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HealthCare Chaplaincy Network™ is a global health care nonprofit organization that offers spiritual-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Our mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve the patient experience and satisfaction, and to help people faced with illness and grief find comfort and meaning—*whoever they are, whatever they believe, wherever they are*. We have been caring for the human spirit since 1961.

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Vol.5, No.9 Caring for the Human Spirit® magazine is published semi-annually: spring/summer, fall/winter.

A LETTER FROM REV. ERIC J. HALL

Rev. Eric J. Hall
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I recently read a story in the latest issue of the Beryl Institute's Patient Experience Journal (Vol.4, Iss. 3) by Allison Christensen about her personal experience as a patient and how difficult it was transitioning from inpatient care for a catastrophic illness to attempting a return to normalcy with fears and concerns about living with a life-changing condition. Most striking in her story was her statement that a patient's recovery experience "is directly impacted by what happens (or what doesn't happen) during the patient's time in the hospital. This is the "long view" of patient experience—the awareness that our actions as healthcare professionals have far-reaching impact. The extra five minutes asking about a patient's values, hopes and fears can mean the difference between feeling like a number and feeling like a person." She reminds us that awareness that the actions and delivery of care has far-reaching impact.

HealthCare Chaplaincy Network and the Spiritual Care Association are dedicated to the promotion of excellence in spiritual care through its clinical training, education, research, and chaplaincy practice to provide quality care to patients, families, and staff. Our work constantly attends to the critical current needs that arise in health care, patient experience, and quality improvement through identifying the evidence that calls for change and improvement. In doing so, our contributions to the profession have raised the bar in how spiritual care is understood and provided. In other words, we are committed to *Chaplaincy Transformed.* This has resulted in two significant developments in the work that we do.

On January 4, 2018 HCCN announced that we have partnered with the Institute for Clinical Pastoral Training (ICPT) which is actively pursuing accreditation with a nationally recognized U.S. Department of Education Accrediting Agency. ICPT is an innovative and creative organization fully committed to the highest quality of clinical training with the willingness to adapt the CPE paradigm to the various settings where chaplains work. Through this partnership, HCCN is able to provide greater access to CPE training that (1) is more closely aligned with the needs of chaplains already in the field; (2) provides interactive distance education and supervised clinical training for chaplains who do not have access to a CPE center; and (3) evidence-based student learning outcomes.

The Spiritual Care Association's certification process includes a test for core knowledge derived from evidence-based quality indicators for spiritual care and a simulated patient exam that evaluates competency in direct patient contact. As candidates have taken this test it is apparent that most chaplains do not come to the SCA process with the needed knowledge, requiring significant time in study and preparation to pass the test successfully. This confirms that the SCA BCC actually represents a significantly higher bar than other BCC processes. In recognition of this fact, we have changed the certification of those who have completed the SCA certification process to Advanced Practice Board Certified Chaplain (APBCC) to recognize the advanced didactic and clinical education, knowledge, skills, and scope of practice they possess. APBCC defines a level of chaplaincy practice that utilizes extended and expanded skills, experience and knowledge in assessment, planning, implementation, diagnosis and evaluation of the care required. Those who have come to the SCA as BCCs for reciprocal certification now have a time-sensitive process to complete the knowledge test in order to receive the designation of APBCC. To ensure that spiritual care always reaches to provide excellence, we are excited about the future as we continue committed to *Chaplaincy Transformed.*

Peace and Blessings!

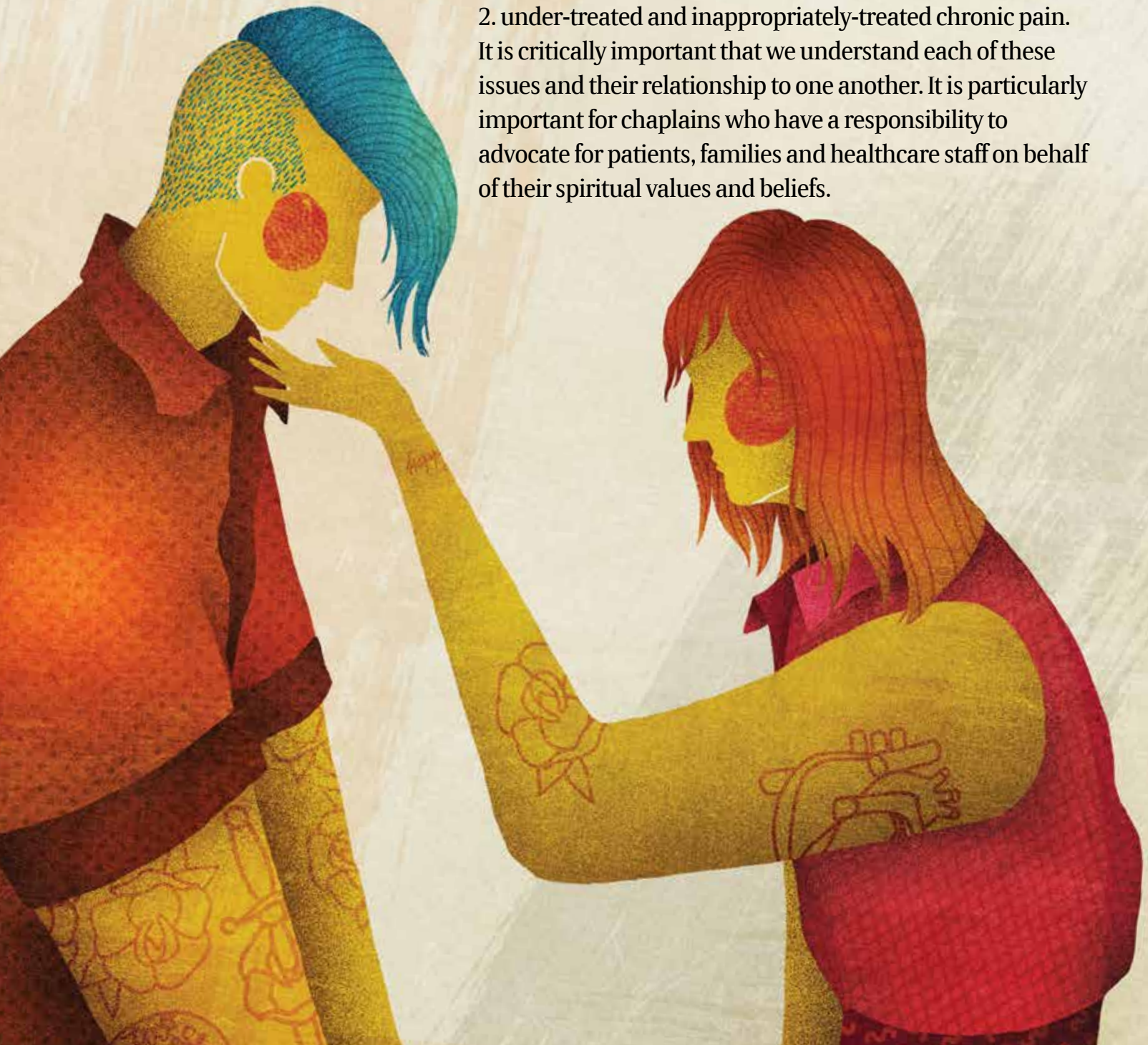
CHRONIC PAIN:

Managing patient care in the midst of increasing regulatory restrictions

By **Myra Christopher and Rev. Sue Wintz, BCC**

America is facing two major public health crises:
1. what has been called an "opioid" epidemic and
2. under-treated and inappropriately-treated chronic pain.

It is critically important that we understand each of these issues and their relationship to one another. It is particularly important for chaplains who have a responsibility to advocate for patients, families and healthcare staff on behalf of their spiritual values and beliefs.



In the 1980s, various studies reported that serious pain was grossly under-treated in the US. One reported that nearly a third of nursing home residents who reported cancer pain received nothing for their pain – not even a Tylenol. Americans associated pain, sometimes excruciating pain, as unavoidable at the end of life. This is not surprising for a culture that sees pain as weakness, punishment or character building. From early childhood, children are taught "when the going gets tough, the tough get going" or "don't cry – be a big boy or girl." Some are even taught that Christ suffered for us and pain is redemptive. Too many Americans, however, had seen loved ones writhe in pain and heard them beg for the next pain shot only to be told that it was "not time yet" – even when their loved one was actively dying. At the same time, new pain medications came on the market that were aggressively marketed and people, including physicians, were told that they were safer, more effective and less likely to be abused. Healthcare professionals were told that there was no excuse for any of their patients to experience pain; pain was unacceptable if patients were receiving good pain care.

In the 1990s, concerted efforts were made to improve pain care and relieve unnecessary suffering. Pain as the 5th Vital Sign was created to more effectively assess pain. The Joint Commission established management of pain as a quality indicator. Doctors were encouraged to prescribe more freely, and patients began to think that pain could and should be completely eradicated. By 2000, Congress proclaimed the next ten years as the "Decade of Pain Control and Research." Then in 2011, the Institute of Medicine published the first comprehensive study ever on pain.[1]

The results were staggering:

- More than 100 million Americans live with chronic pain – more than those with cancer, diabetes and heart disease combined
- The costs in economic terms are between $560-635 billion annually

In humanistic terms, the costs are incalculable. People lose jobs, families, the ability to engage in activities that give meaning to their lives; many even lose notions of self and struggle existentially and spiritually. The solution the Institute of Medicine proposed was a biopsychosocial pain care model. Many argued that the recommendations should have been for a biopsychosocial and spiritual model.

Although the US had struggled with increasing rates of addiction to drugs and alcohol since Vietnam vets returned home in the 1970s (many addicted to both alcohol and heroin), by the end of the 1990s it became clear that drugs that had been prescribed to address serious pain had become preferable to "street drugs," e.g., crack, cocaine, meth among those living with substance use disorders. Furthermore, it became apparent that prescription pain medications were not as safe as had been previously claimed and were contributing significantly to rising addiction rates and unintended deaths associated with opioids, especially when mixed with other drugs and alcohol.

Many of those who became addicted to these meds and/or died were young white adults. Addiction had leeched out of the inner-city to the suburbs, and the media caught fire with this "new" problem. Ultimately, the "War on Drugs" established in the 1970s became the "opioid epidemic." For the first time in medical history, an epidemic was associated with a drug rather than a disease.

The federal government's approach to the opioid crisis has been a "supply-side" solution, i.e., to drastically reduce the number of opioids prescribed and to put pressure on those who prescribe them, especially primary care providers. Inadvertently, this strategy has unintendedly increased the pain and suffering of people like Sue Wintz, a professional health care chaplain who for three decades worked long shifts in hospitals and academic medical centers, primarily in ICUs, trauma emergency rooms and with those nearing the end of life.

"More than 100 million Americans live with chronic pain – more than those with cancer, diabetes and heart disease combined."

Sue was first diagnosed with Rheumatoid Arthritis in 1991 at the age of 34 as a young professional, wife and mother. As the disease progressed, she found herself with increasing and unrelenting pain with flares occurring often. Treatment included biologics, methotrexate, steroids and pain medications but they didn't come without side effects that were often as debilitating as the RA itself. Despite the constant pain and fatigue caused by the disease, she continued her hour commute to and from her work every day as well as her care for and engagement with her family.

Ten years ago, she changed rheumatologists hoping for a different approach to treatment that would make a difference. Her current rheumatologist's treatment includes a holistic team including a nurse practitioner, neurologist, orthopedic surgeon and physical therapy with an emphasis on communication and education. She was additionally diagnosed with fibromyalgia, osteoporosis, thoracic outlet syndrome as well as osteoarthritis and tenosynovitis affecting several joints. With disease activity and surgeries, the chronic pain and fatigue continues. When a flare hits, whether from the RA or fibromyalgia or both at the same time, the pain can be relentless.

In addition to traditional

medical care, Sue has incorporated complementary practices into her disease management. She goes to the gym, maintains a healthy weight, eats a balanced diet, utilizes massage, acupuncture and essential oils and salves, and continues her active life with family and hobbies. However, none of these are covered by her private "high-level" insurance policy and are expensive when paid for out-of-pocket. Even physical therapy requires a high co-pay before her insurance coverage begins to cover it, and then only for a certain number of visits per year.

With diseases like rheumatoid arthritis and fibromyalgia, over-the-counter medicines do not manage the level of pain that occurs. Part of Sue's treatment throughout the years has been the use of opioids for pain management, especially when a flare occurs. She takes them reluctantly; only when the pain is unbearable. To be honest, she doesn't like taking pain medication because of the side-effects, primarily acute abdominal pain that occurs with each dose despite attempts to lessen it. However, there are times when in order to function, that is, to be able to walk, stand, use her hands, and sit or lay without pain, pain medication is essential.

Even though Sue and her rheumatologist have agreed to the lowest dose of opioids prescribed at the moment, her insurance company has already questioned it being prescribed, resulting in her physician's office doing more work to provide evidence of what she needs and why. She has no history of medication abuse or addiction; she has a combination of diseases that have been demonstrated and proven to cause chronic pain that must be treated effectively and comprehensively. As her chronic pain continues to progress due to the nature of her disease processes, Sue worries about the future. As a health care chaplain, she saw the results of debilitative disease and the need for effective pain management and the physical, emotional and spiritual impact on chronic pain patients. She knows that with her diagnoses she will likely follow the same path. Sue works to advocate on behalf of chronic pain patients that they can receive the care they need including the responsible use of opioids. She provides education and training on how to cope with the emotional and spiritual distress, not only from the experience of living with chronic pain, but with the impact of the current misunderstanding and confusion regarding the needs of these patients to be treated.

Whether or not a person identifies themselves with a formal religious, spiritual, or existential tradition, spiritual distress is a common issue for chronic pain patients. Health care providers should ensure that these needs are screened for and formally assessed by a professional chaplain. In their Spiritual AIM model of assessment, which does not presuppose belief in God or any other religious belief system, Shields and Kestenbaum identified three primary spiritual needs all persons have[2]: meaning and direction, self-worth and belonging to community, and reconciliation/to love and be loved. Spiritual distress occurs when these primary needs are not met.

Chronic pain patients often struggle with the meaning of their disease and the changes it makes to their relationship with themselves, others, and the Divine. If no longer able to work or engage in formally satisfying activities, questions and distress can arise regarding what meaning and purpose their lives now have, and how to adapt to those changes. Chronic pain patients may struggle with a sense of betrayal from their bodies, their belief and values system ("Why is this happening me?"), and even the health care system that may not be able to adequately meet their medical needs. Their sense of self-worth is often challenged along with questioning their ability to make decisions, their relationships that can become strained, changed, or broken due to their symptoms and limitations, and their inability to participate in community activities that have been a source of connectedness and support. Anger, sadness, and feelings of abandonment can be common. Depression can be overlooked by health providers or treated simply with medication rather than identifying and addressing the underlying emotional and spiritual distress.

The Spiritual AIM model, when integrated into the care of chronic pain patients by a professional chaplain on the interdisciplinary team, provides a comprehensive assessment of potential areas of spiritual distress, clear interventions, and desired outcomes. As a result, chronic pain patients can be empowered to learn and embrace steps to engage in a healthy spirituality, a core element of whole-person care.The challenge of caring for people like Sue while balancing the benefits and risks of powerful medications has also dramatically increased stress among clinicians to an almost unbearable level.

Clinicians do not want to see their patients suffer, but often feel they must follow guidelines, rules and regulations even when they believe these are contrary to the interests of their patients and their own clinical judgment. Often healthcare professionals find themselves on the horns of a dilemma – not knowing whether to do what they believe is right for a patient or to do what is safest and least likely to draw attention from those who oversee and regulate their practice.

Albert Schweitzer, famed physician and humanitarian, said, "Pain is even a more evil lord over mankind than is death." I would argue the same statement is true about substance use disorders and addiction. People living with chronic pain or substance use disorders struggle with a disease, and a small subset of these patients live with both. All of them are deserving of compassionate, high-quality, patient-centered care. Yet, both patient populations are often treated as morally defective, weak-minded, and/or drug seeking and are, today, often "fired" or abandoned by their

physician – even those patients who have closely adhered to treatment plans and never misused medications. Discernment is central in the role of all faith leaders, perhaps especially for chaplains, those professionals charged with addressing the spiritual needs of patients they serve and with advocating for them, their families and those who care for them. To fulfill this role, chaplains must:

- Become better educated about chronic pain, substance use disorders and the relationship between them.
- Listen to patients carefully. (The number one complaint of those living with chronic pain is "My healthcare provider doesn't listen to me.")
- Recognize personal biases and those that exist in our healthcare delivery system that make it harder for people of color, those in lower socioeconomic classes and those in the LGBT community to receive proper care.
- Help clinical colleagues wrestle with competing values and to come to ethically defensible decisions.
- Support the care team in understanding the difference between pain and suffering.
- Speak out for those who, for whatever reason, cannot advocate for themselves.

The Institute of Medicine's 2011 report, Relieving Pain in America, stated clearly that there is a "moral imperative" to treat pain and that all those in the healing professionals have a duty to care for people living with pain. Although I was on the committee that published this report, I believe we misspoke. I think it would have been better if we had said, "All those in the healing professions are called to care for those living with pain." I would make the same statement about those living with substance use disorders.

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Myra Christopher, LDH *(hon) holds the Kathleen M. Foley Chair in Pain and Palliative Care at the Center for Practical Bioethics (CPB) where she directs the Pain Action Alliance to Implement a National Strategy (PAINS.) The founding director of the CPB more than three decades ago, Myra's life-long mission has been to improve care of the seriously ill and dying. While directing Community-State Partnerships to Improve End-of-life Care for the Robert Wood Johnson Foundation, she became convinced that those who live with chronic pain have a greater burden to bear than do those who are actively dying and shifted her attention to advancing comprehensive chronic pain care. In 2010, she was invited to serve on the Institute of Medicine committee that published Relieving Pain in America in 2011. Myra served two terms as a member of the National Institutes of Health Interagency Pain Research Coordinating Committee and in that capacity served as a member of the Oversight Committee that developed the National Pain Strategy for the Department of Health and Human Services. Her work has been widely recognized by organizations such as the American Academy of Pain Medicine, the Academy of Integrative Pain Management, the American Academy of Hospice and Palliative Medicine, and the National Association of Attorneys General. In 2015, she was named to the Starr Women's Hall of Fame at the University of Missouri Kansas City and in 2017 was given the "Life-Time Achievement Award" by the American Society of Humanities and Bioethics.*

Rev. Sue Wintz, BCC*, is Director, Professional and Community Education at HealthCare Chaplaincy Network and the managing editor of its publication PlainViews®, the preeminent online professional journal for chaplains and other spiritual care providers. She has a major role in the development, design, writing, and instruction of HCCN's professional continuing education offerings. Sue has over 35 years of clinical, administrative, educational design, development and teaching experience in the provision of professional chaplaincy and spiritual care in health care and congregational settings. She is board certified by the Spiritual Care Association and the Association of Professional Chaplains. Sue is a past president of the Association of Professional Chaplains, and in 2013 was given APC's highest honor – the Anton Boisen Professional Service Award.*

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HealthCare Chaplaincy Network, a professional education leader, is committed to fulfilling the National Consensus Project for Quality Palliative Care's Clinical Practice Guidelines for Quality Palliative Care, which state that spirituality is a "fundamental aspect of compassionate, patient- and family-centered care that honors the dignity of all persons."

www.healthcarechaplaincy.org/palliativecare

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Live Well/ *Finish* Well

By **Jim Kraft**

Many people today strive to "live well." They're mindful of what they eat and how much exercise they're getting. They're proactive. They have specific goals to help them achieve a desired quality of life. To put it another way, they are purposeful about how they live their life. They don't just let life "happen."

As a chaplain with over 15 years of experience in both the hospital and hospice settings, I have found that the principles used for living life well can also be applied to finishing life well.

Many patients and healthcare providers alike are under the impression that Advance Care Planning simply means completing a legal document called an Advance Directive. This idea is mistaken. In filling out an Advance Directive, patients are asked to make decisions regarding the future medical care they would or would not want in the case of an event or medical condition that renders them unable to speak for themselves. The problem is that Advance Directives require patients to make broad decisions about specific medical interventions they may or may not want without identifying potential scenarios that could very

well change those answers.

In contrast, Advance Care Planning teaches people how to make medical decisions in light of their prognosis, goals of care, faith, and values. This process equips them to make medical decisions as various scenarios arise. By sharing this process with family members, advocates gain insight into the rationale behind the patient's decisions. And if the time comes that a patient can't speak for themselves, all parties involved can feel confident that the advocate is making decisions that are in line with the wishes, goals, values, and faith of their loved one. Unfortunately, research shows that many seriously ill patients have not had robust discussions about their goals of care and desires for future medical treatment with either their physicians or with family members. Yet research also indicates that more than half of those facing end-of-life decisions will not have the mental capacity to do so for themselves when the time comes.

Only 20-30% of Americans have a current, valid Advance Directive in their medical record. Without Advance Care Planning, the following typical pattern of care can be expected: a series of treatments (that may or not be beneficial); multiple hospital admissions; one final admission into the Intensive Care Unit where every measure to stave off death is exhausted; then (and usually only then) the patient is entered into hospice. While this is certainly not the scenario in every case, it is unfortunately the norm and not the exception in many of our health care institutions today.

A Different Approach

As a chaplain, one of my goals has always been to assist individuals to live their lives as fully as possible. My motto is, "I may not be able to add days to your life, but I can help bring life to your days!" One way chaplains can do this is to help connect those we serve with their source of strength. For many, this source is the God of their faith.

Studies indicate that a person's faith greatly impacts the decisions they make for medical treatment. It is not uncommon for an illness to overwhelm an individual and demand their time and attention. Physical decline, pain, fear, and confusion are often fellow travelers accompanying both patients and families on their medical journey. It is therefore important during this time for patients to see their illness in the greater context of the teachings of their faith. Patients and families who have the opportunity to consider their medical options in light of what they believe tell us that it gives them better perspective and usually strength, hope, and a plan to live life to the fullest. Patients feel empowered to face future medical challenges with purpose. I often tell people, "You can't always control the illness, but you can prepare yourself for how to respond to it."

"... Advance Care planning is a method of discussing, exploring and sharing with others which care and medical treatments a person desires based on their medical prognosis, goals of care, faith, and values."

As touched on earlier, Advance Care planning is a method of discussing, exploring and sharing with others which care and medical treatments a person desires based on their medical prognosis, goals of care, faith, and values. The specific treatments and care that a person wants (or wants to avoid) are discussed and communicated to both physicians and to those who are their advocates (their spokesperson when the individual is unable to speak for themselves). The "fruit" of these conversations creates the foundation for the written document known as the Advance Directive. More important than the Advance Directive is the conversation. A trained Advance Care Planning (ACP) facilitator guides the individual and his advocate into a discussion that explores hopes and fears, goals of care, what "living well" looks like to the individual, and who or what is important for him to achieve his best possible life. This, in my opinion, is work that is perfectly suited for Chaplains.

Chaplains have the capacity to be excellent ACP facilitators. Their skillsets, compassion, and training position them well to explore with their patients more than just the medical side of illness. Often it is within the context of an ACP consult that I utilize many of the Spiritual Care interventions I have in my toolkit: crisis intervention, emotional support, faith affirmation, and life review to name a few.

Benefits of Chaplains Trained as ACP Facilitators

Increased Patient Care:

Not all patients want to see a chaplain, but almost all patients benefit from an ACP consult. Occasionally I come in wearing my chaplain hat, and the conversation naturally moves into the area of Advance Care Planning. More often, I come in wearing my ACP hat and the patient discovers they also have the need for spiritual care. ACP work has broadened my capacity to reach more patients and families who might not otherwise have received a Spiritual Care consult. Just as studies indicate higher patient satisfaction when competent Spiritual Care is provided, studies also show much higher patient satisfaction when effective ACP work is performed.

Integration into the Care Team:
It is no secret that chaplains are tasked with finding ways to integrate into the clinical care team. Advance Care Planning provides a vital service to patients which, when done effectively, better enables patients and providers to work together as they strive toward Shared Decision Making. This is more likely to result in the best and most appropriate plan of care for patients. Chaplains increase their value and role within the care team by offering ACP. They are directly impacting patients and families while affecting everything from re-admissions, earlier entrance into Palliative and/or Hospice care, and reduced end-of-life costs. Most importantly, chaplains as ACP facilitators keep care patient-centered and focused on providing care in accordance with the patient's goals of care, faith and values.

It's all about the Patient
We live in a culture that avoids considering unpleasant things. Talking about and preparing for future medical care when facing a chronic or progressive illness is never easy, but it is necessary. Without such planning, "finishing well" is a goal rarely achieved and life (and ultimately end-of-life) just "happens" to us. Advance Care Planning allows those we serve the opportunity to thoughtfully consider how they want to address their medical concerns and finish life well. While there are many benefits to Advance Care Planning the three primary benefits are:

1. Increased communication between patients and physicians to insure the best personalized care.
2. Spelling out patient wishes so that patient advocates will know what to do when called on to make decisions.
3. Providing confidence and peace of mind for the patient, knowing that their medical decisions will be honored.

Advance Care Planning is another way I, as a chaplain, add value to my organization. Many healthcare institutions today are striving to provide high-quality, safe, innovative care that is still patient-centered. Advance Care Planning contributes to this effort.

Jim Kraft *supervises the Spiritual Care departments at two hospitals and is the Director of Advance Care Planning and Collaborative Care for the Henry Ford Health System in Detroit, Michigan. He is certified in both First and Last Steps as a Facilitator Trainer with Respecting Choices. For more information about ACP or becoming an ACP facilitator, email jkraft2@hfhs.org. Studies cited upon request.*

Guidelines for Chaplains Responding to Inquiries Regarding **Physician Assisted Deaths** (PAD)

By **John Valentino**

Let me begin by stating that this is a guideline for healthcare chaplains, clergy, and spiritual care providers. This is not a guideline for intervening in a Physician Assisted Death (PAD) nor is this an ethical treatise on PAD. Articles on the ethical implications abound on the internet and interventions regarding suicide prevention can be found in a myriad of crisis intervention books. Chaplains reading this article will note that the word suicide is no longer used in what was previously referred to as Physician Assisted Suicide. The rationale for this change can be found at the Death with Dignity website.[1] It is imperative that the chaplain or spiritual care provider access this website to enhance his/her awareness of the rationale and stay up to date with the current language and terminology related to this subject.

Furthermore, this article is not a course on morality or a theological essay on the pros and cons of PAD. This short article is simply written to offer some guidelines for chaplains and spiritual care providers who are asked by patients, families or staff about PAD. If someone approaches you and says, "I have some concerns or am considering PAD and I would like to talk to you about this," how might you and I respond to the question being raised?

Most of us remember how Dr. Jack Kevorkian brought this issue to the public's awareness and his advocacy for PAD. Arrested in 1999, Kevorkian spent eight years in prison for second degree murder. As of this writing, four states in the union have legalized PAD. These states are California, Washington, Oregon, and Vermont. On June 30, 2016, the New Mexico Supreme Court overruled a district court ruling that in 2014 proclaimed physician assisted dying in the state a right, saying the matter should be resolved in the executive and legislative branches. Physician Assisted Dying is, therefore, not currently legal in New Mexico.

According to the American Academy of Hospice and Palliative Medicine, their definition of Physician Assisted Dying (a definition approved by the AAHPM's Board of Directors on June 24, 2016) is "…a physician providing, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life." [2]

Assumptions

We all have assumptions and I want to be clear about my assumptions, some of which the readers may or may not agree with. I believe that these are relatively safe assumptions about the patients or families who might wish to consult with us. The important point I am attempting to model by sharing my assumptions is that chaplains must be aware of their assumptions, attitudes and values regarding this subject. It

is an issue that is not going away anytime soon. Therefore, if someone approaches me with such a question, I assume:

1. This patient has a serious concern and needs to talk about a personal dilemma regarding PAD. I will not treat this subject lightly.

2. The patient may feel desperate, burdened or confused about what to do because of their faith heritage, family of origin, religious or moral upbringing.

3. PAD is clearly an "end of life" issue. Chaplains are obligated to be aware of those issues.

4. This patient has reached the point of considering Physician Assisted Death for a reason. Can we ascertain what that reason is? In most cases, the patient has a terminal illness, may be experiencing uncontrollable pain and wants to end any suffering they are experiencing.

Whatever your assumptions, people have their own reasons for wanting to consult with the chaplain or a spiritual care provider. They had the option of consulting a nurse, a social worker, physician, the hospital ethicist, even an administrator or their clergy. But they didn't. They sought you out. They want to talk to and be heard by a chaplain. The following guidelines and rhetorical questions are offered for reflection if and when you are asked to consult. Let me be clear that as a chaplain, I take no sides in these guidelines. I am neither advocating for or against PAD.

1. Remember your role. My role as chaplain is to allow the patient to talk, to listen deeply and explore their concerns, questions and rationales with the goal of helping the patient seek clarification. (Some rationales, such as financial or monetary gains, will raise ethical issues).

2. Are you willing and able as chaplain to go outside your comfort zone? If you are not comfortable discussing PAD and are not up to date with the issues, make a referral to a colleague who is willing to have this discussion with the patient.

3. Remembering that I am not there to take one side or another, can I set aside my own personal feelings or convictions about this subject so that I can hear the other with "no strings attached?" This includes setting aside my own ethics, values and theology that could derail the conversation.

4. Can I self-supervise myself on the spot in the "here and now" and avoid the temptation to do what Parker Palmer calls "moralizing, advice-giving, fixing, saving, or setting the other straight?"

   Educate yourself and be familiar with various cultural and religious beliefs and differences regarding PAD. For example, according to the website, Torah Musings, Judaism forbids euthanasia and physician-assisted dying.[3]

5. The Halakhah does not forbid the use of narcotics for pain control even though it may possibly hasten one's death, provided that the intent is to alleviate pain.

6. Can I hold another's concern about PAD as 'sacred story' and listen without judgment?

7. Chaplains are encouraged to pay attention to the cognitive abilities of the patient and proceed with caution with a patient who appears to be incapacitated, confused or not able to make coherent decisions. Just because a patient doesn't have decisional capacity doesn't mean they are not able to express deep feelings that are often discounted or ignored by others because they're "demented". They struggle, too, sometimes with end of life experiences. We can still provide spiritual care to the 'least of these' even if it's not going to result in a PAD.

Guidelines

The following guidelines are basic chaplain skills that can be utilized when responding to a PAD inquiry.

- Prior to the start of the conversation, arrange for this discussion to take place in a room where you will not be interrupted. This is not a conversation that should take place in the hallway. Privacy is paramount. Remember, you are walking on sacred ground.

- Exercise patience. It may take some time for the patient to get to the real issue. The patient may take some detours as they work up the courage to confide in you. Trust the silence and the pregnant pauses. This discussion may take more than one visit.

- As in the case of an Advanced Directive, I would not engage in a PAD discussion if the patient appeared to be confused, incapacitated or is not alert and oriented. As an example, I once asked a patient, "Who is currently the President of the United States?" When the patient responded, "Dwight D. Eisenhower," the conversation regarding the Advanced Directive was essentially over.

- Be appropriately inquisitive about the other person's story and ask open ended questions that encourage the patient to talk. Dr. Rita Charon calls this "Narrative Listening." I would add that

Narrative Listening involves allowing the patient to discuss their legacy, their hopes and dreams (lost or fulfilled), what gives them joy. A life review might be in order.

- Ask yourself the question, "What is really going on here?" Ask for clarification if you get confused or don't understand.

- Ask the person to tell you their story with perhaps an invitation, "How did you get to the point of considering PAD?" Keep in mind, this person did not reach this point overnight. It is important to listen for precipitating factors. (This is a process question to help the chaplain understand the whole picture).

- Assuming that the patient is considering PAD due to what they experience as uncontrollable pain, listen carefully to hear if the patient has looked at all other options for pain control. Have they talked to their physician, the palliative care team, or their family? If not, why not?

- Be aware of the power you have as a chaplain and one who carries considerable influence as "a religious and/or spiritual authority figure." Be prepared for the inevitable question, "Chaplain, what would you do if you were me?"

- As a chaplain, am I able to empower and encourage this patient to exercise their voice to their physician(s) or the palliative care team?

- If the patient has not discussed PAD with a physician or is hesitant to exercise his/her voice, ask the patient's permission to share your conversation with his/her personal or attending physician.

- If the patient considers himself or herself "religious" or spiritual, engage the patient around any spiritual concerns they may have about this. Perhaps they have prayed about this. Perhaps they are hesitant or fear they may lose "eternal life." An appropriate question may include, "What spiritual concerns do you have about PAD?"

- Consult with your fellow chaplains but be sure to maintain the patient's privacy and confidentiality.

- Most all of us, no matter how ill, want to live. The patient has reached this point for a reason. If the patient feels or believes that his/her pain is not being adequately controlled, consult palliative care or those who are experts in pain management.

- Exercise your authority and claim your place at the table. As a chaplain, you are a member of the healthcare treatment team. This is not the time for you to feel inadequate, timid or bashful about consulting the medical team and advocating for the patient.

- Be up front and ask the patient if he or she has any intention of harming themselves.

- As you close the conversation, acknowledge and express appreciation to the patient who sought you out and express the hope that your conversation has helped the person gain some clarity.

Conclusion

Physician Assisted Dying is a subject that is here to stay. More states are considering legislation to enact or legalize PAD. It is important for chaplain cognate groups and certifying bodies to offer workshops that include case studies so that all of us can continue to learn and be more competent in our respective ministries. It is my hope that this article and these guidelines will make a small contribution to our awareness of the issue.

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2 www.aahpm.org
3 www.torahmusings.com

Chaplain John Valentino *has been a hospital chaplain and ACPE Supervisor since 1985. He is retired from working as a full time CPE Supervisor in hospitals and currently serves as a chaplain / spiritual care provider with East Mountain Hospice in the Albuquerque, New Mexico area.*

HIGHLIGHTS FROM THE 2018 CARING FOR THE HUMAN SPIRIT® CONFERENCE

This year's Caring for the Human Spirit Conference features keynotes, panels and sessions from some of the most influential leaders in the spiritual care arena. For the full agenda, please visit www.healthcarechaplaincy.org/conference and follow us at #spiritualcareconf2018.

Mark your calendars and join us next year for the **6th Annual Caring for the Human Spirit Conference**
Sheraton Myrtle Beach Convention Center
Myrtle Beach, SC
May 20-22, 2019

KEYNOTE SPEAKER

Spirituality and Meaning in the Context of Relationship-Centered Care

In this presentation, Dr. Michael Rabow will explore spirituality in health care by examining the nature of the patient-clinician relationship in the setting of serious illness. Based on a review of medical literature and his own clinical experience in outpatient palliative care in a comprehensive cancer center, Dr. Rabow will describe common spiritual issues for patients facing serious illness and review recommendations for how clinicians might address patient spiritual distress. Major issues to be addressed in this presentation include empathy and compassion, care at the end of life, the role of the chaplain in outpatient palliative care, clinician grief, and clinician self-care. Dr. Rabow will explore a series of questions central in the patient-clinician relationship, including: How does spirituality manifest as part of routine medical care? How does palliative care help elevate spirituality to having a place among the list of "patient problems" addressed? And, what are the implications of relationship-centered care for clinicians? In this talk, Dr. Rabow will compare and contrast what spirituality means for patients and clinicians in the context of the patient-clinician relationship and at the end of life. Ultimately, care at the end of life offers an opportunity to find common humanity and respect for human dignity between, in both directions, patients and clinicians.

Dr. Rabow is the Helen Diller Family Chair in Palliative Care and a Professor of Clinical Medicine and Urology in the Division of General Internal Medicine, Department of Medicine, at the University of California, San Francisco. Board-certified in internal medicine and hospice & palliative care, he directs a leading outpatient palliative care program – the Symptom Management Service – at the UCSF Helen Diller Family Comprehensive Cancer Center.

PLENARY SESSION

Gaining Hope, Finding Purpose: The Power of a Chaplain in Improving Quality of Life for Patients and Families

All too often, the role of a chaplain is misunderstood in healing the pain of a serious illness. Whether alone or as part of an interdisciplinary team, chaplains can provide relief from suffering for patients and families beginning at the point of diagnosis, and through end-of-life or survivorship. This session will focus on the critical role of the empowered chaplain as part of a family's journey through illness and in healing after the illness' completion. Using an in-depth case study, this session will explore the difference in the role of a chaplain and a social worker on an interdisciplinary palliative care team, the impact of chaplaincy consultations in grief and survivorship and the impact a healthcare chaplain can have on healing existential and spiritual suffering. In addition, quality standards, innovative models of care delivery and innovative payment models for healthcare chaplains will be explored and highlighted.

During her own experience with cervical cancer, Torrie Fields personally learned the value of health care chaplaincy in easing spiritual and existential suffering. It was those conversations with a chaplain that allowed her the clarity and peace to differentiate her vision of quality of life from the shame she felt about her diagnosis, changing her course of treatment. Now, Torrie is an advocate to increase access to, and visibility of, the services health care chaplains can provide not only at end-of-life but throughout the course of illness and into survivorship.

Upon completion of this session, you will be able to:

1. Examine the role of a health care chaplain as part of a team and individually
2. Analyze the impact of a chaplain in the course of a serious illness, in survivorship and after death
3. Describe ways in which health care chaplains are partnering and reimbursed for services provided to seriously ill patients and families

Torrie Fields, MPH, is the Senior Program Manager, Advanced Illness and Palliative Care at Blue Shield of California. She leads the development and implementation of programs and processes at Blue Shield of California that work to improve the quality of life for individuals with serious illness and their families.

Torrie has led the development of highly successful palliative care initiatives including benefit design, case management, caregiver support, medical home development and policy and engagement efforts. Prior to joining Blue Shield, she worked as an applied health services researcher in a variety of settings, including health plans, health delivery systems, local and federal health departments and in university research laboratories. She has extensive experience in health policy development and implementation. In addition to her work with Blue Shield of California, Torrie acts as a consultant and curriculum developer for The Center to Advance Palliative Care and California State University Palliative Care Institute.

She holds a Master's in Public Health in health management and policy from the Oregon Master of Public Health Program, a Certificate in Gerontology from Portland Community College, a Bachelor of Science degree in sociology from Portland State University and a Bachelor of Arts degree in communication theory from University of California, San Diego.

PLENARY SESSION

I Hear You Saying You Need Leaders

I have been a leader in the Association for Professional Chaplains for many years, yet I still wonder why our profession diligently develops exceptional clinical care providers but remains relatively passive in leadership training. For years we have focused our limited resources on clinical ministry instead of intentional, protracted leadership training. But now is the time to intensify our work to identify, train and sustain rising leaders. There is a demand for leaders in our profession and we can produce many more of them by devoting more energy to identifying and nurturing their growth through focused training. The presentation will identify the reasons spiritual care leaders have not been nurtured in the past and what needs to be done going forward.

The presentation is organized around three basic imperatives:

1. We must show our rising leaders how to cultivate a high public profile through effective communication, personal presentation and effective project management.
2. We must train our upcoming leaders to build powerful personal networks through intense, continuous collaboration.
3. We must encourage new leaders to embrace a vigorous spiritual life.

The first concept, cultivating a high public profile, focuses on excellence in public speaking and interactions with executives. Many shy away from these encounters and pay a high price for this avoidance through lowered professional credibility. The second concept includes suggestions about developing professional networks throughout your organizational structure. And the third concept, spirituality, is one that often triggers internal struggles. It's important to acknowledge the spiritual strength of our work and develop leaders who can face the day-to-day challenges this work presents.

The presentation concludes with a word of hope for our profession. With diligence, we can encourage our rising leaders along paths that will enrich them, yield better care for those we serve and strengthen our organizations.

Robert Kidd serves as the system director for Spiritual Care and Values Integration at Houston Methodist Hospital. Bob has spent nearly his entire professional career at Houston Methodist, beginning as an oncology staff chaplain and later expanded his clinical experience to include cardiology, neurology and psychiatry. For the past decade, he has invested deeply in leadership training for spiritual care professionals. At Houston Methodist Hospital, one of the largest private, nonprofit hospitals in the country, Bob has learned that excellence in spiritual care delivery in health care settings includes organizational culture shaping as well as clinical support. Over the years, he has been active in the Association of Professional Chaplains (APC), having served in numerous leadership roles including APC President (2004-06) and membership on its Board of Directors. Bob is endorsed by the Alliance of Baptists and received his MDiv from Southwestern Baptist Theological Seminary in 1985. He is married to Dian Kidd and together they have a daughter, Kathryn. He is also an avid cake baker, gardener, reader and antique shopper.

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SPIRITUAL CARE ASSOCIATION

Providing Standardized, Evidence-Based Education

By **Rev. Sue Wintz, BCC** and **Rev. Brian Hughes, BCC**

In the education world, there are specific definitions applied to the concept of knowledge.[1] Content knowledge is the body of knowledge and information that teachers teach and that students are expected to learn in a given content area; it includes the facts, concepts, theories, and principles that are taught and learned in specific academic courses rather than to related skills which are also learned in order to put content knowledge into practice.[2] In all professions, particularly health care, there is a tension between content or theoretical knowledge ("know that") and practice knowledge ("know-how")[3] in the quest to prepare students to provide effective, value-added, and quality care to patients and families. Health care disciplines, with the historical exception of chaplaincy, have integrated the two by not only acknowledging the tension, but incorporating both kinds of knowledge into their education and credentialing processes.

Evidence-based education and practice is central to all health care disciplines and the current health care environment. According to Masic, "Evidence-Based Medicine (EBM) represents integration of clinical expertise, patient's values and best available evidence in process of decision making related to patients' health care."[4] Evidence-Based Practice (EBP), according to Satterfield "incorporates each discipline's most important advances and attempts to address remaining deficiencies."[5] One of the challenges of both evidence based knowledge and evidence-based practice is teaching how to achieve the application of those skills in clinical care.[6] [7] [8] Health care disciplines including medicine, nursing, social work, physical therapy, and others,[9] [10] [11] [12] [13] have embraced standardized education, including evidence-based knowledge and practice.

Education has been a core component of the mission of HealthCare Chaplaincy Network (HCCN) throughout its history by the provision of clinical pastoral education and professional education through its annual conference, online Spiritual Care Grand Rounds, events and training workshops, and professional and scholarly publications. HCCN's affiliate, the Spiritual Care Association (SCA), as the first multidisciplinary, international, professional membership association, continues that tradition as it offers curriculum, courses, and programs based on evidence-based quality indicators and scope of practice. In doing so, HCCN and SCA continue to do groundbreaking work for the profession of chaplaincy and the inclusion of spiritual care in multidisciplinary education.

In a recent article, HCCN's Director of Professional and Community Education Sue Wintz and Director of Program and Services Brian Hughes, both experienced board certified chaplains, reviewed the literature discussing standardized and evidence-based education throughout the history of professional chaplaincy. The literature showed:

- For six decades, chaplaincy leaders, educators, and researchers have called for the examination of the profession's process of education and training in preparation for certification within the profession including the incorporation of evidence-based knowledge and practice.
- Evidence-based knowledge and practice are not new concepts for professional chaplaincy, but rather ones that were first introduced in 1998: "Evidence from research needs to inform our pastoral care. To remove the evidence from pastoral care can create a ministry that is ineffective or possibly even harmful."[14]
- O'Connor (1998) defined evidence-based spiritual care as "the use of scientific evidence on spirituality to inform the decisions and interventions in the spiritual care of persons"[15] and argued that chaplaincy and science are not opposed.
- Chaplaincy has very little research regarding its education processes. The earliest call to "better measure the effectiveness of clinical pastoral training so we have more objective standards"[16] came from Thomas in 1958. There has been no investigation or study of how many

units of clinical training or what academic degrees have produced the best combination of content/ theoretical and practice knowledge to make a competent chaplain.

- The efficacy or impact of religious endorsement, required by some chaplaincy certification associations, has not been examined. The elements of curriculum content taught in clinical training have not been investigated or examined to determine what topics are needed to provide competent chaplaincy care nor have efforts been made to standardize that curriculum.
- Massey,[17] in observing the need for transformation in chaplaincy training, stated in 2014 that "The process of training chaplains has changed little over several decades. More recently, some involved in healthcare chaplaincy have perceived that new models are needed in forming, training, and evaluating chaplains."
- Fitchett, Tartaglia, Massey and colleagues also questioned the relationship of clinical education training models to fulfill the need to train towards professional competencies." At a time of growing recognition of the important role of chaplains in the care of patients and families, there are no consensus guidelines for how healthcare chaplains should be trained and no organization exercising oversight for the development of such guidelines."[18]

While the concerns chaplaincy educators and practitioners have raised since 1958 have been framed in different ways, the central issue has remained the same. Curriculum, training, and testing needs to be standardized in order to remove inconsistencies in the education and certification of professional chaplains. The lesson is clear from all other health care disciplines that when candidates are tested to measure a person's comprehension of evidence-based content or theoretical knowledge of their field, pass objective observations of their ability to demonstrate it through practice knowledge, the person has met the requirements needed to practice in their field and will reliably provide quality care.[19]

After nearly sixty years of questioning and calls for dialogue by researchers, educators, and leaders between numerous chaplaincy education and certification bodies to resolve these issues which proved unsuccessful, the HealthCare Chaplaincy Network (HCCN) and its affiliate, the Spiritual Care Association (SCA) which was created in 2016, stepped up to integrate evidence-based best practice in more explicit ways into the curriculum, education and training of chaplains and their certification through knowledge testing and a standardized patient exam. By exploring the research on successful models of health care education across disciplines, the SCA patterned much of its structure to incorporate elements of the training of competent physicians, nurses, physician assistants, nurse practitioners, social workers, physical therapists, and other professional clinicians. In doing so, the historical appeals by leaders, researchers, and educators within professional chaplaincy that have spanned decades are finally being heard and responded to with evidence-based chaplaincy training and education.

Courses in the SCA Learning Centers are designed for a variety of persons:

- Chaplaincy students undertaking their clinical training
- Candidates desiring to apply for credentialing or board certification as chaplains
- Chaplains seeking continuing education in areas of interest or growth
- Other health care professionals, including nurses, physicians, social workers, physical therapists, pharmacists, administrators, and others desiring to expand their knowledge of spirituality and to incorporate it into their practice
- Volunteers in chaplaincy departments or community settings

›› For more information about the Spiritual Care Association Learning Center, its courses and programs, visit https://www.spiritualcareassociation.org/learning-center.html

›› To read the full article by Wintz and Hughes, *Standardized Methods of Education within Clinical Training for Chaplaincy*, visit https://plainviews.healthcarechaplaincy.org/articles/standarized_methods_education_chaplaincy

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The SCA Difference:
An Open Letter to Health Care Executives

Dear Health Care Executive,

Is your spiritual care department providing a significant contribution to your health institution's operations, particularly to improving patient experience and care? The value of any health care service is increasingly determined and reimbursed by the quality of that service rather than the volume of services that are produced.

Advances in research in spiritual care have led to an improvement in training and educating new, as well as established, chaplains. Healthcare Chaplaincy Network (HCCN) and its affiliate, Spiritual Care Association (SCA), are committed to assisting your organization ensure, through strategic consultation, education and competency testing, that your chaplains provide the highest quality of spiritual care and measurably contribute to your strategic goals.

All chaplains are not being trained, tested, certified, or continually educated in the same way. This is a reality which impacts the outcomes your organization desires in its care of patients, families, and staff. SCA has the only chaplaincy certification process that includes a test for core knowledge derived from evidence-based quality indicators and standard of practice for spiritual care as well as a simulated patient exam that evaluates competency in direct patient contact. Those who have completed the SCA certification process receive certification as an **Advanced Practice Board Certified Chaplain** (**APBCC**), recognizing the additional knowledge and skill they have demonstrated. They have been trained and tested in department management, HIPAA regulations, cultural competency, the assessment, diagnosis and treatment of spiritual distress, advance care directives, staff support, patient clinical care, grief and bereavement among other essential topics.

We know that the changing demands you face in health care and incorporating the best practices within your setting can be not only challenging but intimidating for your staff. Requiring evidence of your chaplains' ability to provide the best interventions and outcomes to benefit your organization is necessary, as with any other health care discipline, to ensure that your organization's goals are being met. As part of your hiring and ongoing staff evaluation, review the curriculum from the organization they were trained by. Request from their certifying body a copy of the knowledge and competency tests that are required to measure readiness for certification as well as the offerings provided for continuing education for their members.

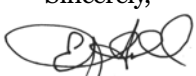
Only the SCA can show you our international outcomes and our scope of practice documents. The SCA will give you access to our curriculum, a sample of our knowledge test questions, the scoring criteria for a simulated patient exam, and a list of our ongoing and current continuing education events. We will share with you our series of White Papers that help chaplains and others understand what chaplains do and how spiritual care contributes.

With HCCN and SCA's clear focus on evidence-based outcomes and cost savings, your Chaplaincy Department will be positioned to contribute to the high quality care your institution aspires to deliver. All chaplains have not been trained, tested, or certified in the same way. There is an SCA difference, and we can help your present chaplains raise the bar and be the difference in your organization.

Do your other non-chaplain clinical team members understand their responsibility and role in identifying and supporting spiritual and religious issues important to patients? In addition to training, education, and certification that transform chaplaincy practice, HealthCare Chaplaincy Network provides the only evidence- and competency-based online education for spiritual care generalists of all clinical disciplines in the U.S.

We can help you create a culture of spiritual care in your organization that will enhance the experience of your patients and their families and empower your health care staff. Contact us at 212-644-1111 x110 today to learn more about the programs available from the HealthCare Chaplaincy Network and Spiritual Care Association.

Sincerely,



Rev. Eric J. Hall
President and Chief Executive Officer

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SPECIAL SUPPLEMENT

SPIRITUAL CARE ASSOCIATION

The interdisciplinary, international professional membership association for spiritual care providers that has created the first comprehensive evidence-based model to define, deliver, train and test for the provision of high-quality spiritual/chaplaincy care

WELCOMING as members all individuals and organizations committed to the delivery of optimal spiritual care as a vital component of whole-person care and the overall patient experience

EDUCATING chaplains, physicians, nurses, social workers, other health care professionals, and clergy via a robust Learning Center

ENGAGING all interdisciplinary team members, recognizing that the delivery of spiritual care requires both generalists and specialists

OFFERING new pathways for chaplain credentialing and board certification to ensure demonstration of clinical competencies

ADVOCATING to advance the integration of spiritual care in health care around the world

From a chaplain:

> **"I feel like I'm finally being recognized that what I do matters. I'm finding a home where I can have community and learn more."**

MAKING SPIRITUAL CARE **A PRIORITY**

SCA, an affiliate of the 57-year-old HealthCare Chaplaincy Network, marks the culmination of decades of **experience, research, discussion**, and **insight** from respected leaders, daily providers, and others interested in spiritual care and chaplaincy.

OUR EVIDENCE-BASED MODEL

18 Quality Indicators define the key aspects of successful spiritual care, provide metrics, and suggest tools to measure that quality	**Scope of Practice** establishes what chaplains need to do to meet those indicators, and effectively and reliably produce quality spiritual care	**Knowledge Base** identifies the standardized training and experience necessary to meet the Scope of Practice	**Objective Testing** assesses the chaplain's knowledge (Standardized Knowledge Test) and demonstrated clinical competencies (Standardized Patient Exam/Simulated Patient Encounter)

OUR STANDARDIZED KNOWLEDGE TEST AND SIMULATED PATIENT EXAM:

- Bring to the profession of health care chaplaincy the same rigor in education, training and testing demanded by other health care disciplines
- Establish the framework for an ongoing process of implementation, research, and quality improvement

OUR STANDARDIZED KNOWLEDGE TEST AND SIMULATED PATIENT EXAM:

Currently, more than a dozen chaplaincy groups within the U.S. offer varying education/training, however, no other organization that trains and certifies chaplains can demonstrate the use of a standardized, evidence-based curriculum nor the scoring of knowledge and competency tests. **This is the SCA difference, and represents a higher bar than any other chaplain certification processes.**

From a chaplain:

> **"Boldly taking the leadership in areas of direct interest to me and our profession … The upgrade of standards for a 'new age' is very welcome."**

USING THIS GROUNDBREAKING AND TRANSFORMING EVIDENCE-BASED MODEL, SCA OFFERS CHAPLAIN CREDENTIALING AND ADVANCED PRACTICE BOARD CERTIFICATION

Advanced Practice Board Certified Chaplain (APBCC) is a chaplain who has demonstrated advanced skills in the provision of and leadership in spiritual and chaplaincy care by successfully completing a test of core knowledge derived from evidence-based quality indicators for spiritual care as well as a simulated patient exam that evaluates competency in direct patient care. Advanced Practice Board Certified Chaplains (APBCC) have been trained and tested in standardized curriculum based on the latest evidence in areas including department management; HIPAA regulations; the assessment, diagnosis, and treatment of spiritual distress; cultural competency; advance care directives; patient clinical care; staff support; grief; and bereavement among other essential topics.

From a chaplain:

> **"It's about time! Thank you for putting this together. It really is the future of chaplaincy at stake."**

Board Certified Chaplain (BCC): The designation of Board Certified Chaplain will continue to be maintained by the SCA. Current BCCs will have to take the core knowledge test around the time of their 5-year anniversary to maintain their BCC. At any time, BCC chaplains may choose to apply and test for APBCC designation.

Chaplain Credentialing is for those working as chaplains who are not board certified, and meet SCA's requirements, which include a Bachelor's degree in a content area relevant to chaplaincy, at least 400 hours of clinical pastoral education, and successful objective testing.

SCA's innovative approach to chaplain training, credentialing, certification, and continued education incorporates the desires and issues raised by those in the field, administrators, researchers, and thought leaders over decades. The Spiritual Care Association:

- Provides education: clinical training for students, continuing education for chaplains and specialized education for other health care disciplines based on a knowledge base founded in the latest research and updated as new evidence and needs appear.
- Brings chaplaincy to the level of training and demonstrated clinical competencies required by other professional disciplines, including doctors, nurses, social workers and therapists, responding to the need for training to be tested, and relies on standardized testing and a simulated patient experience to demonstrate clinical competency, knowledge base, and best practices.
- Opens professional chaplaincy to capable and competent individuals, who can now enter the field through various pathways while ultimately demonstrating the required degree of knowledge and competency. By providing pathways for credentialing and certification that focus on knowledge and demonstration of skills, many who have been unable to meet the requirements that do not consider culture, belief tradition, geographical location, age, and financial resources will now be able to be trained, credentialed or certified, and continually educated to provide the best care for those whom they serve in their care systems.

Standardized Methods of Education within Clinical Training for Chaplaincy

By **Rev. Sue Wintz, BCC** and **Rev. Brian Hughes, BCC**

The Need for Evidence-Based Education

In recent years, professional chaplaincy has begun seeking to base itself on evidence-based practice in order to align with other health care disciplines and the current health care environment. According to Masic's definition, "Evidence-based Medicine (EBM) represents integration of clinical expertise, patient's values and best available evidence in process of decision making related to patients health care".[1] Evidence-Based Practice (EBP), according to Satterfield "incorporates each discipline's most important advances and attempts to address remaining deficiencies".[2] In a study by Weng and colleagues on the implementation of evidence-based practice across medical, nursing, pharmacological and allied health professionals, they stated:

Evidence-based practice (EBP) is clinical practice consistent with the current best evidence. Implementation of EBP mainly involves four sequential steps first, framing a clear question based on a clinical problem; second, searching for relevant evidence in the literature; third, critically appraising the validity of contemporary research; and fourth, applying the findings to clinical decision-making. There are increasing examples illustrating that EBP can help healthcare professionals improve care quality. Implementing EBP by all health professionals is thus needed."[3]

One of the challenges of both evidence-based knowledge and evidence-based practice is teaching how to achieve the application of those skills in clinical care.[4] [5] [6] However, many health care disciplines including medicine, nursing, social work, nursing assistants,[7] and others are integrating evidence-based knowledge and practice into their standardized curriculums.

Evidence-based knowledge and practice are not new concepts for professional chaplaincy, but rather ones that were first introduced in 1998: "Evidence from research needs to inform our pastoral care. To remove the evidence from pastoral care can create a ministry that is ineffective or possibly even harmful".[8] O'Connor defined evidence-based spiritual care as "the use of scientific evidence on spirituality to inform the decisions and interventions in the spiritual care of persons"[9] and argued that chaplaincy and science are not opposed. A great deal of research has been done in the past twenty years to explore the practice and outcomes of chaplaincy to determine outcomes that have become the

basis of evidence-based practice.

The Need for Standardized Training and Curriculum

However, what has been missing is the same focus to link evidence-based best practices to a standardized curriculum in the clinical and educational training of chaplains. In other words, while the profession is working to be evidence-based in its practice of chaplaincy, relying on reputable research to determine the best choices of care for persons, it has failed to apply the same process to the education and training of chaplains. This is despite 60 years of calls by chaplain educators, practitioners, leaders, and researchers across the profession to engage in dialogue regarding the standardization of education and training processes in preparation for certification and practice.

In the education world, there are specific definitions applied to the concept of knowledge.[10] Content knowledge is the body of knowledge and information that teachers teach and that students are expected to learn in a given content area; it includes the facts, concepts, theories, and principles that are taught and learned in specific academic courses rather than to related skills which are also learned in order to put content knowledge into practice.[11] In all professions, particularly health care, there is a tension between content or theoretical knowledge ("know that") and practice knowledge ("know-how")[12] in the quest to prepare students to provide effective, value-added, and quality care to patients and families. Health care disciplines, with the exception of chaplaincy, have integrated the two by not only acknowledging the tension, but incorporating both kinds of knowledge into their education and credentialing processes.

Chaplaincy has very little research regarding its education processes. There has been no investigation or study of how many units of clinical training or what academic degrees have produced the best combination of content/theoretical and practice knowledge to make a competent chaplain. The efficacy or impact of religious endorsement, required by some chaplaincy certification associations, has not been examined. The elements of curriculum content taught in clinical training have not been investigated or examined to determine what topics are needed to provide competent chaplaincy care nor have efforts been made to standardize that curriculum. Meanwhile, other health care disciplines including medicine, nursing, social work, physical therapy, and others,[13] [14] [15] [16] [17] have embraced standardized education, including evidence-based knowledge and practice.

History of Chaplaincy Training and Education

For decades, chaplaincy training, or Clinical Pastoral Training (CPE) has relied primarily upon practice knowledge that focuses on the person of the chaplain, how he or she develops their "inner self," and in turn how that self-growth impacts the ways in which chaplaincy care is provided. Content or theoretical knowledge – the facts, concepts, theories, and principles that are necessary to effective practice and patient benefit, have not been standardized or made consistent within the field and so cannot be standardized in chaplaincy training.[18]

The earliest call to "better measure the effectiveness of clinical pastoral training so we have more objective standards"[19] came from Thomas in 1958. At that time the focus of CPE was in partnership with theological schools to train (Christian) ministers how to be more effective in parish ministry. Even then, "there were very different views of how and where clinical training should contribute to theological education and how the movement should be organized" according to Jernigan.[20] In the early 1970s, Meiburg addressed the need for "greater precision in relating educational structures to instructional objectives."[21] Aist continued to ask this question as he asked numerous questions:

"Do we emphasize the self-development of the student for general ministry? Or do we focus on the acquisition of specific competencies for ministry that might be utilized in specialized settings? Should our educational programs themselves have built-in closure points or do the various types of certification offered by cognate groups offer a sufficient closing process? And what about the thorny issue of curriculum content? Not only how we teach, but what we teach."

"Our subjective intuitions have by and large served us well in certification, but there is growing recognition of the need to make the process more objective and to more clearly specify the levels of knowledge and skill that the candidate must acquire."[22]

In the 1980s, as the effort to include CPE as an integral part of theological education diminished, the focus increased on training chaplains, supervisors, and lay leaders.[23] As clinical pastoral education faced this shift in its historical purpose, supervisory educators such as Hilsman addressed the questions that were being asked.

"Supervisors and department directors are asking, 'What competencies will need to be taught to both established and aspiring chaplains, and how will current training methods be altered to help them assimilate the new learning?' "

"Two reasonable first steps in the process of preparing chaplains for integrated system spiritual care work will be (1) to acknowledge the need for new learnings, and (2) to identify competencies that promise to be useful in emerging health care structures."[24]

Fitchett and Gray found in 1994 that "CPE assessment focuses on curricular objectives, student learning outcomes, and individualized contracts for learning as the basis for training and evaluation. Traditionally CPE outcomes are evaluated qualitatively, using the personal testimony or subjective interpretation by CPE supervisors and students."[25] This was confirmed by a study done by VandeCreek, Hover, and Gleason in 2001, in which they found that quantitative CPE outcomes relied predominantly on self-reported instruments.[26]

By 2000, clinical training education had formally moved to discussions between the Association for Clinical Pastoral Education with other organizations concerned with professional chaplaincies, particularly the Association of Professional Chaplains and the National Association of Catholic Chaplains.[27] This created a renewed dialogue regarding CPE as professional training and the implications for its education processes.

Ford and Tartaglia (2006) spoke to the development of standards for spiritual assessment, specific training in interdisciplinary care, and the emerging need for research education.[28] By doing so, they clearly challenged the historical paradigm that focused solely on personal development in chaplaincy education to include and emphasize content knowledge in order to prepare chaplains to provide effective and quality care to patients and families.

Little[29] continued to question whether clinical training (CPE) was professional training for chaplaincy, with a profession being defined as "requiring specialized knowledge and often long and intensive academic preparation' and professionalism as 'the conduct, aims or qualities that characterize or mark a profession or professional person'" as described by Cornett.[30] To describe the two types of knowledge needed for competent practice and for these definitions, Little turned to Eraut, and while the terms differ from "practice and content/theoretical knowledge" used by Wintz, the descriptions are the same:

"There are two types of esoteric knowledge essential for competent professional practice. Eraut describes the first type as propositional knowledge that is the knowledge which underpins or enables professional action and belongs to the academic forum where the discourse is about facts, ideas and theories. The second type is the practical knowledge, which is the practical know-how inherent in the action itself and cannot be separated from it, for example, knowing to play a musical instrument. This practical knowledge is more difficult to codify and assess than propositional knowledge because of its more 'intuitive' nature. However, Eraut believes that both types of knowledge are essentially the same, claiming that knowing how to use a theory or fact is the result of observing the outcome of its use. Furthermore, these two sets of knowledge are not completely exclusive of each other as students acquire practical knowledge during propositional learning and propositional knowledge during practical training."[31]

Little summarized the outcome of professional education as "a person who has competently mastered the necessary propositional and practical knowledge has formed a professional identity including the integration of the values of public service and autonomy and can be trusted to practice with integrity."[32] In relation to traditional clinical training (CPE), Little stated several issues which he believed needed to be addressed:

"The action/reflection method is excellent for understanding the pastoral interaction but does not necessarily facilitate the further development of the propositional knowledge base."

"Trainees' presentations for supervision broadly determine the content of the CPE program curriculum rather than the curriculum determining the program content. This can mean that some areas of pastoral care do not present themselves in the actual course. This limitation of the action/reflection methodology restricts the ability to provide a well-rounded professional education curriculum."

"CPE tends to leave trainees to gather this knowledge unsystematically through their experiences with patients and from other sources that can be erroneous. This is inadequate for professional education."

"For a valid assessment, the certifying organization [and church authorities] need to define as unambiguously as possible the range of experience and the professional (propositional and practical) knowledge they require at the conclusion of training and set those requirements out as standards for achievement. In addition, standard methods of assessing those standards need elucidation."

"Lacking standardization, there is no professionally acceptable common standard of competence."

"Assessment of professional competence requires a system of grading."[33]

Other professional clinical educators continued to raise the issue of historical clinical training as objective and lacking standardization. Jackson-Jordon and Moore (2010) suggested that BCCI competencies be used as the basis for a CPE-based curriculum intentionally focused on the preparation for professional chaplaincy.[34] In 2012, sociologist Wendy Cadge[35] suggested that future chaplaincy training not be organized on what were the existing platforms but rather learn from

methods used by other professionals that demonstrate professional competency, propositional knowledge, and objective outcome-oriented clinical practice in order to standardize the quality of care that is provided.

In an article describing the use of standardized patients in order to enhance objectivity in the measurement of behavioral communication styles of students, Tartaglia and Dodd-McCue found that it was a valid method. In addition, their study emphasized "the merits of systematically evaluating interview behaviors by categories and sub-categories. The checklist evaluation allows for identification of major response categories as well as student utilization of sub-categories in the interview process. Reliance on self-report by CPE students, historically emphasized in pastoral training, is enhanced by an observer's relatively more objective assessments (and quantification) using the checklist categories."[36]

Massey[37], in observing the need for transformation in chaplaincy training, stated in 2014 that "The process of training chaplains has changed little over several decades. More recently, some involved in healthcare chaplaincy have perceived that new models are needed in forming, training, and evaluating chaplains." Describing the historical provision of spiritual care, he called for chaplaincy to "study itself to learn what measurable outcomes of its work can be found." While acknowledging the importance of CPE in the early formation of persons for ministry, Massey suggested: "it may be ill designed to deliver the techniques, skills, and advanced competencies needed to work in professional chaplaincy." In addition, he pointed out that:

"As it is, the structure of CPE itself only delivers the same territory over and over again — and importantly, that territory is centered on personal formation, not on professional competence."

"The standards governing what constitutes a unit of CPE are written intentionally broadly to leave plenty of room for differences of style and pedagogical philosophy." "While the standards are helpfully broad, they do present in their simplicity a dichotomy of educational activity and clinical practice that is itself an unhelpful concept." "No standards exist for what should constitute a residency, how many units of CPE it should include, or what measurable outcomes should accompany successful completion of a residency."

"What is missing is specific training on techniques and procedures in the delivery of healthcare chaplaincy and the exploration of how specific techniques and practice patterns can deliver improved patient outcomes."

"A re-designed curriculum would surface the full inventory of chaplain-associated knowledge that would be imparted through a variety of pedagogical techniques. The successful student would master the body of propositional knowledge and be able to capably demonstrate this mastery. One could envision a healthcare chaplain competencies test through which a chaplain candidate would demonstrate mastery of this propositional knowledge of chaplaincy intended effects."

Fitchett, Tartaglia, Massey and colleagues also questioned the relationship of clinical education training models to fulfill the need to train towards professional competencies. A disconnect between clinical training and the competencies needed by professional chaplains was revealed by two 2015 studies of ACPE accredited residency program. In the first, less than half of recently accredited or re-accredited CPE residency programs specifically addressed the twenty-nine professional competencies assessed for certification as a board-certified chaplain (BCC) by the Association of Professional Chaplains, one of several certifying professional associations. "At a time of growing recognition of the important role of chaplains in the care of patients and families, there are no consensus guidelines for how healthcare chaplains should be trained and no organization exercising oversight for the development of such guidelines."[38]

In the second, it was found that "only nineteen percent of those centers use an electronic medical record pastoral care documentation tool grounded in a published theoretical model. Combined with the apparent lack of consensus among the pastoral care organizations, these findings contribute to the current environment where chaplains often sit on the periphery of the dialogue between spirituality and healthcare."[39]

Tartaglia encouraged the exploration of a learning/training model for the education of health care chaplains. "As with any educational model, we would begin with the expected outcomes. What knowledge and skills need to be learned? What methods should be employed in imparting those learning outcomes? Then we would ask what structures would need to be put in place to maximize the opportunity for such learning." "Adding another level of accreditation to [ACPE] programs that wish to train healthcare chaplains will require compromises in order to establish a standardized curriculum through joint effort among groups" (those that educate and those that certify).[40]

While the concerns chaplaincy educators and practitioners have raised since 1958 have been framed in different ways, the central issue has remained the same. Curriculum, training, and testing needs to be standardized in order to remove inconsistencies in the education and certification of professional chaplains. The lesson is clear from all other health care disciplines that when candidates are tested to measure a person's comprehension of evidence-based content or theoretical knowledge of their field, pass objective observations of their ability to demonstrate it through practice knowledge, the person has met the requirements needed to practice in their field and will reliably provide quality care.[41]

Attempts at Change throughout the Decades

The history of educating, training, and certifying chaplains is long and complicated.[42 43 44 45 46 47] Too complex for this article, it began as part of the education provided through Protestant Christian seminaries to white male students in the mid-1920s. In his history, Thornton[48] described clinical pastoral education as providing practical training to complement the theological knowledge seminarians received in order to prepare them as pastors in ministry. Freeman elaborated by describing clinical pastoral education as developing "psychological education for professional functioning."Several groups were established to provide educational training, each with their own style and curriculum. Four of those groups, after much debate, joined together to form the Association of Clinical Pastoral Education in 1967. However, other groups have continued to emerge to establish and provide training with various focuses on what was taught as well as methods, which has often resulted in discord, conflict, splits, and even lawsuits. Today there are dozens of organizations offering clinical pastoral education training. As a result, there is no one curriculum or educational process that is standardized across the profession.

The Current Development of Standardized Evidence-Based Chaplaincy Education and Training

After nearly sixty years of questioning and calls for dialogue by researchers, educators, and leaders between numerous chaplaincy education and certification bodies to resolve these issues which proved unsuccessful, the HealthCare Chaplaincy Network (HCCN) and its affiliate, the Spiritual Care Association (SCA) which was created in 2016, stepped up to integrate evidence-based best practice into the education and training of chaplains in more explicit ways. By exploring the research on successful models of health care education across disciplines, the SCA patterned much of its structure to incorporate elements of the training of competent physicians, nurses, physician assistants, nurse practitioners, social workers, physical therapists, and other professional clinicians. In doing so, the historical appeals by leaders, researchers, and educators within professional chaplaincy that have spanned decades are finally being heard and responded to with evidence-based chaplaincy training and education.

HCCN, who has provided accredited clinical pastoral education (CPE) since 1972, has incorporated standardized curriculum into its education process. This addresses the need for chaplaincy to follow the example of other health care professions by creating a process that mirrors their more objective process to assure that a person has both the knowledge and clinical skills to deliver evidence-based quality process, structure, and outcomes for spiritual care.

The Spiritual Care Association (SCA), which certifies chaplains and provides ongoing education opportunities, developed a standardized clinical knowledge-based test as is required within other health care disciplines. The SCA Standardized Clinical Knowledge Test was developed, following the example of other health care professions, by using international subject matter experts, evidence-based knowledge gained through research, the input of senior chaplain leaders, and the most rigorous standards. The scoring is completely objective. The test has now been determined to have a high degree of reliability. The knowledge that is tested is outlined for the candidate ahead of time and is publicly available, thus allowing educators and candidates to fully prepare without any uncertainty about the content of the Standardized Clinical Knowledge Test. For example, questions in the test include health care ethics, basics of world religious/spiritual systems, and spiritual assessment models, grief concepts and processes, and effective communication skills in working with patients, families, and interdisciplinary team members.[49] The test is easily altered so it can be updated regularly in order to integrate new knowledge and research as it is developed.

As part of the SCA certification and credentialing processes the Clinical Knowledge test is coupled with a Simulated Patient Encounter. These encounters are scored

against a list of objective observable behaviors also derived from evidence that are shared with the candidate in advance so he or she is aware of the professional elements being assessed. Simulated patients (SP) are extensively used in medical, nursing, pharmacy, other health discipline education and increasingly in CPE programs to allow students to practice and improve their clinical and conversational skills for an actual patient encounter.[50] [51] [52]

Presently, HCCN and SCA are the only chaplaincy organizations to develop, publicly announce and make available a standardized curriculum that incorporates evidence-based knowledge and practice. They are also the only known organizations who have publicly and personally invited other chaplaincy education and certification associations to participate in dialogue and collaboration around the work of developing a comprehensive standardized evidence-based method of chaplaincy training and education that will be used across all organizations. While many groups have joined into the discussion and are both implementing and contributing to the integration of the curriculum, there remain several groups that have refused to participate, and the lack of collaboration and communication continues to the detriment of providing consistent quality-based, value-added care to patients and families as well as health care staff.

Summary

For six decades, chaplaincy leaders, educators, and researchers have called for the examination of the profession's process of education and training in preparation for certification within the profession including the incorporation of evidence-based knowledge and practice. While research into evidence-based outcomes for chaplaincy care began to occur, there was little effort to apply the same process to the training, education, and eventual certification of chaplains. In 2016, the Spiritual Care Association, which is founded on the call for evidence-based best practice throughout all elements of spiritual and chaplaincy care, patterned its structure and system to develop curriculum, clinical training, and a certification process which reflects that integration. Several chaplaincy education and certification association groups have joined the process, yet many have declined invitations to participate in the dialogue.

The questions that have permeated the field of professional chaplaincy education and practice for six decades of how to standardize curriculum, as well as how to focus efforts of all to embrace collaboration rather than noncooperation and competition continues.

For Discussion

1. What educational themes throughout the sixty-year call to standardization within the training of professional chaplaincy are consistent? Which are not? Which are applicable to today's health care environment?
2. What has been your experience of standardized curriculum throughout your own chaplaincy education?
3. What has been your experience of standardized curriculum education when you compare your knowledge and skills with those of chaplaincy colleagues?
4. Evidence-based knowledge and practice is integrated through all other health care disciplines. Why should it be integrated in professional chaplaincy? Why not?
5. In what ways do you practice evidence-based knowledge and practice in your chaplaincy work?
6. What specific steps would you take to encourage the chaplaincy community, including the various education, certification, and membership groups, to work collaboratively to establish standardized education for the chaplaincy profession?

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Inspiration ... Pass it on!

Editor's note: This column is all about inspiration—to pass along to your patients and colleagues.

GOD AND DOMINOES

By **Rev. Marcos A. Miranda, MDiv, BCC**

I will always remember a gentleman named Sammy, a resident at Gouverneur Nursing Home. This was one of my earliest stops in my chaplaincy career. One day, Sammy's daughter Mayra called me. She was a devout Christian.

"I am so afraid," she told me. "My dad wants nothing to do with God. He doesn't even want me to visit him. I need you – someone, anyone! – to speak to him about God."

There was pain in her voice, but I had to be forthright. "I cannot force your dad to talk about anything he does not wish to talk about. However, if he agrees to see me, I'm happy to meet with him."

I could tell from the long silence she was not happy with this reply.

"What's the point of a chaplain if you can't talk about God?" she demanded.

"The point is, chaplains meet people where they are," I explained.

A few days later, I visited Sammy. When I arrived, I saw him in a wheelchair, looking out the window. I knocked gently. "Sammy?" I asked.

"Who wants to know?" he replied gruffly.

"I'm Chaplain Marcos. I came by to see how you were coming along."

"Who sent you?"

I didn't lie. "Your daughter Mayra."

He turned his wheelchair to face me. "Well, if my daughter sent you to talk to me about God, I suggest you go right back out that door."

I had a hunch it would not be an easy visit. Now, I was certain.

"No, no. We don't have to talk about anything you don't want to talk about."

That seemed to put him at ease. We spoke for about ten minutes before I decided to delve deeper. "Do you have any regrets in life?"

He was silent for quite some time. I've heard all kinds of regrets. Many of them are about ultimate issues. The longer the silence went on, the more I imagined Sammy might even be ready to talk about God. Then, he spoke.

"My only regret is that no one here plays dominoes."

That started him on a monologue worthy of Shakespeare, about the importance of dominoes to his life. He shared hilarious stories of how he'd play for hours with his colorful buddies at the corner bodega. Finally, though, I had to continue my rounds.

"Would you mind if I came by again?" I asked.

"Why not? You seem like a nice fella."

A few days later I showed up… with a set of dominoes I picked up at the local 99 Cent Store, and a dominoes education I'd gained from YouTube.

"I'm here to beat you at your own game," I declared.

"Bring it on."

For the next sixteen visits I lost at dominoes with him. On the sixteenth visit, he looked at me queerly. "Why are you doing this?"

"What do you mean?"

"Week after week you come here and lose. Why?"

"I see how much you enjoy it."

Sammy lowered his head. "I wish my daughter would play dominoes with me instead of trying to force feed me God."

I waited for him to look up at me. "Sammy, try to understand that God is important to your daughter, just like dominoes matters to you. Maybe you guys need to share what's important with each other."

As I headed out for my rounds, Sammy offered some parting words.

"It must be tough to lose, week after week."

I smiled. "I've gotten used to it."

Three days later, I heard from Mayra. Sammy had died.

"I'm so sorry Mayra."

She responded quickly. "Don't be. My dad called and challenged me to dominoes the other night. We used to play when I was a kid. While he was crushing me, he let me talk about God."

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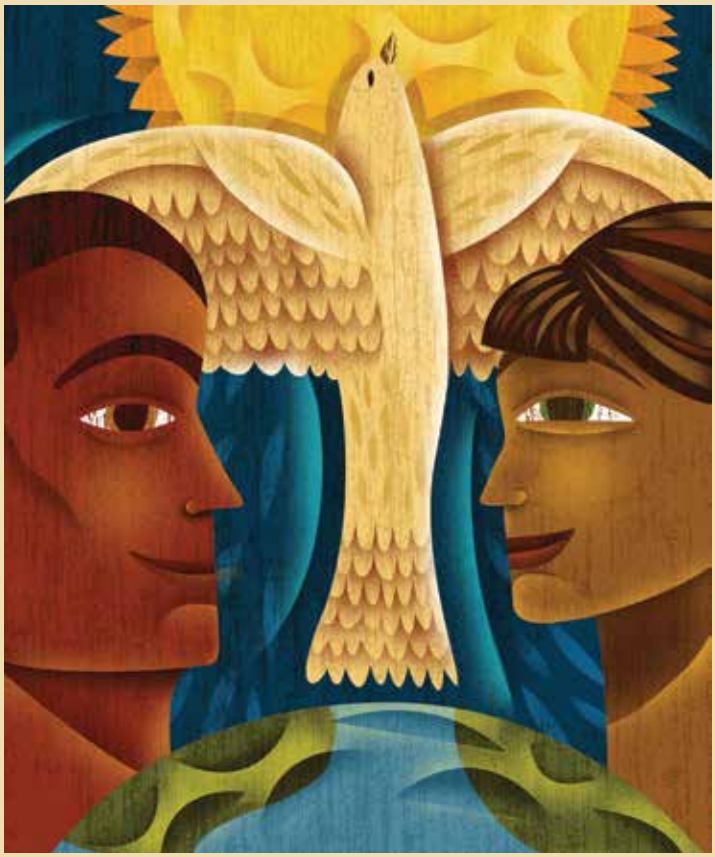

"Faith is the bird that feels the light when the dawn is still dark."

—POET RABINDRANATH TAGORE

Thank You Chaplains And Other Spiritual Care Providers

for accompanying patients and their families
on their spiritual journeys,
compassionately helping them find the wings to fly
even in their darkest hours.

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