabbi Arthur Waskow, *Seasons of Our Joy*, Beacon Press, 1982, 191-192.

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Thich Nhat Hahn, *Being Peace*, Parallax Press, 1987, 87. Resources available at: <http://www.plumvillage.org/>.

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Chaplain Judy Seicho Fleischman, BCC, is Staff Chaplain at Housing Works' West 13th Street Adult Day Treatment Center in New York City. She is a Zen Buddhist priest with Village Zendo and coordinator of the New York City Chapter of Buddhist Peace Fellowship. She is a member of The Buddhist Council of New York and of Congregation Rodeph Shalom..



MyPractice

As professional chaplains we need to be in dialogue with each other about what we do, how we do it, and why we do it a certain way and how these practices benefit our patients. The ultimate goal of **MyPractice** is to build a consensus about what constitutes “good practice” and eventually establish “Standards of Practice” for chaplains. As with quality improvements in our institutions, this is an ongoing process in order to improve our practice.

To have a description of a practice that you use in your setting considered for inclusion here, write it up and send it to *PlainViews* for consideration. The Association of Professional Chaplain's Quality Commission's Best Practice Committee will work with the Managing Editor of *PlainViews* to review submissions and select articles for publication. Your submission does not necessarily need to be cutting edge (although that's okay, too). We want to identify “good practices” that could be recognized as standard practice.

PlainViews will highlight one article in the second issue of each month. **Readers are invited to respond to the featured practice.** Responses will be posted as they are received. This is a great opportunity to start a process that will move us forward in professional chaplaincy.

If you'd like to respond to **MyPractice**, please send a comment of no more than 400 words. You can use the e-form below (click on "hearing from you," link) or submit your commentary to the editor in the body of an e-mail (or as a Microsoft Word attachment) sent to Info@PlainViews.org. Please put the phrase “MyPractice” in your subject line.

We look forward to **hearing from you.**

A Blessing of the Hands Service

A Blessing of the Hands service was held at three separate times during the day: 7:30-8:30am; 2-4pm; and 7:30-8:30pm. This was done in an effort to reach each shift. Altogether we probably shared the individualized service with about 70 nurses. The Chief Nursing Officer (CNO) and the Administrative Director (AD) of Nursing asked me to lead this service last year and then thought of me again this year as they were planning events for nurses' week.

I set up a make-shift chapel in one of our education classrooms in the Patient Tower (as our chapel is located in the old main tower) because it is more convenient for the nurses. As a nurse enters the room she is greeted by the CNO and the AD of Nursing and directed to the corner of the room that has become the temporary chapel. 1-3 nurses would stand in front of the table to receive the blessing of the hands (which included a scripture reference, Psalm 24: 4a-5; a brief explanation of what this service was about; a discussion of the significance of the uniqueness of our hands in the healing process; a prayer; and an anointing of the palms of the hands with a small bit of baby oil gel (in a squeeze bottle—it's easier to administer and clean up). I made it my goal to have the CNO and AD of Nursing be the primary ones responsible for promoting this event. At least one of them were present and in the room each time a nurse received this blessing. Since we are a faith-based hospital, there is a bit more emphasis on the Christian perspective.

BLESSING OF THE HANDS SERVICE

Read Psalm 24: 4a-5

When we reach our hands out to provide care, to do our work as part of the care of others, we are saying to others, “You are important to us, and you are cared for by the efforts of many who value

you and your needs.”

Please hold your hands in front of you and observe their appearance. Think of all you do with your hands each day that contributes to the health care needs of our community.

You have chosen to bless others with your hands in the work you do. Now we are going to bless your hands in recognition of the holiness of what you do everyday. Please place your right hand in the palm of your left and extend your hands to receive the blessing.

O Holy God, bless these hands that they may continue to be a blessing to others. Amen

Please read the following prayer silently to yourself before you leave this place.

Holy God, may Your presence be in all that I do. Renew in me awareness of your sustaining love that touches me each day, opening the eyes of my heart to see that you touch the world through the work of my hands. Amen

When you have finished reading the prayer, please look up to me for the anointing of the oil. Using a pitcher of water and a large bowl, employees' hands can receive an optional symbolic cleansing, after which a small drop of oil is dabbed into each hand as the chaplain reads a special blessing.

“Holy God, bless these hands to be instruments of healing. Amen”

ADDITIONAL RESOURCES:

Blessed be these hands that have touched life.
Blessed be these hands that have felt pain.
Blessed be these hands that have embraced with compassion.
Blessed be these hands that have been clenched in anger, or withdrawn in fear.
Blessed be these hands that have drawn blood and administered medicine.
Blessed be these hands that have cleaned beds and disposed of wastes.
Blessed be these hands that have anointed the sick and offered blessings.
Blessed be these hands that grow stiff with age.
Blessed be these hands that have comforted the dying and held the dead.
Blessed be these hands, we hold the future in these hands.
Blessed be our hands, for they are the work of your hands, O Holy One. (author unknown)

Thoughts to Consider in Explaining Purpose:

Our hands were not created just for ourselves. Take time to remember the tiredness and aching they have known, the cold and the heat, the soreness and the bruises. Remember the tears they have wiped away, our own and those of another—the tears that our hands have caused others to shed, the blood they have bled, the healing they have experienced. How much hurt, anger and even violence they have expressed...how much gentleness, tenderness and love they have given.

Take time to think of your hands. Remember they once were the hands of a newborn baby. Consider all you've done and the activities and skills you've mastered since then.

How often have your hands been folded in prayer, a sign of both their powerlessness and their power? Think of the handshakes, the pats on the back, the waves of hello or goodbye or even maybe at times, the clenched fist.

Rev. Steve Brown is Director of Pastoral Care for Baptist Memorial Hospital-Golden Triangle (Columbus, Mississippi). Steve is an ordained Baptist minister with a Masters of Divinity degree from Southeastern Baptist Theological Seminary (Wake Forest, North Carolina). In addition, Steve completed three years of post-seminary clinical residencies in pastoral care and counseling from Baptist Health System in Birmingham, Alabama. Steve has also served as an interim pastor at local churches of various denominations in the Columbus community. Steve's wife, Kelly, and their two daughters, Kessler and

Kennedy, are Episcopalian. It has been good to discover blessings in a variety of faith expressions.

Send your comments about **MyPractice** to info@PlainViews.org.



Review

Rev. Phil Pinckard reviews the book

Kidney for Sale By Owner

First, a disclaimer: I am a donor's dad. Our only son, Mark 18, donated his liver, kidneys, corneas and heart valves at his death resulting from injuries sustained in a vehicle accident on 20 May 2002. We have intimate personal experience with the emotional and spiritual benefits of the humanitarian "gift of life."

Mark J. Cherry, associate professor in the department of Philosophy at Saint Edward's University in Austin, TX, has written a detailed analysis addressing the complex issues that surround the sale of organs. He raises important moral questions about how we understand the body and moral authority in our society. "Is a global consensus and its promotion of a worldwide legal prohibition [of a market for human organs and tissues] morally justified?"[1] In 2002, the American Medical Association voted to promote studies to assess whether financial incentives would likely increase the pool of cadaver organ donors.

The text is organized in five major sections. Chapter 1 outlines the moral debate within the medical practice of transplantation and the attendant public health care crisis. Cherry considers 'global consensus' then critically assesses the claims that financial incentives would undermine free and informed consent, coercing the poor to offer their organs for sale; possible exploitation of the poor; corrosion of 'gift of life' sentiment and moral repugnance of creating a free market economy for organ donation and transplantation.

In the second chapter Cherry assesses conditions necessary and sufficient to create a market in human organs. His analysis explores foundational issues including the relationship between persons and their bodies; human organs as property; the distinction between justified and unjustified moral repugnance; and the moral limits of society or government when it interferes [his word] in consensual exchange of body parts. Does such logic lead to moral acceptance of legalized prostitution [consensual sex for hire] or 'multiple marriage' of teen-aged girls among members of the FLDS? Without intervention on moral grounds, would not slavery yet co-exist with free-enterprise in our nation?

Chapter 3 seeks to evaluate the costs and benefits of a free-enterprise organ market. Cherry evaluates the advantages and/or disadvantages of the market's impact on healthcare, allocation of resources, and whether such a market would lead to greater liberty, equality, and altruism. What prevents an individual from offering his/her healthy kidney for sale for a price? Like the landowner [see Matthew 20:1:15] "Don't I have the right to do what I want with my own money [body]?"

The fourth chapter considers the historical and philosophical roots of crucial moral institutions, ontological considerations, and political theoretical premises, as well as understandings of moral concerns. What are permissible uses of the body and its parts which frames the so-called 'global consensus' that prohibits a market in human organ exchange?

Chapter 5 brings these diverse analyses together to show why the apparently strong consensus against the selling of human organs is misguided. Each chapter includes a summary which I found helpful to the reader.

In his introduction, Cherry notes that "The Transplantation Society, the World Health Organization, the Nuffield Council on Bioethics and the U. S. Task Force on Organ Transplantation each has issued pronouncements condemning the creation of a for-profit market in human organs." [2] He further notes that "The U. S. Congress, the National Kidney Foundation, the United Network for Organ Sharing [UNOS], the American Medical Association, the American Society of Transplant Surgeons, and the World Medical Association have similarly denounced proposals to broker human organs for transplantation." [3]

Despite his intelligent presentation and detailed arguments, I remain unconvinced. Professor Cherry is

cogent and persuasive. A time may come when a market in human organs and tissues becomes acceptable, even preferable to our current system. Until then, much work remains. Since 2003, the number of organs from deceased donors, both from brain death and cardiac death [DCD] has significantly increased. Consent rates have risen, but there remains a disparity between donors and potential recipients. I encourage you to read this book and draw your own conclusions

Footnotes:

[1] p. x.

[2] p. ix.

[3] Ibid.

Kidney for Sale by Owner, Cherry, Mark J., Washington DC: Georgetown University Press, 2005, 276 pp.

Rev. Phil Pinckard, M.Div., BCC, BCCC, is Director of Chaplaincy Services & Education at the Medical Center of South Arkansas. An ordained elder in the Church of the Nazarene, he was endorsed as a healthcare chaplain in 1997. Phil is a Board Certified Chaplain [APC] and a Board Certified Clinical Chaplain, Certified Pastoral Counselor and a CPE Supervisor-in-Training [CPSP]. Phil presented workshops on parental grief/organ donation at the 2006 Association for Death Education and Counseling [ADEC] and the 2006 American Academy of Bereavement [AAB] conferences. In March he presented "A Fatherless Son, A Sonless Father" at the 2008 Association of Professional Chaplains [APC] conference. Married since 1976 to Jodie, they're parents of Heather and Mark [1984-2002] an organ/tissue/bone/cornea and heart valve donor after his accidental death 20 May 2002. Mark's right kidney recipient, Caitlin Pendzinski, is the subject of Now Caitlin Can: How a donated organ makes a child well, a book for children, written, illustrated and published by Ramona Wood of El Dorado.