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Spiritual Care and the New Frontier of Health Care

The Rev. George Handzo, BCC, CSSBB
Director, Health Services Research & Quality
HealthCare Chaplaincy Network

The movement away from the inpatient setting may be the most evident and universal trend in health care in the US and world. This movement is not just to brick and mortar outpatient settings but into patients' homes and the community in general. This is clearly what patients want, and it lowers costs and improves medical outcomes. The current crisis caused by the coronavirus has only heightened the focus on keeping patients who are often older—and by definition sick—out of the hospital where they have a far greater chance of coming into contact with viruses of various kinds. The outpatient palliative care clinic of one major medical center is seeing all patients by telephone or video conferencing. Those who need to be seen in person come in to a specially equipped and staffed clinic space where they can be treated safely. Several other hospitals we are aware of are severely restricting non-essential in person access to patients. In many other practices, patients are seen in their homes either by a regular member of the team or by a specially trained community health provider.

While this movement to outpatient care clearly has its advantages, it also has a great many challenges. Most health care practitioners, including most chaplains, are not trained to work in this way. For instance, being able to see a patient and "be present" with them is foundational to how we assess and intervene. Consequently, providing care over the telephone puts a premium on listening with new intensity and discernment. It can require replacing the data we would normally gather by being able to see a patient with questions we might ask over the telephone. Most chaplains are not familiar or comfortable with the technology needed for video conferencing.

HCCN/SCA has embraced the challenges posed by this new world of health care, and the opportunities it provides. The evidence is very clear that those who are older and sicker arguably have the most pressing need for spiritual care. Isolation at home heightens that need. These well-documented needs provide a mandate for chaplains to find ways to meet and provide the professional spiritual care that these patients require.

Fortunately, we are able to draw on significant experience in this field. Our virtual chaplaincy training and certification program has given us a detailed understanding of how to teach, deliver and evaluate spiritual care via technology. Our years of delivering spiritual care by video conferencing and telephone have given us significant data on how to assess and intervene in these venues. One of the lessons we have learned, for instance, is that patients and caregivers are often far more comfortable with doing spiritual care over the telephone than chaplains are. They value the convenience and, in many cases, the anonymity.

Another obstacle within outpatient care is the transmission of data. In an age where hackers seem always to be ahead of data owners in their sophistication, we must be ever vigilant about protecting the patient data that is so fundamental to our practice. Fortunately, we are engaged with emerging clients who share our values and operate in the community and home-care space. Together we can devise systems that provide the highest level of protection for patient data while enabling chaplains to effectively and efficiently communicate with the broader health care team. We also have valuable lessons to learn from our hospice colleagues who have provided home care for many years.

As health care continues to grow in the outpatient and community settings, we are fully committed to assuring that it is care for the whole person—including the spiritual. These changes will require openness to providing care in ways that have long been considered inconsistent with high-quality spiritual care. However, we have taken up the challenge of overcoming these barriers in the name of providing the best spiritual care to all patients who need and desire it.

To all healthcare workers, first responders, essential workers, and chaplains who are working to keep us safe and healthy around the world

Your selflessness and tireless efforts during the COVID-19 pandemic are what give us hope that tomorrow will be brighter.

Thank you for getting us closer to that moment.

HealthCare Chaplaincy Network™

SPIRITUAL CARE ASSOCIATION
Making Spiritual Care a Priority

A New Paradigm for the Testing of **Competence in Health Care Chaplaincy Certification**

By **The Rev. George Handzo, BCC, CSSBB, Director, Health Services Research & Quality**
HealthCare Chaplaincy Network
The Rev. Susan Wintz, BCC, Director of Professional and Community Education
HealthCare Chaplaincy Network

In 2016, the HealthCare Chaplaincy Network announced a new initiative, the Spiritual Care Association (SCA). The major impetus for this effort was the need we perceived in the field to dramatically raise the integration of spiritual care into health care. The evidence we saw increasingly indicated that, while care for the whole person — including spiritual care — was more frequently valued in the health care system, full integration of spiritual care, especially chaplaincy care, was lagging. Chaplains were not valued and seemed indeed to be losing ground as partners in care.

SCA sought to address this issue for the first time with a coordinated, multipronged effort, which included:

- Supporting and encouraging the production and dissemination of evidence for the efficacy of spiritual care and chaplaincy care, especially to providers, regulators, and payers.
- Strong advocacy on both state and federal levels to fully educate decision-makers on the contributions of chaplaincy care in promoting improved medical outcomes and reduced cost.
- Building a robust, accessible learning platform to help chaplains fill the knowledge gaps that seemed to be standing in the way of full integration of spiritual care.
- Designing and implementing an evidence-based chaplain certification system that could reliably test competence as defined by the health care field.

One of the recurrent themes from the health care field that led to the creation of SCA was that board certification in chaplaincy was not a reliable predictor that the chaplain would deliver high-quality spiritual care. We viewed this feedback as a serious threat to the chaplaincy profession, and to the provision of quality spiritual care to patients and their caregivers. Indeed, the traditional system for certification in health care chaplaincy, which included such elements as relying on a chaplain's self-reports of clinical contacts with a patient of their choosing, was subjective to the degree that it could not perform reliably. There was no attempt to systematically test core knowledge. It was focused primarily on the amount of training a chaplain had, and with whom, as opposed to a focus on demonstrating competence.

Following the model of Competency-Based, Time Variable (CBTV) now increasingly used in medical and nursing education,

SCA developed the first evidence-based quality standards in spiritual care, which led to the first core knowledge test in health care chaplaincy. To evaluate the quality standards and attendant behaviors that need to be directly observed in patient visits, SCA designed and implemented a process that employs professional actors as simulated patients. Certification candidates interact with the patients over Zoom, and the visit is scored by specially trained professional chaplains. This process marks the first time that a chaplaincy certification process has tested clinical competence in health care chaplaincy by observing chaplains doing bedside spiritual care under real-world conditions.

We have now published the results of the simulated patient exams for our first 155 candidates.[1] Our analysis was able to support several important outcomes, and the thorough method used to develop the simulated patient process supports good validity. In a survey of those who took the test, over 90% agreed or strongly agreed that "the items on the scoring sheet I received were relevant to my work." Interrater reliability between the two reviewers scoring the exam was 87% — well within the range normally considered satisfactory. About two-thirds of the candidates passed the test on the first attempt, which is within the range of what is usually considered a good certification exam. We anticipated that a significant number of candidates would find the technology to be a barrier. This did not turn out to be the case, with only about 10% of the candidates reporting any difficulty with the technology.

We have been hoping to test the relationship between the amount of Clinical Pastoral Education (CPE) taken and whether the candidate had a seminary degree on the one hand and whether the candidate passed the test on the first attempt on the other. For many years, the industry standard has been 1600 hours of CPE and a seminary degree although the relationship between these standards and chaplain competence has never been tested. We anticipated that the barrier to this analysis would be that our candidate pool would be too heavily weighted toward the group that did not meet the industry standard. In fact, our candidate pool largely does meet the industry standard which suggests that candidates are choosing to be certified by SCA for reasons other than not being able to meet the industry standard for training. With that limitation, the preliminary finding is the correlations between amount of CPE taken and whether on has a seminary degree and performance on the exam were almost zero.

In the article, we detail lessons learned from the development of the process to date, along with quality improvement and research opportunities for the future. We do hope to do an item-by-item analysis of the candidate's performance to identify prevalent weaknesses that should be responsive to further training. Finally, we conclude that, "On the whole, it now seems clear that this process provides a viable option for any chaplaincy certifying body to test clinical competence." We believe that this process merits a head-to-head trial with the traditional process.

[1] Handzo, G, Wintz, S. (2020) A New Paradigm for Testing Clinical Competence in Chaplaincy Certification. Journal of Pastoral Care & Counseling. 74(1), 53-60. DOI: 10.1177/1542305020904401

RESOURCES & EDUCATION

The Catalog for All Things Spiritual Care

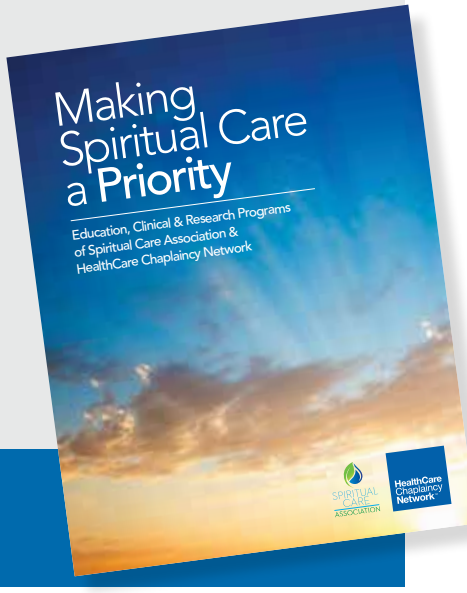
HealthCare Chaplaincy Network and the Spiritual Care Association are the leaders in research, education and clinical care. Since 1961, we have been working to make spiritual care a priority and have created educational opportunities, programs and services to assist spiritual care providers and institutions of a variety of fields the guidance and formation that will meet their specific needs.

Want to know more?

You'll find information on SCA's
- Annual Caring for the Human Spirit Conference
- University of Theology and Spirituality
- Learning Center
- Health Care Chaplain Division
- Nursing Division
- First Responder Chaplain Division
- Hospice Division

And more

Our comprehensive Catalog on Spiritual Care is available by visiting http://healthcarechaplaincy.org/docs/priority/catalog.pdf



Introducing

Corporate Chaplain Division of the SPIRITUAL CARE ASSOCIATION

Spiritual Care in the Workplace

The Corporate Chaplain Division of the Spiritual Care Association is a partnership between SCA and the National Institute of Business and Industrial Chaplains (NIBIC). NIBIC supports the advancement of spiritual care in the workplace. It has established academic and professional criteria for the practice of this specialized chaplaincy professional. These standards help to ensure that skilled, effective chaplains and every person providing spiritual care, counseling and consultation in workplace settings meet the professional standards.

What is a Corporate Chaplain?

A corporate chaplain is an interdenominational, ecumenical chaplain that ministers to people in business and industry settings. They respond to individual and family needs, as well as work-life concerns such as job stress and career. Corporate chaplaincy is preventive, as well as problem-solving. It is a carefully structured ministry that is conducted by carefully trained chaplains, working within the boundaries of cooperative and supportive business industry.

Membership Benefits

Members of SCA's Corporate Chaplain Division will automatically receive dual membership in SCA and NIBIC.

For more information and member benefits, please visit www.NIBIC.com

Chaplaincy with Serious Illness Patients

By **Brian P. Hughes, APBCC, MDiv, MS**

Many often assume that chaplains primarily focus on patients who are dying. Yet chaplains have a central role in providing care for those with serious illness. Serious illness is best defined as a "health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains the caregiver."[1] People live for months, years, or even decades with conditions that used to be considered fatal. As a result, spiritual care with seriously ill patients often can be longitudinal, spread out over more than just a single visit, and often not confined to one particular setting — such as acute care or a skilled nursing facility.

The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care (also known as the NCP Guidelines) functions as the "clinical Bible" for palliative care teams. It states that all people with serious illness should have access to palliative care, and that this care should be "aligned with patient-family preferences and goals."[2] It can be challenging to explore with families their preferences and goals, and the values that underlie them. When chaplains play a leadership role in values discussions with patients and families, this contributes to a better understanding of the non-medical factors influencing decision-making.

A recent article describes a multisite randomized control trial for 210 Parkinson's disease patients and 175 caregivers, comparing those who received outpatient palliative care — with chaplains as integrated team members — with those who received standard care. The chaplains in the study are specifically described as having experience with Parkinson's disease patient care. This study demonstrates that those receiving the palliative care had a marked improvement in quality of life, better symptom burden, and better rates of advance direction completion.[3] Chaplains assist in exploring values and beliefs with patients and families, as well as helping them with anxiety, managing change in function and role, grief, bereavement, and spiritual well-being.

In addition to focusing on the patient with serious illness, chaplains often provide in-depth and nuanced spiritual care for caregivers as well. One study looked at chaplains providing caregiver support to seriously ill patients, focusing specifically on relationship review, forgiveness, and legacy.[4] This gave the caregivers a much-needed and appreciated opportunity to reflect on making meaning, adjust some processes or areas of focus, and improve quality of life, anxiety, and spiritual well-being.

There are ample opportunities in healthcare to proactively integrate chaplaincy care with those who are seriously ill. One study reflected the struggle of how chaplains are often utilized close to end of life in the intensive care units of the hospital, rather than being consulted sooner, when they are able to make more substantive contributions to the plan of care, well-being of the patient and family, and issues concerning grief, bereavement, anxiety, and meaning making.[5] As a result, chaplains were only consulted on less than 6% of ICU patients, therefore missing many opportunities to make a unique positive impact.

Chaplains provide evidence-based, best-practice spiritual and emotional care when working with those with serious illness, and their caregivers and loved ones. They serve as an important member of the interdisciplinary care team, providing leadership and care that helps explore the patient values and beliefs, which in turn impacts their health care choices and outcomes.

The Rev. Brian P. Hughes, APBCC, MDiv, MS *is the Director of Programs and Service for HealthCare Chaplaincy Network. A passionate chaplaincy advocate, he is the assessor for the Excellence in Spiritual Care Award, a consultant, and a chaplaincy researcher. He has worked as a chaplain in New York City, Dallas, Phoenix, and Philadelphia, and lives with his wife and two elementary school-aged children in Dallas, TX.*

[1] Kelley, A. S., & Bollens-Lund, E. (2018). Identifying the population with serious illness: the "denominator" challenge. *Journal of palliative medicine*, 21(S2), S-7.

[2] National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp.

[3] Kluger B.M., Miyasaki J., Katz M., et al. Comparison of Integrated Outpatient Palliative Care With Standard Care in Patients With Parkinson (would this not be "Parkinson's"?) Disease and Related Disorders: A Randomized Clinical Trial. *JAMA Neurol*. Published online February 10, 2020. doi:10.1001/jamaneurol.2019.4992

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Health Care Chaplain Division of the
SPIRITUAL CARE ASSOCIATION

Thinking About Becoming a Health Care Chaplain?

The Health Care Chaplain Division of the Spiritual Care Association focuses on the spiritual dimension of professional health care chaplains in a number of varied clinical settings. SCA, in partnership with its 60-year old affiliate, the HealthCare Chaplaincy Network (HCCN) supports the advancement of health care chaplaincy and spiritual care as an integral aspect of whole person care for all.

Benefits of Membership

- Belong to a supportive professional community that welcomes both novice and seasoned health care chaplains
- Access to current best-practice standards of spiritual care for those of all faiths and no faith preference. Be notified of new research publications related to spiritual care
- Discounted price for online professional educational courses
- Three free Spiritual Care Grand Round Webinars annually with CEU credit
- Discounted registration for the Annual Caring for the Human Spirit® Conference
- Free electronic subscription to the Journal of HealthCare Chaplaincy
- Free subscription to the Caring for the Human Spirit® Magazine
- Free Spiritual Care Tip of the Day emailed to you
- Free access to over 15 years of PlainViews® articles and archives
- Membership directory and networking opportunities
- Opportunities to present at a national level and/or publish an article or be featured in our various publications
- SCA Membership card will be mailed to you

To become a member or for more information, visit www.spiritualcareassociation.org/health-care-chaplains

The Evolution of the Spiritual Care Association from The Hospital Chaplaincy

A PERSONAL PERSPECTIVE

By **David B. Case, M.D.**

As I step off the Board after more than 20 years of service, I find myself reflecting on how much this organization has changed and why that has happened. From its inception, this chaplaincy has inserted a spiritual care giver onto the team of healthcare professionals in the hospital setting. The mission of what is now the Spiritual Care Association has expanded to teach the rendering of spiritual care to professionals and volunteers, as well as clergy, in environments outside of the hospital. These remarkable changes characterize the dedicated and talented staff of the organization and its Board of generous supporters.

The forerunner of the present Spiritual Care Association was incorporated in 1961 as the East Midtown Protestant Chaplaincy with Protestant clergy on the east side of Manhattan who were encouraged to provide a hospital presence for their patients. Eventually, this hospital-based ministry hired one dedicated hospital chaplain. In 1977, these groups and the full-time chaplain merged with a women's volunteer group founded in 1874 that furnished bibles and fruit to patients in the city hospitals, thereby forming The Hospital Chaplaincy.

In the early 1980s The Reverend John Twiname took over leadership of the organization, and with the able help of his wife, Carolyn, transformed this small chaplaincy program into an internationally recognized model for multifaith pastoral care ministry, education and research. Specifically, Twiname made a transition from Protestant/Christian orientation to one that included all of the other faith traditions: Jewish, Muslim and other communities. He journeyed up to Harlem and met with the Board of Rabbis to enable recruitment of the first Muslim and Jewish chaplains. Beyond that, he changed the business model to one in which hospitals paid for the organization's chaplaincy services. In addition, Reverend Twiname solicited the interest and financial support of businesses and philanthropic individuals. In order to fund continuing pastoral education (CPE), Reverend Twiname organized the longstanding fall Gala, a fundraiser that invited a wide range of participants and bestowed honors on chaplains and other caregivers from the Chaplaincy's network of hospitals.

The Reverend Doctor Walter J. Smith, S.J. succeeded Reverend Twiname in the 1990s and continued the expansion of services to hospitals, training of chaplains and supervisors, and support from philanthropy. When Father Smith asked me, an internist and medical school teacher, to join the Board of the HealthCare Chaplaincy (HCC) in 2001, I wondered why he had recommended me. After all, I did not have much experience with chaplains in the hospital, nor were we able to be major contributors. Father Smith was in the process of enlarging the Chaplaincy Board, with special attention to health care providers. He also focused on broadening its diversity and reach to all faiths, and he even included those who do not belong to any faith community. I soon learned what an important role HCCN played in training chaplains, providing chaplains to some hospitals, and supervising their activities in many New York City and nearby hospitals. In addition, as part of the continuing pastoral education, training and supervision activities, a robust research program was developed

Under Father Smith's leadership, the organization's activities expanded across the country, leading to the preparation of a "white paper," a document used to describe and validate the role of chaplains in healthcare. With this came the development of common standards for healthcare chaplaincy in order to justify specialty certification. Once this certification process was completed, it was gifted to the Association of Professional Chaplains. During Father Smith's tenure, a major grant from The Templeton Foundation was awarded, which created the first standardized terms and language about what chaplains do.

As successful as the HCC had become, several changes in the health care environment became a challenge to the HCC and its well-developed programs.

First, several major hospitals decided to run their own chaplaincy programs, both to contain costs and to exert their need for independence. Second, a significant percentage of medical and surgical practices moved out of hospital inpatient service to outpatient venues, due to the increased expense of hospital stays and the technological development of safe and effective office and ambulatory care methods. Third, the training programs for chaplains that had traditionally required candidates to set aside a year or two for post-graduate chaplaincy training—often away from their families and at considerable expense—began to lose popularity. Given the shift away from the need for hospital care and the constraints of training, the HCC leadership explored the possibility of developing a larger presence in the growing field of palliative care. In the absence of significant philanthropy to support the construction of a palliative care center, however, attention was turned to other options.

At this point in 2014, Father Smith stepped down from the Presidency and Alzheimer's Foundation head Reverend Eric Hall was selected to lead the HCC. Within a very short time, Hall and his team began a program to take the HCC to international sites, create new methods for CPE and board certification, and embrace other healthcare groups for spiritual care training: nurses, first responders, physicians, social workers, palliative care and hospice workers, and volunteers. The name of the organization was changed to the HCC Network or HCCN. Programs for these non-clergy healthcare groups were developed and expanded rapidly. In 2016, the Spiritual Care Association was founded to more directly reflect the mission of the evolved HCCN organization, which was no longer primarily hospital-based.

Reverend Hall and his energetic staff initiated the Caring for the Human Spirit Conference, an international conference that initially presented the findings of the John Templeton Foundation's research. With each succeeding year, this meeting has drawn hundreds of attendees from all over the world and from all backgrounds, and it features a broader curriculum base that includes all aspects of spiritual care.

The programs of the SCA differ from the "chaplain-based" ones in several ways. Religious endorsement is no longer required for certification. In the SCA domain, CPE and courses for spiritual care certification for each group of caregivers became online. In the SCA domain, CPE and courses for spiritual care certification for each group of caregivers became available online, with a distinct effort to align them with those of other health professions through the introduction of evidence-based or knowledge-based curricula. In addition, standardized patients (highly skilled actors) are used to simulate patient encounters to elicit specific competencies in a uniform manner. These kinds of educational and evaluation methods ensure that core knowledge is provided, and the skills and performance of a spiritual caregiver can be measured objectively without the variables of patient heterogeneity and supervisor bias.

To unite all of these efforts, SCA separated from the Association for Clinical Pastoral Education in 2019 and partnered with the Institute for Clinical Practice Training, which is more tailored to the general spiritual mission of the SCA. Most recently, the newly founded SCA University of Spiritual Care and Theology joined with the SCA, thereby providing an academic base for spiritual care education and training.

By training and certifying more healthcare professionals and volunteers in spiritual care, the SCA is positioned to address some of the major problems that face not only the United States but other nations. The diminished influence of modern religions is evident in the reduced numbers of registered members or attendees of worship, and there has arisen an epidemic of loneliness that leads people to seek comfort in trusted relationships with caring individuals, particularly in times of physical, social, and spiritual need. We read about mass shootings, increased numbers of young people who take their own lives, deaths from drug overdoses, flaunting of rules and laws that bind us together, and other issues that indicate a widespread malaise—and a place for well-trained individuals to step in, using spiritual care methods with proven value. This nation and the world are now facing one of the most serious crises in recent history: the pandemic of COVID-19 and its devastating health, economic and emotional impact. In response to this, the SCA has built a new website, www.atimeforcompassion.org, which will provide spiritual guidance and link to a free opportunity to speak with a chaplain by phone. The SCA deserves our support, especially in this timely mission.

I feel honored and privileged to have served this wonderful organization, and I intend to continue to support it and remain connected to its mission. As a physician, I have seen the difference between physical care and spiritual care. It is my hope that in years to come, spiritual care will be incorporated into the curriculum of medical students, nurses and others. This is an optimal time in the history of healthcare for the inclusion of spiritual care, and the SCA is the organization that best meets the challenge of making that happen.

David B. Case *is a retired internist and cardiovascular specialist who taught at the medical schools of Cornell and Columbia. He was a founding partner of New York Physicians, LLP and a recipient of the Lifetime Achievement Award from the Healthcare Chaplaincy. He is a Master of the American College of Physicians.*

First Responder Chaplaincy for the 21st Century

By **Rev. Fr. Jeff Wolfe**

First Responder Chaplain Division — a Resource for All First Responder Chaplains and First Responder Chaplain Organizations

The Spiritual Care Association (SCA) recently announced the formation of a First Responder Chaplain Division (FRCD). The goal of the Division is to support the continuing process of professionalization for First Responder Chaplains (FRCs) and their emergence as a chaplain specialty among other professional chaplains. The Division also facilitates dialogue among the major First Responder Chaplain Organizations (FRCOs) for the purpose of standardizing and raising the level of relevant training, and sharing and developing best practice.

All FRCs adhere to some form of code of ethics, whether through an FRCO such as the International Conference of Police Chaplains, the Federation of Fire Chaplains, the International Fellowship of Chaplains, and the National Police and Fire Chaplain Academy, or through their local jurisdiction. All have basic requirements for training and practice. All have requirements which mandate continuing education. These are critical to the formation of a new professional group.

Since 9/11 there has been huge growth in professional chaplaincy in all segments of our society. When we think of a professional chaplain, we no longer only think of the hospital chaplain or military chaplain. There are now nursing home chaplains, palliative care chaplains, trauma center chaplains, corrections center chaplains and

First Responder Chaplain Division

of the

SPIRITUAL CARE ASSOCIATION

Are you a fire, police, or first response chaplain? Are you a volunteer or community leader looking for more training in spiritual care for crisis, trauma, and disaster first response?

Then the First Responder Chaplain Division of the Spiritual Care Association is perfect for you!

The First Responder Chaplain Division of SCA focuses on the spiritual dimension of professional first response practice including professional chaplains, volunteers, community leaders, and all members of a first response team.

Join Us!

EARN YOUR CRISIS, TRAUMA, AND FIRST RESPONSE CERTIFICATE

The Crisis, Trauma, and First Response Certificate Course for Chaplains provides the basic and fundamental skills and knowledge needed in order to provide chaplaincy spiritual care to those people who have been impacted by an emergency, crisis, trauma, or disaster. Upon completion of this online, self-guided course, you will earn the Crisis, Trauma, and First Response Certificate.

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The SCA's comprehensive training manual is a resource for those who currently provide spiritual care as members of a first response team, or who desire to begin a chaplaincy component within their team. Drawing on national expertise in the fields of first response, emergency, and disaster chaplaincy and volunteer management, this manual addresses key areas such as diverse and vulnerable populations, communication skills, psychological first aid, and more.

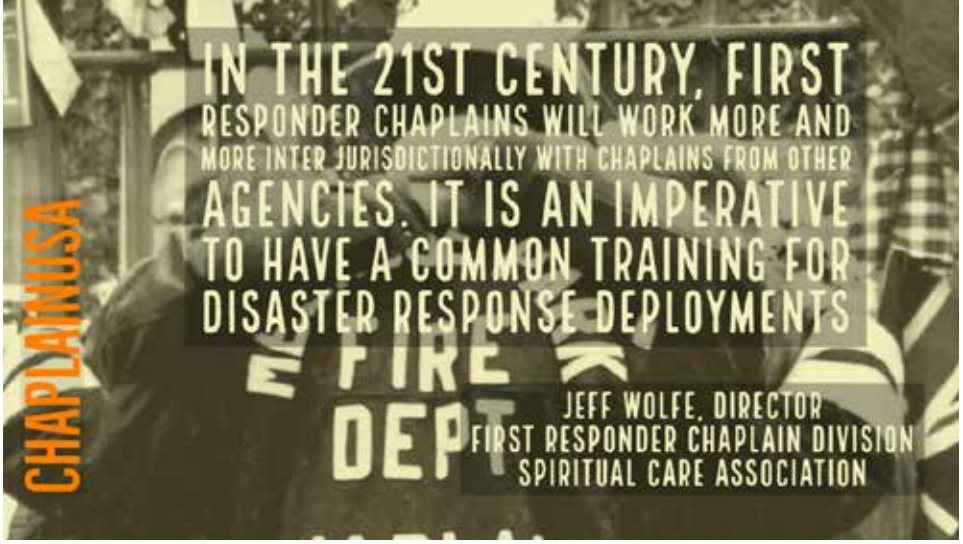
Learn More at www.spiritualcareassociation.org/first-responder-chaplains

corporate chaplains. The public is also becoming increasingly aware of police, fire, EMS and disaster chaplains, who are now more commonly known as *First Responder Chaplains.*

In order to serve the ever-increasing needs of first responders, 21st century First Responder Chaplaincy must become a profession recognized by its peers in both chaplaincy and the first responder community. If FRCs want to be *effective* chaplains, advanced-level training will become the new minimum core competency.

SCA was founded on an evidence-based approach to chaplaincy education, training and deployment. The FRCD of SCA aims to become a collaboration partner with other FRCOs to:

- Identify best practices across FRCOs
- Establish standard certification and training for areas outside FRCOs' typical core competencies, such as Disaster Response Chaplaincy
- Become a conduit of direct communication with FRCs and FRCOs.
- Be a vehicle for future collaboration on specific needs within the first responder community, such as police and firefighter suicide
- Be an advocate for FRCs and FRCOs



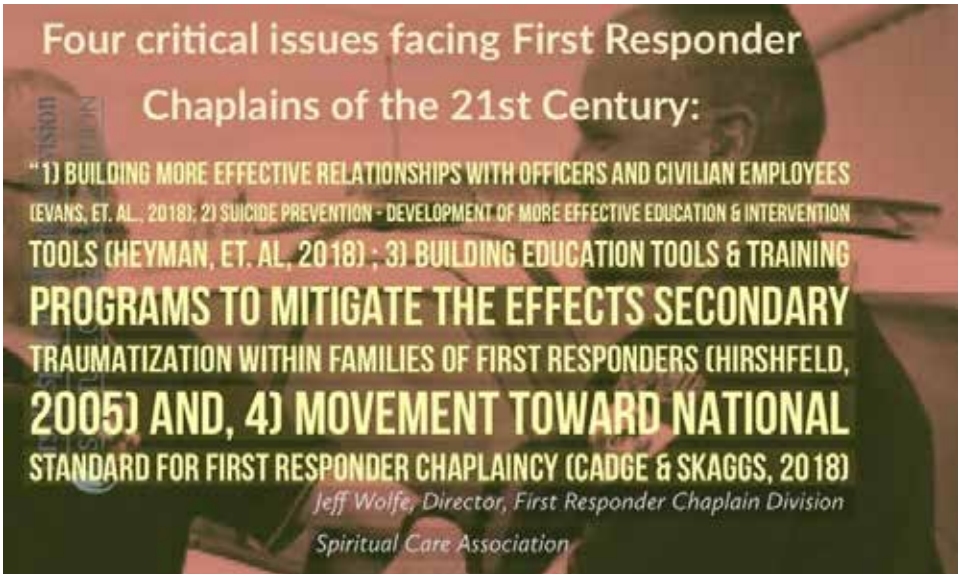
As the weeks and month progress in 2020 and beyond, the FRCD will:

- Continue to hone its mission/purpose, goals and objectives in collaboration with the FRCOs
- Seek out best practices not only among current FRCOs, but also among other chaplain communities
- Work with the FRCOs to move toward a national standard for disaster deployments
- Work with the FRCOs to determine and adopt basic and advanced-level knowledge tools and skillsets

A PROFESSIONAL FIRST RESPONDER CHAPLAIN ADOPTS BEST PRACTICES

BEST PRACTICE *commercial or professional procedures that are accepted or prescribed as being correct or most effective. Example: "the proprietors are keen to ensure best practice in food preparation, storage, and serving"*

— Oxford Online Dictionary



There are four critical issues facing First Responder Chaplains (FRCs) in the 21st century:

- Building more effective relationships with first responders and civilian employees (Evans, et. al., 2018)
- Development of more effective education and intervention tools for suicide prevention (Heyman, et. al., 2018)
- Building educational tools and training programs to mitigate the effects of secondary traumatization within families of first responders (Hirshfield, 2005)
- Movement toward a national standard for First Responder Chaplaincy (Cadge & Skaggs, 2018)

To even begin to address the four critical issues facing FRCs in the 21st century, especially removing suicide as the number one killer of police and

firefighters, FRCs must find ways to collaborate, share, and adopt best practices. Many are already widely shared. Regardless of which FRCO has credentialed FRCs serving local police, fire and EMS personnel, these are the methods and tools which time and again have proven effective — whether serving the LAPD, the Minnesota Fire Department, or the EMS personnel at a local hospital in Orlando, Florida. One example of a best practice would be Critical Incident Stress Management or CISM. FRCOs already have the same basic core competency courses. Consistency of FRC education, training, expectations and outcomes is necessary and must be congruent among all FRCOs to begin the process of becoming a true profession (regardless of whether a paid chaplain or a volunteer[1]).

We are still working on finding a best practice for Suicide Prevention and Intervention (SPI). We know from FRCs working with police and fire that chaplains are trained on the topic of SPI; however, if the FRCs don't build a relationship with the officer or firefighter before the critical incident occurs, neither will think of the chaplain before either contemplating suicide or attempting to complete it. As of last year, suicide is the #1 killer of police officers and firefighters,[2] followed by line of duty deaths. Despite this, some FRCs are either not taught the topic at all, or they may have been taught to employ the knowledge for a different audience, and they can't adapt it to first responders.

We also do not have a best practice for building relationships with first responders, or as a colleague of mine would call it, "face time with first responders." Job number one for all FRCs is getting "face time" or building relationships with those first responders. *All the best practices and chaplain training in the world will not be utilized by an FRC unless they have established at least an acquaintance with the officers, firefighters, dispatchers, EMS personnel, and civilian employees of the public safety agency they serve, BEFORE a critical incident occurs.*

LEARNING THE "TOOL" TAKES TRAINING: USING THE "TOOL" CORRECTLY TAKES EXPERIENCE

Critical to understanding what makes a crisis intervention model successful is the recognition that no one model will always fit every situation.

"Crisis Intervention Model - What Makes One Fail"
— Crisis Consultant Group, LLC

Have you ever gone to fix something on your car and realize you don't have the correct tool? It can be the most frustrating thing. If you are like me, you try to fix it with what you have. But not being MacGyver, I usually use the wrong tool and make the problem worse. Then there are those of us who read a book once about the tool, and just like that, we think we know everything there is to know about how to use the tool. And then when we go to use this new tool for the first time, we use it incorrectly and make the problem even worse, all because we didn't understand the nuances of the tool's use in appropriate situations. *Training on best practices must also include mentoring and observation in practice sessions before the chaplain is released for field work with first responders.*

As a First Responder Chaplain, we carry an invisible equipment belt of tools to a run, scene, or contact with an officer or civilian employee. These tools are the skills and knowledge we have learned, hopefully through instructor-led classes and field training with an experienced First Responder Chaplain. Some of these tools are not "one size fits all." Each run, officer, firefighter, EMT and scene is unique. As a First Responder Chaplain with our invisible tool belt, we must know not only *how* to use the tools in a split-second assessment of a scene or encounter with a first responder, but also *when* to use which tool. Sometimes a situation calls for no further intervention than our physical presence and silence. This can be the most difficult part of being a First Responder Chaplain. *A best practice does not yet exist for how to make a split-second assessment of a scene or a first responder before we decide how we as FRCs can be helpful. The FRC must first DO NO HARM.*

As a Boy Scout, I learned the scout motto. For those who haven't been in Boy Scouts, you may still have heard the phrase "Be Prepared." Lord Robert Baden Powell, founder of what has become the modern-day Boy Scouts, explains what he means: 'Be Prepared' means you are always in a state of readiness in mind and body to do your DUTY."

This is the same motto First Responder Chaplains should adopt. But what exactly does that mean? The knowledge and skills we most recently learned as new First Responder Chaplains become the tools we go to because they are fresh in our mind. Sometimes they work as we learned in class, but sometimes those recently learned tools fail us miserably. New and seasoned First Responder Chaplains alike often try to apply the same set of tools to every situation. But when we arrive on a scene or are talking with a first responder (police, firefighter, EMS personnel or disaster response worker) who appears to be having difficulty with the scene or some other unrelated issue, we can make the situation worse by applying a tool that is not needed. *Assessment before acting is critical as an FRC to ensure we do not rush in where angels fear to tread.*

CHAPLAINCY IS AN ART AS MUCH AS A SCIENCE

Chaplains' biggest gift is to be present and listen.
— Diane Johnson, American Novelist, Pulitzer Prize Recipient

First Responder Chaplaincy is as much an art as it is a science. The *art of chaplaincy* is knowing what to look for in an individual. Not all pastors make good First Responder Chaplains, and not all good First Responder Chaplains are ordained clergy. During recruitment, the staff chaplain or volunteer manager must know through observation and intuition whether the applicant possesses a calling to First Responder Chaplaincy. The applicant may lack the ability to actively listen or may speak about themselves throughout the entire interview. These applicants will not be successful as an FRC, even if they receive proper training.

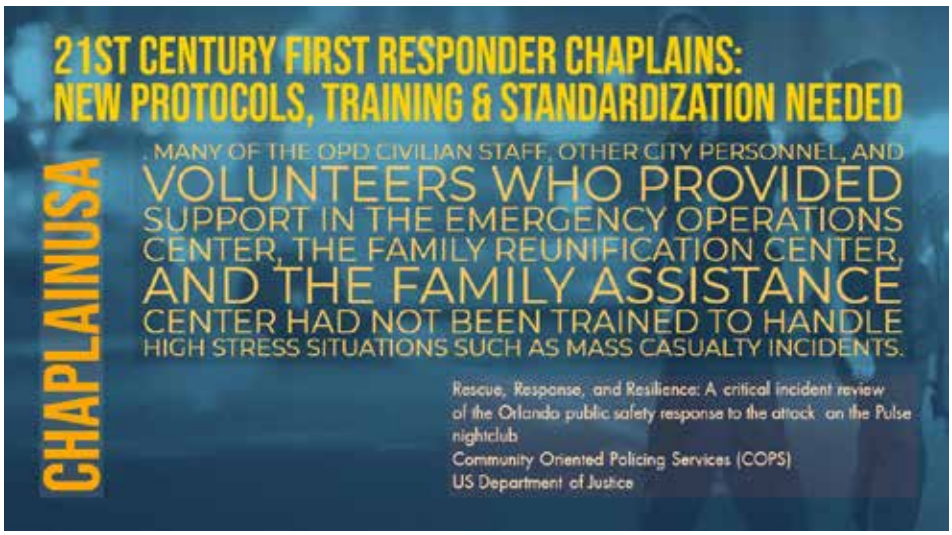
The *science of chaplaincy* is the knowledge we receive in training that we can use successfully in the field. The training can be in Emotional and Spiritual Care, Crisis Intervention, Disaster Care, Compassion Fatigue, Secondary Trauma, Legal Aspects Chaplaincy, Ethics, Contact with First Responders, Face Time with First Responders and their Families, Long Term Recovery, or Suicide Prevention and Intervention. Even learning basic tenets of other religions (especially around death and burial rituals) and knowing how to intervene with those of no religion, are just some of the tools we can acquire as First Responder Chaplains.

Then there are tools that some individuals already have before even starting First Responder Chaplain training, including reading body language, assessing when someone wants to be alone, sensing whether a person wants a hug or whether they do not want to be touched—possibly for cultural or religious reasons, and knowing when an officer does or doesn't want to speak with you. Some individuals may not even realize they have these skills; it's just something they unconsciously know how to do. For other First Responder Chaplains, these skills can be developed if given the proper mentoring by a Sr. Chaplain during field training. Yet others will decide that these skills are ones they cannot or do not want to develop, and so chaplaincy is not for them.

EVERY CHAPLAIN NEEDS BASIC TRAINING

Chaplaincy is not about the Chaplain's faith nor proselytization; it's about the faith, or no faith, of those we serve. Meeting their human needs. Bringing a sense of sacred into the mundane.

— Jeff Wolfe, Director
First Responder
Chaplain Division
Spiritual Care Association



Regardless of whether someone is brand new to First Responder Chaplaincy serving as a Police Chaplain, Fire Chaplain or EMS Chaplain, or they have been a First Responder Chaplain for 20 years, learning new tools and how to use them in appropriate situations is a *continuous process.* Basic Chaplaincy covers what the title implies – the basics. New skillsets and knowledge include but are not limited to: Command Structure; 10 Codes, The First Responder Department's General Orders (and if your chaplain office has them, Chaplain General Orders); radio communications; writing and submitting chaplain run reports; crime scene protocols and procedures; Red Cross basic first aid, CPR/AED for Pediatrics and Adults; Psychological First Aid; Spiritual and Psychological

First Aid; Skills for Psychological and Emotional Recovery; Grief Counseling and support; Suicide Prevention; Emotional Survival for Law Enforcement (Gilmartin); and How to Build Relationships with Officers. These topics may be considered basic tools, depending on the FRCO and the police department, fire department, or EMS company or department.

When someone joins a professional chaplain organization such as the International Conference of Police Chaplains (ICPC), the International Fellowship of Chaplains (IFOC), or the Federation of Fire Chaplains (FFC) they can learn these tools, including when and how to use them appropriately to be an *effective chaplain*. For example, there are 12 basic courses[3] required by ICPC in order to receive their Basic Chaplain Credential:[4] Introduction to Law Enforcement Chaplaincy, Death Notifications, Stress Management (burnout, compassion fatigue, CISM, post-shoot trauma), Ceremonies and Events, Confidentiality and Legal Liability, Ethics, Responding to a Crisis, Law Enforcement Family, Substance Abuse, Suicide, Death and Injury, and Sensitivity and Diversity. If you covered an overview of CISM in chaplain basic training, it does not mean that you as a First Responder Chaplain now understand when and how to implement a tool such as CISD, CMB, Safer-R, or Defusings. These are considered advanced tools that require extensive training, role-playing, observation by qualified instructors, and passing a written test.

FIRST RULE OF CHAPLAINCY: DO NO HARM

Should we encourage a person to talk about trauma immediately? Maybe not. The World Trade Center tragedy showed us much more harm than good would have been done had we pushed firemen and police officers into full-scale interventions early on.[5]

— Rev. Dr. David Fair, PhD., CTS
Master Chaplain, ICPC

The first tenet of being a good chaplain in the 20th or 21st century is "Do No Harm." Most chaplains go through some type of training. Larger departments may have their own Chaplain Academy (anywhere from 21-40 hours of classroom training and 0-6 months of field training). Some smaller departments may employ field training with a seasoned chaplain until he or she thinks you "get it." Other small departments may take any clergy they can get. For this individual, it's "on-your-own, on-the-job training" – the most dangerous type of chaplain, because he or she is not a member of any FRCOs and may be unaware they (or formal training and credentialing) exist.

AN EFFECTIVE CHAPLAIN CONTINUOUSLY LEARNS

Regardless of department size, 21st century chaplaincy demands that all First Responder Chaplains (police, fire, EMS, and disaster chaplains) have at least up-to-date basic training and begin adding useful tools to their chaplain toolbelt. Since 9/11, there is a need for more advanced chaplain training to keep up with the evolving needs of those served by First Responder Chaplains. For example, the United States has more mass shootings than any other country.[6]

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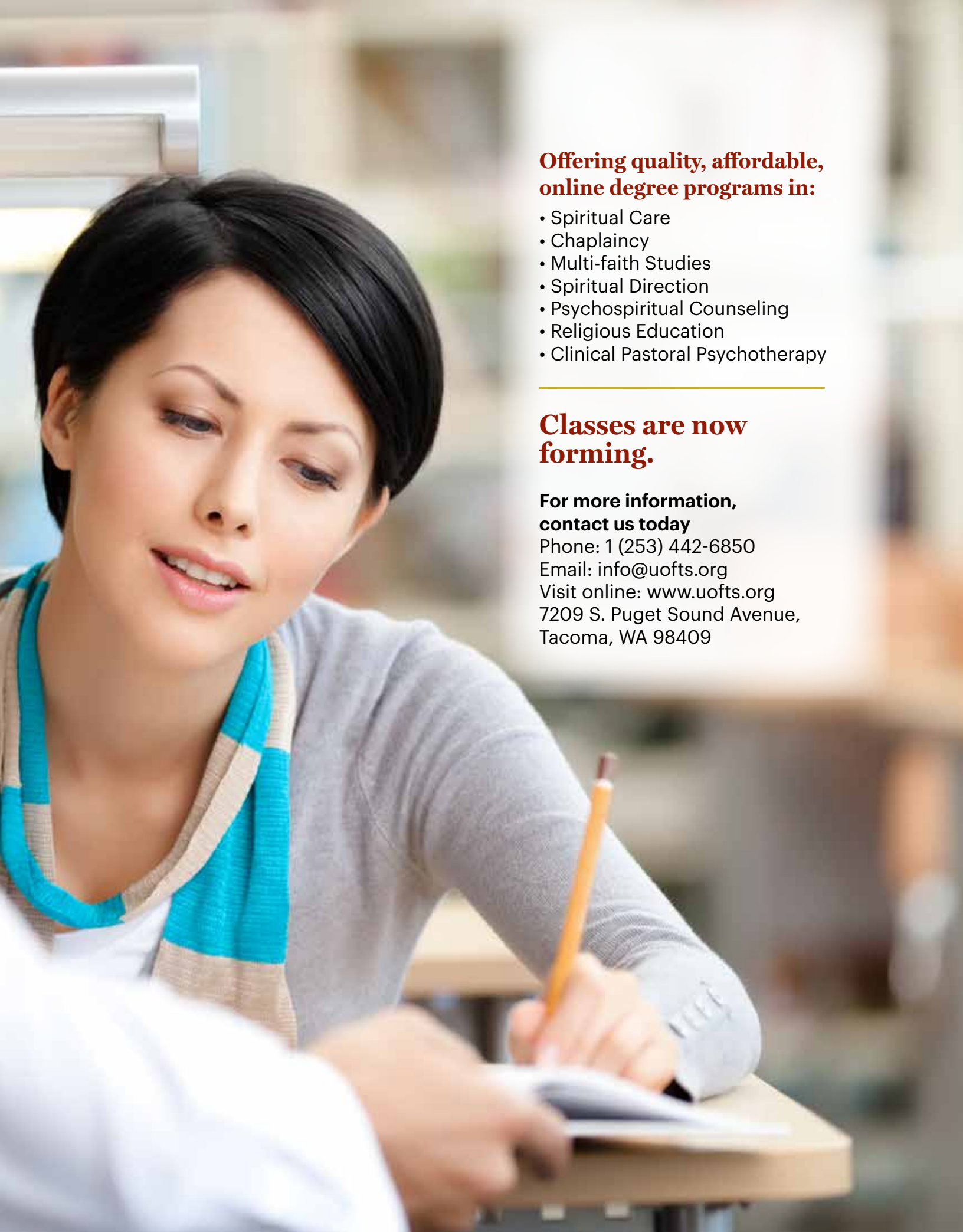

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According to the *New York Times*:

> *Mass shootings have risen drastically in the past half-dozen years.*
>
> ***There were, on average, 16.4 such shootings a year from 2007 to 2013, compared with an average of 6.4 shootings annually from 2000 to 2006. In the past 13 years, 486 people have been killed in such shootings, with 366 of the deaths in the past seven years. In all, the study looked at 160 shootings since 2000. (Shootings tied to domestic violence and gangs were not included.)*** [7]

Suicide is the #1 killer of police officers and firefighters[8] (line of duty death is second). Global warming has changed weather patterns to the extent that tornadoes, floods, and hurricanes are not only more frequent but more intense. Yet Basic First Responder Chaplain Training in the 20th century covered none of these topics. Was it because there were no officer suicides in the 20th century? In many instances, we still don't consider suicide prevention a required basic course.

Many of the previously mentioned organizations were founded in the 20th century in recognition of the fact that police chaplains or fire chaplains (where roughly 90-95% of First Responder Chaplains are volunteer) might be able to pool resources and talent to learn from one another. Structured training for a department in Sacramento could be shared with chaplains serving in Indiana. Today it means that medium and smaller-sized police and fire departments without their own First Responder Chaplain training program can grow their experience and wisdom through collaboration with a First Responder Chaplain Organization.

Over the next several months, the FRCD will add to the current 38-hour online certificate course "Crisis, Trauma, and First Response." The FRCD will collaborate with other FRCOs, Department of Homeland Security's Center for Faith Opportunity Initiatives, and other National Organizations Active in Disasters (novad.org) such as the Red Cross to determine best practices for Disaster Response Chaplains, and establish an advisory board consisting of members from other FRCOs and FRC experts. This FRCD advisory board will guide the FRCD into the future with new tools and skillset training that meet the ever-growing needs of First Responder and Disaster Response Chaplains — and begin to establish First Responder Chaplains as a profession respected among its peer groups.

Jeff is the Director of Spiritual Care Association's First Responder Chaplain Division, an Adjunct Professor SCA University of Theology & Spirituality, a Contributing Editor and Writer for ChaplainUSA.org, a Franciscan Priest, and a Chaplain with Indiana Guard Reserve.
He can be reached at: jwolfe@spiritualcareassocation.org

[1] 90-95% of First Responder Chaplains are volunteer

[2] Heyman, Dill, and Douglas, "The Ruderman White Paper on Mental Health and Suicide of First Responders", ©2018, Ruderman Family Foundation, section on White Papers and Research

[3] Currently there are 12 basic courses required by the International Conference of Police Chaplains. In 2020, some of these courses will be combined into one course, and others will be introduced for the first time, such as Suicide Prevention and Intervention [source: Current ICPC Board Member.]

[4] See http://media1.razorplanet.com/share/510898-4965/resources/1310118_CredentialingPamphlet201712.pdf (website link to ICPC's Credential Pamphlet). For more information visit http://www.icpc4cops.org/credential/index.html.

[5] Fair, PhD, CTS, Dr. David, from ChaplainUSA.org's Facebook Group "Police Chaplain Coffee Shop" post by Dr. Fair in 2019

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[7] Schmidt, Michael S., Reporter, The New York Times, Sept 24, 2014, © 2014 The New York Times

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Social Determinants of Health: The Role of Faith Community Nurses and Congregations

By **Caryn Paulos MSN, RN-BC and S. Denise Brown MSN-ED, RN-BC**

Social determinants of health (SDOH) is currently the new buzz phrase in health care. Although the terminology feels new, the concepts have been around forever. Understanding what SDOH are and how they impact individual health varies based on who is addressing the topic. According to Healthy People 2020, social determinants of health are the conditions that people live in. Living conditions include the home, workplace, school, worship, and play.[1] This definition can be expanded by the basic premise that a person's environment, resources, and emotional state impact the individual's health and their health outcomes.[2] Meeting basic needs for food, shelter, resources, emotional support and spiritual care is fundamental to ensuring social determinants of health do not negatively impact health and well-being. A person can have an illness addressed by healthcare, but if they cannot meet basic needs for life or lack hope, they will continue to have health issues and become a burden in the current health care system environment.

The impact of poverty, malnutrition, unsafe neighborhoods, unstable housing, and poor education on individual health and well-being is widely documented. However, making the connection between poor social conditions and health is not commonly made. What we are beginning to learn is that there is a direct connection between the two. For example, poor nutrition and access to healthy food has been identified as having a significant impact on health. Not only does poor nutrition negatively impact the growth and development of children but it also effects immunity to disease and healing for all ages. Poor performance in school is also linked to hunger and inadequate nutrition, which can lead to chronic poverty and lifelong impact.

Lack of transportation and availability of safe walking paths is another significant barrier for individuals in meeting their health needs. Research has shown that approximately 3.6 million people missed medical appointments, physical therapy appointments and medical testing, or did not have access to prescription medications due to no transportation.[3] Social activities and spiritual connections are also limited by transportation needs. This is especially true in senior populations. When people are cut off from activities they once participated in, or are not able to be with family and friends or attend social gatherings, the consequences are great. Social isolation can result in depression, hopelessness and further deterioration in physical health.

Poor housing conditions or the lack of a secure place to live has a wide-reaching impact. Where you live effects your health, and zip codes can have a greater impact on health than a person's genetic makeup. Environmental factors and deteriorated housing conditions lead to illness and chronic diseases. High-poverty neighborhoods and public housing are associated with the presence of cockroaches, mold, lack of heating and air conditioning, and poor water quality.[4] All these environmental conditions have related to higher rates of disease and lower quality of health. Poor living conditions can also lead to emotional insecurity and hopelessness.

No community is immune to social determinants of heath

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and their impact on people. Who would understand this better than communities of faith? Going back to the beginning of time, God established standards of practice when interacting with mankind on cleanliness, diet, proper health, and caring for one another. All three major Western religions (Judaism, Islam, Christianity) share this focus. The book of Leviticus, written by Moses and shared by all three religions, outlines God's guidelines for care. Chapter 19:18 instructs all to "…not seek revenge or bear a grudge against anyone among your people but love your neighbor as yourself." In the Roman Empire or the era of the New Testament, Jesus taught us to love our neighbors as ourselves (Mark 12:31). The New Testament also references care of the poor and widows by the early church. The Moors (Islam) were leaders in the practice of healthcare with their knowledge of sanitation, sterility, and surgery, and some of these practices still exist today.

Throughout the Middle Ages, it was religious groups—monasteries, mosques, temples and churches—that provided for the poor and addressed health and healing practices. During the 1800s, the church renewed the vision to treat the poor and ill and created the idea of healing institutions. Florence Nightingale, founder of the modern-day nursing program, revolutionized hospitals from places of death to places of hospitality and healing. She educated physicians to look beyond treating a wound to treating a person holistically, and physicians deferred this role to the RN. "*Holistic nursing care involves healing the mind, body, and soul of our patients. It involves thinking about and assisting patients with the effects of illness on the body, mind, emotions, spirituality, religion, and personal relationships. Holistic care also involves taking into consideration social and cultural differences and preferences.*"[5] Faith organizations provide a holistic approach to caring for people. Providing food, shelter, healthcare, and spiritual care have all been the work of faith-based groups throughout the history of the world.

The earliest hospitals, clinics and medical care institutions in the US were established by religious organizations. This is apparent in hospital names such as Catholic, Lutheran, Episcopal, Jewish, Adventist, Methodist, etc.[6] Science and medical advancements of the 20th century led to clashes with religion and politics. Hospitals began to drop spiritual interventions to demonstrate they were on board with advancement in the sciences. In the 21st century, hospitals began to renew their commitment to spiritual care and identify the need to address SDOH.

Hospitals are not designed to care holistically for communities, although they see the need to do so. This is where the faith community rises to meet the health needs of those they serve. Individual faith communities provide for social determinants of health every day, although they may not use the term. Houses of worship offer fellowship, provide meals to those in need, conduct checks on hospitalized and homebound members, provide transportation, and help to provide funds for housing and utilities. Education and training on a variety of topics, including financial, parenting, support groups and grief counselling, can also be commonly found in faith communities. Faith communities walk the full path of life with members, from recognizing births to supporting families through death and grief. Faith organizations are God's love in action.

Because nurses are also on the front line of addressing patient needs for SDOH, they are a great support to congregational efforts. Nurses are trained to care holistically for their patients, addressing mind, body and spirit while advocating for needs. Through assessment, nurses identify specific needs and can intervene directly or advocate for necessary resources. Patients may have no family to assist them with home care and find themselves in situations of hopelessness. Uniquely positioned, nurses are able to connect people to their spiritual provider, social groups for support, case managers, and other agencies as needed. Because of experience and training, having a nurse as part of care ministry is a natural fit. Nurses have been recognized as the most trusted and ethical profession for 18 years in a row, according to a 2019 Gallup Poll. Patients share their fears, frustrations, anger, hope, laughter and tears with nurses. Spiritual care is an extension of the nursing practice and is deeper than religion. It is about the core of human behavior and belief. The nurse recognizes that spiritual distress can be as agonizing as physical pain, and unfulfilled spiritual needs will hinder a patient's ability to heal.[7]

Faith communities should consider adding an RN to their health cabinet or benevolence

ministries. When they partner with a nurse, they can strengthen their ministry and better address SDOH within their congregation, improving health outcomes. The nurse can tie together spiritual care, religious values, and medical treatment so that all three align. A patient diagnosis and prescribed medication could require diet changes or other impacts on faith traditions. The RN in a faith community understands religious guidelines and can assist the patient on diet that matches faith traditions, or advocate for medications or treatment alternatives that the patient would not know are available. When a nurse is a member of the congregation, they also know the families, individuals, life events, living conditions and history that impact health. This specialty of nursing is called Faith Community Nursing. The Faith Community Nurse (FCN) is recognized as a specialty of nursing with its own scope and standard of practice. FCNs focus on intentional care of the spirit, connecting it with traditional nursing practice and healthcare outcomes.

When nurses listen to concerns or needs of individuals, they use their assessment skills to hear more than the words being said. A great example of this is Rebecca's story, which started as a simple prayer request. While praying with a member of her congregation for God to heal her and provide for her needs, Rebecca picked up on the nuances of what was being said. After praying for God to intervene, Rebecca realized she was positioned to be used by God to answer this need. She asked questions, gathered specific information and discovered that the person had been prescribed a new medication that she could not afford; after insurance, the copay was $500 a month. The congregant was too embarrassed to talk to her doctor about this and felt she would just go without the medication and trust God for healing. Rebecca assured her that God could heal, but often He put people in their path to assist. With permission, Rebecca reached out to learn about the medical condition and alternative treatments, of which there where none. Through contact with the drug manufacturer, the FCN was able to secure a scholarship that would cover 100% of the out-of-pocket costs. The prayer was answered, the need met.

Often members of a faith community will seek out the RN for assistance before they will contact other members or clergy. Nursing is trusted. Sometimes a person is embarrassed to bring forward prayer needs because they worry that word will get out or they might be judged or misunderstood. A nurse will have people come to ask prayer for hemorrhoids, athletes' foot, infertility, sexual issues, mental health issues and spiritual concerns: "I'm hearing voices in my head; do you think I'm demon-possessed?" Men are more likely to discuss that they have been sexually abused, and it's impacting their marriage and they don't know who they can trust to discuss this. Individuals would rarely be that specific with a pastor or lay member, but they feel they can trust the nurse with the raw truth. It is through high-level trust that needs are better identified and met.

Through the connection of nursing care and traditional care activities of faith communities, social determinants of health are addressed and ultimately lead to holistic health and well-being. Congregations that address SDOH can break down the walls of stigma and promote spiritual healing. Providing hope where it has been lost heals the body, mind, and spirit. Congregations are on the front line of community health and healing, promoting better health outcomes as they address SDOH.

Link: https://www.youtube.com/watch?v=gJSkDTfhyiQ&t=46s

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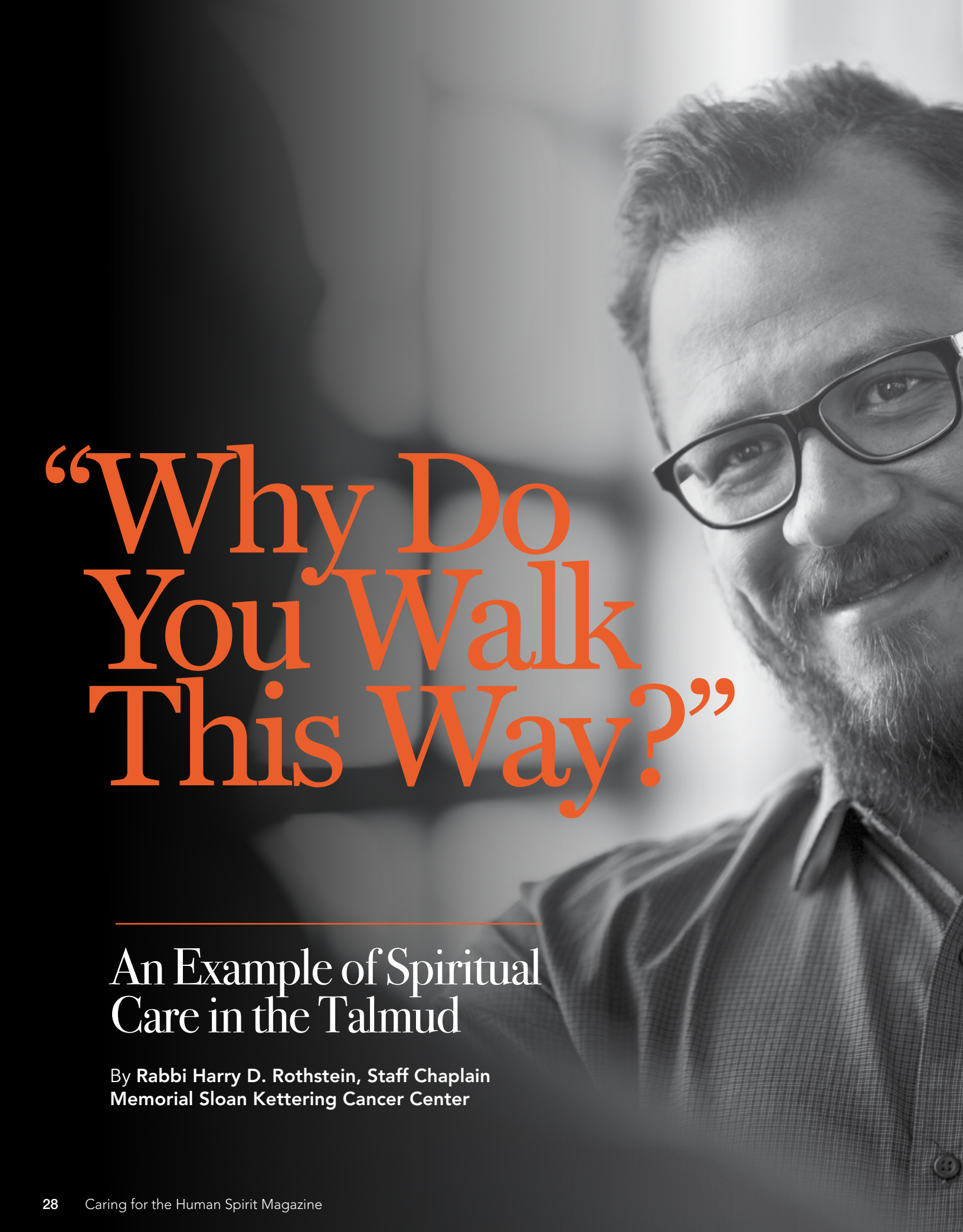


"Why Do You Walk This Way?"

An Example of Spiritual Care in the Talmud

By **Rabbi Harry D. Rothstein, Staff Chaplain**
Memorial Sloan Kettering Cancer Center

There are moments in the delivery of spiritual care when our identities as chaplain and patient, hospital employee and health care recipient, fall away. We are simply two human beings communicating with each other, a moment reflecting a hint of the divine.

When a chaplain steps into a patient's room, they assume an attitude of compassion by listening to the woes and needs of another human being who may have suffered a breach of relationship or loss of meaning on many levels. Within the interdisciplinary health care team, the chaplain offers a unique nonjudgmental listening ear and steady presence to a broken heart. Physicians offer the benefits of modern medical science; social workers offer emotional sustenance and help heal broken relationships. Psychologists and psychiatrists evaluate and offer therapy and medicine. Chaplains do much – but most critically, we listen.

The discipline of professional spiritual care has progressed significantly, and chaplains do far more than simply listen. After listening to the patient's understanding of their situation, the chaplain can devise appropriate interventions, review their outcomes and develop a further plan for spiritual care as necessary.

Still, the essential rote of spiritual care remains – to continuously offer a listening ear and compassion at all hours of the day and night. We simply open our ears, minds and hearts to others who have suffered a breach of relationship with their bodies, personal space, loved ones, careers or what they find transcendent in their lives – that which fills them with meaning.

All faiths teach compassion and offering a listening ear to those in anguish and despair, and Judaism provides an insightful example in its sacred texts. The Talmud is an enormous work of sixty-three tractates describing intricate debates of learned rabbis focusing on "the right way of action" in religious law, ethics and most every human endeavor. The tractate *Semachot* (6:11-12) mentions that those who worshipped in the Temple in ancient Jerusalem walked clockwise in its precincts when attending to their religious needs in the ordinary course. But those who mourned the loss of a loved one, felt cast out by society, were concerned about another who was ill, or had lost something, walked counterclockwise. So, the "regular" (clockwise) walking worshippers would encounter the new attendees walking in the opposite direction and greet them gently with the query, "Why do you walk this way?"

To those who suffered the death of a loved one, the regular walking attendees would say, "May the One who dwells in this house comfort you." In my experience, chaplains offer comfort to those who not only suffer from debilitating disease and loss of health, occupation and financial strength, but who may have also lost a loved one in the recent past – a burden even beyond coping with disease.

To the one who was an outcast, they said, "May the One who dwells in this house turn their hearts so they may take you back," or "May the One who dwells in this house open your heart so that you listen to your friends and they take you back." In my experience, the heart of spiritual care is encouraging the patient to find a way back to a lost relationship with their body, loved ones, their occupation or the transcendent.

To the counterclockwise walkers in the Temple precincts whose loved one was sick, the regulars would say, "May the One who dwells in this house be merciful to your loved one." Chaplains often encourage patients to find a way to address their serious illness, as well as for family members to address the serious illness of their loved one.

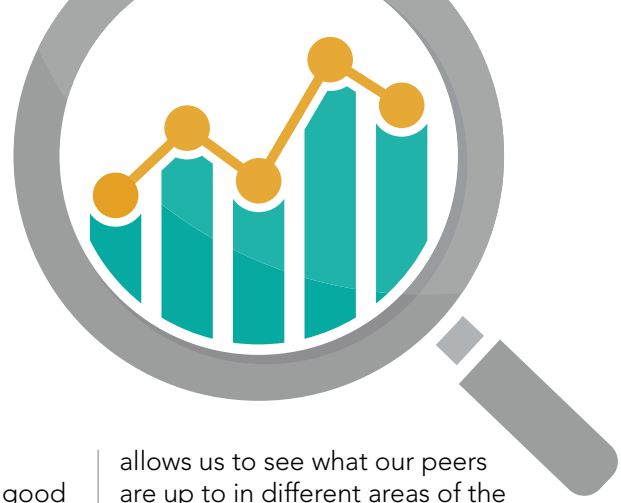
And, to the one who had lost something, the regular attendees said, "May the One who dwells in this house cause the one who found it to return it to you." Chaplains often encourage patients who have lost their health to use their spiritual and religious "tools" to regain their spiritual health.

Seeking to regain one's spiritual health during illness is as old as humanity. The compassion at the core of today's spiritual care has many antecedents in the world religions. This is just one example of addressing the human heart that goes beyond a Jewish text. Spiritual care is universal in its fundamental stance of seeking the help of another person to heal a very human heart.

My thanks to chaplains Brian Kelly and Margo Heda for their valuable suggestions.

Rabbi Harry D. Rothstein *has been working at Memorial Sloan Kettering Cancer Center for 13 years. Before that he has worked as a rabbi in congregations, as a corrections chaplain for NY State Department of Correctional Services, as a chaplain for the NY State Office of Mental Health and as a hospice chaplain. Rabbi Rothstein was ordained in 1974 by the Hebrew Union College-Jewish Institute of Religion and later earned his Doctor of Ministry in Pastoral Counseling from the same College-Institute during his work for the Office of Mental Health. He says, "Working at MSKCC is the best thing I have ever done for another human being."*

RELUCTANT ABOUT RESEARCH?



By **Travis Greene, M.Div., BCC**

There is a scene in the film *Dead Poets Society* that I love. Unconventional poetry teacher Mr. Keating (played by Robin Williams) has his students open their poetry textbooks. The textbook instructs them in how to plot poems on a bar graph based on the importance of the poem's objective and the perfection of the language in achieving it. The class begins to dutifully copy down the chart from the textbook. But I share in the students' glee when Mr. Keating tells them to rip those pages out. You can't quantify poetry!

That is how I suspect many chaplains feel when considering the relationship of their work to research. I know that is my first reaction. Incorporating being research-informed and research-literate into my practice of chaplaincy is a daunting task for which I feel generally ill-equipped. After all, I gravitated toward chaplaincy because of a comfort with the squishiness of human emotions, personal stories, and embracing mystery. I deal in matters of spirituality, tradition, and the human heart. I am less concerned about the biological process of an illness than with the human experience of it. Why bring a bunch of spreadsheets into this?

Turns out there are some good reasons that have helped me to think differently about research.

One is simply that healthcare, whether in a hospital, hospice, mental health, or other settings, is evidence-based. Our colleagues of other disciplines base their work on researched evidence, and while we must maintain our own distinct identity as a profession, we must also be intelligible to those we work with. Research will also help us make the case to those we work for, as fiscal decision-makers are perhaps more likely to be moved by evidence than anecdote.

But these strategic considerations are less compelling to me than the value of research literacy in becoming a better chaplain. Our learning model is based on action and then reflection in a group setting, but then we finish CPE. Keeping up to date with the field of research helps us continue to learn from each other. It gives me new tools for the toolbox, as it were, or helps me refine the ones I currently use. This may be especially important for chaplains who are the only spiritual caregiver in their organization, or who work with only a few colleagues. Following research allows us to see what our peers are up to in different areas of the country and world, and with different populations than the one we serve.

Lastly, research literacy is transforming not only my practice but my conceptions. As I began to consider how to quantify what seems to be unquantifiable, I realized I was unconsciously thinking of spiritual pain as subjective while physical pain is somehow objective. But this isn't true! There is no scan for "pain particles" that gives an objective measure of physical pain. We just ask people, or if the patient cannot speak, we use cues like facial expression. How do we measure spiritual pain? We just ask people. Quantifying spiritual pain may be less familiar, but who better than a chaplain to help patients do so, and to lead in studying this under-researched aspect of human wellbeing?

Travis Greene is a Spiritual Care Coordinator at Suncoast Hospice, a member of Empath Health. He is endorsed as a chaplain with the Alliance of Baptists and board certified by the Association of Professional Chaplains.

Additional Reading

Kelly, E. & Swinton, J. (Eds) (2019) *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigms of Care.* London: Jennifer Kingsley Publishers.

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Hospice Division of the SPIRITUAL CARE ASSOCIATION

The SCA's new Hospice Division focuses on the spiritual dimension of professional practice including professional chaplains whose specialization is in this setting, as well as community leaders serving as chaplains or spiritual care generalists, and all members of a hospice team.

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Hospice Chaplaincy Certificate

This online, self-guided course is designed for those interested in the specialized work as a chaplain within a hospice team. Its purpose is to empower learners with the basic skills and knowledge needed in order to provide care to persons and families who are admitted to hospice as well as to contribute effectively as a member of the hospice interdisciplinary team.

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