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SPRING/ SUMMER 2019

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SPECIAL SECTION

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WHITE PAPER

THE CHAPLAINCY TAXONOMY

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A HEALTHCARE CHAPLAINCY NETWORK™ PUBLICATION

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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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A LETTER FROM REV. ERIC J. HALL

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Much has been made recently by many people, including HCCN, about the emergence of evidence-based practice (EBP) as the central paradigm for chaplaincy care. George Fitchett and colleagues in their recent volume on evidence-based health care chaplaincy suggest that EBP is the emerging paradigm. As evidence, they point to the adoption by the Association of Professional Chaplains of a competency in research to achieve Board Certification.

HCCN has long supported research and evidence-based practice in chaplaincy. We applaud the continuing accomplishments of the Transforming Chaplaincy project. Our certification process is the only one in the field of health care chaplaincy that requires candidates to demonstrate a grasp of core knowledge in the field.

It is said that EBP risks reducing chaplaincy to a practice based on numbers and formulas thus abandoning, or diminishing, the historic strengths of chaplaincy centered on personal as well as professional formation. We believe that this critique is based on a misconception of the true meaning of EBP. "Evidence" and "research" are not synonyms. Historically, EBP is described as a three-legged stool. The three components are identified as research or outside knowledge, research or outside knowledge, patient preferences and values, and a category variously called clinical expertise, judgment or wisdom.

Some seem to fear that EBP will cause one or both of the other two legs to be neglected or even abandoned. We agree this would be highly detrimental to good practice. Thus we have taken steps to make sure those two legs are fully attended to in chaplain training and certification. Incorporating patient preferences and values we believe requires the chaplain to carry out and document a comprehensive spiritual assessment. Thus we advocate for training in assessment in CPE programs and include it in our core knowledge test.

We prefer the term clinical wisdom for the third leg because, in our understanding, this must include what chaplain's have called "presence." To fully understand and enter into the spiritual distress of another, we must be able and willing to be present to them on a very intimate level. In turn, this requires what has been called "formation," understood as being present to ourselves in a way that allows for presence to others in a compassionate and non-judgmental way.

Our understanding of the nature and importance of clinical wisdom has led us to abandon the use of self-reported written clinical reports in our certification process and substitute encounters with simulated patients. In these encounters, the candidate visits with the patient with little prior knowledge of who the patient is or what their concerns might be. In reviewing the tapes of these encounters, reviewers can see all of what the chaplain does and says, and all of the verbal and non-verbal ways they present themselves and establish a relationship of security and trust with the person. The chaplain needs to demonstrate a sense of deep caring for the patient's or caregiver's human predicament and observable respect for the dignity and worth of the person. Attending to the three legs of this evidence-based stool is an ongoing process to which we are fully committed.

Chaplains, Parish Nurses, and Community-based Clinics: **The Vision of Rev. Dr. Granger Westberg**

By **Dr. Sharon T. Hinton D.Min, MSN, BSN, RN-BC**

The Reverend Dr. Granger Westberg was a visionary. He pioneered chaplaincy, church-based clinics and parish nursing. Westberg's insights about the importance of faith and health are still relevant today.

CHAPLAINCY: THE FIRST STEP

The story is told that when Granger Westberg was a 27-year-old pastor, he attended a conference and happened to have dinner with a group that included the chaplain at Chicago's Augustana Hospital. Westberg was enthralled by the chaplain's stories of ministering to sick people, so when the chaplain mentioned that he was going on vacation and needed a substitute for a month, Westberg volunteered. On the day Westberg arrived, he found a note of instructions that said, "See every patient every day." The hospital had hundreds of beds, and according to Westberg, he abandoned the instructions by noon and instead persuaded the nurses to help him select patients in need of spiritual care.

Westberg was intrigued by the challenge of discovering which hospital patients would benefit from a chaplain's visit. He believed that chaplains providing spiritual care filled an important need vital to a patient's holistic health and healing.

"In 1940 a commission of the American Protestant Hospitals Association surveyed 400 hospitals. Only 18 of the 214 responding hospitals had full-time chaplains. Westberg saw enormous potential for hospital chaplains and resolved to reshape hospital chaplaincy and to raise the level of professionalism in the field." (Westberg, p. 63) By age 30, he was officially working in the role of chaplain and soon began initiating joint seminars for ministers, doctors, and other healthcare providers.

Photo courtesy of PepTalk Productions LLC

CHURCH-BASED CLINICS

Westberg described his idea of church-based clinics as "an action-research experiment to determine whether an ordinary congregation of people can assist physicians in providing healthcare to patients whose physical symptoms have been brought about chiefly by human problems, namely the stresses and strains of life." (p. 172) His goal was to link religion and medicine in a way that offered a cost-effective strategy for providing care to the underserved in a familiar, welcoming environment.

He opened the first clinic in 1970 and continued to develop the concept. In the early 1980s, Westberg's church-based clinic concept caught the attention of Scott Morris, a young medical school graduate and ordained United Methodist minister. Intrigued by the idea of providing affordable healthcare to the underserved, Dr Morris moved to Memphis, TN, one of the poorest major cities in the United States. He opened the Church Health Center in 1986. More than 85% of Church Health patients live at or below the federal poverty level of less than $12,000 per year. Now known as Church Health, the organization had 54,622 patient encounters in 2018. In addition, Church Health provides training, education, and outreach for individuals and organizations interested in replicating their model of care.

PARISH NURSING

While piloting his church-based clinic concept, Westberg made an interesting observation that would

create an entirely new specialty practice for registered nurses. He noted nurses were the glue between the care provider and those receiving care. According to Westberg, "A large percentage of Americans are kept well by the relationship to their community of faith. If we could have nurses easily available in churches, we would pick up the early cries for help that we're now missing…A nurse is needed more as a kind of pastoral figure than strictly a medical technician. I see many nurses having this pastoral quality, but it is going to waste because they are kept busy doing technical things." (p. 223)

Lutheran General (now Advocate Health) in Chicago, IL, became the first hospital to support Westberg's parish nurse concept. Six part-time nurses were hired as part of the division of pastoral care and placed in community congregations. The experiment was a huge success, and in 1985, the Parish Nurse Resource Center was created to keep up with the demand for information about the program. Shortly after, the name was changed to the International Parish Nurse Resource Center (IPNRC). The first International Westberg Symposium was held in 1987 to bring together parish nurses from around the world for fellowship and education. The IPNRC moved from Chicago to the Deaconess Foundation of Saint Louis, MO, in 2002. The practice has evolved from six parish nurses in a pilot project to 10,000+ faith community nurses across the USA and worldwide in every major religion and Christian denomination.

CHAPLAINCY, FAITH-BASED CLINICS, AND FAITH COMMUNITY NURSING

Westberg's concepts have come full circle. In 2012, the IPNRC moved from St. Louis to Memphis, TN, as a ministry of the Church Health Center, one of the nation's first church-based clinics. In 2018, the Healthcare Chaplaincy Network (HCCN) partnered with the Westberg Institute and Church Health to offer chaplaincy and spiritual care continuing education to faith community nurses. In 2019 HCCN and the Westberg Institute have entered into an agreement to jointly provide the Westberg Symposium at the Caring for the Human Spirit Conference from April 20-22, 2020, in Santa Fe, NM. In 2019, the Spiritual Care Association created a new nursing division to not only provide education and support for faith community nurses and nurses in other practice areas by providing spiritual care education, but also to strengthen the interdisciplinary practices of both nurses and chaplains to assure that all people regardless of healthcare setting receive high-quality, best-practice wholistic care. Granger Westberg would be pleased!

NURSES AND CHAPLAINS IN PARTNERSHIP

Regardless of the setting, when healthcare providers work together, the outcomes improve. For example: Mr. Reed is a member of the faith community where Mary FCN works to provide community outreach health ministry. Mary FCN works closely with clergy and other community service organizations to provide wholistic care for Mr. Reed. She received Foundations of Faith Community Nursing training through the Westberg Institute, and her local faith community nursing network coordinator is an employee of the local hospital's chaplaincy department. Mary FCN doesn't work in the hospital setting, but because of the community-hospital network relationship, she has access to hospital resources, including a working relationship with the hospital's chaplains and the chaplains working with the local hospice. When Mr. Reed became ill and was admitted to the hospital, Mary FCN was able to not only represent the congregation in partnership with clergy, she was also able to provide information and insight to the hospital nurses and chaplains who would provide hospital care, assuring that Mr. Reed's spiritual preferences were included in the plan of care. When Mr. Reed is ready for discharge, or hard decisions about healthcare choices must be made, he and his family have a strong web of support from their community-based clergy, Mary FCN, members of the community of faith, and the hospital-based nurses, healthcare providers and chaplaincy. This is Westberg's concept of wholistic healthcare at its best.

Westberg's vision for professional chaplaincy and faith community (parish) nursing continues to grow by serving the needs of people where they are, considering individual beliefs, traditions and customs as part of the plan of care. Faith community nurses do not replace clergy, chaplains or other clinical-service nurses. They work in partnership to support both the person receiving care and the care provider. By working interprofessionally, best-practice care is provided, and better outcomes are achieved

For more information:

- https://spiritualcareassociation.org/nursing.html
- www.westberginstitute.org
- https://www.healthcarechaplaincy.org/conference.html

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New National Palliative Care Guidelines Call for Improved Access to Spiritual Care

By **The Rev. George Handzo, BCC, CSSBB** and **The Rev. Susan Wintz, BCC**

Many people living with a serious illness who are receiving treatment for their condition, whether heart failure, lung disease, cancer or another illness, don't have access to palliative care, which can make all the difference in how they feel physically, emotionally and spiritually. New palliative care guidelines set out to improve access to this care, which provides relief from the symptoms and stress of serious illness, improves quality of life for both the patient and the patient's family, and is provided concurrent with disease-focused treatments.

To improve access to this care, the new *Clinical Practice Guidelines for Quality Palliative Care, 4th edition* urges clinicians and health care organizations to integrate it into the services they provide for all people living with serious illness, regardless of their diagnosis, prognosis or age, including pediatric patients. The guidelines also call for palliative care to be available wherever people receive their care, including: outpatient clinics, cancer centers and long-term care facilities, office practices, homeless shelters, dialysis units and at home. With this new statement of scope, these guidelines cover much of what health care chaplains generally do in their clinical practice.

The 4th edition was developed by the National Consensus Project for Quality Palliative Care (NCP), comprised of 16 national organizations with extensive expertise in palliative care and hospice, including the HealthCare Chaplaincy Network (HCCN). The guidelines were published by the National Coalition for Hospice and Palliative Care of which HCCN is a member. *Of note is that this is the first time any chaplains have been officially party to the development of these guidelines. Two chaplains served on the Writing Group, and two served on the Steering Committee. HCCN was not a member of the Coalition when the last edition of the guidelines was written.* Previous editions of these guidelines have proven to be major drivers of U.S. policy on palliative care.

The new edition expands on the eight domains of palliative care: structure and processes of care; physical access of care; psychological and psychiatric aspects of care; social aspects of care; spiritual, religious and existential aspects of care; cultural aspects of care; care of the patient nearing the end of life; and ethical and legal aspects of care. Major areas of expansion for this edition include the more explicit inclusion of pediatrics, the explicit expansion of palliative care into bereavement services, and an emphasis on community palliative care, which includes home care and any other setting outside of the hospital. The guidelines include tools, resources and practice examples to help with implementation.

The field of palliative care suffers from a lack of general understanding of what it is and is not — much like chaplaincy. These guidelines quote a couple of definitions, including those used at the Institute of Medicine and the Centers for Medicare and Medicaid Services:

Care that provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness and their families. Palliative care may begin early in the course of treatment for a serious illness and may be delivered in a number of ways across the continuum of health care settings, including in the home, nursing homes, long-term acute care facilities, acute care hospitals, and outpatient clinics. Palliative care encompasses hospice and specialty palliative care, as well as basic palliative care. (Institute of Medicine)

...patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." (Centers

for Medicare & Medicaid Services)

The new edition contains several implications for clinical practice and organization, including:

Clinical Issues

- Spiritual care is an essential component of quality palliative care.
- Spiritual care services, including screening, history and assessment, are performed on admission and regularly thereafter using standardized tools.
- Interventions using professional standards of practice are part of the basic provision of quality care available to all palliative patients.

Organizational Issues

- Palliative care services include salaried professional chaplains as team members, and related programmatic expenses.
- Affiliation agreements with spiritual care departments in health systems, hospitals or hospice programs can provide timely access to professional chaplain services.

Additionally, partnerships with faith community leaders are encouraged and nurtured.

For chaplains, these guidelines challenge us to deliver care to patients of all ages, including children. It encourages care across the whole continuum rather than care concentrated on inpatient settings. Chaplains will need to develop and implement models that enable efficient and effective care in community settings, including integrating community faith group leaders into the care team.

The guidelines embrace the generalist-specialist model for delivering spiritual care in health care, in which the chaplain is the spiritual care specialist and other disciplines are spiritual care generalists. The glossary features what can now be considered a widely endorsed definition of what a professional health care chaplain is.

The professional chaplain is master's level prepared and has taken clinical chaplaincy training. Board Certification in chaplaincy is preferred. Certified chaplains may also specialize in palliative care and have specialized certification. The chaplain is the spiritual care specialist on the IDT, and is trained to address the spiritual and religious concerns of all patients and their caregivers, regardless of their spiritual or religious beliefs and practices. The chaplain is also an emotional care generalist and interfaces closely with the social worker and other mental health providers to provide psychosocial-spiritual care as a unified domain.

So what can you do right now to ensure your patients and their families are getting this vital care?

1. Download the guidelines and read them in their entirety.
2. Spread the word to your colleagues.
3. Review the eight domains with your health care team and/or your organization's leadership — especially the *spiritual, religious and existential aspects of care* domain — to assess how you can best address the gaps in care and the needs of people living with a serious illness and their caregivers.
4. Identify specific action steps that your department and organization can implement to provide quality palliative care and focus on the easily attainable goals first.

HCCN is also providing several avenues for educating yourself and your colleagues on these new guidelines and how you might integrate them into your practice. The courses on palliative care offered through the HCCN Learning Center have been substantially revised and updated to include these guidelines and their implications. The HCCN Caring for the Human Spirit Conference on May 20-22 in Myrtle Beach, SC, will feature multiple opportunities to learn about these guidelines and their implications for spiritual care, including a plenary given by Dr. Betty Ferrell, co-chair of this project, and a plenary given by Chaplains Karen Ballard, Sarah Byrne-Martelli, and Malcolm Marler on the implications of the new guidelines for pediatrics, bereavement, and community spiritual care, respectively.

The purpose of the guidelines is to improve access to quality palliative care by fostering consistent standards and continuity of care across settings. Please join us in this national effort so that all people living with serious illness and their families will receive the best care possible.

Learn more at **www.nationalcoalitionhpc.org ncp** and follow **@CoalitionHPC** (#NCPGuidelines).

Rev. George Handzo *oversees projects devoted to the strategic assessment, planning and management of chaplaincy services and to developing the evidence for the efficacy of chaplaincy care. He has authored or co-authored over seventy chapters and articles on the practice of spiritual care and chaplaincy care. George is a past president of the Association of Professional Chaplains which in 2011 awarded him the Anton Boisen Professional Service award, its highest honor. He serves on the Distress Guidelines Panel of the National Comprehensive Cancer Network and the Geriatrics and Palliative Care Comm of the National Quality Forum.*

Rev. Sue Wintz, BCC*, is Director, Professional and Community Education at HealthCare Chaplaincy Network and Spiritual Care Association. 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 community settings. She is board certified by the Spiritual Care Association and the Association of Professional Chaplains.*

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— Allison Kestenbaum, MA, MPA
Palliative Care Chaplain,
UC San Diego Health

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FILLING THE "CHAPLAINCY GAP"

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

My cell phone rang at about 6:00 a.m. on January 28, 2017. As a longtime clergy member and board-certified chaplain, I am used to unusual phone calls at odd hours. This one, though, made the word "unusual" seem ordinary.

I hadn't paid attention to the news the day before, enjoying the blessed solitude of temporary ignorance. So, I was entirely unaware that on January 27th, President Donald Trump announced Executive Order 13769, which placed a moratorium on entry to the United States by visitors from certain nations, mostly Muslim-majority. The sloppy roll-out of the order meant that many travelers from nations like Iran, Iraq, and Syria had boarded planes to enter America with their documentation intact, but on landing here, they were being held against their will instead of proceeding through the usual customs and immigration process.

It is widely known that more than 700 such individuals were detained in American airports for hours or days during the period after the Trump order was announced.

The phone call had come from an authority at New York City's John F. Kennedy International Airport, asking if I would come there as a chaplain. I spent the next several days at the airport. I got little sleep, as I spent many hours tending to the spiritual and emotional needs of scores of detainees who had left their nations of origin expecting a normal customs and immigration procedure on landing in America, but for whom the rules changed while they were in mid-flight.

Many of the detainees were angry, upset, confused, and distraught. The majority had a poor command of English; few were fluent in our language. Nonetheless, I had to do my best to engage in crisis spiritual and emotional care. Most of the time, I was alone. I would have given a great deal to have had a number of trustworthy, multi-culturally trained providers with me.

Their help would not have been for just those being detained, or for the exhausted employees. Were they present, I too could have benefited from their spiritual succor. This was tough work, but however challenging it was for me morally and politically, my discomfort paled in comparison to the challenges of the women and men I was attempting to help. My work would have been better had there been others on hand doing the same thing that I was doing.

The problem was that there were not many other crisis-trained chaplains immediately available, and for those who were, getting them cleared to perform their duties in the highly guarded areas of the airport was close to impossible. We've got a chaplaincy gap in America. Once upon a time, there may have been a sufficient balance between population, crises, and available clergy and certified chaplains, but that time has passed. Populations — especially urban populations — continue to grow and diversify. Today there is a greater need for the spiritual and emotional help that chaplains can provide in times of deep need, whether they are members of the clergy or lay persons; board-certified or not.

Couple these sociological demographic trends with a demonstrated decrease in the number of people who want to become ordained clergy and board-certified chaplains, and what emerges is the chaplaincy gap. When wildfires swept through the hill country of the California coast north of Los Angeles this past autumn, hundreds

of thousands went to sleep not knowing whether they might be made to evacuate. With natural disasters, gun violence, epidemics, and the day-to-day work of chaplains at the institutional –level, the ordinary cohort of board-certified chaplains can be overwhelmed. There are just not enough fingers for holes in the dike.

In a perfect world, there would be plenty of clergy and board-certified chaplains available at all times. Faced with the chaplaincy gap, though, board-certified chaplains and clergy must think out of the box. The choice is stark: either leave people in crisis without anyone trained to offer spiritual succor, or find a different way to train folks that might not be perfect, but which would not sacrifice human suffering on the altar of not-good-enough.

Recently, we at the New York State Chaplain Task Force joined forces with our friends at the Spiritual Care Association, an affiliate of Healthcare Chaplaincy Network, to address the chaplaincy gap in times of crisis through an innovative program we call the First Responder Chaplain Division of the Spiritual Care Association. What are first responder chaplains? We use this definition:

A first responder chaplain is a member of a faith community trained in modern principles of clinical and crisis chaplaincy, who is available to provide spiritual care and emotional support to those in crisis in situations where community-based clergy and/or chaplains are either overwhelmed or unavailable for service, or where the facts are such that there is such demand for spiritual care services that it exceeds possible coverage by the community's available clergy and/or chaplains. Every first responder chaplain receives specific training in areas such as spiritual assessment and counseling, grief and bereavement, religious and cultural sensitivity and literacy, introduction to the Incident Command System, competency in disaster, basic life support, and self-care, and is accountable to both their faith community and their supervisor, under whose auspices they will volunteer. The training would be available to clergy members, seasoned and board-certified chaplains and lay persons.

So far, so good, right? A crisis or disaster happens and community-based certified chaplains and clergy are overwhelmed or unavailable, so trained first responder chaplains get deployed to help fill the gap. But, not so fast. Not everyone in our field is comfortable with the latter part of our definition, which allows for the training of lay persons as chaplains, especially when the basics of such training may be completed in 35-40 hours, in comparison to the 400 hours required for one unit of clinical pastoral education.

Scripturally speaking, there is a storied history in the three Abrahamic faiths of pastoral care by non-clergy. Within Christianity, the first spiritual leaders were simply Jewish elders. The words found in 1 Peter 5:1- 4 are instructive: "Be shepherds of God's flock that is under your care, watching over them—not because you must, but because you are willing, as God wants you to be; not pursuing dishonest gain, but eager to serve; not lording it over those entrusted to you, but being examples to the flock." Paul's epistle to the Corinthians implores Christians to be "imitators of me, as I am of Christ," whose ministry on earth was marked by caring for the downtrodden (1 Corinthians 1-34).

Within Judaism, there are many rituals that require at least ten adult participants, such as the reading of the Torah in synagogue and the saying of the prayer for the dead. Without mutual support, these rituals are impossible. It is well known that three common pillars of Judaism are *Torah, tefilah,* and *gimilut chassadim*, generally translated as the study of scripture and rabbinic authority, prayer, and the doing of deeds of loving kindness. In Islam, the Quran notes, "The believers, men and women, are Auliya (helpers, supporters, friends, protectors) of one another" (Quran 9:71). Giving charity, attending funerals, feeding the hungry, and kindness to neighbors are prized.

With all this scriptural support for the idea of lay spiritual guidance, what could possibly go wrong with lay first responder chaplains (or, as a research study of the subject currently underway in New York City calls them, "para-chaplains")?

A lot. Maybe even more than a lot.

One potential problem is that clergy and chaplains could hate the idea, because para-chaplains could be seen as edging into territory of care that had previously been reserved for them. There is precedence for this possibility, as in the way that medical doctors (including psychiatrists) seek to protect the territory of medication prescription against moves by psychological professionals — including clinical psychologists who might have even greater specific training in mental disorders — to gain the power of the prescription pad. The *technical term for this phenomena is professional encroachment.*

In actual fact, though, fear of professional encroachment isn't a big issue. At least, it was not with a dozen eminent senior clergy and board-certified chaplains who were granted anonymity for the purposes of the para-chaplaincy study. To be sure, the clergy and chaplains interviewed had at least twenty years of experience — their names would be recognizable to many — and their position in their communities and respect in the field are secure. Many of them did point out that while they felt no threat from para-chaplaincy, it was possible that less-experienced people could be more sensitive.

They did raise other, more significant concerns. One recurrent issue was the possibility of a para-chaplain committing the egregious error of proselytizing for her or his particular faith, in the course of doing spiritual assessment and counseling.

That the para-chaplain might be well-meaning, or following in the perceived traditions or injunctions of a faith community, is irrelevant. It is a cardinal rule of chaplaincy to respect the faith position of the person being counseled. In fact, it may be *the* rule.

A Muslim imam summed up the issue: "Many people of many different faith traditions, not just one particular faith tradition, have their own group of individuals who would like to convert people to their way of life." A Christian clergy member agreed, saying, "The concern in that, of course, is having para-chaplains who may not hold to the best practice of being multi-faceted and multi-cultural." And, a rabbi interviewed for the study remarked on "cultural and religious appropriateness." Clearly, this is a sensitive issue for which even one slip-up could have devastating programmatic consequences. It is not hard to imagine the headline at Slate.com:

"Disaster Victim Sought Spiritual Counseling and Got a Religious Pitch Instead."

Another sensitive area in para-chaplaincy is the scope of the para-chaplain's duties. In the scriptures and traditions cited earlier, there were no limits envisioned on lay religious counseling, perhaps because the world was simpler and the threats more universal. Plagues, invaders, and earthquakes threatened everyone equally. Today, clergy and board-certified chaplains work in a variety of settings. Some problems that bring them to action are acute — a crime, fire, or tragedy — while others are chronic, like an illness. Other chaplains are posted to settings, like cruise ships and schools.

Where para-chaplains should be used was a subject of disagreement among the participants interviewed for the study. One clergy member pointed out that too often, it is too easy for people to cross boundaries that they should not, "and suddenly you have people there who have not been duly authorized to be on a scene." Another wanted para-chaplains to work only under the direct supervision of a clergy member or board-certified chaplain who was already on the scene. As one clergy member noted, "The question would be accountability. Who would they be accountable to?" There were clergy and board-certified chaplains who wanted to restrict the use of para-chaplains to mass emergencies like the airport detentions following the Trump executive order. Others saw the para-chaplain's role more expansively. When there was a need for a chaplain, and a chaplain was not available, these clergy and board-certified chaplains argued for the use of para-chaplains.

The key for so many of the clergy and board-certified chaplains is para-chaplaincy training, in many different areas of practice. For example, the issue of multicultural sensitivity arose again and again, because para-chaplains would be counseling people from potentially many different faith traditions. A board-certified chaplain declared that "religious and cultural sensitivity would be crucial," while a regular clergy member insisted, "They should have some training in terms of dealing with certain beliefs that people may hold in the different religions. They don't have to be an expert in them, but there are certain things that a person should know."

Multicultural issues are just the start. Those interviewed for the study pointed out important areas of training to be done in spiritual assessment, basic psychology and personality disorders, crisis intervention, family dynamics, and specific problems like suicide, domestic violence, drug overdosing, alcoholism, and criminal justice. Then, there are the processes of chaplaincy. Clergy and board-certified chaplains pointed out such areas as "active listening," "reflective listening," and asking the right questions. As one clergy member emphasized, "All too often, I think we get into a culture where the clergy has all the answers, and we don't. But maybe we can ask certain questions that will lead the people to a solid, right decision for themselves." One more area of training would also need to be mandatory reporting of domestic and child abuse.

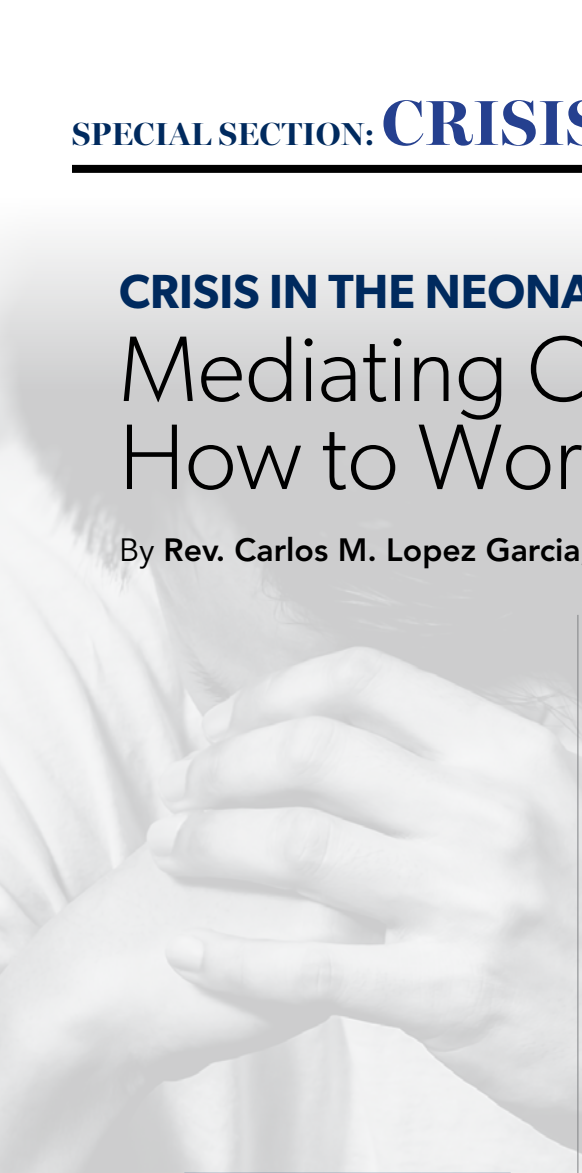
With all these subjects to cover, para-chaplaincy training like the first responder chaplain certificate program being offered by the Spiritual Care Association will not be for dilettantes. Instructors and students can look forward to intensive standardized training, including competency testing, as well as a great amount of oversight by veteran board-certified chaplains. Not everyone who wants to be a para-chaplain can succeed or should succeed. There may be painful conversations where an honored member of a congregation is told, "This isn't really for you." Still, there is a chaplaincy gap. The need is great, the time is short, and first responder chaplains are one way that the gap can be filled.

The Rev. Marcos A. Miranda, D.Min., BCC is the Founder, President and CEO of New York State Chaplain Task Force, and its national division U.S. Chaplain Task Force, both affiliates of Spiritual Care Association. He also serves as senior pastor at Action In Christ International and as assistant dean at New York Divinity School. An author, consultant and educator, he has traveled throughout the United States delivering lectures, trainings and workshops on crisis, trauma and disaster spiritual care. A board-certified chaplain, he currently serves as chaplain at Homeland Security Investigations and the New York State Fraternal Order of Police.

CRISIS IN THE NEONATAL UNIT:

Mediating Crisis and Learning How to Work Through Your Own

By **Rev. Carlos M. Lopez Garcia, MAPCC, MSED, MSEL**



"My crisis was necessary for me to better understand myself and, via my own enlightenment, my ability to administer spiritual care was renewed."

It was a Thursday afternoon around 4PM. I had just arrived at the hospital, and as I walked into the Pastoral Care Office, the phone rang. It was the head nurse of the neonatal unit. I heard an ensuing argument in the background and the urgency in her voice as she requested the presence of a Chaplain. She needed help. There was a family in crisis, a young man losing his temper with the doctor who presided over his wife's still-birth. I told her I was on my way. I took the elevator to neonatal, and the doors opened to the grieving screams of a young man visibly in pain. As I made a right and passed the nurses station I saw a young man face to face with the doctor, venting his anger, cursing and shouting about how he was going to sue this physician and the hospital. Three nurses in front of their station were standing by awaiting my intervention as I arrived.

As the young father — a Puerto Rican male in his early 20's dressed in a white t-shirt, blue jeans and sneakers — continued his rant, I slowly approached the two. The tension associated with his anger and sense of loss was heavy in the air. I gently made my way between them facing the young man, my back towards the doctor. My immediate instinct was to quietly shush him as a mother would a crying newborn. I began to do so and he lowered his voice. Your inner intuitions and discernment are usually right. Act on them without hesitation. Chaplains are a de-escalating presence. We are the representation of God, especially during times of crisis. Always project a peaceful disposition. He calmed down enough for me to focus on my surroundings. I saw an open door several feet from him and gently nudged him towards it. It was his wife's room where, post-partum, she laid in a bed hooked up to monitors and intravenous meds intermittently awakening from her sedation. The young man walked to the foot of her bed where their baby was wrapped, swaddled in a heavy cloth. He picked her up into his arms, sat in the rocking chair and began rocking as though in a trance quelling the storm within, the baby's phantom cries without.

His mother-in-law was standing by the picture window on the other side of the bed, towards its headboard. She looked at me, made eye contact, and nodded her head affirmatively as though giving me permission to approach her grief-stricken daughter. As I slowly walked to her bed, the young woman stretched out her arm towards me, holding my hand ever so tightly. I did not let go. She was saying so much with the embrace of her grip. Her emotions were speaking in the absence of her voice. I could think of no words at the moment that could bring her solace. I don't even believe that any script or spontaneous oration would have done any good. At times, if nothing else, our ministry of presence will suffice. I bowed my head in reverence to the hope of new life that had died in that room

that afternoon. I began praying in silence for her strength and for that of her family. Three minutes of silence elapsed, then she slowly released my hand from her grip. She had spoken clearly enough for her body, experiencing anesthetic withdrawal and racked with heartrending sorrow, to rest for a while.

As I made my way to the foot of the bed, her husband stood up from the rocker. He placed the baby on her legs and unwrapped the cloth, revealing a beautiful baby girl with blue discoloration around her face and neck. He raised her up to me and said, "Father, please pray for my baby." I could not deny him. If complying with his wishes of spiritual care was going to bring him a moment of peace, if not a sense of closure, I was to oblige. I held the child aloft in my arm as I would a baby during a christening or child presentation ceremony and offered a brief prayer aloud. "Heavenly Father, thank you for the life of your daughter. Thank you for bringing her unto us. We pray that her love will forever live vibrantly through her loved ones. May her peaceful presence always be felt in their lives. Receive her innocent soul into your arms of love. Thank you again, if but for a brief moment, for sharing her with us. To you she returns. In the name of The Father, The Son and The Holy Spirit we pray. Amen." I gently placed her down on the cloth upon the legs of the mother. Thanking me he wrapped her anew, taking her into his arms and returning to the rocking chair, rocking his daughter as if to sleep in his embrace.

I looked at the grandmother standing by the picture window. She nodded an affirming "thank you" to me. I felt that my time there providing spiritual care services had come to a close for that day. The crisis had been mediated. I returned the nod to her and slowly walked backwards to the door, not wishing to give them my back or show any sign that could be misinterpreted as disrespect. As I got to the threshold, I bypassed the nurse's station and took the elevator to the lobby. I then proceeded to walk across the street to the parking garage. I was having my own moment, overwhelmed by what I had just experienced. I felt the onset of a panic attack. I needed to find a quiet space and did. This was my own mini-crisis I had to work through. As I stood in the darkness of a void between two parked cars, my back against the wall, I cried and spoke to God through tears and questions. Why did this baby have to die? Why was there so much pain in the world? Were my thoughts perennial questions that never seem to have an answer? I took several deep breaths and exhaled slowly. As chaplains we need to check our own emotional disposition and attitude before re-engaging our base. Self-care remains a forefront issue with us all; and as challenging and intrinsically rewarding as chaplaincy is, we risk the danger of being overcome by compassion fatigue if we continue to ignore its warning signs.

After dealing with my emotions, I was ready to reenter the hospital. My crisis was necessary for me to better understand myself and, via my own enlightenment, my ability to administer spiritual care was renewed. We are only as good to others as we are good to ourselves. Know your limitations and love yourself enough to know when to take a break, introspect, reassess, refocus and re-engage. Another's crisis can be subjective, but never discount what others are feeling nor disregard the labeling of their situation as a crisis. Be an active listener, validate and normalize their emotions. Facilitate their journey in pulling away the layers of their emotions. Actively engage them in dialogue where they acknowledge and demystify their emotions so they can see the road to their own healing – a road we all have within.

As a Crisis Chaplain Responder I am reminded daily of the following truths: Never curse your crisis. Crisis and chaos are natural and necessary elements of nature. There is a certain struggle and friction that threads through life, birth, love, death and mourning whose energy can either unite or divide. Constructively engage crisis and embrace the lessons it has to offer. In T*he Road Less Traveled*, one of my favorite and foundation-forming reads, M. Scott Peck affirms that chaos and its reveal is essential to the community-building process, central to bringing others together, and pivotal to ushering in a better mutual understanding of each other and of self. As for adversity, we will always contend with moments of personal anger and crisis. It's how you manage the sparks that makes the difference. We must become better managers of our emotions while under fire. Welcome the wisdom you can glean from any adverse situation; and quelling the crisis of others equips you to better deal with the crisis within. May our collective journey towards a balance of self lead us to a deeper sense of communal authenticity and the ability to confront crisis with peace, vulnerability and transparency.

Many await your help.

Carlos began his journey in Chaplaincy in 2001 at Long Island College Hospital while a student at The Blaton-Peale Graduate Institute of Mental Health. He went on to complete an MA in Pastoral Care & Counseling (NYTS, '05) while dedicating his young adult life to urban ministry in varying capacities at The Latino Pastoral Action Center (LPAC 1994-2011). As a bi-vocational minister he earned an MS in Early Childhood Education (FCLC, '08) and an MS in Educational Leadership (FCLC, '13). He has combined his expertise in both fields (Chaplaincy & Education) into his teaching of this sacred vocation. He currently is the Queens Borough Supervisor for the NYSCTF and Pastor of Damascus Christian Church of Queens Village, NY.

Ministering to Vulnerable Populations During Disaster: My Experience in Puerto Rico Following Hurricane Maria

By **Rev. Daniel Delgado, D.Min.**

During 2017, our nation experienced record-level natural disasters that devastated many of our states and U.S. territories. The sheer number of devastating hurricanes and tornados impacting our country were historic, to the point that some in the media compared them to biblical end-time destruction. It was during this year working as a First Responder Chaplain and Emergency Manager that I encountered some of the greatest lessons in my life on providing ministry of presence to vulnerable populations—specifically, serving the senior community and the unique struggles they confronted during disasters.

One week after Hurricane Maria, I led a team of four Chaplains from New York State Chaplain Task Force to Puerto Rico. We were providing logistical support to two New York Assembly Members and their team. As a seasoned emergency manager with multiple national disaster deployments under my belt, I chose a team of Chaplains who had diverse skill sets. Chaplain Peter was a seasoned Protestant Minister and part of the Teamsters Union in NY. Chaplains Manny and Haydee were Eucharistic Ministers in the Roman Catholic Church, as well as talented professionals with years of technical and planning experience. The mission was to help contact local politicians and organizations and provide technical assistance in establishing distribution of disaster relief resources from our organization and partners. Upon arriving in Puerto Rico, we were able to arrange lodging at the Teachers Retirement Housing in San Juan. This retirement home had 148 residents. This is where our mission expanded due to assessment of need.

To preface this experience, it's important to add that we were in a disaster which brought island-wide destruction that Puerto Rico had not experienced in over fifty years. While this retirement home had better resources than most due to the Teachers Union in Puerto Rico, there were needs unique to vulnerable populations that went unmet. The greatest of these was spiritual and emotional care. The spiritual well-being of the residents had deteriorated, as they had not been able to go to Mass or have communion brought to them since before Hurricane Maria. This was impacting the hopelessness common in disasters and exacerbating the residents' ailments, both mentally and physically. Our team was able to assess this after talking to residents, staff and medical personnel.

I met Carmen, a 78-year-old

resident who was in a wheelchair. Her social worker had asked that I talk with her. She explained that Carmen was a religious woman who had been unable to attend Mass since before Hurricane Maria. The disaster had limited the services of local priests and clergy who were overwhelmed and were themselves victims of the disaster. I approached her to engage in conversation. She had a sad look on her face, and as we spoke, I could hear the sense of hopelessness and loss. I engaged with open questions that helped create the space for her to unpack what she was feeling. With such sadness, she shared that the impact of the disaster was compounded by the fact that she could not go to

church and partake of communion at Mass. She explained how important it was to her to be able to practice her faith. Our conversation lasted about 30 minutes. I told her I would check back in with her.

It was that conversation that added a new priority to our mission. We must provide spiritual care to these residents. I briefed my team about my meeting with Carmen. They shared similar experiences in speaking with residents. The planning started immediately. As a Protestant Chaplain I would not be able to provide communion to the Roman Catholic residents, but two members of my team, Chaplains Manny and Haydee, were Eucharistic Ministers of the Roman Catholic Church. I spoke to the director of the facility and requested permission to provide spiritual care. With very little time to strategize and a small window within our original mission, the plan was set. Staff announced that there would be a Mass the very next day. A shift in the atmosphere after this announcement produced a sense of anticipation, a stirring of hope that seemed to have been quenched by Hurricane Maria started to permeate the facility.

The next day we provided communion to every resident who attended our service. Oh, the look of joy on Carmen's face when we arrived. Tears of joy started to flow, and the most amazing thing happened. Carmen started to sing from her wheelchair a song from her faith. The residents joined to form an amazing chorus of voices. As the two members of my team ministered communion, the remaining members of the team and I provided ministry of presence and reading of scripture. The impact of that day will never be forgotten. That thirty-minute conversation with Carmen led to providing spiritual care to over 140 residents in a retirement home for teachers in the midst of a disaster zone.

This experience marked my life and affirmed the passion towards my vocation. It also confirmed the data I had gathered over multiple deployments to national disasters. Spiritual Care for vulnerable populations could no longer be an afterthought of planning for disaster services. I served as an Emergency Manager for one of the lead disaster organizations in our nation, which has done a great job in many areas of service. Yet the need for attending to the human spirit through spiritual care has never been a priority in their planning. Spiritual care by trained First Responder Chaplains must be a priority in the services provided to those affected by disasters. It is especially crucial to senior populations who, in their golden years, have developed a greater sense of comfort from their faith. This is what we do as Chaplains. We step into the pain of those suffering, and not out of sympathy but out of compassion — a divine mandate fueled by love and empowered by faith. We bring — and at times become — that hope in the midst of chaos.

Rev. Daniel Delgado, D.Min. *serves as Senior Vice President of Operations for New York State Chaplains Task Force, Associate Pastor of Action In Christ Church International, and Founder of Third Day Missions, Inc. His mantle is Prophetic in purpose, Apostolic in function, Pastoral in compassion and Evangelistic in outreach.*

The Role of Personhood in Testing

By **The Rev. George Handzo, BCC, CSSBB** and **The Rev. Susan Wintz, BCC**

The certification process for the Spiritual Care Association (SCA) has broken much new ground and introduced several long-overdue innovations to more reliably test chaplains' competence. Chief among those are the first and only core knowledge test in the profession and the use of simulated patients to test clinical competence. The latter replaces self-report written reports to increase objectivity in the certification process.

The question that may be raised is whether, with its emphasis on objectivity, the SCA has lost any focus on or concern for how the personhood of the chaplain is developed and expressed. This is not at all the case. While the SCA believes that the personhood the chaplain brings to the clinical encounter has to translate into demonstrably effective care, it firmly believes the "being" the chaplain brings is a critical component of who a chaplain is. To ensure that is incorporated into the certification process, the scoring sheet for SCA's simulated patient exam includes:

Does the chaplain exhibit an evident sense of deep caring for the patient's or caregiver's human predicament? Is this attitude clearly therapeutic in the sense of effecting a relationship where the person feels accepted and understood by the chaplain? Does the engagement contribute to the person(s) having a greater sense of comfort, acceptance — even for the unacceptable; connected to self and others, and even a sense of wellness, wisdom, and peace? Finally, does the chaplain use their clinical acuity in a caring way to move some or all these goals forward?

The SCA process ensures that both elements — clinical and personal development — are part of a chaplain candidate's certification process, and both are reviewed and measured professionally and objectively.

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JANUARY 2019

The Chaplaincy Taxonomy: Standardizing Spiritual Care Terminology

HealthCare Chaplaincy Network™

SPIRITUAL CARE ASSOCIATION
Making Spiritual Care a Priority

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HealthCare Chaplaincy Network™ (HCCN), founded in 1961, is a global health care nonprofit organization that offers spiritual care-related information and resources, and professional chaplaincy services in hospitals, other health care settings and online. Its mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve 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.

The Spiritual Care Association (SCA) is the first multidisciplinary, international professional membership association for spiritual care providers that includes a comprehensive evidence-based model that defines, delivers, trains and tests for the provision of high-quality spiritual care. Membership is open to health care professionals, including chaplains, social workers, nurses and doctors; clergy and religious leaders; and organizations. SCA, with offices in New York and Los Angeles, is a nonprofit affiliate of HealthCare Chaplaincy Network.

www.healthcarechaplaincy.org
www.spiritualcareassociation.org
212-644-1111

INTRODUCTION

The chaplaincy profession stands at a rare moment in its history. American health care has shifted from fee-for-service to fee-for-value to advance the overall goals of providing better care for individuals, improving population health management strategies, and reducing health care costs. In this new arena of fee-for-value, chaplains have an opportunity to confidently articulate their distinctive contributions to health care.

Previously, in the fee-for-service environment, chaplains sought to find a way to measure or quantify the care they provided. This was largely accomplished through volume statistics. "How much chaplaincy were we delivering? How many visits? How many resources? How many sacraments, or books, or things did we give out? The problem with that, of course, is that it is not a metric of quality, and it doesn't tell us anything about whether what we did made any difference."[1]

Value-based health care requires every health care provider, including chaplains, to demonstrate that their services contribute to specific outcomes, which in turn lead to high-quality health care. Globally, funding for professional chaplaincy increasingly needs to be justified. Chaplains must find ways of explicitly communicating alignment of their professional efforts with those of the institutions they serve—with the ultimate goal of making a significant and unique contribution to the overall health and well-being of patients, families and staff. This requires standardizing how chaplains communicate about what they do.

NEED FOR COMMON SHARED LANGUAGE FOR CHAPLAINS

In order to demonstrate value, professional health care chaplains need a common language of what they do, how they do it, and why it matters. There has been an increase in the number of studies demonstrating the unique positive impact chaplains have on the "quadruple aims" of health care. These include patient clinical outcomes,[2 3 4] patient satisfaction,[5 6 7 8 9] employee engagement/retention,[10 11 12 13 14] and finances.[15 16] Yet, inter-professional clinical staff remain largely unaware of much of what chaplains accomplish on a daily basis.

Chaplaincy practice and terminology have not been standardized. Chaplains provide personally chosen spiritual assessments, make significant contributions to desired contributing outcomes, and offer specific spiritual care interventions in order to achieve these outcomes. Yet, there is a "lack of clarity about what it is that chaplains do when they spend time with patients. Given this, it is possible that the role of a chaplain could be misunderstood by other healthcare staff, and, as a result, for the chaplaincy service to be underused."[17]

Without this shared language, chaplains struggle to communicate to the inter-professional health care team what goals they seek to achieve, how those outcomes contribute in a distinctive way toward the patient's plan of care, and what tools or interventions they use to achieve them. Chaplains come from many different faith traditions and perspectives, and they do not necessarily all view their role in the same way, nor do they consistently articulate it. A shared language helps to address this. "The main thing about a normative language is that our interdisciplinary colleagues don't really know yet very well what we do and why we do it, and that is partly because we describe the same things in many different ways, or sometimes we describe different things the same way."[18]

Chaplains have struggled to arrive at consensus in even the most fundamental terms for the profession. What are the agreed-upon definitions of religion and spirituality, and how are they similar and different? What is the substantive difference between spiritual distress, spiritual pain, spiritual struggle, spiritual crisis and spiritual despair? Why are all of these terms used in spiritual care literature if they appear to be functionally synonymous? What is the difference between pastoral care, spiritual care and chaplaincy care?[19] The definition of a spiritual assessment can mean both any kind of assessment of the patient or family's spirituality (including a spiritual care screen, spiritual history, or more formal comprehensive spiritual assessment), or it can be a more functional formal instrument like Fitchett's 7x7[20] or Shield's Spiritual AIM.[21] Also contributing to the confusion in language is a certain fuzziness in differentiating between tools designed for clinical use versus those used for research.

"In order to demonstrate value, professional health care chaplains need a common language of what they do, how they do it, and why it matters."

"Chaplains perform a variety of interventions with therapeutic intent yet lack a unified and consistent naming set for these interventions which would better portray to the [inter-professional] team what goals and results they strive to make."[22] While many chaplains functionally customize the tools they use, there is a cost to such improvisation. The lack of consensus around definitions and meanings of terms muddies the waters and creates unnecessary and ultimately avoidable obstacles for advancing the field of chaplaincy, let alone clearly and consistently communicating what chaplains do. By way of example, a chaplain might read about some new template or tool for spiritual assessment. Then, the chaplain individually tweaks it to fit their experience, their context, their experience, and their assumptions. Instead of using the tool as it was created, the chaplain morphs it into something more comfortable or that feels like a better fit. The problem with this functional reality is that it results in diffusing and confusing the discussion. Instead of having common language and terms for what spiritual care interventions chaplains provide, and shared ways of communicating them, the result is many individualized methodologies and tools. In doing this, continuity, clarity, and much of the research foundation that may have supported the original tool, term, or intervention have potentially been jeopardized. It also creates potential inconsistencies and issues around communication with the patient, family, and staff about what it is the chaplain is seeking to concretely do and hoping to achieve.

Chaplains are currently without an authoritative, normative list detailing what it is they do. As chaplains face growing "pressure to quantify the scope of the work and to provide an evidence base for it, a taxonomy offers the possibility of developing a shared language to articulate the content and process of the work. This helps the chaplain use a core vocabulary to create a framework within which to work and to explain what they do to staff from other disciplines who work with the same patients, as well as to different chaplains working with the same patients."[23] The word taxonomy comes from the Greek works *taxis*, meaning arrangement, and *nomia*, meaning distribution. It is defined as "a process or system of describing the way in which different living things are related, by putting them into groups." The Chaplaincy Taxonomy, discussed in detail below, is a strong move forward for the field of professional chaplaincy. The Chaplaincy Taxonomy is a "list that [captures] the breadth of chaplaincy activity, from granular hands-on specific tangible tasks all the way to the broader goals and outcomes and intended effects chaplaincy may have."[24]

The taxonomy was researched and produced with the assistance of a John Templeton Foundation grant through HealthCare Chaplaincy Network. Kevin Massey, Tom Summerfelt, Marilyn Barnes, and their team at Advocate Health Care (now AdvocateAurora Health), developed the taxonomy. There have been previous efforts to describe what it is that chaplains do. Hanzo and his co-authors aimed to analyze the records of chaplain visits, including how the chaplains allotted their time.[25] Vanderwerker and her co-authors analyzed referrals to chaplains over a two year period.[26] Bryant sought to better understand the role and self-understanding of chaplains from minority faith traditions.[27] Hummel and colleagues explored 101 journal articles over a 25-year period relating to spiritual care, and compiled an inventory of 66 discrete spiritual care interventions.[28] Puchalski and colleagues,[29] and Aldridge[30] also contributed their own

catalogue of chaplaincy interventions. The Advocate team then used these precursor lists as a base to generate the first set of 348 items.

In a robust mixed-method approach, the Chaplaincy Taxonomy team then ultimately arrived at 100 items for the taxonomy through "a literature review, a retrospective medical record review, chaplain focus groups, self-observation, and experience sampling of chaplains in the course of clinical work. The items were scrutinized, categorized by chaplain focus groups, and categorized and rated by chaplains by way of concept mapping. The resulting taxonomy is a confident inventory of chaplain activities organized around a hierarchical structure."[31] The creators of the taxonomy ultimately determined 100 was sufficient in an attempt to keep it useful, as that was the number of items that remained after the different editing processes. This number still allows for the wide variety of intended effects, methods, and interventions chaplains utilize regularly.

The Chaplaincy Taxonomy is separated into three groups of terms. The first category is **Intended Effects.** This is the desired contributing outcome[32] the chaplain is striving to help address or meet. It is the goal or the perceived need of the encounter. Intended Effects seek to articulate **"Why"** the chaplains did what they did. To what end is the chaplain working?

"The Chaplaincy Taxonomy is a full, yet economical, inventory of what chaplains do and why."

The next set of terms is the **Methods** column. Methods are a kind of bridge, or "via," between the Intended Effects and the Interventions. They seek to describe how a specific intervention supports the intended effect. The Method is the way in which a specific action or activity supports a purpose, goal, and outcome. This is the **"How"** of the chaplaincy encounter.

And finally, the Chaplaincy Taxonomy has a list of potential **Interventions**. The Interventions are the concrete chaplain gestures, actions, or activities in a visit. This is the **"What"** of the encounter. Many chaplains, upon using the taxonomy for the first time, find it helps them remember the various tools in the toolkit. When chaplains use these tools with intention, specificity and consistent use of terms, the taxonomy helps clarify what they are seeking to accomplish, how they plan to contribute to that outcome, and why.

A nursing clinical pathway is "a multidisciplinary plan of best clinical practice . . . [and] aim[s] to improve, in particular, the continuity and co-ordination of care across different disciplines and sectors. [They] can be viewed as algorithms in as much as they offer a flow chart format of the decisions to be made and the care to be provided for a given patient or patient group for a given condition in a step-wise sequence. This process is consistent with the use of clinical pathways for nursing and other inter-professional health care communication in the United States. The criteria of nursing clinical pathways are that "(1) the intervention was a structured interdisciplinary plan of care; (2) the intervention was used to translate guidelines or evidence into local structures; (3) the intervention detailed the steps in a course of treatment or care in a plan, algorithm, guideline, protocol, or other 'inventory of actions'; (4) the intervention had timeframes or criteria-based progression; and (5) the intervention aimed to standardize care for a specific clinical problem, procedure or episode of health care in a specific population."[33] The Chaplaincy Taxonomy is a significant step toward this commonly utilized standardized clinical communication.

The Chaplaincy Taxonomy is a full, yet economical, inventory of what chaplains do and why. It has been published and made available for any chaplain, chaplaincy department, hospital, healthcare system or other spiritual care-providing organization to use for free, provided the list is used in a consistent way. Its authors, and now the Chaplaincy Taxonomy Review Council (an inter-organizational, international body within the profession promoting the use of standardized language for chaplaincy interventions and outcomes now charged with its stewardship and advancement),[34] are fully aware that further study and refinement can continually improve the list to help it better represent the intended effects, methods and interventions chaplains use daily. The intent is for an ongoing real-world consistent use of the Chaplaincy Taxonomy by chaplains and chaplaincy students from a wide range of different health care contexts. Those chaplains who do use it will be invested in improving it through substantive feedback and suggestions to

the Chaplaincy Taxonomy Review Council. The Council reviews all suggestions and ultimately decides which changes are made. They can be reached at: AAH-chaplaincytaxonomycouncil@advocatehealth.com.

One excellent example of how suggestions enhance the Chaplaincy Taxonomy is a contribution from Paul Nash's team of pediatric chaplains in Birmingham, England. They have worked with the taxonomy and and suggested several additions specific to the pediatric context.[35] The hope is that chaplains as a profession will take full ownership of the Chaplaincy Taxonomy, use it as a normative language now, and commit to partner together to continually improve it, fills its gaps and reduce its redundancies. This will likely include other clinical context-specific efforts such as mental health or palliative care. The chaplaincy profession can endeavor to consistently use its phrases and terms not only in our documentation but in our research, presentations, publications and writing, and we can request that publishers consider it the foundation of a style guide when publishing about spiritual care.

THE CHAPLAINCY TAXONOMY[36]

INTENDED EFFECTS	METHODS	INTERVENTIONS	
Aligning care plan with patient's values	Accompany someone in their spiritual/ religious practice outside your faith tradition	Acknowledge current situation	Facilitate closure
Build relationship of care and support	Assist with finding purpose	Acknowledge response to difficult experience	Facilitate communication
Convey a calming presence	Assist with spiritual/religious practices	Active listening	Facilitate communication between patient and/or family member and care team
De-escalate emotionally charged situations	Collaborate with care team member	Ask guided questions	Facilitate communication between patient/family member(s)
Demonstrate caring and concern	Demonstrate acceptance	Ask guided questions about cultural and religious values	Facilitate decision making
Establish rapport and connectedness	Educate care team about cultural and religious values	Ask guided questions about faith	Facilitate grief recovery groups
Faith affirmation	Encourage end of life review	Ask guided questions about purpose	Facilitate life review
Helping someone feel comforted	Encourage self care	Ask guided questions about the nature and presence of God	Facilitate preparing for end of life
Journeying with someone in the grief process	Encourage self reflection	Ask questions to bring forth feelings	Facilitate spirituality groups
Lessen anxiety	Encourage sharing of feelings	Assist patient with documenting choices	Facilitate understanding of limitations
Lessen someone's feelings of isolation	Encourage someone to recognize their strengths	Assist patient with documenting values	Identify supportive relationship(s)
Meaning-Making	Encourage story-telling	Assist someone with Advance Directives	Incorporate cultural and religious needs in plan of care
Mending broken relationships	Encouraging spiritual/religious practices	Assist with determining decision maker	Invite someone to reminisce
Preserve dignity and respect	Explore cultural values	Assist with identifying strengths	Perform a blessing
Promote a sense of peace	Explore ethical dilemmas	Bless religious item(s)	Perform a religious rite or ritual
	Explore faith and values	Blessing for care team member(s)	Pray
	Explore nature of God	Communicate patient's needs/ concerns to others	Prayer for healing
	Explore presence of God	Conduct a memorial service	Provide a religious item(s)
	Explore quality of life	Conduct a religious service	Provide access to a quiet place
	Explore spiritual/religious beliefs	Connect someone with their faith community/clergy	Provide compassionate touch
	Explore values conflict	Crisis intervention	Provide Grief Processing Session
	Exploring hope	Discuss concerns	Provide grief resources
	Offer emotional support	Discuss coping mechanism with someone	Provide hospitality
	Offer spiritual/religious support	Discuss frustrations with someone	Provide religious music
	Offer support	Discuss plan of care	Provide sacred reading(s)
	Setting boundaries	Discuss spirituality/religion with someone	Provide spiritual/religious resources
		Ethical consultation	Respond as chaplain to a defined crisis event
		Explain chaplain role	Share words of hope and inspiration
		Facilitate advance care planning	Share written prayer
			Silent prayer

The Chaplaincy Taxonomy is the result of research by Advocate Health Care with a grant from HealthCare Chaplaincy Network provided by the John Templeton Foundation entitled "What Do I Do? Developing a Taxonomy of Chaplaincy Activities and Interventions for Spiritual Care in ICU Patients." Used with permission from Rev. Kevin Massey, Advocate/Aurora Health.

Paul Nash and his U.K. colleagues in pediatric chaplaincy offer the following additions to the taxonomy based on their research:

TABLE 1: PEDIATRIC-SPECIFIC INTENDED EFFECTS

INTENDED EFFECT	COMMENT
Build self-esteem	Sickness can erode this, particularly when it impacts appearance
Create conducive space for spiritual care	Environment can be important as can trust
Create sacred space explored and held	So spiritual and religious needs can be explored and held
Demonstrate kindness and compassion	In both word and deed
Empower/offer control	Few options for control and choosing to participate in relation to treatment
Engender resilience	Identifying coping mechanisms and support
Enhance spiritual wellbeing	Build on existing spirituality
Facilitate fun/play	Seeking to lift spirits
Feel part of a community	Have left other communities and sense of belonging important
Help find new normal	Taking into account limitations and changes
Identify and process emotions	Explore in a variety of ways, name
Lessen boredom	Particular issue for those in isolation
Mediate between patient and family	When have different perspectives
Nurture spirituality	Look at connectedness, purpose, meaning, hope, and identity
Offer acceptance and affirmation of personhood	Regardless of condition, verbal and nonverbal
Provide a normalizing experience	Do things which they would do when not in hospital
Provide an opportunity to give	They are often receiving a lot and want to be able to give back too

TABLE 2: PEDIATRIC-SPECIFIC METHODS

METHOD	COMMENT
Celebrate religious festivals	Taking account of religious needs and observance
Encourage gratitude	Research shows benefits of this
Explore forgiveness	Important for some situations and conditions
Explore identity	Sickness often brings big shift in identity which needs time to process and come to terms with
Explore worldview	Changing circumstances can challenge world view particularly religious elements

TABLE 3: PEDIATRIC-SPECIFIC INTERVENTIONS

INTERVENTION	COMMENT
Engage in a participative spiritual care activity	Main BCH approach to doing spiritual care (see Nash & colleagues, 2015)
Facilitate a family activity	Sometimes most appropriate to engage with all of the family, not just patient
Facilitate a group activity	Some work is done with groups to facilitate peer support or build community
Leave a gift	Reminder of what has been done or spiritual or religious item
Provide self-directed activities	To facilitate further exploration

The pediatric-specific taxonomy items are the result of research by Paul Nash's Pediatric Chaplaincy team at Birmingham Children's Hospital, Birmingham, U.K., entitled "Adapting the Advocate Health Care Taxonomy of Chaplaincy for a Pediatric Hospital Context: A Pilot Study." Used with permission from Rev. Paul Nash, Birmingham Children's Hospital.

What is remarkable about this second study is that Nash and his colleagues sought to use the taxonomy with their own chaplaincy team, and they also identified additional items that fit their unique context of pediatrics in the National Health Services in the United Kingdom. Instead of being in an urban adult acute care teaching hospital, they were in pediatrics in the United Kingdom, with the many layers of difference between the two different health systems. They prioritized their own creation of terms and use, and in doing so found that five of the top ten most utilized items in the pediatric version were the same as the original chaplaincy taxonomy. The take-home here is the convergence. It suggests that the taxonomy is "onto something" fundamental or basic about spiritual care. So much so that it applies to a broad variety of health care contexts.

Nash and his team's efforts demonstrate how proactive engagement with the Chaplaincy Taxonomy can yield valuable additions and suggestions for improvements in the tool. Of these additions, the ones which were most significant in frequency were engage in a participative spiritual care activity, leave a gift, engage in supporting the whole family, and wellbeing and resilience. In the future, the Nash team anticipates evaluating how the taxonomy may be used in work with families (which is common in a pediatric context), and if there will be additions that reflect full scope of this work.

THE CHAPLAINCY TAXONOMY IN PRACTICE

Advocate also produced a Chaplaincy Taxonomy User's Guide, edited by Marilyn Barnes.[37] This User's Guide can be found online at: www.chaplaincytaxonomy.org. The User's Guide contains a glossary of terms defining each of the items on the Chaplaincy Taxonomy.

"The Chaplaincy Taxonomy Review Council is inviting readers of this publication who are currently using the taxonomy, to assist in refining and nuancing the definitions for each of the items."

The Chaplaincy Taxonomy Review Council is inviting readers of this publication who are currently using the taxonomy, to assist in refining and nuancing the definitions for each of the items. If you are interested in providing feedback on either the definitions used for the taxonomy or on the items themselves—including suggestions for new ones— please email: AAH-chaplaincytaxonomycouncil@advocatehealth.com. The User's Guide "includes both the alphabetical listing of the taxonomy items . . . and another listing of the taxonomy items grouped into categories of similarity to assist a user in selecting items. For example, categories such as "Grief," "Relationships," and "Spiritual/Religious Practice" group together items that pertain to each other on these themes."[38] The User's Guide also contains numerous real-world vignettes, designed to help chaplains better understand how the taxonomy connects with daily clinical interactions.

The Chaplaincy Taxonomy is intended to be used as is. It is not meant to be taken as a starting point, with each Spiritual Care Department that adopts it changing it to fit their unique understanding, context, experience and comfort. Ideally, if a Spiritual Care Department wishes to begin to use the Chaplaincy Taxonomy, they would email: AAH-chaplaincytaxonomycouncil@advocatehealth.com, register their use of it, and begin to use it as it currently exists. If those using it wish to offer suggestions for additions to it, there is a process in place for that. Paul Nash's example of how his team at Birmingham Children's Hospital submitted suggestions would be the template for such efforts. But in order for the instrument to be useful, in order for there to be potential research connected to it, those organizations that use the Chaplaincy Taxonomy should all be using the same instrument. This foundation of consistency helps the collective body of professional chaplaincy better understand what changes need to be made. To coordinate the use and modifications of the taxonomy across time and contexts, its authors and the Chaplaincy Taxonomy Review Council ask that any suggestions for changes come directly to them.

The *process* of using the Chaplaincy Taxonomy is as important as the items themselves. In order to clearly describe the process, it is essential to define some terms.[39] Items within the taxonomy can be combined to formulate clinical communication known as a Spiritual Care Pathway, which is the building block of a Spiritual Care Plan. This Spiritual Care Plan is developed based upon a Spiritual Assessment. These combinations of items from the taxonomy, formulated in a consistent and clear way, mirror the format and methodology used by other inter-professional colleagues for clinical communication.

Pathway: The assemblage of an Intended Effect – Method – Intervention

Spiritual Care Assessment: A disciplined technique to surface spiritual care needs, e.g., Fitchett's 7X7,[40] Shields' Spiritual AIM,[41] Monod's Spiritual Distress Assessment Tool,[42] etc.

Spiritual Care Plan: The pathway or pathways developed in response to the identified spiritual care needs surfaced in the spiritual care assessment

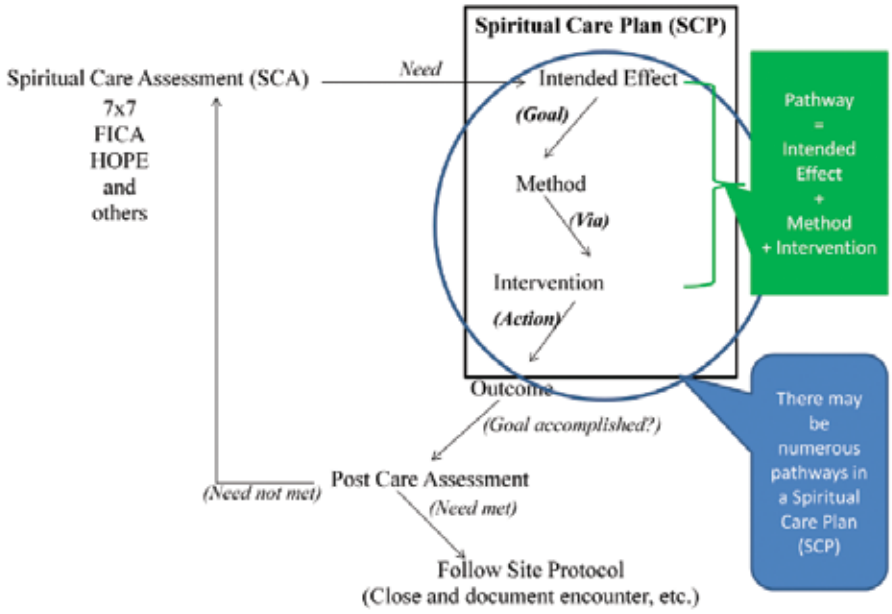
Technique: Any intervention which includes faith-specific or personal stylistic content

For those familiar with Van De Creek & Lucas' Outcome Oriented Chaplaincy,[43] [44] the structure of the Chaplaincy Taxonomy and process will be familiar. The Desired Contributing Outcome from Outcome-Oriented Chaplaincy is synonymous with the Intended Effects within the taxonomy. The Interventions are the same in both paradigms. The Plan, Measurements, and Spiritual Assessment of Needs, Hopes & Resources from Outcome-Oriented Chaplaincy are consistent with the Spiritual Care Plan, Pathway, Spiritual Care Assessment and Technique – all described more in depth below.

"The taxonomy items can be groups and associated together in nearly infinite combinations to develop a grouping we have come to call a "pathway," which is the assemblage of an Intended Effect, Method, and Intervention. A pathway or pathways make up a Spiritual Care Plan, which is developed in response to the identified spiritual care needs surfaced in a Spiritual Assessment."[45] This process is visually represented in **Figure 1** below.

Process-wise, within the visit itself, the chaplain listens and assesses for a need, which creates an intended effect. Based on this intended effect, the chaplain determines which method is best to use for a specific intervention. The pathway is what is created.

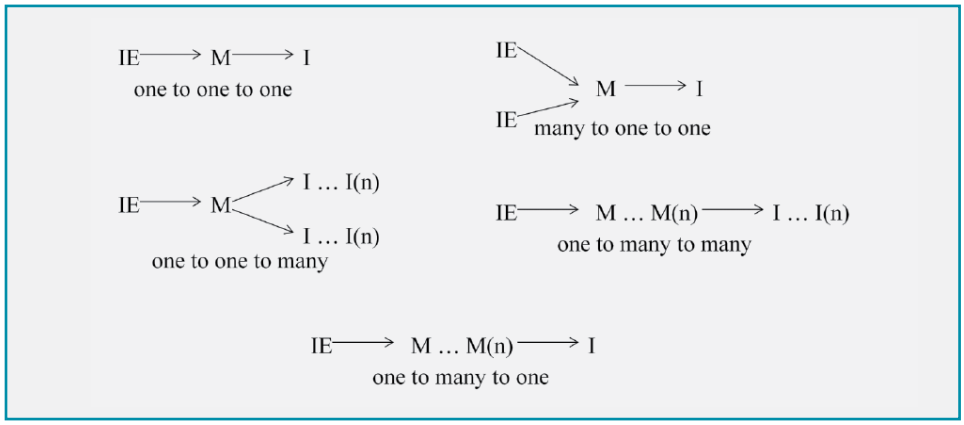
FIGURE 1: CHAPLAINCY PATIENT-CENTERED OUTCOMES MODEL



This model was developed by Revs Marilyn J. D. Barnes and Kevin Massey during the research for the Advocate Health Care project resulting in "What Do I Do? Developing a Taxonomy of Chaplaincy Activities and Interventions for Spiritual Care in ICU Patients." Used with permission from Rev. Kevin Massey, Advocate/Aurora Health. ©Advocate Health Care 2014.

The FICA[46] and HOPE[47] instruments are technically both Spiritual History tools, most often used by non-chaplain clinicians that are Spiritual Care Generalists. They are not formal Spiritual Assessment instruments, more often used by professional chaplains, who are Spiritual Care Specialists.[48]

The idea of a pathway borrows from the common American nursing lexicon and process. Nurses in other countries may use similar tools and strategies but have different names for their instruments. A chaplaincy pathway for a visit might include "aligning care plan with patient values" (Intended Effect), "educate care team about cultural and religious values" (Method), and both "incorporate cultural and religious in plan of care" and "facilitate communication between patient and/or family and care team" (Intervention). This brief example demonstrates the reality that a pathway should have at least one from each category (Intended Effect, Method, and Intervention), or perhaps multiples. The User's Guide represents this visually in the following diagrams:



This model was developed by Revs Marilyn J. D. Barnes and Kevin Massey during the research for the Advocate Health Care project resulting in "What Do I Do? Developing a Taxonomy of Chaplaincy Activities and Interventions for Spiritual Care in ICU Patients." Used with permission from Rev. Kevin Massey, Advocate/Aurora Health. ©Advocate Health Care 2014.

A chaplain constructs a pathway once the visit has been completed and the spiritual care assessment has already uncovered a concrete need or outcome. There is also the need for ongoing re-assessment. It may be written up at the time of the visit, but it is constructed throughout the process (both within the visit itself, longitudinally throughout the patient's hospitalization, and/or within the entire scope of the relationship between the patient and chaplain). Just as more than one Intended Effect, Method or Intervention can be chosen to represent a spiritual care visit, there also may be more than one pathway for each Spiritual Care Plan. Once this Spiritual Care Plan is complete, the chaplain's unique personal style or distinctive approach to spiritual care, called one's technique, is used to implement the plan. For example, one pathway may well include the Intended Effect of "promote a sense of peace," the Method of "assist with spiritual/religious practices," and the Intervention of "perform a religious rite or ritual." The chaplain-specific technique for that pathway could be "Sacrament of the Anointing of the Sick."[49]

The Chaplaincy Taxonomy has also been programmed into both of the major Electronic Medical Records (EMRs), EPIC and Cerner. For EPIC users, go to the User Web Community Library and search for Mount Sinai's Spiritual Care Form. It is called "T SPIRITUAL CARE ASSESSMENT." You can provide that to your site IT lead as a guide for building it at your site.

For Cerner users, programming to incorporate the taxonomy into forms has been uploaded to the Cerner Users' Group. Your IT team can search for it there and also contact Advocate Health Care for assistance with incorporating it into your site's system.

This enables those using it to potentially coordinate and participate in ongoing research, refinement, and discussions about the taxonomy. One can register at: www.chaplaincytaxonomy.org.

HOW TO BEGIN USING THE CHAPLAINCY TAXONOMY

The hope is that more chaplains will adopt the use of the Chaplaincy Taxonomy in their daily practice of spiritual caregiving, and in their clinical communication, research and quality improvement initiatives. The basic process might include the following steps:

- Read the Chaplaincy Taxonomy articles and resources here and at: www.chaplaincytaxonomy.org
- Discuss with chaplains within your department to get buy-in. How this will impact clinical communication and logistics for implementation?
- Discuss with administration to get buy-in
- Make the case for why your department is seeking to standardize its clinical communication and processes
- Align documentation templates with this system. For EPIC Electronic Medical Records users, there are templates being used by other systems, and a pending "EPIC Everywhere" open-source option (no additional cost to make a custom template) option; for Cerner, there are also templates being used by other systems, and plans to make it an open source in the near future. For specifics on this and the latest updates, contact the Chaplaincy Taxonomy Review Council at: AAH-chaplaincytaxonomycouncil@advocatehealth.com
- Teach the new system and Chaplaincy Taxonomy paradigm to chaplains and key non-chaplain clinical players (those who engage with chaplaincy's clinical communication) through role playing, lunch & learns, grand rounds, etc.
- Register your institution's use of the Chaplaincy Taxonomy via email at: AAH-chaplaincytaxonomycouncil@advocatehealth.com

> "Chaplains do certain things and perform unique interactions that our clinical partners can know them by. When chaplains consistently name and call those things the same way, it reinforces and magnifies the recognition by others that they do those unique things."

CONCLUSION

To meet the needs of evidence-based medicine and measurable outcomes that value-based health care transformation demands, chaplaincy needs reform in many areas of its traditional scope. Health care chaplains must move quickly to present more uniform practice patterns, evidence for the efficacy of our contribution, and consistency of formation and certification, or risk being further marginalized in the health system. The creation of documentation systems in electronic medical records led many chaplain departments to engineer their own lists of what chaplains do, which may have had no structured methodology other than the personal choices and preferences of the chaplains who developed the lists. When myriad chaplains, and hospitals and health systems produced numerous subjective lists of what chaplains do and why, they did so because no standard truly existed to guide taxonomy choices. As a result, chaplaincy continues to have a diluted and diminished voice in the field of health care.

Alternatively, the chaplaincy field can choose to use a normative language now. The Chaplaincy Taxonomy is a robust, clear, concise and constructive tool for the daily use of chaplains clinically.

The leaders of the Chaplaincy Taxonomy project encourage chaplains to remember that although they may not personally have chosen to word something a certain way, the point of a shared terminology is that chaplaincy will have unified method for making it clear to the health care industry that spiritual care is associated with measurable actions and outcomes. Chaplains perform unique interactions that are identifiable as spiritual care. These interactions become the chaplaincy's professional signature. When we consistently refer to these interactions in the same way, we reinforce and magnify them, and by extension, the chaplains performing them.

For complete list of references please go to:
https://www.healthcarechaplaincy.org/the-chaplaincy-taxonomy-standardizing-spiritual-care-terminology

DISPATCHES *from the* Front

By **Carl Magruder M.A., M.Div., BCC**

"Oh, Peace, bless this mad place!" — THOMAS MERTON

Bald Hills Road hits the border of Redwood National Park, and the badly potholed pavement turns to gravel. A dust cloud billows up from the knobby tires of my old motorbike as I head east from the coast toward the Hoopa Indian Reservation. On my magic carpet, this chaplain finds the space to meditate and reflect on what it means to care for the human spirits of palliative care patients in this rural context.

Humboldt County is staggeringly beautiful, culturally unique, and bucolic. At the same time, the average family income is $12,000 lower than the national average. Humboldt leads the state for gun deaths, suicide, car crashes, and strokes. It is second for alcohol-related liver disease and drug overdoses. The Netflix series "Murder Mountain" is certainly not a complete view of rural Humboldt, but it isn't inaccurate, either. Healthcare is the single-largest employer in the county, but healthcare resources are woefully inadequate.

Enter ResolutionCare, the dream of Michael Fratkin, MD. I first heard Michael on NPR. His critique of the medicalization of dying called to mind George Bernard Shaw: "The reasonable man [sic] adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man."

As a cradle Quaker, all of my heroes have been unreasonable people trying to make the world a better place. I sent my resume to ResolutionCare, hoping their new endeavor would be fluid enough to be shaped around a person-centered approach to wellness. Little did I know that the systems were fluid enough that I would soon call our mission of mercy to Humboldt County "the wild, wild west."

The MediCal pilot program that provided capitated payments for palliative care patients had stipulations which created a particular demographic niche for us. Patients were to have a life-limiting illness such as cancer, COPD, CHF, or liver failure, and not be eligible for Medicare. Thus, much of our census is working class white folks under age 65 who suffer from the "diseases of despair"—alcoholism, morbid obesity, methamphetamine/other drug addiction, tobacco use, depression, and trauma. Low income, low literacy, and low life expectancy are common. For me, it was an abrupt change from the relative idyll of Marin County hospice work.

These patients have particular spiritual challenges, too. In diverse wisdom traditions, the primary obstacle to spiritual growth is what Sigmund Freud called the "ego." For many hospice patients I've worked with, the ego was softening, allowing miraculous spiritual growth, healing, and transformation as death approached. Palliative care patients, still seeking curative treatment, are often in the desperate throes of an ego tantrum. The ego clings to life, desperately insisting that it is inviolate, immutable, immortal, when it is really just terrified. The existential limbo of palliative care provides the perfect environment for spiritual suffering. These souls need spiritual accompaniment.

In the four years since ResolutionCare started, we've launched satellites in Mendocino, Shasta, and Del Norte Counties, and proven our worth, so that Blue Shield and other payers have taken us up. This provides broader socioeconomic diversity to our census, though still selecting folks under 65 who are living with a life limiting illness. [Anytime Medicare wants to start capitated payments for palliative care of seniors, we are ready to enroll them!] We provide much of our care through telemedicine, using the Zoom video conferencing platform.

I sometimes describe us as the Navy Seals of palliative care. You can drop us in from 10,000 feet, and we will bring competent, compassionate care to anyone we meet. Our social worker, Nikki Lang, coined our unofficial motto: "People caring for people by doing what makes sense."

On our way to a joint visit during my early days at ResolutionCare, Fratkin was driving, texting, checking the GPS, trying to get a cardiologist

on the phone, and talking to me. "Eventually, you'll have ghosts all over this town," he told me. "I've taken care of a cat lady who lived there, and a retired firefighter who lived down that street…" Now I have cherished ghosts of my own all over Humboldt County. Here are stories of two people who taught me valuable wisdom:

The Medicine Man. Lucas would never call himself a medicine man or a shaman. The practice of humility among the Hupa, Karuk, and Yurok people means that others may give you an accolade or credential, but you don't hang it on yourself. The first time we met, I kept my body turned toward him, and made good eye contact, as I'd been taught in CPE. Well, that's pretty rude and pushy among most Native Americans in this part of the world. Nonetheless, Lucas and I created a bond. For a respected spiritual leader like him, talking to this outsider helped.

Lucas was a "two-spirit" person, occupying both male and female ritual space. He showed me how to "pick sticks" for baskets and taught me about the tradition of the dance families. He invited me to a "Jump Dance" held on the river for the renewal of the world. I camped in his family camp, feeling the mystical state of the fasting dancers and singers at the close of their ten-day rite. I married Lucas to his life partner, Jonathan, as no local church would marry a same-sex couple, and the clear song he offered as a blessing before the wedding meal belied the state of his health. When he died, he was buried on his family land allotment, where he had also been born a little more than half a century before.

The Gardener. When we first enrolled her, Sally didn't want to know her test results. She'd taken the most intense treatment for her Stage IV cancer, and she didn't want to know if it had worked. "I'm tired of being a patient!" She took advantage of the need for a wig — "I always wanted to be a redhead." She sucked the marrow out of every day by gardening, spending time with friends, taking her dog for walks which got longer and longer, and then shorter and shorter again. I got no answer at her front door one June day, and she called from the side of her tiny cottage. I found her standing barefoot on her back porch in a sundress, aiming a diminutive .410 shotgun at a gopher hole, waiting for the resident to put his head up. I noticed the melted wax appearance of the skin on her upper arm and shoulder. She'd been in a house fire during her childhood that claimed the lives of her older sister and younger brother.

Sally's survivor's guilt later led her into an addiction that prevented her from being the mother she wanted to be for her daughter. Though she'd been a sober and responsible accountant for many years when the cancer diagnosis came on, and the daughter had grown up to have kids of her own, we talked about how little it helped to reason through her regrets, guilt, and shame. "I cannot ever be forgiven," she said. "Is that for you to decide?" I asked. "I cannot ask God for forgiveness." We walked the dog past the Catholic Church with its outdoor shrine to Mary. "Could you imagine telling Mary that you are willing to be forgiven?" Sally couldn't go into the church, and couldn't approach God, but she could stand outside the church where Mary might intercede for her. She made a practice of visiting the Virgin on her walks, allowing herself to approach the possibility of God's forgiveness and self-forgiveness.

> "TO 'LISTEN' ANOTHER'S SOUL INTO A CONDITION OF DISCLOSURE AND DISCOVERY MAY BE ALMOST THE GREATEST SERVICE THAT ANY HUMAN BEING EVER PERFORMS FOR ANOTHER."
>
> -Douglas von Steere

I facilitated some conversations with her daughter, who had long ago forgiven her and became her primary caregiver. Healing poured into their relationship and Sally's life, even as she transferred to hospice to complete her journey.

The Team. As any healthcare chaplain knows, we carry a responsibility for our team members, who are also our teachers. With a budget one-fourth that of hospice, and patient situations our admissions nurse frequently refers to as a "hot mess," my team are at risk for burnout and moral injury. With a "Bug List" on the office whiteboard alerting all to which patients are pediculous or otherwise infested with bedbugs, scabies, fleas, or crabs, they carry on. When a son sells his mother's oxycontin to buy methamphetamine, we make an APS referral, hoping it will do more good than harm. We've had more than one patient spend time in jail. If one of our people goes to the ED, we accompany them so they won't be shamed, ignored or treated as drug-seeking. The excellent Hospice of Humboldt will only travel an hour from their doors, so any further out, we're hospice too.

But we are frontierspeople. Like the wild lupin that grows in the fields along the gravel road flying below my tires, we blow with the wind, take advantage of every drop of water, and bloom where we are planted. There are no hothouse flowers at ResolutionCare. No one says, "That's not my job." We muck in.

My tires roll onto the long bridge over the Klamath. I stop the bike mid-span, drop the kickstand, and hit the kill switch. My boots scrape gravel as I walk to the bridge railing. Looking up, I raise my arms and give thanks for this day, this place, this good work to do.

Carl Magruder M.A., M.Div., BCC *is director of Spiritual Support Services at ResolutionCare. He is currently having his smokejumper boots rebuilt in anticipation of a busy fire season with American Red Cross Disaster Spiritual Care.*

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

Discovering the Ultimate Chaplain on 9/11

By **Paul de Vries, PhD, President of NY Divinity School**

September 11, 2001, in New York City still seems like yesterday. So much of what transpired then and in the days and weeks immediately following remain absolutely vivid in my mind, my heart, and my gut.

As that 9/11 Tuesday played out so utterly painfully, and the scope and ravages of its tragedy were felt and understood even more in the immediate days thereafter, I faced frequent flashbacks to previous community tragedies I had experienced — and at which I had been a first responder. There were constant replayings of vivid images of death and loss. Additionally, there were priceless recollections of Biblical Scripture selections safely stored in my heart and memory. There were also persistent prayers. Our Lord Jesus Christ, what is happening?! How can we feel and affirm your Presence in this profoundly horrific tragedy? Please, *Lord God, help us empathetically understand and compassionately care for the real needs of all the people around us! Please, God, help us to receive fully and share generously your amazing Presence and your awesome healing grace, effectually, now.*

We chaplains are, in a sense, "portable chapels on two legs." As spiritual first responders we seek to represent God's Presence effectually — including through our hearts, hands, and hopes. We know we are in the "Valley of the Shadow of Death," with much evil present. However, we fear no evil, for the Lord is with us.

On the morning of 9/11, my wife and I were on the train, going to our offices from a nearby suburb of New York City — hers for business, mine for teaching. The commuter train conductor made an announcement about the attacks and then turned his personal radio on loudly for all in our train car to hear. Some passengers moved into our train car from other cars to be able to hear updates.

At a major stop, at the train conductor's suggestion, my wife and many others got off to catch the next train back home. I continued into Manhattan to be available as a chaplain, to see how I might help my students and colleagues, brothers and sisters, strangers, associates, and whomever. And my wife and I were both especially concerned for the safety of our son, whose gifted-geek computer consulting office was in the shadow of the World Trade Center (WTC).

Actually getting to my midtown office was a challenge. Out of concern for possible terrorists in the train tunnels, the conductors were not allowed to bring the commuter train closer than the 125th Street station. I quickly found a bus across town to Broadway, but no buses were allowed to go south from there. If there were terrorists on the ground, the city did not want to assist their movement. As I waited for a taxi to hail, I witnessed a man break into a small retail store. He set off an alarm and the police arrived in a minute, while he was still collecting his loot. Perhaps he was hoping that all 40,000 uniformed NYPD officers were downtown helping rescue people at the burning WTC twin towers!

A taxicab came soon, and I asked

Photo by Tor de Vries

to be dropped off at a corner a half block from my office. I caught the spirit of caution. The cabbie was heatedly talking into his cellphone in a Middle-Eastern language. The eerie 9/11 streets zipped by the cab windows, and the smoke rose from lower Manhattan. I paid the cabbie and entered the raw world of NYC streets and sidewalks, now densely populated with pensive, frightened people.

Immediately, I saw a tall, muscular, handsome African-American man in business attire, standing frozen by himself in the swirl of people on the sidewalk on Broadway. And he was weeping uncontrollably. Spontaneously, we two strangers bear-hugged, firmly, silently. Minutes

transpired. Neither of us had words.

"Can I help you, my brother?" I finally asked, softly. "Yes, please!" he exclaimed, his voice cracking. He briefly recounted to me that he was supposed to be at work on the 86th floor by 8:30, but his 12-year-old "disobedient daughter" had made him very late. Always this daughter had been a nearly perfect "angel," but that morning she had been a total pain in the anatomy! She could not find the dress she "had to wear," and then could not find the right shoes to go with the dress. And then she remembered that she had more homework to finish, and she could not bear to go to school without the completed assignment. And he had been yelling at her all the while, and then scolding her all the way down the street as he walked her to the school.

Now, what to do? He was now safe only because his disobedient "angel" had thrown him way off his schedule. (Does God also work through such "disobedient angels?") Briefly we thanked the Lord for his daughter and her Divinely gifted "disobedience" that morning. Then, at my suggestion, he literally bolted through the crowded sidewalks back toward his daughter's school to apologize to her and thank her for saving his life.

I ran too, to my office a half-block away. The safety of our son was weighing heavily on my heart, as well as the welfare of my team, colleagues, students and friends. I guessed that the office — a Grand Central Station in its own right — was the best place for me to reach out to others, and for them to reach me, by phone call or by paying a visit. The cellphone systems were now strained. Sure enough, the second I unlocked the door, the office phone rang.

It was our son on the phone! Thank God! It was our son!

Tor was safe! He had to be in the WTC that day, Tuesday 9/11, and elsewhere on Monday. However, at 3:00 AM Monday morning he had been awakened by a literal voice from the Lord telling him to switch his appointments for the two days — Monday and Tuesday. He had seriously doubted, but obeyed, nevertheless. Faithfully, in spite of not understanding, Tor did his business in the WTC on Monday 9/10, and was many miles away on the morning of 9/11. [Tor's personal testimony, observations and photography are available at: www.RememberSeptember11.us.] We talked for a while. When we hung up, I shouted some grateful praises to the Lord for His voice and His grace — and that our son had obeyed. Faithfully, we have taught our children to hear and to obey the Lord's voice, without fully realizing that the Divine Voice could also save their lives!

That day we counseled others and began our strategy for more first-responder training. I also called a personal friend, a godly man, a church leader, who owned an air-conditioning-heating-engineers office near WTC. How was he? He explained that he had scheduled an expert team meeting at 8:30 AM in a room high in one of the WTC towers, to plan some timely air-quality improvements. He and the other ten engineers were all coming from other places. However, at 7:00 that morning he had an inexplicable horrible feeling about the meeting, and he called everyone to postpone it for another day. God's giving him that horrible feeling saved those eleven additional lives.

Over the following days and weeks, for more than 3,000 leaders, I facilitated timely training for first responders and volunteer chaplains — with special equipping in crisis counseling, and victim ministry.

Nevertheless, we already understand that the ultimate first responder was God himself. Of the estimated 30,000 that were in the WTC towers that morning, more than 27,000 were rescued — the largest rescue from a burning building ever. However, usually there were 60,000 people in the towers on a weekday morning.

That means that approximately 30,000 other people who "should have been" in the WTC that morning did not come to work, to shop, to eat, or to explore — detained by a whole host of amazing factors. The stranger on the street, our son, and the eleven heating-and-cooling engineers on our friend's team were a tiny representative sample of a whole host of Divine protections for women and men who had planned to be in the WTC. Thankfully, their plans were Divinely interrupted. None of them were "better" than those who perished, but we are grateful for those precious Divine interruptions.

As a chaplain, it is an unspeakably precious honor to represent the Lord's Presence to people in need. That morning of 9/11 we were wonderfully, powerfully reminded of the elemental truth that the Lord is the ultimate first responder, showing his Presence, being the ultimate Chaplain for all of us in need — even well before the terrorists did their awful deed.

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

—POET RABINDRANATH TAGORE

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