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Professional Practice

Chaplain Carolynne Fairweather, D. Min., on being of service in the community

Reaching Beyond Our Own Walls

I don't know why I decided to go to a local Catholic Church morning mass twice a week, as part of my Lenten Disciplines this year. I am an Episcopal priest with no Catholic background; yet, it seemed as if I was given a proverbial shove – that it would be good for my soul to do it. I started attending on Ash Wednesday and listened carefully to the priest's homily. He talked about fasting, being baptized into Christ's death as well as his life, and he seemed to put a lot of emphasis on realizing that each person came from dust and to dust would return.

I began to attend on Mondays and Wednesdays. For the first two weeks of Lent, I was a regular visitor and received a blessing during the Eucharist. I remember feeling particularly blessed by the priest on Monday, February 18th. He had looked me directly in the eyes when he offered me a blessing. It felt to me as if our souls met during the moment he spoke. I never got to personally meet him, as I had to leave right after the Eucharist to get to work.

When I returned home after a retreat on February 24th, my husband and I watched the 5:00 news. There had been a drowning of three men from our town on Saturday. Their small crabbing boat had capsized; none of them was wearing a life vest. Death came quickly in the 43-degree water. Their pictures were shown and I recognized all three from the 7:30 a.m. Mass I attended. It was the priest, his older brother and another parishioner. I went into shock, as much for the parish as for myself. The thoughts that raced through my mind, quickly became one – What could I do to be of service to this parish? I thought about sending flowers, writing a letter, having a Mass said, but none of those seemed right. As I discussed what I could do, with my own priest the next day, she said, "Well, you're a hospital chaplain and you deal with this sort of thing all the time. How about offering to do some bereavement work with them?"

The next day I wrote the parish a letter, offered them some bereavement support and stuck the letter to the church door when I went for my morning walk. The parish secretary called on Wednesday afternoon to ask if I could come that evening when they had their 1st–5th graders and their parents coming in.

When I arrived, I greeted two other chaplains from the local hospital and we went into the church to meet the children. The parish staff did a superb job in talking to the children, giving them all the information they knew, talking about why the three weren't wearing life jackets, then asking where the children thought they were now. The education director recalled that two weeks earlier, the priest had asked them, "What's the first thing you'll say when you get to Heaven?" The answer was, "Ahh!!"

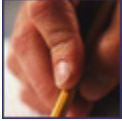
We, chaplains, were introduced to everyone as the experts in grief and some of the children came to talk to us. One second-grade girl was sad because she was about to make her first Holy Communion and she wanted the priest to see her new dress. Another fifth-grade boy wanted to know what condition the priest's body would be in. Gentle questioning revealed that he really wanted to know if the fish had bitten into his body. The children, then, went to tables in the parish hall- one for each grade- drew pictures and wrote messages on large sheets of paper, which were displayed for the service held last Friday night. The

pictures showed the priest's dog howling, "I miss you, Father" and there were lots of boats, fish, crabs, whales and various sea monsters depicted. We were asked to come back on Friday evening during the viewing to be available to other parish families and did so.

Chaplains in the community are often not recognized or called upon for the skills they can offer to others who are hurting from sorrow, grief or pain. It is up to us to extend the offer of service in places we would not have ever thought of being. At the beginning of Lent, I didn't know why I decided to attend this Catholic Church, but God did and I thank God for the experience.

Chaplain Carolynne Fairweather, D.Min., BCC, has been the chaplain at Legacy Meridian Park Hospital in Tualatin, OR, for the past eleven years. She is the State Representative to APC for Northern Oregon and an assisting Episcopal priest at Christ Church Parish in Lake Oswego, OR. She and her husband, the Rev. Dr. Roger Weeks, live in Newberg, OR.

Do you have thoughts about professional practice you'd like to share with your colleagues? Send an e-mail info@PlainViews.org.



Advocacy

Rev. Dr. Stavros Kofinas on European Chaplaincy

Growing and Maturing in and with Europe: European Chaplaincy on the Rise

In reviewing the histories of religions and that of health care in Europe, one will immediately see that there is a very close correlation between the two, a correlation which shaped a great part of medical care as well as the culture of Western Civilization. Today, some of the major providers of health care within the European Union are religious institutions. Hospitals, hostels, special care units, counseling centers are operated and funded by various Faith groups. So it is that within the European Union, thousands of chaplains serve health care settings, offering the spiritual care and guidance that is essential for one's recovery and offering spiritual support to health care workers as well.

The way chaplaincy is organized within the European Union varies from country to country. One of the reasons for this is due to the fact that there are distinct cultural factors that characterize the national identity of each country. Perhaps this is not well understood by those outside of Europe. Even though a sharp distinction of cultural factors has somewhat changed over recent years due to a trend toward multicultural societies, there are still elements of life-styles that maintain a national cultural identity. One of these factors is religion. So it is that in most countries there are national chaplaincy organizations of Churches of a denomination that administer the work of chaplains. There are also some multi-faith chaplaincy organizations that bring chaplaincies together in each country. In other cases, the national religious authority (Metropolitan, bishop, etc) directs spiritual health care.

After five meetings of various chaplaincies between 1990 and 2000, *The European Network of Health Care Chaplaincy (ENHCC)* was formed at the 6th consultation which took place in Crete. Based on the "Cretan Declaration"[1], the Network is the largest body composed of official representatives from all the Christian denominations and chaplaincy organizations of Europe, which provide pastoral care in various health care facilities. The Network aims at mutual sharing and understanding both on a religious, cultural and organizational level. It brings together the various chaplaincy experiences of all the health care systems in Europe. Since Crete, the ENHCC has had three consultations: Turku, Finland (2002), Dublin, Ireland (2004) and Lisbon, Portugal (2006). This coming May (2008), participants of some 46 chaplaincies from 32 European Countries will gather for their 10th gathering in Tartu, Estonia.

The challenges facing European Chaplaincy remain to be focused on networking within a Europe that is growing but remains diverse in many ways. But this only adds to the richness the *ENHCC* has, a richness of culture and know how that that each chaplaincy brings to the opportunity of together on common goals and concerns. Two major contributions have been made in the past: the forming of the "Standards for Health Care Chaplaincy" and a joint "Statement on Palliative Care". At the upcoming Consultation, the participants of the Network will review European policies and developments regarding care at the end of life.

Within a growing Europe, chaplaincy cannot remain isolated in its own self concerns. This is why efforts have been made to establish relations with *Commissions of the EU* and with the *Church and Society Commission Conference of European Churches*. It has also formed working relations with the *American Association of Professional Chaplains*. As Europe grows, all of us that participate in the *European Network of Health Care Chaplaincy* hope that we can contribute to its maturity and its unity. By doing this, we are sure that we will grow and mature as well.

Footnote:

[1] See "Cretan Declaration" at (www.eurochaplans.org)

For more information on the *European Network of Health Care Chaplaincy*, please visit our Web site:
www.eurochaplans.org.

Fr. Stavros Kofinas was born and raised in the U.S.A. He received his Doctor of Ministry in Clinical Psychology and Psychiatric and Pastoral Care from Andover-Newton Theological School. He was ordained a deacon in 1974 and a priest in 1976. After moving to Greece, he became the chaplain of the Red Cross Hospital in Athens and then the priest of the parish of St. Nicholas in Thebes. He piloted a training program at the Red Cross Hospital for priests of the Archdiocese of Athens and special care programs for dialysis patients and mothers whose children suffer from beta-thalassaemia. He organized the initial chaplaincy program for the Thriasion Hospital of Elefsis and has served as supervisor for the Counseling Center of the Metropolis of Peristeri. His All-Holiness Patriarch Bartholomew placed Fr. Stavros as coordinator of pastoral health care issues for the Ecumenical Throne and he is in charge of organizing the first Consultation for Pastoral Health Care for all the Metropolises of the Ecumenical Patriarchate that will take place in Rhodes in 2008. In 2000, he organized the 6th Consultation for Hospital Chaplaincy on the island of Crete. It was at this consultation that the European Network of Health Care Chaplaincy was founded. Today this Network consists of 46 chaplaincy organizations from 29 European countries. In 2002, he was elected as coordinator of the European Network and was re-elected for a four-year term in 2004. During his term he has formed close relations with the European Union in matters regarding health care and spiritual care and has made special efforts in bridging chaplaincy concerns with the American Association of Professional Chaplains. Fr. Stavros married Georgia Pistolis in 1972. They have one daughter.

Do you have thoughts about advocacy you'd like to share with your colleagues? Send an e-mail to info@PlainViews.org.



Education & Research

Rev. Craig Rennebohm, D. Min., on the way of companionship

From the Street to Stability: A Community Mental Health Chaplaincy

Dee pushes his shopping cart long the sidewalks and alleys in an old neighborhood of warehouses, run down apartments and slowly gentrifying streets. 12 years ago profound suspicions and a haunting conspiracy began to take shape in his thoughts. He trusted no one, left his job, lost his apartment and began a hidden and frightened pilgrimage. His only sanctuaries were church porches and doorways. These "God doorways," he said, were his only safe haven, but even then he was asked to leave when staff or parishioners found him sleeping outside or warily guarding his few belongings. Dee is one of more than 8,000 homeless souls in Seattle on any given night.

A study at the largest single adult shelter estimates that 40% of the 20,000 homeless individuals who seek help there in the course of the year have a history of mental illness. In a study at the largest day drop-in center for homeless women in Seattle, 90% of the women self reported histories of trauma and abuse. Deinstitutionalization and a lack of community mental health services leaves uncounted numbers of our sisters and brothers wandering our neighborhoods isolated, ignored, deeply vulnerable and bound by the most serious and complex of mental disorders.

Founded in 1987, the *Mental Health Chaplaincy* in Seattle provides four basic services: outreach on the streets with homeless individuals who struggle with symptoms of mental illness, but have no care or treatment; spiritual care on the psychiatric units and in the community mental health program of the county hospital; consultation and training in mental health ministry with local congregations; and advocacy for an effective, readily accessible community mental health system.

At the heart of the Chaplaincy's ministry is the "way of companionship." The chaplain, practicum students and interns, and volunteers working from their local churches, practice a patient Samaritan approach, offering hospitality, sharing the journey side by side, listening pastorally and accompanying homeless individuals on the path from the street to stability.

Learning from these basic acts of service, the Chaplaincy and companion teams in local congregations have partnered with local community mental health programs to develop innovative shelter, housing and community support programs which support recovery and integration into the community, ending the cycle of homelessness, emergency room visits, brief hospitalizations or jail and return to the street.

In addition to resources used in the companionship training, the *Mental Health Chaplaincy* has developed the *Gentle Bible*, brief daily scripture-based readings supportive of healing and recovery. *Wisdom for the Journey*, a discussion resource, encourages the exploration of four basic spiritual care issues: discerning what is of the spirit and what is of illness in the midst of mental illness; how both religion and brain science help us understand the illness experience; what practices of faith are supportive of healing and wholeness; and questions of purpose, meaning and vocation in the face of mental illness.

These and other resources are posted at www.mentalhealthchaplain.org.

Craig Rennebohm is a United Church of Christ Minister, raised in Madison, WI, and a graduate of Carleton College, Chicago Theological Seminary and the Pacific School of Religion's D. Min. program. Craig lived and worked with street gang members on Chicago's south side and served as Minister to Community at Christ Church United in Lowell, MA where he was a campus and juvenile court chaplain and on the staff of the Lowell Pastoral Counseling Center. From 1975 to 1986 he was pastor of Pilgrim Congregational Church in Seattle, renewing the congregation through an extensive neighborhood mission including a variety of ministries with homeless individuals. In 1987, Craig founded the Mental Health Chaplaincy, a ministry that includes outreach on the streets with persons who are homeless and mentally ill, spiritual care

in hospital and community mental health center settings, training and consultation in local congregations and a wider work of education and advocacy. Craig is the author with David Paul of Souls in the Hands of a Tender God, forthcoming in May 2008 from Beacon Press.

Do you have thoughts about education & research you'd like to share with your colleagues? Send an e-mail to info@PlainViews.org.



Spiritual Development

Tamara Zujewskij, R.N., M.Sc.N., on an enduring love

Helen and Jim

Jim woke with a start in between dreams suddenly halted by the ringing of the phone. "I would like to speak with Mr. Jones." It sounded so ominous. Gradually, the message arrived sending a wave of hot, burning lava through his ears reaching his chest and arms. He fought the message with disbelief. Helen was dying.

They were husband and wife, a union like no other. A simple life filled with blessings of children and passion. There were challenges which they overcame – always together. How would they overcome this one? Helen was dying, leaving him. He would be alone. Other family members had died – why did it have to be Helen this time. Just as they started enjoying their grandchildren it would all come to an end.

She had a bad cold that turned into pneumonia. She would get over it. The doctors would know how to treat her – he tried to convince himself. He heard Helen's words imprinted in his memory "I have no regrets. We have done what we wanted and I am happy with that." When she said those words he felt a distancing, a separating – as if she knew something he did not. He felt her power and his powerlessness in those words. It was only yesterday that she had said that to him. Now, she was lying there, fighting for breath, unable to say a word. Those words penetrated him now. Why had he not asked her more? Why did they not talk more, embrace more? Maybe if they did, he would have more to hold onto now, when his heart was being ripped apart.

Jim phoned his daughter and son. He knew he had to tell them that their mother was dying, but how? They too hoped that she would get better. "Mother is dying we need to go there, be with her, so that she is not alone."

The drive to the hospital transpired in slow motion. Everything around him continued its normal pattern. The early morning traffic was the same. He felt like shouting, yelling at the top of his voice – his Helen lay dying, his life was changing and nothing around him was tuned into his pain. He was angry, but at who or what? He could not drive fast enough to get to Helen, who was there alone. He did not want to lose her too soon. He kept praying – praying that God would get them there on time.

The hospital seemed dark when they arrived; everyone was sleeping. Might the nurse have been mistaken? Was Helen only sleeping? When he entered her room, there was no doubt. Helen's body was working so hard to breathe. It was painful to see her this way. He could not help her. She knew he and the children were there in the way her body responded. "You know we are here," he said to Helen. He noticed a change in her face. That area around her eyes, her mouth; he wondered if she might say a word to them. There were words last night.

There was such sadness in his heart. She was leaving him. Memories – that is all that would be left. He was fighting with himself. She was still here and he was already sending her away. How to be here in this moment? Do I hold onto her – holding on means hope – and she is dying, so there is no hope. Just 'being' without any direction was so different. He wanted to do. There was nothing he could do. Dying – a state of being here and not being here – a state of leaving. It was tearing him apart! He was breathing deeply as if to help Helen breathe. His children gathered around their mother holding her hand, tenderly speaking to her. He spoke to her too – whispered loving words in her ear. He knew she heard them.

He wondered where she was going – what it would be like there. Would he meet her again? Would she see her parents and his brothers who had gone there before? He wondered what he really believed.

When she stopped breathing he knew this was the end of 'us.' She was at peace which brought momentary relief and a sense of peace in his body. The depth of his loss welled up inside of him; his tears

flowed freely. He did not realize he was crying. Somehow he knew that he could carry on but it would not be an easy path.

Then he thought of their grandchildren and how they would miss her. He made promises to himself to make sure they remembered their grandmother. His future would not be totally without her – he had the grandchildren in whom there was a spark of their grandmother and this knowing lifted his head just a little higher in his moment of grief.

Tamara Zujewskyj has been working in the profession of nursing for over 35 years. She is a registered nurse and has both a Bachelor of Science in Nursing from the University of Alberta and a Master of Science in Nursing from the University of Western Ontario. She has held positions as staff nurse, educator, and member of a national research team. Tamara has worked internationally in Ghana, West Africa and supported the Canadian-Ukrainian Partner's in Health program both in Canada and Ukraine. Since 1999, she has worked as a Parish Nurse at the Edmonton Moravian Church and has taken a unit of Clinical Pastoral Education at the University of Alberta Hospital. It was during her posting as chaplain intern at the Hospital that she wrote her reflection on the dimensions of the experience while supporting a family during their journey through dying, death and continuing with life.

Do you have thoughts about spiritual development you'd like to share with your colleagues? Send an e-mail of any length to info@PlainViews.org.



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.](#)

Response to Thick and Thin (to read Nancy's article, please scroll down)

The case study in all three variations strikes me as odd. It may be summarized as follows: A patient refuses a mode of pain-control medication delivery that the oncologist advocates. Unable to persuade the patient, the doctor enlists the help of the ethics committee.

Only the first variation cites the oncologist's stated concern: "the patient is not making a fully informed decision." The second variation provides some explanation for this in stating that the patient and oncologist have a language barrier. It also adds the background that the patient has religious reasons for not wanting the pump. In the third variation the reason for refusal is apparently the patient's vanity.

If the language barrier were really the problem, presumably the oncologist could call in a professional medical interpreter in order to translate the conversation. This suggests that language is not the problem. Similarly, the oncologist probably is not an expert in the patient's religious practice, so I doubt whether the oncologist thinks the patient is misinformed about his own religion. The same can be said about the third variation's concern for personal appearance. Surely she is not misinformed about her desire to look a certain way in the company of her friends.

What is left, then, for the ethics committee to consider is the power relationship between physician and patient. Does the patient have the authority to refuse a palliative treatment? Can a patient legitimately choose pain over medication? What is at stake for the oncologist? Why must s/he protect the patient from pain? Is absence of pain the highest value? Or is it simply that the oncologist needs to control his/her patients and have the final word on every intervention? Why was this case brought before the ethics committee?

I believe it is vitally important to protect the patient's right to say "No." Without it, the patient has no rights at all.

Rev. Dr. Paul D. Brassey, Chaplain
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Thick and Thin

A recently published survey of 600 US hospitals reported that chaplains are among the five professions consistently involved in ethics consultations. In hospitals where ethics consultations are performed by members of more than one profession, 94 percent of all consultations include physicians; 91 percent include nurses; 71 percent include social workers; 70 percent include chaplains, and 61 percent include administrators. Other professions, such as attorneys, or lay persons, are involved much less frequently.

This study is well worth finding and reading.[1] It provides a snapshot of how ethics consultations work and how well those involved in them are prepared for this responsibility. It also calls attention to the troubling frequency of “practice variation” in how similar cases are handled and resolved between different hospitals and even within the same hospital. In health care, reducing practice variation is a good thing. Standardizing infection control measures and medication labeling, replacing handwritten orders with computerized orders, and providing patients with written information about their treatment regimens keeps patients safer and makes the delivery of care more efficient and effective.

Reducing practice variation is also a goal of health care teams, including ad hoc teams such as ethics consultation services. Cases with similar clinical features tend to involve similar ethical obligations. For example, all patients or surrogates considering a particular treatment decision should receive the same information, and the same opportunities for discussion, so they can all make informed decisions. However, these clinical similarities may be masked by the presence of personal details that can seem to “explain” a case. These details can include information about patient’s religious beliefs – and also professionals’ own beliefs concerning these beliefs. Here’s an example:

A 71-year-old patient with advanced colon cancer has been offered the option of receiving pain medication through a portable infusion pump as an alternative to oral analgesics that have not been well tolerated. The patient has refused the infusion pump, stating that the device would be a barrier to participation in activities that are deeply meaningful. The patient’s oncologist is concerned that the patient is not making a fully informed decision, and calls for an ethics consult.

That’s a fairly “thin” description. It includes the clinical facts, but little about the patient and the nature of those “deeply meaningful” activities. So here’s the same case with “thicker” description:

Mr. A, a 71-year-old man with advanced colon cancer, has been offered the option of receiving pain medication through a portable infusion pump as an alternative to oral analgesics that have not been well tolerated. Mr. A. has refused the infusion pump, stating that he did not believe that the device was compatible with his religious tradition’s customs concerning garments that can be worn during worship services. Mr. A’s first language is not English; his son usually serves as his interpreter. He has a large family, and several family members, including his wife and eldest son, are involved in his care.

But what if the same ethics consultation service was asked to consult on this case, too?

Ms. A, a 71-year-old woman with advanced colon cancer, has been offered the option of receiving pain medication through a portable infusion pump as an alternative to oral analgesics that have not been well tolerated. Ms. A. has refused the infusion pump, stating that she was not comfortable wearing the device to the weekly meeting of her book group. Ms. A’s first language is English. She is widowed and lives alone. Her sister is involved in her care.

Are these the “same” case, or different cases? How can this ethics consultation service – let’s imagine it consists of two physicians, two nurses, a chaplain, a social worker, and a risk manager – discern the common features of these cases and the common ethical obligations that may underlie them? How should they discuss the meaning and relevance of the distinctive features in each case? What, specifically, can the chaplain contribute to the analysis of each case and to the comparison of these cases? And what kinds of additional expertise may be needed, but may not be present on this team?

This is an interactive column, and I welcome your analysis and recommendations concerning these cases. You may also wish to use them, and the survey cited below, in your own department, ethics consultation service, or ethics committee.

[1] Fox, Ellen, Myers, Sarah, and Pearlman Robert A. (2007), "Ethics Consultation in United States Hospitals: A National Survey," *American Journal of Bioethics*, 7 (2): 13-25.

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.



Rabbi Daniel Coleman on age and the freedom to just be

Judaism and (Our Struggle With) Dependence

The core theme of many Holidays both religious and secular is freedom. In Judaism, Passover and *Sukkot* celebrate our exodus from Egypt and journey towards being an independent nation in the Land of Israel. America celebrated Independence Day and prides on being "The Land of the Free." But what happens when our identification with these ideals of freedom and independence are impacted by circumstances beyond our control? What happens as we grow old? When we begin to lose our mobility, together with the strength and energy to contribute to, care for, and provide for our family, for society, and even ourselves? How do we come to terms with a state of dependence when our religion and society uphold independence as the greatest of virtues?

Many of the elderly Jewish patients I visit are particularly troubled by this issue as Judaism encourages its adherents to partner in creation – to be people of action, observant of *Mitzvahs*: obligations to ourselves, to each other, and to G_d. How then do we reconcile the time in our lives when we lose the ability to be as creative as we once were, and are prevented from performing certain *obligations* because of our frailty and failing health? Can we as professionals draw on teachings from our tradition or Biblical personalities to assist us in our work with the elderly and give our clients 'permission' to be dependent on others (be that financially, physically, or otherwise)?

I posed some of these questions to colleagues in the National Association of Jewish Chaplains (NAJC). This article incorporates a selection of their responses.

At the outset, it is important to recognize that there may be no easy resolution or reconciliation of these issues. To be cognizant of the fact that you will never be the same – that you will never be 'you' again, is more than a minor shock to the system. It is a death. Perhaps, suggests one of my Rabbinic associates, such people should say *Kaddish*[1] for the death of who they were, and have a naming for the new person they have now become.

This certainly does not mean that questioners should be silenced or laments discouraged. Judaism strongly believes in the importance of questioning.[2] Often the best response we can provide is simply to listen to and accept the question or lament. Encouraging and validating the expression of feelings of inadequacy, loss and uselessness and emotions such as frustration and anger can be a great gift.

In one nursing home I am aware of, this principle has been utilized to engender an environment of peer-support. Residents report that simply listening to and empathizing with other residents who are also experiencing loss of self worth and independence restores a sense of usefulness and a feeling of contributing to the lives of others. No longer are their own hardships viewed only as a burden on themselves and others. These very same burdens and losses may at times have utility in helping them to relate to the suffering of a peer.

Who better to support others grieving their independence than another in a similar situation? In the absence of a clinically trained chaplain or therapist, one frail individual – because of their own experiences – may be the only one who can really listen to another without trying to talk them out of their despondent state.

In this vein, an additional therapeutic approach and intervention rooted in theology, might encourage clients to journal their fears and outline their feelings as they walk through the valley of the shadow of death. After all, the Hebrew Bible documents the struggles that our ancestors faced along the road to the Promised Land. Despite – and perhaps because of – the challenges they faced, their legacy and teachings continue to impact us to this day. This reflective and creative journaling process may also inspire clients to write an Ethical Will. Thus, instead of dwelling only on their sorrow and laments they can be encouraged to express highlights of their life narrative and the spiritual worth and characteristics that they bequeath to the next generation and by which they will be remembered.

For some professionals and clients it may be meaningful to reflect on the notion that the climax of G_d's Creation was the cessation from creating anything new – the Sabbath. Judaism invites its adherents to emulate G_d and refrain from creative activity (*melacha*) on the Sabbath. This opportunity to take time out enables us to appreciate the accomplishments of our creative efforts and to focus on spiritual nourishment and replenishment.[3] The concept of Sabbath could help transform a time of helplessness to a time of connecting with our Source; a time of inaction to a time of true rest from running, mastering and creating; a time of vulnerability to a time of simply being and appreciating.

An extended Sabbatical (i.e. ageing) allows some elderly to develop a deeper appreciation of the world around them and their Creator, This period can provide a time for reflection, appreciation, and integration of the many accomplishments that they achieved in this world. It can also provide much needed space for others to consider and thank them for the many contributions that may have previously been taken for granted.

Ultimately, it is humbling to realize that G_d has organized the world so that even when a person no longer has center-stage, or is bereft of a role to play in most of the scenes, the show still goes on. As does the duty to be thankful[4] . Each morning our traditional prayers declare: "*Kol zman shehanashama bekirbi...*" "As long as You G_d desire that my soul remain within me, I am grateful to You..." During times when life is viewed as a burden and consists of a string of indignities it may be hard to be thankful for the daily gift of life. Working with, living with, and loving those whose life circumstances have highly sensitized them to their dependence on G_d and those created in G_d's Image, can at least provide us with multiple opportunities to be thankful to G_d and afford us a renewed appreciation of all the health we enjoy. Often it is only when we are witness to these blessings ebbing away that we truly recognize their value and impact on our lives.

Sometimes, those we minister to are reluctant to inform loved ones about the debilitating nature of their ailments lest they 'worry too much' or seek to put them in a nursing home etc. While these concerns are very real and must be acknowledged, we may find an opportunity to present an alternative perspective that invites our clients to reflect on their experience as providers of care for their children, partner or others. The client will recall times when it was hard to provide care because the recipient was ungracious or unwilling to accept help and support. As a result, they may have felt rejected, slighted or despondent. Now that roles are reversed,[5] can the client find the courage to receive graciously from others? Especially when children become the caregivers, can the client permit them to show their *Hakarat HaTov* (appreciation) for all the years and resources that were devoted to raising & supporting them?

Clients could be further guided to develop a sense of greater utility by continuing to give to others through concrete displays of gratitude and appreciation. Examples include words and letters of thanks to medical practitioners, and taking a few minutes to provide valuable feedback on the survey they receive after a hospital discharge. In striving to contribute with whatever resources are at their disposal: time, money, or simply words of praise, clients may even begin to feel less dependent as their provider of care also becomes a recipient.

There is a longstanding Jewish tradition for birthday greetings to include the wish: *Ad Meoh V'esrim* (till 120). Today there are plenty of examples of people living beyond that age; however, this was the age at which our great teacher Moses passed away. The *Torah* makes a point of telling us "his eye had not dimmed and his vigor had not diminished" (Deuteronomy 34:7)." This implies that the rest of us are unlikely to be as fortunate. Just as we started life dependent on others and G_d for our basic survival, so we will end our life in a state of dependence. May G_d grant us the wisdom and insight to remember 'the days of old' and recognize that we need not always be do-ers: sometimes we can contribute by simply being.

Footnotes:

[1] *Kaddish* (lit. sanctification) is the traditional prayer that demarcates sections of the congregational service, and is often recited on behalf of the congregation by a mourner in honor and memory of a loved one.

[2] Jews are encouraged to question at a very young age. Hence the primacy of assigning the youngest participant in the Passover *Seder* to articulate the *Mah Nishtana* (Four Questions that are designed to spur further discussion about the meaning and significance of independence). Note further that the *Talmud* (the central repository of Jewish lore, logic and wisdom) uses questions as its principal modus operandi and a model for subsequent Jewish philosophic & legal discussion and clarification.

[3] Those who aren't constantly engaged in the creative activities of their youth are perhaps better positioned to access their *neshama yeseira* (the added dimension of soul described in the Talmud and Jewish mystical sources) that the average person only has access to on the Sabbath.

[4] It is interesting to note that the name Judah or 'Jew' is etymologically derived from the Hebrew word *Modeh* – to **thank** and **admit** our dependence on G_d. (see Genesis 29:35 where Leah names her fourth son).

[5]In Talmudic phraseology this is termed *Galgal haChozer* – a 'revolving wheel,' or colloquially: 'wheel of fortun.e'

Rabbi Daniel Coleman, BCC, serves as staff chaplain at North Shore University Hospital (Manhasset), a HealthCare Chaplaincy partner institution, providing specialist spiritual care to patients, visitors and staff of all faiths and none. Prior to this he worked as a chaplain in a Bronx nursing home and taught classes on Jewish topics for various assisted-living facilities. Programs that he facilitates at North Shore's Center for Extended Care & Rehabilitation have been transmitted live to homebound elderly across the U.S. via Dorot's University Without Walls. He is blessed with a wonderfully supportive wife and the opportunity to talk to and about G-d in both his professional and personal life.

Do you have thoughts about **LongView** you'd like to share with your colleagues? Send an e-mail of any length to info@PlainViews.org.



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.](#)

Caring for the Caregivers E-Journal

In 2004, as the Director of a new Pastoral Care Department, I sought a corporate sanctioned space to remind my medical center family that it's the relational that binds us together – not just the tasks that drive us to excellence in patient care and evidence-based medicine. I sought uncontested ground that was paperless, practical, and accessible by most; whose scope would respect the dignity and spirituality of all persons. I did not have a "pulpit to preach from" in this non-sectarian institution, so I created a virtual one – the bi-monthly *Caring for the Caregivers E-Journal* was born.

For two years, the journal received praise from the entire community. As I made rounds in those early years, I was formally introduced to new colleagues who met me through the in-reach work of the letter. Anecdotal stories revealed that the journal "captured what was missing organizationally spiritually," as one said and hit an institutional nerve that reverberated far beyond the work place as it was forwarded to spouses, kids, and relatives because "it was so helpful." Our Food and Nutrition Services had advance notice in preparing meals sensitive to specific religious holidays because of reading the Interfaith Calendar – a part of the journal. Staff was made acutely aware that there was more to the world of faith and meaning-making than their usual suspects of Catholicism, Judaism, and Protestantism. At best, the *E-Journal* served as a strategic calling card of compassion, education and introduction to an institutional culture that had yet to meet me in person or embrace the ministry of professional chaplaincy I represent.

Change is inevitable. After two years without one complaint, an administrative decision was made to decrease e-mail traffic. A periodical without circulation is a dead periodical. For the next twelve months the "*E-Journal*" vanished. I mourned its untimely death with members of its

readership. Yet I understood that it was an idea whose time had come and possibly passed as the organization brought on-line its own e-news letter. My goal operationally is to be in the moment and give my attention, energy and dollars to those things which are most meaningful, and have the greatest impact; discarding the rest.

In January 2008, the *E-Journal* was back as part of the revitalization effort of our primary corporate newsletter – *The Vassar Voice* (VV). The VV is produced monthly and hard copies are made available house-wide and mailed to our physicians, internal departments and board members. It is now featured prominently as part of our mainstream sanctioned discourse with a wider readership. While changed, its core remains – the story-theology part. As Howard Thurman said, "people recognize the voice of the genuine in others." The story still stirs the human soul and resonates as deeply as before.

The driving force of the *E-Journal*, now subsumed in the primary media forum, keeps the light of spiritual care shining in our corporate window. It provides balance along side our quality accomplishments. It reaches persons and places I often cannot and builds bridges to cross when I arrive.

The Rev. John Simon, M.Div., M.T.S., BCC, is Director of Pastoral Care at Vassar Brothers Medical Center. A native Texan, he has been engaged in ministry for 20 years 10 of which have been in healthcare chaplaincy. An ordained Baptist minister, Rev. Simon entered ministry from a previous career in internal auditing. He has served in various senior leadership positions in the parish, non-profit administration and hospital contexts in TX, CT, CO, and PA. Clinically trained with 8 units of clinical pastoral education, Rev. Simon is board certified through the Association for Professional Chaplains. His educational background includes a bachelors of business administration in Accounting with a minor in Marketing from Prairie View A&M University in Prairie View, TX; a Masters of Divinity degree from Yale University Divinity School in New Haven, CT; and a second Masters in Theological Studies with distinction from the Iliff School of Theology in Denver, CO. Additionally, Rev. Simon completed two additional years of graduate research at the University of Denver in the area of religion and social change. He integrates his diverse background in education, experience and professional training in his ministry. The results have positively impacted the relationship between the medical institution and faith communities in which he now serves.

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



Reviews

Sarah Masters reviews the film

In Her Own Time: The Final Fieldwork of Barbara Myerhoff

In Her Own Time: The Final Fieldwork of Barbara Myerhoff is a film that reveals how a confluence of events drew one very secular academic into a closer relationship with her Jewishness.

Professor Barbara Myerhoff was an anthropologist with an academic career in the study of community. She was well known in academic circles, and, in the early 80s, she decided to study and film the Orthodox Jewish community of the Los Angeles district of Fairfax.

Two years after undertaking the project, Barbara Myerhoff received a diagnosis of terminal lung cancer. In her role as an anthropologist, she continued to question individuals considering conversion to Orthodox practices and, for a while, she maintained her distance as an objective academic from the religious practices of the Orthodox Jews she studied.

But Myerhoff also decided to explore her own relationship with Orthodox Judaism, and so she asked documentary film director Lynne Littman to capture the importance of religious traditions and practices in the Orthodox community in far more personal terms. Myerhoff purified herself in the *mikvah*, and among other things, asked the Rebbe to bless her in writing. She even "changed her name to 'trick' the angel of death." She actively pursued answers to the tough questions she posed long after becoming wheelchair-bound, up to the time of her death at age 49.

In Her Own Time: The Final Fieldwork of Barbara Myerhoff gives to viewers a social exploration of an Orthodox Jewish enclave from an anthropological perspective. The film also highlights Myerhoff's personal journey, and shines a light on the enduring values of commitment to a life steeped in ritual and spiritual community.

Completed: 1985
Running Time: 60 Minutes
Director: Lynne Littman
Producers: John Bernstein, Vikram Jayanti and Lynne Littman

If you are interested in purchasing this film, you can do so at www.directcinema.com. The price of \$150.00 for a copy of the film, which is still in educational distribution and not in home video distribution, includes public performance rights.

Sarah Masters is the Managing Director of the Hartley Film Foundation, a non-profit foundation dedicated to cultivation, support, production and distribution of the best documentaries and audio meditations on world religions, spirituality, ethics and well-being.

Book Review

Rev. Ken R. Hayden reviews

The Absolutely True Diary of a Part-Time Indian

This novel is written by a well known and award winning Spokane/Coeur d'Alene Indian, Sherman Alexie. Alexie engages the issues of suffering, oppression, spiritual values of two cultures and hope. It's the story of Arnold Spirit, known on the reservation (rez) as "Junior". Arnold is born with hydrocephalus and teased as "hydro" by some of his friends. As a 14 year old, with his black rimmed, thick coke bottle glasses, Arnold dreams of becoming a cartoonist. The novel is interspersed with cartoons by Junior. Life is hard on the rez. He says, "The kid was born with 10 too many teeth, so he gets them pulled — all in a single day, because the Indian Health Service pays for major dental work only once a year."

While thumbing through the face page of his geometry book, he sees his mother's name. Arnold is incensed that since the time his mother went to the rez school, no geometry books have been purchased. He hurls the book at his white teacher, Mr. P, and is kicked out of school. Junior and Mr. P. have a heart-to-heart talk which is painful, powerful and propels Arnold to act on his dream. He decides to transfer from his reservation school to an all white high school. He leaves the rez but does not forget his family or his best friend, Rowdy.

Arnold soon earns the respect of his new schoolmates with his humor, courage and strength. Arnold reflects on the impact of alcohol on his father, his sister and many cousins and friends. Considered a traitor by those he left behind, Arnold questions his dream, his family relationships and friendships. He appears to be falling apart.

Arnold struggles with his identity as a Spokane Indian. Seeing his accomplishments in the new school, he pointedly wonders if he will be accepted for who he is, in either cultural context. The death of Arnold's treasured grandmother and later, the sudden death of his father's best friend, Eugene, places himself between reason and powerful emotions. "After my grandmother died, I felt like crawling into the coffin with her. After my dad's best friend, got shot in the face, I wondered if I was destined to get shot in the face, too." Arnold says, "I'm fourteen years old and I've been to forty-two funerals. That's the difference between Indians and white people." The book engages issues of culture, identity, loss, death, and hope. A great book for those who are engaged by story.

Alexie, Sherman. *The Absolutely True Diary of a Part-Time Indian*. Little, Brown and Company, New York, NY, 2007, pp 240.

Rev. Ken R. Hayden, is a certified ACPE CPE Supervisor, Manager of the Department of Pastoral Care & Education, York Hospital, York, PA. He is an enrolled member of the Eastern Delaware Nation.

Do you have thoughts about these reviews you'd like to share with your colleagues? Send an e-mail to info@PlainViews.org

Book Review

Rev. Dorothy Shelly reviews

Mourning Has Broken

Perhaps everyone has a story that could touch your heart – the many stories that make up *Mourning Has Broken* deeply touched mine. Page after page, the inspiring stories of grief are full of riches. I affirm the foreword comments of Alan D. Wolfelt, grief specialist, “The stuff of healing is story writing and storytelling. Tell the story of the death and you begin to acknowledge it. Tell it 10 times and you begin to let it enter your heart. Tell it over and over again and you find it becoming a part of who you are.”[1]

Koven, with a background in social services and journalism, and Pearl, with a background in art therapy and psycho geriatric therapy, have put together a marvelous collection of 50 first-person stories of wisdom and insight from various authors about healing after the loss of a loved one. Both editors deeply believe in the creative healing process of writing and have compiled this anthology of hope after they experienced the challenging journey through the pain of grief.

Chapter headings include: "Poetry, Writing & Journaling," "Refreshment Break," "Narrative Essays, Letters, and Mixed Formats." As a poet and critic of that trade, I found the poetry to be soul-awakening. It was a foretaste of what was to come as each writer seemed unafraid to grapple with and honestly confront the raw emotions of grief. Whatever the format, these personal narratives are a blessing to the reader whether presently experiencing grief or journeying with another in the healing process.

Mourning Has Broken is a perfect pick for pastoral care providers and I have a hunch it will be a resource tool that will frequently be taken down from my bookshelf.

[1] p. xiv.

Koven, Mara, Pearl, Liz, eds. *Mourning Has Broken: A Collection of Creative Writing About Grief and Healing*. KOPE Associates, Toronto, Canada, 2006, pp 224.

Rev. Dorothy Shelly, BCC, RN, is a long-term care chaplain at Phoebe Richland Health Care Center, Richlandtown, PA. She is Vice President of the United Church of Christ Professional Chaplains and Counselors and is a poet and author of Anybody See My Shoes? Poetic Reflections From A Chaplain.

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