Bearing Prophetic Witness: A Strategy to Integrate Patients' Spirituality into Medical Care for Holistic Healing

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This doctoral project entitled

BEARING PROPHETIC WITNESS: A STRATEGY TO INTEGRATE PATIENTS’ SPIRITUALITY INTO MEDICAL CARE FOR HOLISTIC HEALING

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and submitted in partial fulfillment of the requirements for the degree of

Doctor of Ministry

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BEARING PROPHETIC WITNESS: A STRATEGY TO INTEGRATE PATIENTS’ SPIRITUALITY INTO MEDICAL CARE FOR HOLISTIC HEALING

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ABSTRACT

Bearing Prophetic Witness: A Strategy to Integrate Patients’ Spirituality into Medical Care for Holistic Healing
Annette Gildemann
Doctor of Ministry
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2020

The goal of this project is to equip hospital chaplains to carry out a cogent spiritual assessment, pastoral intervention and documentation model. The purpose of equipping chaplains for this essential ministry function is to integrate spiritual narratives into medical charts which focus narrowly on physical cure in order to promote holistic healing for patients. The project was carried out in MultiCare Health System’s six Puget Sound Region acute care hospitals located in the cities of Tacoma, Puyallup, Auburn and Covington, Washington.

The theological reflection section provides biblical insight into how medical practice diverged from the compassionate healing ministry of Jesus. With this divergence theological anthropology changed and people were understood in reductionistic terms. Because of this skewed view of imago dei, patients’ spirituality was pushed to the margins of medical discourse. This section develops a biblical foundation for the role of prophetic witness for the missiology of healthcare chaplains. In this role, chaplains can work to restore holistic healing so that the practice of medicine once again functions in the service of God.

The ministry strategy section describes the goals of the training manual and how it was implemented. Prior to the implementation of the training manual the chaplains completed a self-assessment of their knowledge and confidence levels regarding their spiritual assessment abilities. The results of the survey showed that chaplains were uncomfortable with a broad range of pastoral interventions and lacked confidence in their spiritual assessment abilities. It also showed a high degree of receptiveness to learning new ministry strategies to improve holistic care in their hospitals. The project discusses outcomes, insights and future implications for on-going quality improvement. This is a ministry strategy that can be used by other chaplain departments to integrate holistic healing into their ministry contexts.

Content Reader: Rev. Dr. Libby Boatwright, BCC-PCHAC

Words: 291
In memory of my grandmother who first taught me how to faithfully care for the sick, and to my husband and children who supported me all the way to the finish line.
ACKNOWLEDGEMENTS

I would like to thank the chaplains at MultiCare Health System for their dedication to the patients, families and staff in our hospitals. Their openness to embrace a new model of spiritual assessment, intervention and documentation is now inspiring a new vision for ministry in that context. I would also like to acknowledge all the patients I have served over the years who have been my greatest teachers and inspired me for this work.
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS iv

PART ONE: MINISTRY CONTEXT

INTRODUCTION 2

CHAPTER 1: ANALYSIS OF MINISTRY AT MULTICARE HEALTH SYSTEM 11

PART TWO: THEOLOGICAL REFLETION

CHAPTER 2: LITERATURE REVIEW 30

CHAPTER 3: A THEOLOGY OF BEARING PROPHITIC WITNESS 48

PART THREE: MINISTRY PRACTICE

CHAPTER 4: GOALS AND STRATEGY 73

CHAPTER 5: IMPLEMENTATION AND ASSESSMENT 86

SUMMARY AND CONCLUSION 98

APPENDIXES 108

BIBLIOGRAPHY 161
PART ONE

MINISTRY CONTEXT
INTRODUCTION

Throughout history and across cultures, there have been various places dedicated to care for the sick. For example, ancient Egypt had the temple of Isis and ancient Greece had the Asclepieion of Asclepius. In the Roman empire the valetudinarium served as a place to care for the sick.¹ It was into these societal practices of tending the sick that “Christianity entered the world as a religion of healing.”² The Christian practice of caring for the sick ran counter to established social practices. Christians did not care for the sick “in the context of loyalty to the Greek gods and goddesses.”³ They did not care for the sick out “the reciprocal hospitality that had prevailed in ancient Greece, [nor] the family-oriented obligations of the Romans, [instead] Christianity…targeted particular social groups marginalized by poverty, sickness and age.”⁴

Christians found their inspiration for offering generous hospitality to the sick in the charge entrusted to them by Jesus. He commissioned them to heal the sick and proclaim the kingdom of God where all sickness, sin and suffering are no more (Lk 9:2, Lk 10:9, Rv 21:4). Seeking to faithfully live out their sacred duty, Christians devotedly tended the sick in their communities inspired by the verses in Matthew 25: 31-46. “The memory of Jesus prompted what Henry Sigerist, the eminent historian of medicine, called

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³ Ibid., 7.

‘the most revolutionary and decisive change’ in the tradition of medicine. That change was this: the sick were ascribed ‘a preferential position.’”

Giving the sick a favored position meant that the Christian community turned toward those who were ill with compassion. Christians did not abandon the sick, even when their own health and lives might be imperiled by the contagion. For example, during “the plague of the third century in Alexandria, Christians distinguished themselves by their heroic care of the sick.” When other people in the community fled and forsook those who were dying of plague, Christians tended the sick, and some of those people who were suffering from the plague were healed because of their ministry.

It was the Christian ethic of hospitality to the sick that prompted St. Basil of Caesarea to found the first Christian hospital around the year 369. It was “conceived as a religious center as much as a refuge, soup kitchen, and medical institution for those in distress…the lines remained blurred between welfare, social control, spiritual care [and] medical assistance furnished by physicians.” The model St. Basil used to care for the sick was holistic in nature. By providing safety, food, medical care, and space for religious practices the physical, social, and spiritual needs of patients were recognized as integral to the healing process. St. Basil’s model of providing holistic care faithful to

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5 Verhey, Reading the Bible in the Strange World of Medicine, 9.

6 Ibid.

7 Ibid.


9 Risse, Mending Bodies, Saving Souls A History of Hospitals, 85.
Scripture “quickly became the prototype of many other such Christian institutions...by the twelfth century the Pantokrator hospital in Constantinople maintained seventeen physicians, thirty-four nurses, and six pharmacists; it served patients on five specialized wards.”

For the following two centuries the Church played a vital role in providing refuge, solace and a place of holistic healing for those who were infirm. For example, a hospice built in Beaune, France between 1441 and 1491 still stands as a testament to this kind of holistic care. Named “The Hotel of God,” it was a place where “a small army of nurses and volunteers tirelessly supported the physical and spiritual well-being of the dying.”

In 1492, the year after “The Hotel of God” was completed, the hospice movement ended. At that time, a shift away from the holistic care that was shaped by deeply held Christian convictions began to occur. This shift is apparent in how medical education emphasized that the best care for the patient came from “concentrating exclusively on the physical aspects of caregiving,” and distanced itself from the spiritual aspects of care.

The change that was occurring can be traced in how doctors of the time described their work. For example,

10 Verhey, Reading the Bible in the Strange World of Medicine, 12.


12 Ibid., 15.

13 Ibid., 16.
admonitions of the Christian faith, a new element appeared: the importance of competence, defined as mastery of the literature and its reasoned application to the medical problem of the patient.\textsuperscript{14}

Driven to contribute to the body of literature about human anatomy, in 1506 Leonardi da Vinci dissected a corpse. He published drawings of what he found inside the human body, and his actions were so shocking that the Church ordered him to stop.\textsuperscript{15} The moratorium on dissecting cadavers held for three hundred years, until the mid-1800s which marks a pivotal point in medical education. It was at that time that cadavers became routinely used in training aspiring doctors. This meant that,

for the first time in the history of medicine, physicians were invited to peer into the darkened recesses of the human body and find there the locus, the very substance, of disease—this revolutionary change—the capacity for gazing upon and touching the lesions that are the sources of infirmity and death altered forever our ways of seeing patients and their afflictions.\textsuperscript{16}

As medical students dissected cadavers to learn more about human disease and the causes of death, they “began to view the bodies set before them not as people but as objects. This ability to divorce oneself emotionally came to characterize the mind-set of the medical community…This was not simply a by-product of medical education. It was the goal.”\textsuperscript{17}

\begin{flushright}
\textsuperscript{14} Al Jonsen, \textit{A Short History of Medical Ethics} (New York: Oxford University Press, 2000), 44. \\
\textsuperscript{17} Lindsey Fitzharris, \textit{The Butchering Art: Joseph Lister's Quest to Transform the Grisly World of Victorian Medicine} (New York: Scientific American, 2017), 40.
\end{flushright}
Formed by an educational system that prized diagnosis above all else, doctors increasingly saw humans very narrowly. It is this way of seeing people, with detached medical observation, that Foucault termed the “medical gaze.”\textsuperscript{18} The “medical gaze” subsequently gave rise to a new medical culture which Foucault named the “‘clinic’…[that is] the scientific, pathological approach to medicine that emerged between the Enlightenment and the establishment of the university clinic in the nineteenth century.”\textsuperscript{19} Ironically, the “medical gaze” holds a “paradoxical position…if one wishes to know the illness from which [an individual is] suffering, one must subtract the individual, with [their] particular qualities.”\textsuperscript{20}

As the practice of medicine continued to move toward professionalization, the “medical problem of the patient” became the laser focus of the profession.\textsuperscript{21} The holistic nature of St. Basil’s vision which sought to “render a medicine worthy of the gospel” was replaced with a reductionist view of humans as merely their diseased state.\textsuperscript{22} Dr. Richard C. Cabot, author of \textit{Training and Rewards of the Physician}, which was published in 1918, “complained that ‘the human side of medical practice’ was ordinarily left out of

\textsuperscript{18} Philips and Benner, eds., The Crisis of Care Affirming and Restoring Caring Practices in the Helping Professions, 144.

\textsuperscript{19} Daniel Sulmasy, \textit{The Rebirth of the Clinic An Introduction to Spirituality in Healthcare} (Washington DC: Georgetown University Press, 2006), xi.


\textsuperscript{21} Jonsen, \textit{A Short History of Medical Ethics}, 44.

\textsuperscript{22} Verhey, \textit{Reading the Bible in the Strange World of Medicine}, 6.
medical education.”23 The illness was seen in isolation and the person was reduced to symptoms and signs that could be categorized and treated.

By reducing the value of the individual, the conversation between doctors and patients about illness, pain and suffering was drastically altered. “The voice of the patient which had been so central to the Hippocratic doctrine, was silenced by the growing medicoscientific dialogue in which the uninitiated patient was unable to take part.”24 The topic of discourse became narrowly focused on the signs and symptoms of the disease and other aspects of the patient as a person were ignored. Blind to the person in their fullness, their particularities and their hopes, their fears and their suffering, people were reduced to their physical bodies. Their physical bodies were further reduced to their pathology and so “power over the body had been transferred from the patient to the physician.”25

The emerging culture of medical practice that Foucault detected in the nineteenth century is now fully entrenched in twenty-first century medical practice. Today, “the goal of physician communication emphasizes gathering objective data rather than compassionate, empathic listening to learn about the disease in the context of the patient’s story.”26 During a medical encounter it takes “an average of roughly 23 seconds

23 Jonsen, A Short History of Medical Ethics, 86.


25 Ibid., 178.

for doctors to interrupt when patients are talking.”

The curtailed communication does not allow patients to name their suffering and how they might cope with their illness. Doctors may clinically give a diagnosis, but “for the sufferer the name of the dis-ease is probably something quite different. Flannery O’Conner’s letters sometimes mention her lupus, but that is not the way she named her suffering…. the name of the dis-ease may be Humiliation or Loneliness or Despair or The Threat of Death.”

In other words, the narrow focus on physical cure leaves out the spiritual narrative. Patients regularly report that they want their spirituality considered as they deal with their illness and make medical decisions, and yet spiritual/religious issues remain a misunderstood, minimized or ignored facet of the personhood of hospitalized patients.

To set medicine again within the holistic healing story of Jesus that sees people in their fullness as image bearers of God, we need to remember the essential truth that,

when illness threatens the health, and possibly the life of an individual, that person is likely to come to the physician with both physical symptoms and spiritual issues in mind…through these two channels, medicine and religion, humans grapple with common issues of infirmity, suffering, loneliness, despair, and death, while searching for hope, meaning, and personal value in the crisis of illness.

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28 Verhey, Reading the Bible in the Strange World of Medicine, 106.


Given this reality, “the desire for a new form of medicine is real and deep. People today are not ready to give up scientific progress and all that it has to offer, but they rightly sense the need for more. Their desire is spiritual. They want a form of medicine that can heal them in body and soul.”\(^{31}\) With a foot in both the world of medicine and in the world of religion/spirituality, healthcare chaplains are uniquely placed within the context of modern healthcare culture to help birth this new form of medicine. Working within the culture they can help fashion a transformed way to practice medicine that sees patients, not with a detached “medical gaze,” rather a medicine that sees hospitalized persons with renewed vision, in their human fullness, with the compassionate gaze of God.\(^{32}\)

To this end, this project will develop an accurate and through spiritual assessment rubric with supporting pastoral intervention strategies to address the identified spiritual needs of patients. It will also design a cogent documentation model to equip the chaplains at MultiCare Health System to record patient spiritual narratives in their medical chart. In this way the patient’s spirituality is recognized and supported as integral to healing, rendering once again, “a medicine worthy of the gospel.”\(^{33}\)

Part 1 of this project includes an introductory section which briefly explains how the profession of medicine divorced itself from spiritual narratives, leaving people

\(^{31}\) Sulmasy, *The Rebirth of the Clinic*, xiii.

\(^{32}\) Philips and Benner, eds., *The Crisis of Care Affirming and Restoring Caring Practices in the Helping Professions*, 144.

\(^{33}\) Verhey, *Reading the Bible in the Strange World of Medicine*, 6.
without an essential component of healing when they are faced with illness or death. It also includes chapter one which recounts the history of MultiCare Health System and evaluates the current state of the ministry in this setting. The chapter concludes by identifying three core ministry challenges facing chaplains working in this context.

Part 2 of this project contains chapters two and three and these chapters work together to develop a theological reflection of what it means for chaplains to bear prophetic witness in the context of modern healthcare. Chapter two is a literature review of five journal articles and two books which ground the theological reflection for relevance in the healthcare setting. Chapter three develops a theology of prophetic witness. First it critically examines the culture of modern medicine and how *imago dei* became obscured by reductionistic medical practices. It will contrast these reductionistic medical practices with the compassionate, holistic healing ministry of Jesus. Finally, the chapter will cast a vision for what it means for chaplains to bear prophetic witness in modern healthcare settings. It offers three prophetic tasks to help chaplains accomplish the purposes of God in the healthcare context, bending the culture of modern medicine toward holistic healing.

Part 3 of this project contains chapters four and five and draws on the preceding parts to develop and carry out a ministry strategy that is theologically relevant, equipping chaplains to bear witness and prophetically speak for holistic healing in healthcare settings. It comes complete with a training manual to support chaplains in their work.
CHAPTER 1:
ANALYSIS OF MINISTRY CONTEXT AT MULTICARE HEALTH SYSTEM

This chapter examines several factors that impact the current ministry of chaplains serving the patients, families and staff at MultiCare Health System. First the chapter explores the historic roots and current vision and mission of the health system. Next it examines the current community in terms of population health, demographics, socioeconomics and religious views as important contextual factors which inform chaplain ministry in this setting. It concludes with three identified ministry challenges that form the crux of the new ministry initiative.

History and Mission of MultiCare Health System

In 1880, Bishop John A. Paddock and his wife, Fannie, pictured below, received a new ministry assignment.¹ They were tasked with serving the congregation at St. Peter’s

Episcopal Church, the first church built in Tacoma, Washington.² Wanting to serve not only the church members but all of the people residing in the small frontier town, Fannie began to explore the most pressing needs of the community.³

She learned that the living conditions were harsh and “a lack of proper sewer systems and an overabundance of rain were, in part, a cause of illness that plagued Tacoma… [the population was] threatened by outbreaks of typhus, whooping cough and other contagion.”⁴ In addition to disease, physical injury was always a concern for “those loggers, miners and fishers who came to town with injuries and illness” and there was no hospital to care for their medical needs.⁵ Armed with this information Fannie began to ask friends and acquaintances to donate a brick to build a hospital in Tacoma, raising $500 for the project. As Fannie and her husband made the long journey west from Brooklyn, New York, she became ill and died.⁶


⁴ Bowlby, “Call the Doctor! Part 1.”

⁵ Ibid.

⁶ Hallman, “Fannie’s Dream, 130 Years Later.”
However, her dream of providing healthcare for the people of Tacoma went forward and “exactly a year to the day after Mrs. Paddock had passed away, ‘her’ Hospital was dedicated. It was from the beginning that which she had hoped for – a ‘House of Mercy.’ It housed the sick and injured for seven years, until a more permanent facility was built at 312 South J St, where MultiCare’s Tacoma General Hospital now stands.”7 The pictures below show Fannie’s “House of Mercy” compared with the campus of Tacoma General Hospital as it appears today.8

Growing from a single hospital, today MultiCare Health System spans the state of Washington with hospitals in the cities of Tacoma, Puyallup, Auburn, Covington, and Spokane.9 It is “the largest community-based, locally governed health system in the state of Washington.”10 Currently, the purpose of MultiCare is to care for the communities it serves and is reflected in its mission statement: “Partnering for Healing and a Healthy

7 Bowlby, “Call the Doctor! Part 1.”
8 Ibid.
9 Ibid.
Future.” The existing mission and vision of MultiCare Health System finds its roots in Fannie’s dream for a place of refuge for the sick and injured of Tacoma.

**Population Health, Demographics, Socioeconomics and Religious Views**

Although the medical needs in Tacoma have changed over the years, people still suffer from medical conditions. Because of this, access to comprehensive medical care is a continuing community need. In 2016 MultiCare undertook a Community Health Needs Assessment (CHNA) and found that the top medical issues for the people of Tacoma were women’s health with a focus on early prenatal care due to poor birth outcomes (5.8 infant deaths/1000 births), obesity, tobacco use, and mental health. The CHNA also identified a focus on culturally competent care for staff at MultiCare as the population in Tacoma becomes more diverse.

Recent population statistics found that over 216,000 people make their home in Tacoma. The community has “a racial composition of White: 66.01%; Black or African

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13 Ibid.

American: 9.86%; Asian: 8.80%; Two or more races: 8.48%; Other race: 4.28%; Native American: 1.29%; Native Hawaiian or Pacific Islander: 1.28%. The largest age group is 25 to 44, which makes up 29.6% of the population. About 15.9% of the population lives below the federal poverty line.” The Pew Research Center further reports that the people of Tacoma are religiously diverse: 61% Christian, 1% Jewish, <1% Muslim, 1% Buddhist, 1% Hindu, 1% Unitarian, 1% New Age, 32% unaffiliated (nones), and 1% who did not know. The Barna Group ranks Tacoma number nine on their list of “the most post-Christian cities in America,” and the city has also been ranked as number three on the list of top ten dechurched cities in America.

**Chaplaincy at MultiCare Health System**

The importance of meeting both the physical and spiritual needs of the people who came to Fannie’s “House of Mercy” for care was recognized as integral to holistic healing. For this reason, the first physician of the hospital, Reverend E. F. Miles, MD,

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also served as the hospital chaplain.\(^\text{19}\) However, over time, the priorities of MultiCare came to reflect the values and attitudes that permeated the broader context of modern medical culture and the move from holistic healing to cure took hold.

As the “clinical gaze” replaced the compassionate gaze of God, MultiCare used its financial resources to expand medical departments, growing the specialty services in ever narrower ways of seeing patients.\(^\text{20}\) While Tacoma General Hospital continued to employ a chaplain, it did not expand the chaplain department on pace with the growth of the medical system. Tacoma General Hospital, which has grown to 437 beds, still only has one full time day shift chaplain reflecting the institution’s financial priority of medical care over spiritual care of patients.

Across MultiCare’s hospitals there are 1,730 licensed beds and chaplains are available to respond to the spiritual needs of patients around the clock every day of the week.\(^\text{21}\) To meet this need, MultiCare allots 10.6 Full-time Equivalent (FTE) chaplains. This is made up of a combination of 6.2-day shift staff with the rest of the FTEs comprised of per diem staff who agree to be on stand-by and promptly respond only when called on nights and weekends. Besides in-patient care, chaplains also serve the patients at MultiCare’s four outpatient cancer centers. The Chaplain Services Department

\(^{19}\) “MultiCare Grows to Serve the Community,” \textit{MultiCare Health System}, accessed July 20, 2019, https://www.multicare.org/multicare-history/.


oversees two staff support programs: Code Lavender program and Schwartz Center Rounds. MultiCare Health System is also an accredited Clinical Pastoral Education center to educate future chaplains, offering two residency positions. The center is housed at Good Samaritan Hospital and students are placed across the healthcare system.

The chaplains at MultiCare Health System serve in a wide range of settings, and yet staff allocation is at bare minimum levels. The disparity between the magnitude of the spiritual need and the minimum provision of service presents the chaplaincy department with several ministry challenges. However, before examining these ministry challenges in detail, understanding in brief the emergence of professional chaplaincy in healthcare settings is important background information to fully appreciate the current ministry challenges.

**Healthcare Chaplaincy as a Profession: A Brief History**

“As a distinct profession, healthcare chaplaincy emerged from efforts to change Protestant theological education in the 1920s, that is, to get students out of classrooms and into interaction with individuals in a range of contexts.”

This effort is most clearly traced to The Reverend Anton T. Boisen when he was chaplain at Worcester State Hospital. Starting with just a few students in 1925, this type of theological education in

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hospitals grew steadily over time. Now known as Clinical Pastoral Education (CPE), it is the current educational model required for board certification by the Association of Professional Chaplains. From these roots in the 1920s, healthcare chaplaincy has tried to find its way as a profession in the medical setting, refining and redefining its identity over time to show the value of spiritual care for the wellbeing of patients.

In the 1940s after chaplains organized into a profession, they began to advocate for themselves using various methods to achieve their desired outcomes. As healthcare changed over the years, so too did the strategies used by chaplains. “First chaplains adopted the language of healthcare around questions of identity, charting and accreditation…[and later] chaplains used not just the frameworks, but the methods of healthcare-evidence based research-to try to demonstrate their value.” For example, when financial pressures began to be a factor in the 1970s chaplains began to lobby for their role and adopted the language of healthcare to show their unique contribution and to differentiate themselves from community clergy.

In the 1980s the efforts atlobbing continued as chaplains unsuccessfully attempted to prompt the Joint Commission to require hospitals to employ chaplains, in hopes of fully legitimizing their role on the healthcare team. By the early 2000s the focus of the Association of Professional Chaplains turned inward as they wrote professional standards for the chaplain profession attempting to formalize the role and function of

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25 Ibid., 57.
In 2003 a potential professional turning point came when JCAHO stated that ‘patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values.’ Hospitals were to ‘demonstrate respect’ for patient needs, including the need for ‘pastoral care and other spiritual services.’ Additional language about religion and spirituality was included in the guidelines about dietary options, pain concerns, resolving dilemmas about patient care issues, end-of-life issues, and the treatment and responsibilities of staff. JCAHO Associate Director of Standards Interpretation explained that the Commission ‘expects you to conduct a spiritual assessment of every patient in every healthcare setting to determine how a patient’s religion or spiritual outlook might affect the care he or she receives.’

Additionally, in 2008 and again in 2013, JCAHO mandated that any hospital who offers Palliative Care Services must employ a chaplain or spiritual counselor as part of the palliative care interdisciplinary team. Over a ten-year period, JCAHO three times emphasized the importance of spirituality in patient care. Remarkably, sixteen years after JCAHO issued their first mandate in 2003, the chaplain profession still has no standardized way of conducting spiritual assessments. There is still no unified voice in terms of communicating interventions or desired outcomes in using various interventions. In the absence of an agreed upon assessment by the Association of Professional Chaplains in healthcare settings.

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26 Ibid.


Chaplains, many hospital systems are developing their own and therefore there are numerous spiritual assessment models and various tools for intake.

In addition to hospital systems working in isolation to create their own assessment models, recently there have also been coordinated efforts to assist chaplains in their efforts to address this professional gap. For example, in 2018 George Fitchett spearheaded a website called “Transforming Chaplaincy.” This site functions as a think tank of collective ideas aimed at research literacy for chaplains. It assists chaplains in incorporating current research on spiritual care into chaplain practice to improve patient outcomes. The goal is that “the resources give [chaplains] the tools they need to transform chaplaincy in their institutions.”

The chaplains at MultiCare Health System minister at the crossroads of the legacy of the chaplain profession’s struggle with identity and function, and with the effects of sweeping changes in healthcare. The intersection of these realities relates to three main areas of ministry challenge that warrant analysis.

**Core Ministry Challenges**

The first ministry challenge discussed in this section has to do with monumental shifts in how healthcare is funded. The second challenge has to do with the perceived role and function of chaplains and how this can negatively influence their potential to fully integrate on healthcare teams. The third challenge is rooted in the fundamental

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differences between medical pedagogy and chaplain pedagogy. These differing educational philosophies stem from differing views of patients and what constitutes the best way to care for the sick. These differences lead to communication challenges between the disciplines.

Challenge 1: To Demonstrate Value

A pressing challenge facing MultiCare chaplains is proving the efficacy of chaplain care so that hospital administrators see value in the service chaplains provide. Since 2007 when the Institute for Healthcare Improvement launched a program called the Triple Aim, the way healthcare organizations had historically functioned slowly began to change. In the thirteen years since 2007, the effects of the Triple aim which seeks “to improve the patient care experience, improve the health of a population, and reduce per capita health care costs at the same time” have had significant implications for all aspects of healthcare, including chaplains.

One of the foundational changes stemming from the Triple Aim is that of moving from fee-for-service to value-based care models. George Handzo, who serves as a director at the Healthcare Chaplaincy Network, illustrates the moment he realized that value-based healthcare applies to chaplains too. He recalls, “So I went in with all my numbers about cost per visit over thousands of visits and [my administrator] said

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31 Ibid.
something like, ‘Oh George, these numbers are really impressive, but tell me: What difference has this made to my patients?’ And I had no idea how to demonstrate that.”32

Moving from a concrete measure, such as number of patients seen, to a qualitative measure, such as proving how effective the chaplain visits are, is a challenge. Rising to the challenge to show efficacy of chaplain care is essential in the current healthcare context where budget constraints are a constant reality. “Ultimately, ‘those who don’t demonstrate value will not be funded,’... while they’re very cheap by health care standards, a penny-pinching hospital administrator might very well zero them out if [that person] doesn’t understand what they contribute.”33 In light of this observation, the reduction or elimination of the provision of spiritual care in hospitals is a reality that will be faced by Spiritual Care departments who do not demonstrate value to the healthcare system they serve.

A major obstacle to showing value is that “in the context of increasing emphasis on evidence-based practice, the effectiveness of or need for spiritual support may be called into question in the absence of rigorous evidence.”34 Of significance, therefore, is research that links what hospitals are measured against, such as patient satisfaction, length of stay, and/or readmission rates, to how chaplain visits positively affect these


33 Ibid.

metrics. Currently, there is a body of research emerging that demonstrates the value chaplains add. For example, “a 2013 study by Harvard researchers illustrated that patients whose spiritual needs have been met have chosen less aggressive care…[and]…A 2015 Mount Sinai paper showed that chaplain visits boost patient satisfaction.”

Additionally, a comprehensive analysis of the U.S. health care system highlights a heightened awareness that, in addition to quality medical services, social determinants of health such as education, income, housing and social support play a very large role in health. A case also has been made that religion and spirituality are among those social determinants, albeit frequently unrecognized.

As research-based evidence begins to accumulate, what chaplains positively contribute toward institutional goals and operational plans will become better understood, solidifying the valuable role chaplains play in holistic care and healing. “George Fitchett has led the way for chaplains in this area…He states, ‘in an environment where the lingua franca is research, we need to be able to demonstrate what we contribute.’ That begins, he says, with careful charting and evaluations by chaplains.”

35 Abrams, “Hospital Chaplains Stick to the Heart of the Job Amid Healthcare Industry Changes.”


37 Abrams, “Hospital Chaplains Stick to the Heart of the Job Amid Healthcare Industry Changes.”
Challenge 2: To Fully Integrate on Healthcare Teams

A second ministry challenge is fully integrating into healthcare teams. Because historically chaplains have used various strategies to find their place in healthcare, this has affected how chaplains themselves understand their role. When chaplains experience role ambiguity, then other disciplines also have a difficult time understanding exactly what chaplains bring to the table. “Many chaplains see their work as a ministry of presence…it’s the being there…walking alongside people and being persistent with that.”38 Another chaplain defined their role as a “story catcher.”39

While being present and hearing stories are valuable and healing interventions, they are role descriptions that are hard for other healthcare disciplines to grasp. When chaplains describe their work in language that other disciplines do not understand then integration on teams becomes elusive. This misunderstanding of the chaplain role ultimately negatively affects holistic care for patients. For example,

Silvestri et al. (2003) found that…both patients and caregivers rated faith in God as second to only their oncologists’ recommendations. By contrast, physicians in that study believed that a person’s religious faith should be the least important factor patients should consider when weighing treatment options…to the extent that healthcare professionals do not see the relevance of referring patients to chaplains for treatment issues, this creates a professional gap in patient care that leaves patients without guidance and counsel regarding religion, spirituality, and related issues.40


If viewing the chaplain role as irrelevant and therefore failing to refer to chaplains can be a barrier to full integration on teams, so too can understanding the chaplain role too narrowly. A study done at Duke University found that physicians reported that chaplains are only helpful in two situations. One circumstance is when a patient is dying and may be unable to respond and do not receive the benefit from chaplain support that they may have otherwise received. The other situation is if the patient brings up spiritual or religious issues.41 Another study found that, while nurses, physicians, and social workers indicated it was important to refer patients to chaplains for end-of-life issues, they thought it much less important to make referrals for issues related to treatment, pain and depression, and anxiety and anger…This may be because many healthcare professionals do not see a link between physical symptoms and spiritual issues, and as such they tend to treat these issues as medical or emotional as opposed to spiritual…most healthcare professionals would not think to connect unresolved grief, chronic anxiety or demoralization with unresolved spiritual issues. These differences in perspective among the disciplines may partly reflect disparate views regarding the chaplain’s role.42

The ambiguity of the chaplain role is also set more broadly in the context of post-Christendom culture where some people may be unfamiliar with what a chaplain is, or what a chaplain does. For example, fifty-four percent of people in Washington self-reported that they are either religiously unaffiliated (32%) or that they held no religious


beliefs (22%). Because of this, they may consider the chaplain role unnecessary in hospital settings. Added to this is that the default setting of many hospitals on admitting a patient to the hospital is to enter the patient’s religion as none, even though they may have an embedded spirituality. These factors are important because “in the context of healthcare the belief systems of those with no religion is complex…one qualitative study found non-religious people to be quite spiritual, believing in an afterlife and a search for meaning. Patients and families often find themselves particularly inclined towards spirituality during a health crisis…as they strive to make sense of, and derive meaning, from events.”

As more research is being done on the intersection between health outcomes and spiritual care, the role of the chaplain will no longer be seen as irrelevant, too narrowly defined or unnecessary. Rather it will be appreciated as a full partner in “the close collaboration of clinical disciplines in care of the human spirit that is emerging as a core need in healthcare culture.” In tandem with broader research that is being done by others, MultiCare chaplains can help elucidate the role of the chaplain with well documented chaplain interventions that reflect the full scope of chaplain practice. In this


way, chaplains will become integrated in fuller ways on healthcare teams in service of better health outcomes for patients.

Challenge 3: Bridging the Communication Gap

A third ministry challenge is that there are fundamental differences between the medical model of training and the chaplain model of training. Each of these training models derives from different educational philosophies. Each uses a different language, and each employs a different approach to relationship with the patient. All these differences in training add up to significant communication challenges between disciplines.

As noted previously, when medical education began to professionalize, clinical detachment became a goal of the profession. Seeing people in their fullness as humans was sacrificed in the quest to correctly diagnose and successfully treat the medical condition. This means that the medical model sees patients as their disease state. Sometimes patients are referred to, not by name, but by their diagnosis. In contrast to this reductionistic way of seeing people, chaplains are trained to see people holistically as a “living human document.”⁴⁶ Chaplains understand that patients are first people who are dynamically involved in their own lives and are actively working to make meaning from what they are experiencing. The disparate views that doctors and chaplains hold about the

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nature of persons can lead to communication challenges about what constitutes best practice in patient care.

Another central difference is that medical education is a traditional system of education in which medical students are expected to master a body of knowledge defined by a set curriculum. In contrast, Clinical Pastoral Education (CPE) is an outcome based educational model focusing on the formation of the chaplain as a person rather than on a certain skill set to be mastered. This means that chaplain students set their own learning goals for each unit. There is no set standard knowledge base that chaplains must know upon completion of CPE. Because of this training focus, when students emerge from their four units of CPE many are not equipped to carry out spiritual assessments. Many are unprepared to document pastoral interventions or spiritual care plans.

Because chaplains were not communicating spiritual assessments or spiritual care plans, doctors searched for another way to gain this information. To understand the spiritual aspect of patients, Dr. Puchalski developed the spiritual history tool FICA.47 Other doctors generated additional spiritual history tools such as HOPE48 and SPIRIT,49 just to name a few. Clearly there are doctors who want to incorporate the spiritual aspect

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of their patients in their care. The challenge for chaplains is to close the communication gap and document in a clear, concise way doctors can understand.

Chaplain notes need to be informative and efficient compelling clinical colleagues to read them. In this way the patient’s spirituality once again is incorporated into their overall care plan for whole person care. This is a critical ministry need which must be addressed so that the patient is seen in their full personhood, restoring imago dei into medical practice. When the inherent dignity of the patient is upheld, we will once again “render a medicine worthy of the gospel,” which offers compassionate holistic healing and is not reduced to a sole focus on cure.50

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50 Verhey, Reading the Bible in the Strange World of Medicine, 6.
PART TWO

THEOLOGICAL REFLECTION
CHAPTER 2:
LITERATURE REVIEW

The five journal articles and two books reviewed in this chapter lay the groundwork for the theological reflection chapter and the ministry strategy sections of this project. The first section reviews two articles that provide critical background for understanding the ambiguous nature of the chaplaincy role on healthcare teams and how this limits their contribution to holistic patient care. The second section of this chapter reviews two books and a journal article to establish the context of how modern medicine as an ideology has forgotten the healing ministry of Jesus. This key memory lapse ignores the spiritual issues to which Jesus always attended, leaving sufferers devoid of holistic healing. The third section reviews two journal articles which work together to offer a way forward for chaplains to define a clear role for themselves to robustly contribute to holistic healing. The new role suggestion is to bear prophetic witness to the spiritual aspect of hospitalized persons, communicating \textit{imago dei} clearly to the rest of
the healthcare team. When chaplains function in this way they can work to invite shalom and holistic healing back into modern medicine.

**The Current Role of the Healthcare Chaplain: Ambiguous and Obscured**

The two journal articles reviewed in this section highlight that currently the chaplain’s role on healthcare teams is ambiguous. The articles work together to underscore the importance of developing a clearly defined role for healthcare chaplains at a time when financial constraints could further deplete provision of chaplain service. If the chaplain role remains obscured, and therefore eliminated, then the spiritual needs of patients may go unmet during critical illness resulting in unaddressed suffering. As some of these patients do not have a community of support to work out questions of meaning and purpose outside of the hospital, chaplains can play a vital role in holistic healing at a crucial time in their lives.

“Healthcare Chaplaincy as a Companion Profession” by Wendy Cadge

Wendy Cadge’s thesis in her article “Healthcare Chaplaincy as a Companion Profession: Historical Developments”\(^1\) is that historically healthcare chaplains have seen their role as a profession that works in parallel to other healthcare professions as they sought to fulfill a role that other healthcare professionals do not. The way they have advocated for the legitimacy of their role has shifted over time. Her argument follows a

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linear timeline from the 1940s to the present day, tracing the changes that professional chaplain organizations have made in order to find their place in modern medical culture. She describes how chaplains have “used multiple strategies to articulate and re-articulate their professional mandate between 1940 and the present to become a companion profession, one that comes alongside another without seeking to challenge others’ jurisdiction.”

Understanding that chaplains have a long history of seeking to serve in places of “institutional voids,” desiring to work with other disciplines in ways that are not perceived as challenging contributes to the topic in two ways. First, it contributes to the topic in terms of understanding why the role of the chaplain is seen as optional on most healthcare teams. It gives important background as to why full integration of the chaplain role on healthcare teams became elusive. A second contribution this article makes to the topic is in giving a broad understanding of how chaplains themselves have understood their role in healthcare settings. It explains why chaplains began to adopt healthcare language and why there is a current push for chaplains to do research, or at least be research literate, as chaplains continue to try to demonstrate their benefit to healthcare teams.

This historical understanding of the development of the chaplain profession builds a foundation for this topic and assists in the development of a ministry strategy that can fill the silent void where patient stories of illness used to be. It helps in the building of a

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2 Ibid., 45.
3 Ibid.
strategy that is true to the professional competencies of chaplains and that authentically represents the voice of the patient. This strategy can equip chaplains to step into this void to bring holistic healing and humanity back into healthcare in truly collaborate ways which can positively influence patient and institutional outcomes.

The limitation of this article considering the ministry challenge is that it is retrospective in focus, tracing the historical roots of the chaplain profession. The article does not give any future oriented perspectives for chaplains to move into current healthcare challenges. This article, however, does build on the literature by giving professional chaplains the opportunity to take a comprehensive view of their history and how they have sought to build occupational legitimacy in the past. It gives a stepping off point so that a new ministry strategy can be formed that aligns with current challenges to meet the spiritual needs of patients today.

The “institutional voids” remain and how and where chaplains see those voids can be opportunities for new ministry strategies. The void of patient voices in medical records can invite the role of a prophetic voice for chaplains in helping silenced human voices be heard and honored so that the healthcare team relates to the patient with compassionate, ethical care.
“The Role of the Healthcare Chaplain: A Literature Review,” by Fiona Timins

The thesis Fiona Timins and her colleagues put forward in their article “The Role of the Healthcare Chaplain: A Literature Review,” is that the role and contribution of chaplains is often obscured and misunderstood by other members of the healthcare team. They argue that while “the potential importance of faith in supporting global health concerns was recently highlighted in the Lancet…[there is] a depletion in service provision in response to global and national financial constraints.” Their aim is to elucidate the role and contribution of the professional healthcare chaplain for patients and healthcare teams with a view to informing best practice in future healthcare chaplaincy.

They begin with a historic perception of the chaplain role as a relationship-based care model that seeks to help patients find meaning and comfort in illness and works to address patients’ spiritual, pastoral and religious needs. They write that the role of the chaplain often remains obscured on the healthcare team and explain that the lack of evidence-based research in the field makes “a comprehensive understanding of the role, scope and contribution of chaplaincy services difficult.” Because of this lack of understanding and due to growing financial constraints, the authors point out that there is a current tension for the chaplaincy profession to show value and to make a case for their continued presence on healthcare teams.

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5 Ibid., 88.

6 Ibid., 90.
This article contributes to the topic first by highlighting the tensions facing professional chaplains today, and then with their suggestion of a possible future role for chaplains. First the article gives chaplains valuable insight into how other disciplines view the role of the chaplain and seeks to clarify how the limitations placed on the chaplain role by other disciplines impact patient care. They then suggest that, with the rise in the number of people who do not identify themselves with a particular religion, yet do describe themselves as spiritual, there may be a future emerging role for chaplains.

They report that “in the context of healthcare, particularly end of life situations, the belief system of those with no religion is complex.” They conclude that professional chaplains are in a position to assist with better health outcomes for patients, but because their role is not clearly defined, it limits their contribution to patient care. If this trend continues chaplains will not be given the opportunity to contribute all they could to holistic healing.

The main limitation of this article is the broad international focus. In other countries with national healthcare, the role of the chaplain has been primarily viewed as overtly religious. However, in the United States, healthcare chaplaincy has identified itself as a profession that is multi-faith/no faith, and not sponsored by any one church. Their finding that chaplains may play a role for ethical decision making at end of life as the only role they discuss in detail is narrow in scope and limited in focus compared to

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7 Ibid., 91.
the broad range of interventions that are within the scope of practice for professional chaplains.

This article builds on the literature by highlighting the growing need for a healthcare profession which specializes in understanding the complexities of multi-faith spiritual care to improve patient outcomes. It makes the case that professional spiritual care is an essential component of ethical healthcare committed to holistic population health. It further provides empirical, anecdotal evidence of the need for the chaplain role on health care teams.

**The Ideology of Modern Medicine: Silencing Spiritual Narratives of Illness**

The two books and one journal article reviewed in this section discuss how the ideology of modern medicine results in obscuring *imago dei*. They work together to build a foundation for understanding how the shift in medical assessment resulted in negative effects for patients. Allen Verhey discusses the reductionistic focus of modern medicine to the detriment of holistic patient care. Arthur Frank discusses how modern medicine silences patients’ voices, and Simon Lasir highlights how modern medicine leads to relational alienation for patients seeking medical care.

*Reading the Bible in the Strange World of Medicine* by Allen Verhey

In his book, *Reading the Bible in the Strange World of Medicine,* Allen Verhey’s thesis is that when a person enters the healthcare realm then that person has entered a

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world that is very different from the world of Scripture in its orientation and motivation for being. While Scripture states that humans are formed in the image and likeness of God and therefore have inherent dignity and worth, the world of medicine sees people primarily as their disease state and interactions with them are limited to treating the presenting medical problem. Various chapters of his book show how this fundamental understanding of the human person plays out in modern medical ethics and how the dignity of human beings became obscured as bioethics became secularized.

The way this book contributes to the topic is his analysis of how modern medicine has become an ideology that dehumanizes persons. As medicine diverged from the purposes of God for healing and became focused on cure, the spiritual aspect of person was forgotten. He writes also to set medicine in the all-encompassing work of God in renewing all things, saying that modern medicine must serve the cause of God. “Life and health [are] part of a larger good, not the *summum bonum.*” His aim is that Christians will have a thoughtful, wise, biblically based approach to the complex issues in modern healthcare to bend them to the cause of God.

The limitation of this book is that chaplains work in a very diverse world. It is essential that each chaplain is grounded in their own theological convictions, and Verhey does an excellent job at helping Christian chaplains form a set of guiding principles. It does not, however, help them work out pathways to navigate how to practically bridge the gap between a biblical worldview and the ideology that drives modern medical

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9 Ibid., 6.
culture. If chaplains are unclear on their stance it can exacerbate the role ambiguity felt by some chaplains (both how they see themselves and how other disciplines see them). It can also cause division around the differing views about the purpose of medicine (healing as understood by the healing ministry of Jesus, or cure as seen by modern medicine) which can add to the tension between who and what chaplains are to be and do in modern medical settings.

This book builds on previous literature by critically examining the logic of modern medicine’s ideology, particularly around the meaning of compassion, and invites chaplains to think deeply about health, healing and human dignity in our culture today. Having a solid grasp on God’s purpose for medicine helps chaplains with identity formation in healthcare settings and assists them in defining the terms of how and where they add value to the organizations they serve. It gives a broad framework to help them consider how to prophetically speak into those institutional morals with God’s vision for shalom and holistic healing.

_The Wounded Storyteller_ by Arthur Frank

Arthur Frank addresses three main topics in his book _The Wounded Storyteller_. First, he states that ill people need to tell their story. Second, he says that the story ill people tell is not only about their body, but also through their body. Third, he points out that the social context of when and where the story is told affects what aspects of the

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story are voiced and what aspects of the story are silenced. He begins his book with the third topic, that of telling stories in the context medical of settings.

He reflects that medicine as a profession was born in modernity and still operates according to the rational, scientific framework of that ideology. It values objective truth, lab results and symptoms of the illness as the only story worth telling. In modernity what the doctor described as the story became the story of illness, giving the doctor the final and authoritative word. He goes on to explore the cultural clash that occurs when people who live in our current postmodern culture find themselves as patients where doctors still retain the values of modernity. Because of the cultural shift from modern to post-modern, patients are less willing to surrender parts of their story or let doctors define for them what is important in the healing process. He claims that “postmodern times are when the capacity for telling one’s own story is reclaimed…the postmodern divide is crossed when people’s own stories are no longer told as secondary but have their own primary importance.”

Frank highlights four primary illness stories that people tell to make meaning and find healing in the face of acute sickness and chronic disease. The four types are: the restitution narrative, the chaos narrative, the quest narrative, and testimony. He writes that many people, especially in healthcare, do not want to hear these stories because they are difficult to hear, full of suffering and unfulfilled desire. He points out that “their

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11 Ibid., 7.
uncomfortable quality is all the more reason they have to be told. Otherwise, the interrupted voice remains silenced.”

The way this book contributes to the topic is that it opens a new way to think about illness and healing. It sheds light on the healing power held in stories and invites them back into medical care. It argues the fact that stories must be allowed to flourish, and that what is important to the patient must be invited into conversation. Their voices must be heard because what is silenced is not integrated or healed.

The limitation of this book for chaplains is that in acute care hospitals a chaplain may only see a patient one time due to limited staffing allocations which can make follow-up care difficult. The framework of the book assumes a story that is developed over a longer period of time and while chaplains can play a part in the forming of the story, they are not able to have long-term relationships with people over the course of their entire illness as meanings and hopes change. This builds on the previous literature in that it establishes a role for chaplains in the critical juncture of inviting postmodern stories into modern medical culture. It demonstrates the important role of making meaning and finding hope as integral to the healing process as being able to share illness stories can be a factor in determining a positive health outcome.

In integrating the patient voice into the medical record, the patient’s story is more than a collection of facts about their illness, more than lab values, test results or the diagnosis. The patient is seen as a person and how the illness is affecting their whole self,

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12 Ibid., 58.
how it is impacting their life, their relationships and what it is that is drawing them
toward peace and healing. This act of telling their whole story and having it witnessed
can help them find shalom, even in “the shadow of death” (Psalm 23:4).

“Reconciliation Through Narrative: Toward a Theology of Spiritual Care in Public
Health Care” by Simon Lasair13

Simon Lasair’s thesis is that “any encounter with a health care system forces the
health care receiver into a situation of potential conflict between their private spiritual
and/or religious values and those enshrined and enacted by state funded, regulated and
mandated health care systems.”14 Given this statement, his thesis is that “chaplains are
duty bound to uphold the personal and spiritual integrity of his or her client, regardless of
what the health care system might communicate to the client concerning him- or her-
self.”15 He proposes that in doing this chaplains are inhabiting liminal spaces and thereby
equip their patients to use their spiritual and religious freedom in healthcare settings
which by nature are alienating. Lisair illustrates this point when he writes,

as western medicine has encountered patient cases of increasing complexity and
acuity, there has been a corresponding explosion in the complicated technologies
needed and utilized to treat illness and injury…[however] time spent with patients
by medical personnel to build human relationship has correspondingly seen an
inverse correlation…as a result of all these variables, alienation has been an
increasing experience among patients and their families receiving care in the
West.”16

13 Simon Lasair, “Reconciliation Through Narrative: Toward a Theology of Spiritual Care in
14 Ibid., 160.
15 Ibid., 167.
16 Ibid.
The way that his argument contributes to the topic is that as chaplains equip their patients to use their own spiritual and religious freedom in healthcare, something of the personhood of the patient is retained. In this way chaplains assist patients in reclaiming their voice and finding hope in their own healthcare narrative in a system that is increasingly isolating. The limitations of the article in the context of the presenting ministry challenge is that it is focused primarily on private work between the chaplain and the patient. While this is an important aspect of the ministry challenge, there must also be a way for the medical team to know the patient’s full story. The challenge must be met by incorporating a way to communicate with the healthcare team so that the patient’s full personhood is reclaimed by the healthcare community that is seeking to serve them, such as with clear and concise charting in the patient’s electronic medical record.

This article builds on the previous literature by more clearly describing how patients are negatively impacted when their voices are silenced and makes the case that their stories must be told to foster wellbeing. It also begins to define a distinctive role for chaplains on the healthcare team as practitioners uniquely able to provide this healing ministry in a dehumanizing system meant to restore health. It builds on the previous literature by illustrating how chaplains, as they attend to the spiritual resources of the patient, and as they are attuned to patient narratives, can help usher in holistic healing.

In deeply listening to patient narratives and providing appropriate pastoral and spiritual interventions chaplains can disrupt “whatever experiences of alienation the client might have lived through in the context of his or her medical care. It is precisely in this
way that Christian chaplains manifest the work of the gospel, the gospel of reconciliation, healing, transformation and peace."\textsuperscript{17}

**A Renewed Role for Healthcare Chaplains:**
**Bearing Prophetic Witness in Modern Medical Culture**

The two journal articles reviewed in this section point a way forward for healthcare chaplains by offering a vision for a more well-defined, robust role in modern medicine. The first journal article offers a way forward in terms of the missiology of chaplains and what that might mean for a future chaplain role on healthcare teams. The second journal article narrows the focus from what chaplains might do in terms of their role, to how chaplains might harness the major communication tool between disciplines, the electronic medical record, to advocate for *imago dei*, and holistic healing in modern medical settings.

“Is Being There Enough?” Explorations of Incarnational Missiology with Chaplains by Sarah Dunlop\textsuperscript{18}

Sarah Donlop’s thesis is that being present is adequate in terms of chaplains’ ministry, but that in terms of chaplains’ theology, more than presence is required. She explains that the theology that undergirds a ministry of presence must also be

\textsuperscript{17} Ibid., 170.

prophetically in conversation with the context in which the ministry of presence is practiced. Her article reflects her findings after inviting several chaplains involved in various ministry settings to reflect on the missiology of their work.

She interviewed chaplains working in hospitals, in industry, in the marketplace, with the police and in university settings to find out how they view their work and how they navigate the tension inherent in chaplaincy in non-religious contexts. She found that chaplains saw themselves in five main ways: being there; functioning like a parish priest; incarnating something of God; connecting people to the transcendent God; and connecting people to the church. She argues that overall the findings show that chaplains see “that dialogue within the missional context and prophetically speaking into the context are the two key missional activities that should be led in tension.”

The limitation of this source considering the ministry challenge is that the project focused on the Church of England’s involvement in chaplaincy and was aimed to understand “the extent, character and narrative of Anglican involvement in chaplaincy.” While the article certainly has implications for hospital chaplaincy, the limited scope of the study and the inclusion of chaplains in various ministry settings makes the findings of limited use for developing spiritual assessments, interventions and documentation in the medical record. The way that this article contributes to the topic is highlighting the very real tension that exists for chaplains in modern healthcare. It builds on the previous

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19 Ibid., 184.

20 Ibid., 176.
literature by helping chaplains more clearly understand their role and function. It gives them a vision for what it is they are doing on healthcare teams.

Many chaplains describe their work as “ministry of presence” and this article builds on the present ministry strategy by also inviting chaplains to consider a prophetic aspect to their work. Navigating the roles that chaplains take on for themselves, along with the roles expected of them, in modern medical settings can be confusing for chaplains as they find their place. As Donlop points out “the prophetic element of the mission is often complex…the chaplain must be adept at conveying the faith in a manner that engages the variety of people encountered.”

In modern medicine the critical prophetic conversation for chaplains is finding a way to restore holistic healing to medical practice. One way to do this is by clearly documenting the spiritual aspect of hospitalized persons in their medical records. This can perhaps become a “new liturgy for a changing culture” bending modern medical culture toward Kingdom values.

“Chaplain Documentation and the Electronic Medical Record: A Survey of ACPE Residency Programs” by Tartaglia, Alexander, Diane Dodd-McCue, Timothy Ford, Charles Demm and Alma Hassell

The thesis of this article is that there is an untapped potential in using the electronic medical record in documentation for chaplain training, charting and for on-

21 Ibid., 184.
22 Ibid.
going quality improvement. The authors argue that while the electronic medical record provides a platform for enhancing chaplain communication with the rest of the healthcare team, it is an underused tool. They urge the development of spiritual assessment and intervention models that are standardized. They further urge documentation models that can describe the assessment and intervention strategies employed by the chaplain to help the rest of the healthcare team both understand chaplain care and how this care contributes to holistic healing for the patient.

The limitation of this article is that the sole focus is on a Clinical Pastoral Education (CPE) residency program rather than the focus being on professional chaplains. Since CPE has its own focus for training this can affect what students believe to be important to document in the medical record. The limitation is related to how this article builds on previous literature in that it highlights the need for ongoing training in documentation. It invites the need for chaplain departments to engage in continuous quality improvement. “Documentation based on reliable measures could contribute to the development of evidence-based practice as well as enhanced-inter-professional communication and collaboration in achieving desired patient outcomes.”

The way this article contributes to the topic is the focus on using the electronic medical record as “a documentation tool that captures both the unique contribution of spiritual/religious care and chaplains’ contributions to interprofessional plans that enhance patient outcomes.” This moves the topic forward by encouraging the

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24 Ibid., 50.

25 Ibid., 48.
development of a spiritual assessment model that is comprehensive enough to capture common spiritual themes and yet accessible enough that it is not overwhelming for healthcare chaplains to actually use. Having a standardized model encourages common language in charting which can then begin to build a language for describing how chaplains are contributing to the holistic care of patients. Being able to tell the story with identified spiritual themes allows the patient’s voice to be heard among the medical history that only focuses on the medical problems of the patient. This gives a fuller picture of the patient as a person, contributing to whole person care.

Summary

Historically the role of the chaplain on healthcare teams has been ambiguous. Because chaplains have operated in ways that were hard for other disciplines to understand their role has been obscured and underutilized. Given the current climate in modern medicine where patients are seen in reductionistic ways, chaplains need to move into a clearly defined role which robustly speaks for the benefit of patients who are longing to be seen and treated as whole people, made in the image of God. The next chapter will develop a theology of bearing prophetic witness for the missiology of chaplains in healthcare settings to address this ministry need.
CHAPTER 3: A THEOLOGY OF BEARING PROPHETIC WITNESS

This chapter will develop a theological foundation of bearing prophetic witness for the missiology of Christian chaplains in modern healthcare settings. First, this chapter will identify cultural forces that drove changes in medical practice which led to the severing of the long-standing partnership between medicine and religion. It will then identify theological paradigm shifts in medicine that resulted in medical practice moving from holism to reductionism in the care of patients. It will show how in medicine’s myopic quest for bodily cure the spiritual aspect of patients was silenced and *imago dei* was obscured. Next the chapter will cast a vision for what it means for chaplains to function as prophetic witnesses in the context of modern healthcare; it will explore possibilities for how this new role for chaplains could influence the culture of modern medicine toward holistic healing practices. The chapter concludes with an exposition of
Mark 5: 24b-34 as an example of what restoring *imago dei* and holistic healing could look like in modern contexts.

**Medicine and Religion: A Severed Relationship**

For most of its history the practice of medicine was holistic. Deeply influenced by Hippocrates, the goal of medicine was to benefit the whole patient. “The Hippocratic oath was initially written ‘against the stream’ of the conventional attitudes toward euthanasia and abortion in Greece. The ascendancy of the Hippocratic tradition in medicine is probably itself in part a result of the rise of Christianity.”¹ From the founding of the earliest hospitals through the end of the eighteenth century “a medical-religious partnership…was common in both launching and managing hospitals and in the moral and vocational framework of many nurses and physicians. There was a generally recognized spiritual connotation related to the practice of medicine as a vocation and sacredness in the care of the sick.”²

As the nineteenth century dawned the meaning and practice of medicine changed, and modern medicine was born.³ At that time in history, the philosophy of naturalism gained cultural acceptance. Scientific medicine built on naturalism held that the cause of

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disease was purely biological. It also saw patients through the lens of Cartesian dualism. In this view the qualities of a person that transcend the biological were minimized as restoring bodily health was the goal of medicine. In this narrow view of humans, the meaning of health was a body free of disease or sickness. The way that physical illness might impact the spiritual aspect of the person was marginalized as irrelevant in the pursuit of finding a cure for the illness. As a result, what had been a long partnership between religion and medicine, in the service of God for the healing of the sick, was severed.⁴

**From Holism to Reductionism: Abandoning Theological Roots of Holistic Healing**

When medicine diverged from religion, the theological reflection that had long been part of medicine was abandoned.⁵ When theological reflection was pushed to the margins of medicine, theological anthropology was drastically altered. While modern medicine saw humans in a mechanistic way, as the diseased parts of their physical bodies, biblical wisdom taught that humans are made of an inextricably unified material body and an immaterial spirit. Genesis 1:26 records that people are created “in the image (tselem) and likeness (damuth) of God. This is the only place in the Old Testament where these two terms are used in conjunction with one another. The general significance is that [humans are] closely patterned after [their] Maker.”⁶ Psalm 139:15 expands on this

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⁴ Balboni and Balboni, From Hostility to Hospitality Spirituality and Professional Socialization Within Medicine, 2-6.

⁵ Verhey, Reading the Bible in the Strange World of Medicine, 6.

imagery saying that humans are intricately woven together by God. The word woven is the Hebrew word “םַקָר (rā·qām) meaning to weave variegated cloth…formed, fashioned, formally, woven, i.e., be created and fashioned out of existing materials, as a figurative extension of weaving cloth into a product.”

Diane Langberg writes that there are three fundamental aspects woven into humans as they are made in the image of God. She names these aspects as “voice, relationship and power.” Each of these facets of imago dei is disregarded in modern medial culture resulting in harmful effects for patients. We will examine each one of these three aspects of imago dei in turn.

Silenced Voices: Ignoring Spiritual Narratives

“With the advent of the autopsy the fundamental norms of medicine transformed. It became a practice of power; a form of control; a scientific discourse; a form of applied engineering.” Having “reduced the patient to a lifeless corpse…medicine became a scientific practice untampered by humility and unchastised by awe. It became blind to the mystery within the person and blind to the mystery that lay beyond the range of its scientific gaze.” This kind of medical practice dramatically altered what could be discussed and what was silenced in the patient’s narrative of illness. The only topics

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10 Ibid., xiii.
allowed into the discussion were factors objectively related to the diagnosis of the disease which is rendered “in fifteen minutes or less after a succession of rapid-fire, yes-or-no questions.”\textsuperscript{11} This communication style stripped patients of their voices and ignored this central aspect of their personhood.

Genesis 1 records that God hovered over the vast emptiness of a formless universe, and then God spoke. “\textit{God said}—This phrase, which occurs so repeatedly in the account means: willed, decreed, appointed; and the determining will of God was followed in every instance by an immediate result.”\textsuperscript{12} Through God’s voice, everything that exists was brought into being. God’s word initiates and sustains life (Ps 33:6, Ps 119, Mt 4:4, Heb. 11:3). In the New Testament, John 1:14 says that Jesus is the Word which “suggests that self-expression is inherent in the Godhead…[and] the created ones have also been given voice. We need to understand what our voices were meant to be if we are to comprehend their loss.”\textsuperscript{13}

In the medical context when patients’ voices are silenced, they are cut off from an essential aspect of who they are as people made in the image of God. Their unique personhood is diminished, and the care they receive may not fit the context of their lives. Rita Charon and Martha Montello write in \textit{Stories Matter: The Role of Narrative in Medical Ethics} that “in the absence of the patient’s narrative, medical care fails and is


\textsuperscript{13} Langberg, \textit{Counseling Survivors of Sexual Abuse}, 46.
unethical.” Human suffering ensues as this aspect of imago dei is ignored by people who are meant to care for the sick in their time of need.

Depersonalized Clinical Relationships

Genesis 1:26 records that the creation of humans was an act of a harmonious decision between the Father, Son and Holy Spirit. They did the work of creation in partnership, and humans who are created in God’s image bear this relational mark within them. In the New Testament John 1:1 says, “In the beginning the Word was with God.”

The word translated “with” is the Greek word πρὸς meaning “to, towards, with. A strengthened form of pro; a preposition of direction; forward to, i.e. toward.” Louw and Nida give added insight into the richness of the word when they write that it carries “a mark of association, often with the implications of interrelationships.” As people made in God’s image, humans long for authentic face-to-face relationships. Patients want to sense that their doctors are with them, in all of who they are as people.

In modern healthcare authentic human connection is routinely compromised. For example,

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14 Rita Charon and Martha Montello, Stories Matter: The Role of Narrative in Medical Ethics (New York: Routledge, 2002), 139.

15 All Scripture used throughout this document is New International Version unless otherwise noted.

16 James Strong, Enhanced Strong’s Lexicon (Logos Bible Software: Woodside Bible Fellowship, 1995), Strong’s Greek 4314 “πρὸς.”

in a multisite study, Harvard investigators surveyed 230 patients with advanced cancer. Most (88 percent) considered religion to be at least somewhat important...72 percent said their spiritual needs were minimally or not at all supported by the medical system...not only are spiritual needs important to patients, but 66 to 81 percent of general medical patients say they would have greater trust in their physician if he or she asked about their religious/spiritual beliefs.\(^{18}\)

When patients sense their doctors turning away and dismissing issues that are important to them, such as spiritual beliefs, they feel unsupported and alienated in these encounters. The relational aspect of *imago dei* is thwarted.

In contrast, the Bible demonstrates the importance of being in a trusted relationship to experiencing deep healing. The Psalms affirm that spiritual discourse affects physical health. David writes in Psalm 32:3-4, “When I kept silent, my bones wasted away through my groaning all day long. For day and night your hand was heavy on me; my strength was sapped as in the heat of summer.” Then in Psalm 32:5 when David brought his concerns before God, he found mercy, authentic relationship and forgiveness. His spiritual pain was healed, and his physical body became asymptomatic. Other Psalms continue the witness that God heals sin, disease and sorrow and that physical bodies reap the benefits of alleviated spiritual pain (Ps 103:3, Ps 147:3). Through the witness of the Psalms God invites humans into authentic relationship in which human beings can bring their whole selves to God for healing.

Modern Medicine’s Power Distance: Limiting Patients’ Agency

The original mandate to humans in Genesis 1:26 was to be stewards of creation, to partner with God in caring for others and the world. This means that an essential aspect of *imago dei* is to exercise power or agency in the world. In health care relationships this power or agency is routinely stripped from patients by tactics doctors use to control the power dynamics. For example, in medical encounters “health care providers indicate their power by using jargon, dictating the topics, disregarding the patient’s initiative, interrupting, questioning, and controlling the time.”¹⁹ In her article “Managing the Power Dynamic Between Doctors and Patients,” Lisa Esposito observes that “it takes an average of roughly 23 seconds for doctors to interrupt when patients are talking.”²⁰ These interruptions are justified in modern medical culture when the doctor determines that what the patient is saying “may not contribute to a doctor’s cognitive process of reaching a diagnosis.”²¹

The doctor’s power to dictate what is allowed into the encounter and what is left out comes from their medical expertise. It also comes as a result of how society socializes patients to behave during medical encounters. Foucault asserts that, political order is maintained through the production of ‘docile bodies’—passive, subjugated, and productive individuals. Through its many institutions—schools,

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hospitals, prisons, the family—the state brings all aspects of life under its controlling gaze. The institutional disciplining, surveillance, and punishment of the body creates bodies that are habituated to external regulation….and thus produce the types of bodies that society requires.\textsuperscript{22}

These societal constructs work together to cement the doctor’s power and reinforce the passive role expectation of the patient in modern medical encounters. In this way medicine operates as an ideology maintaining social control over patients for society’s ends. It regularly obscures \textit{imago dei} by silencing patients’ voices, endorsing detached clinical relationships and undermining the patient’s personal agency.\textsuperscript{23}

\textbf{Bearing Prophetic Witness to \textit{Imago Dei} for Holistic Healing}

In modern medicine the prophetic vision “is to nurture, nourish, and evoke a consciousness and perception alternative to the consciousness and perception of the dominant culture” which regards patients as no more than their physical bodies.\textsuperscript{24} This vision energizes a role that moves “from the secretive ministry at the margins of healthcare toward open expression of its social action that expands pastoral theology and contributes ambitiously to public and political theologies.”\textsuperscript{25} This new role calls for a missiology that engages in a robust prophetic conversation with the reductionist practices


\textsuperscript{24} Ibid., 13.

\textsuperscript{25} Dillen and Vandehoeck, eds., \textit{Prophetic Witness in World Christianities Rethinking Pastoral Care and Counseling}, 178.
of modern medicine. It calls for a role of bearing prophetic witness to *imago dei* aimed at returning holistic healing to medical practice.

By nature, expressly bearing witness to *imago dei* is a prophetic act that criticizes the reductionist view of humans that dominates the ideology of modern medicine. In bearing prophetic witness chaplains can work to restore what the patient has lost in modern healthcare in each of the essential aspects of *imago dei*: “voice, relationship and power.”

Each of these aspects holds possibilities for how this new role for chaplains could influence the culture of modern medicine. The prophetic vision gives rise to three prophetic tasks that chaplains can undertake for a more robust role to foster holistic healing. Each task contains an element relating to documenting in the medical chart. Each task also offers additional suggestions for tasks beyond documenting in the medical record which could influence the broader culture in modern medical contexts.

**Prophetic Task 1:**
**Unmuting Silenced Voices**

The main communication tool between disciplines is the electronic medical record (EMR). This platform presents a viable opportunity for chaplains to help patients give voice to their spiritual perspectives by documenting them in the EMR for integration into their overall care plans. When chaplains say that they provide a “ministry of presence” or describe their function as a “story catcher,” it is a healing intervention for the patient.

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26 Langberg, *Counseling Survivors of Sexual Abuse*, 46.

However, it does not go far enough because this intervention is limited to the patient-chaplain encounter. Understanding the chaplain role in this narrow way has resulted in vague language in chaplain documentation. Many chaplain notes in the medical record state that the chaplain met with the patient (ministry of presence), and that the chaplain listened to the patient (caught the story). This does not translate well into clinical language that doctors understand as relevant to patient care. If patients’ voices are to be heard again, chaplains must “be more deliberate in translating the language of the profession into terms understood in the healthcare setting.”28

As a prophetic witness, chaplains can clearly and concisely document patients’ spiritual concerns knowing that this subversive act is returning an essential aspect of the patient back into consideration in their medical care. In this way chaplains participate with the patient in a “vital human strategy for sustaining a sense of agency in the face of disempowering circumstances.”29 When the patient’s voice is heard, a profound sense of personhood is returned. Functioning as prophetic witnesses to patients’ spirituality, chaplains can be active participants in unmuting silenced voices so patients can experience deep holistic healing beyond bodily cure.

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Beyond documenting in the medical chart, chaplains can also have an influence in returning the patient’s voice to modern medical settings by working with the narrative medicine movement. This movement is described as a rigorous intellectual and clinical discipline to fortify health with the capacity to skillfully receive the accounts person give or themselves-to recognize, absorb, interpret, and be moved to action by the stories of others. It emerged to challenge a reductionist, fragmented medicine that holds little regard to the singular aspects of a patient’s life and to protest the social injustice of a global healthcare system.\(^\text{30}\)

Even though the above description of narrative medicine depicts the heart of the work of chaplains Rita Charon and her colleagues did not turn to chaplains for help in implementing this work. Instead they turned to “psychoanalysis, Zen Buddhists, philosophers, literary scholars, and oral historians.”\(^\text{31}\) Because chaplains are skilled experts at how to carefully listen to patients’ stories and hear how their values and hopes intersect with their medical care, there is a viable opportunity for chaplains to step into their prophetic role and work with doctors who want to learn how to utilize narrative medicine in their practice to more fully connect with their patients. This is especially true when patients make medical decisions their doctors do not understand. For example, there was an elderly woman who decided to undergo dialysis against her doctor’s recommendation. The doctor could not comprehend this decision. However, the doctor used the principles of narrative medicine to deeply listen to the patient’s story the doctor


\(^{31}\) Dillen and Vandehoeck, eds., *Prophetic Witness in World Christianities* Rethinking Pastoral Care and Counseling, 179.
learned the human side of the decision. The fuller story was that the woman’s granddaughter was expected to graduate from college in eight months and she wanted to attend the graduation ceremony. When the doctor knew the whole story, then she completely supported the decision.

Prophetic Task 2:
Promoting Authentic Doctor-Patient Connection

“The concept of personhood has theological roots associated with the doctrine of God…thus models that are relational in nature and uphold connection remain crucial missing pieces that need to be regained within the patient-clinician relationship.”\(^{32}\) The ideology of modern medicine places primary importance on the physician’s diagnostic capabilities and turns what at its core is a human to human relationship into a detached observer-object transaction. “As a scientist the clinician must be objective and neutral in order to identify and cure the disease and must avoid becoming caught up in [their] own emotional and subjective feelings.”\(^{33}\) This relational stance is thought to save time and keep the focus on diagnosis, not considering that hearing the patient’s story will help with the diagnosis or realizing how little time it takes to connect emotionally with their patient. In fact, “medical research has shown that the amount of time to takes for patients to feel heard by their physicians is as little as ninety-two seconds.”\(^{34}\)

\(^{32}\) Balboni and Balboni, From Hostility to Hospitality Spirituality and Professional Socialization Within Medicine, 169.

\(^{33}\) Ibid.

\(^{34}\) Dillen and Vandehoeck, eds., Prophetic Witness in World Christianities, 179.
Research has also shown that most patients want their doctor to ask about spiritual issues and that many doctors feel uncomfortable discussing such issues.\textsuperscript{35} To address this gap, in 2001, The Joint Commission, which accredits healthcare organizations, decreed that health care providers ‘receive training on the value of spiritual assessment.’ Partly as a result, the number of medical schools with some education on spirituality and health has increased from 13 percent in 1997, to around 90 percent in 2014. But many medical schools provide only a single lecture on the psychological aspects of end-of-life care.\textsuperscript{36}

Functioning as a prophetic witness in this context means clearly identifying the primary place trusted relationship plays in healing and actively fostering opportunities for these doctor-patient relationships to flourish. The main way chaplains can foster the healing partnership is by plainly documenting the places where religion and medicine intersect, such as the avoidance of blood products, issues around gender and modesty, dietary regulations and end of life care. Clearly stating patients’ preferences in the medical chart can help doctors understand the places where religion and medicine meet and work to navigate these in conversation with their patients.

Beyond the medical chart, another way in which chaplains can support the doctor-patient relationship is by understanding the scope of current research on spirituality and medicine. The research “has grown exponentially in the past decade and the majority of


\textsuperscript{36} Ibid.
studies report significant relationships between religion/spirituality and better health."\(^{37}\)

When chaplains are fluent in the literature and are able to discuss the findings with their physician colleagues, it can help doctors feel more confident in discussing these subjects with their patients. Dr. Koenig, who pioneered the integration of spirituality in healthcare, states,

> all health professionals should be familiar with the research base, know the reasons for integrating spirituality into patient care, and be able to do so in a sensible and sensitive way. At stake is the health and well-being of our patients and satisfaction that we as health care providers experience in delivering care that addresses the whole person—body, mind, and spirit.\(^{38}\)

A third way chaplains can support the doctor-patient relationship is by introducing the variety of spiritual history tools currently available and by encouraging their use:

> The goal of each of these tools is to obtain a comprehensive understanding of a patient’s relationship to spirituality, what the patient’s spiritual beliefs are, and what his or her goals are for spiritual health…[and]…helps the clinicians understand how the spirituality of patients influences their understanding of their illness and health, their coping with suffering, and their finding meaning in the midst of what is happening to them.\(^{39}\)

The time is ripe for prophetic action in this area. Physicians themselves are suffering under a dehumanizing healthcare system. Many long for deeper connection with their patients and are looking for ways to find meaning and joy again in their work. In their


\(^{38}\) Ibid.

recent article, “Moral Injury and Burnout in Medicine: A Year of Lessons Learned,” Wendy Dean and Simon Talbot identify one of the ways to heal moral injury in healthcare is to “privilege the patient-clinician relationship.”40 As prophetic witnesses, chaplains can help doctors form relationships with patients that are open to spiritual discussions and offer true human connection, restoring this aspect of *imago dei* for the patients and the doctors. In fulfilling this prophetic task chaplains can help “patients and doctors find their way to unite in the shadow of death, to respect what is unique about each one, to join in authentic regard, and to face the unknown with courage, justice and hope.”41

Prophetic Task 3: Disrupting the Power Distance

In modern medical encounters “the patient is passively controlled and often reminded that [their] own subjective experience and agency are less relevant to healing.”42 Additionally, “medical discourse usually does not attend to the institutional causes of suffering.”43 In other words, the spiritual/religious aspect of patients is not the


only thing that gets silenced in medical encounters. In fact, “the exclusion of social context from critical attention is a fundamental feature of medical language.”

Pushing the social context out of medical encounters discounts the fundamental relational aspect of imago dei. Focusing solely on the patient in isolation from their communal life solidifies oppressive ideologies and does not address broad factors related to social determinants of health. These ideologies include social class, where “doctors sometimes voice explicit ideological message that legitimate the current class structure of society.”

Other ideologies that remain unvoiced and yet profoundly affect the dominance and subordination power dynamic in medical discourse are related to gender role expectations, aging and race.

Harmful ideologies continue to thrive, often below the surface of awareness, because “teaching about social determinants of health is allotted little time in medical education. Researching them at academic medical centers is held in lower regard than clinical drug trials and basic science.” Placing greater value on pathology than learning about compassionate communication can dehumanize health care practice. “By 1910, in fact, almost all criticisms that were to become so familiar in the late twentieth century were already being directed toward American hospitals. From the patient’s perspective,

44 Ibid., 232.

45 Ibid.

46 Ibid., 233.

the hospital seemed impersonal and bureaucratic. Staff physicians infrequently treated the whole patient.”

The rise of the hospice movement in the United States “derived at least in part from a desire to escape professional dominance as well as the desensitizing environment of the hospital” at the end of life.

It is in this complex healthcare environment that chaplains, functioning as prophetic witnesses, “speak truth to power [and] advocate for their patients in the power dynamics of healthcare, and they speak of hope and redemption to engage the minds and heart of others in constructive action in deeper and wider connectedness with life and with God.”

Foucault recognized the capacity of language to disrupt oppressive power dynamics when he observed that discourses are not once and for all subservient to power or raised up against it... We must make allowances for the complex and unstable process whereby a discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling point of resistance and a starting point for an opposing strategy. Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart.

Language is a powerful social force and the way that it is used in medicine can drive how patients are understood and how they are regarded. For example, some patients who are prescribed very expensive medication do not fill the prescription. Because they do not

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50 Dillen and Vandehoeck, eds., Prophetic Witness in World Christianities, 181.

take their medication, they end up back in the emergency room. When they come back multiple times in a short period, they are despairingly labeled as non-compliant or called frequent flyers.

As prophetic witnesses, following the example of Jesus who skillfully used language in the form of metaphor, story and parable to subvert oppressive ideologies, chaplains can use alternate language to disrupt stigmatizing labels and offer a new vision for whole person care. The place that this language would have the most impact is in the Next Steps area of the RAIN documentation format. In this area of the chaplain note, chaplains can deliberately use language that raises awareness about the limits of medicine, skillfully bringing attention,

to the implications of health care interactions for patients’ self-identities, life-plans and autonomy capabilities [to] facilitate recognition of potentially oppressive aspects of health care regiments, and support the development of respectful, bilateral relations that enable patients to develop and exercise self-governance skills, both within and beyond health care encounters.52

By carefully choosing respectful patient-centered language, chaplains can help the power dynamic shift from antagonism against the patient, or domination over the patient, to partnership with the patient. In this way the patient’s agency is welcomed and collaborative, comprehensive care plans can be formed.

When the spiritual and social aspects of patients are respected in tandem with the biomedical aspects, then holistic healing can return to the practice of medicine. In this

context shalom can be found, and medicine can again work in partnership with God for holistic healing. The following example from the healing ministry of Jesus casts a vision for what holistic care of people could be.

**An Encounter with the Great Physician: Mark 5:24b-34**

The compassionate healing ministry of Jesus stands in contrast to the reductionistic depersonalized practices of modern medicine. Among the numerous stories in scripture about Jesus’ healing ministry stands an encounter in Mark 5:24b-32 that vividly illustrates how Jesus cared for the woman who came to him. Central facets of his healing ministry were compassionate personal relationship, inviting dialogue, and restoring human agency for holistic healing.

Immediately preceding this passage Jesus had freed a demon-possessed man and was on the way to heal the daughter of Jairus, an official in the local synagogue (Mk 5:1-24a). As he is on his way to see the girl, he is followed by a large crowd of people. The healing encounter we will examine picks up in Mark 5: 24b.

5:24b  A large crowd followed and pressed around him.

In his account of this encounter Luke uses even stronger words for the nature of the crowd saying that they “choked,” or “stifled Him.”

53 This sets the stage for the events to follow. It shows the resolve of the woman to seek Jesus despite the obstacles. She was an active agent in her own healing. The crowded scene also highlights the compassion of

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Jesus to seek her out individually for a personal encounter after her long years of forced separation from community life.

5:25 And a woman was there who had been subject to bleeding for twelve years. That she had been bleeding for twelve years demonstrates her dire need of healing. It also points to her social isolation because her bleeding would have made her ritually unclean and unable to attend synagogue or participate in communal religious life (Lv 15: 25-33). The text is silent about her age and her explicit diagnosis. There is no mention of a husband or family so perhaps her affliction has cost her these relationships. “Her discharge of blood causes her to be discharged from society because it makes her a major bearer of impurity as a person with a flux. She is therefore similar to the leper as one suffering from cultic uncleanness and is excluded from normal social relations.”

5:26 She had suffered a great deal under the care of many doctors and had spent all she had, yet instead of getting better she grew worse. Besides the personal and social cost of her disease she had spent everything she had to get better. Her resources were depleted. The doctors were baffled and powerless to cure her. She was left poor, sick and in great need on every level of her being. Her affliction increased despite her tenacious efforts at cure.

5:27-28 When she heard about Jesus, she came up behind him in the crowd and touched his cloak, because she thought, “If I just touch his clothes, I will be healed.”

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No doubt she had heard the stories of Jesus’ power over disease and a flicker of hope was born. She “slinks up behind so that she will not be observed and hopes that she can slink back into the anonymity of the large crowd with anyone knowing of her unlawful contact.”

Her action was driven by her desire for healing. Interestingly, she is not made well, at least not directly... The woman did touch Jesus and immediately ‘she was healed of her disease’—‘healed’ (ἰάομαι), but not ‘made well’ or ‘saved’ (σῴζω). Only in conversation with Jesus; only in conversation that is open and honest, telling Jesus the ‘whole truth (v. 33); only then, from the mouth of Jesus is she ‘made well.’

5:29 Immediately her bleeding stopped and she felt in her body that she was freed from her suffering.

She reached out in faith and touched Jesus and finally found the healing that had eluded her for twelve years. In that moment she was released from her suffering. The Greek word “suffering” carries with it the idea of extreme pain and includes the range of meanings of “a) a scourge, lash, of leathern thongs with pieces of metal sewn up in them, (b) severe pains (sufferings), disease.”

At last she was not only physically healed, but her mental, emotional and spiritual anguish was ended. With the touch of Jesus, the torment and misery of living in lonely isolation was also a thing of the past as she was free to rejoin community life.

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55 Garland, The NIV Application Commentary, Mark, 220.

56 Fredrick J. Gaiser, Healing in the Bible Theological Insight for Christian Ministry (Grand Rapids: Baker Publishing Group, 2010),168.

57 Strong, Enhanced Strong’s Lexicon, Strong’s Greek 3148 “μάστιξ, ῥόγος, ῥ.”
5:30-32 At once Jesus realized that power had gone out from him. He turned around in the crowd and asked, “Who touched my clothes?” “You see the people crowding against you,” his disciples answered, “and yet you can ask, ‘Who touched me?’” But Jesus kept looking around to see who had done it.

Jesus immediately (euthys) realized in Himself (from epiginōskō, ‘know fully’; cf. v. 29) that power had gone out from Him or, more literally, ‘power from Him (on account of who He is) had gone out.’ This unusual expression has been understood in two ways. One view maintains that God the Father healed the woman and Jesus was not aware of it till afterward. The other view is that Jesus Himself, wishing to honor the woman’s faith, willingly extended His healing power to her. The latter view is more consistent with Jesus’ healing ministry. Power did not leave Him without His knowledge and will. However, He exercised it only at the Father’s bidding (cf. 13:32). The touch of the garment had no magical effect. Aware of how the miracle took place, Jesus turned around ... and asked, Who touched My clothes? He wanted to establish a personal relationship with the healed person, untainted with quasi-magical notions.58

Jesus stopped and initiated a personal relationship with the woman who came to him for help. He used his power to heal and restore her on all levels of her personhood: physical, social, psychological and spiritual.

5:33 Then the woman, knowing what had happened to her, came and fell at his feet and, trembling with fear, told him the whole truth.

Just as Jesus knew in himself that power had gone out from him, the woman now knows within herself that she had been healed. She knows she is the one Jesus seeks. However, he is not seeking out the woman to shame her as she might have feared. He desired a personal relationship with her so that He could offer individualized care for her needs. He makes a safe place for her to tell her whole story, without interruption or trying to control

the topics of conversation. In telling her story the whole community knows she is healed, and they can welcome her back again.

5:34 He said to her, “Daughter, your faith has healed you. Go in peace and be freed from your suffering.”

Not only does Jesus restore her to her community, he restores her to her place in the people of God by calling her daughter. Perhaps she had suffered greatly, wondering if she was cursed of God for those twelve long years. Jesus lays any of those anxieties to rest with her restored identity. “‘Wellness’ or ‘being saved’ comes only in the personal encounter with Jesus that involves words, communication, and promise.”

Not only does he not curse her, he gives her a blessing when he tells her to go in peace. “This is not simply a word of dismissal. The Hebrew term for peace that forms the background for the New Testament concept of peace is shalom. It covers wholeness, well-being, prosperity, security, friendship, and salvation.”

In stark contrast to the reductionist scientific methods of patient care in today’s healthcare culture, the healing ministry of Jesus is personal, holistic and compassionate. In his encounters with people he does not leave them alienated and alone with their suffering. Instead he moves toward them; he is with them without overpowering them to offer deep healing on all levels of their personhood. He invites their voice, truly interested in their story which fosters trusting relationships. He uses his power to preserve human dignity and restore shalom. In memory of Jesus’ healing ministry, Christian


60 Garland, The NIV Application Commentary, Mark, 222.
chaplains can work to evoke a medical culture that sees hospitalized persons with renewed vision, in their human fullness, with the compassionate gaze of God.
PART THREE

MINISTRY PRACTICE
CHAPTER 4:
DESIGN OF THE TRAINING MANUAL

This chapter will review the design of the training manual. First, it will summarize the key theological insights and explain the implication for the manual. It will then discuss the goals of the training manual and describe the specific components of the manual and how they are contextually sensitive. Finally, it will discuss the target population and identify the intended impact of the manual for their ministry.

Key Theological Insights

Compassionate care of the sick is important to God. In Exodus 15:26 God says, “I am the Lord, your healer.” The healing ministry of Jesus tangibly demonstrates God’s care for the sick. In Matthew 25: 31–46 Jesus explicitly states his solidarity with the sick and elucidates the eternal consequences connected to the treatment of the sick. The example of the early church demonstrates how they faithfully sought to care for the sick as Jesus commanded. In living out their mission they were active in building
hospitals and hospices. They knew that “care for the sick included competent medical care, [but] could not be reduced to medical care…life and health are great goods, but they are not ‘second’ gods.”

When medicine broke away from its partnership with religion a profound theological divergence occurred. As naturalism replaced the theological underpinnings of medical practice, cure of the body became the goal of medicine. With advancements in diagnostic capabilities, the advent of antibiotics, and the implementation of aseptic surgical practices modern medicine can prolong physical life. People now survive medical emergencies that formerly would have caused their death. With this ability to forestall death, a medical hubris crept in and scientific medicine now carries with it the “expectation that technology with deliver us from our mortality.”

This expectation of medicine comes at great cost to the way people are treated when they become sick. In this way of caring for the sick, divorced from the compassionate holistic healing example of Jesus, “patients came to feel like scientific specimens rather than human beings.” It is into this theological void that chaplains can have a profound impact, bending medical culture to once again recognize imago dei and serve the purpose of God in holistic healing of the sick, even when there is no cure.

1 Allen Verhey, Reading the Bible in the Strange World of Medicine (Grand Rapids: Eerdmans Publishing Co., 2003), 10.

2 Verhey, Reading the Bible in the Strange World of Medicine, 143.

Implications of the Training Manual

One implication of the training manual is that MultiCare chaplains, who are contextually situated to influence how the sick are treated, are now able to intentionally use their words and actions to restore whole person care to medical practice. They are more robustly serving as advocates for patients and humanizing the medical record so that patients are seen beyond their pathology. They are using clear and plain language so that the healthcare team easily understands the spiritual, social and emotional aspects of their patients for holistic healing.

Currently, there are powerful forces that operate in healthcare that work against compassionate care for the sick. When “enormous institutional resources are expended toward the combination of research, growing bureaucratic controls, and the bottom-line of the market” compassionate patient-centered care is at risk. Therefore, a second implication for the training manual is that by holding up the spiritual aspect of patients’ chaplains can help repair the relationship between spirituality and medicine and with that restored partnership medicine itself can begin to heal. As Balboni and Balboni note, a separation of medicine from spiritual resources is now increasing taking its toll on our social systems aimed to care for and health the seriously ill. There is no clear sign of any power besides spirituality and religion strong enough to reorder the impersonal and hostile powers surrounding medicine or to health the sickness that fester within the patient-clinician relationship.


5 Ibid.
Goals of Training Manual

There are four main goals for the training manual. The first goal is to equip chaplains to carry out spiritual assessments. To meet this goal the training manual first addresses what it means to do a spiritual assessment and how this is different than a description of the situation. For example, previously the documentation standard at MultiCare was to briefly tell the patient’s story in the chart note. While this is an essential function of helping the patient be seen as a person it does not always translate well into clinical language. Many clinicians could not understand actionable items within the story or relate it to how it might impact medical care. Because of that, the chaplain’s note was seen as a nice story and largely irrelevant to medical care.

In order to restore the spiritual aspect of patients to medical care, chaplains must clearly state the spiritual needs and strengths of the patient. Therefore, they must do an explicit spiritual assessment. A challenge to this is that the Clinical Pastoral Education (CPE) chaplains complete in order to become board certified professional chaplains does not focus on spiritual assessments. It does teach chaplains how to recognize emotion but not to follow it to the spiritual antecedent. This training manual addresses this gap by equipping chaplains to recognize and assess broad spiritual themes that underlie emotion. It teaches them to articulate their assessment in a clear, concise way.

A second goal of the training manual is to educate chaplains on a wide range of interventions and related outcomes to address spiritual issues. Because CPE training does not teach a single spiritual assessment model that all chaplains learn to use, it can also miss teaching which pastoral interventions are the most effective to achieve desired
outcomes. The training manual first defines interventions and what it means for a chaplain to use an intervention. CPE training stresses that chaplains have no agenda when they are with a patient. Some chaplains take this to mean that chaplain ministry is passive, or simply reflecting the patients’ statements of emotion back to them. This manual offers robust pastoral interventions that follow the patient’s lead and support deep holistic healing. It also gives chaplains language to use to describe their interventions so the care team can begin to see the range of chaplain interventions beyond prayer or attending to grief.

The third goal of the training manual is to improve documentation practices. Previously the documentation format at MultiCare followed an acronym called REAP. REAP stands for reason for visit, experience in the room, assessment and plan. This was written in a narrative format grouped into three paragraphs. The first line was the reason for the visit. The second paragraph detailed the experience in the room, which usually turned into a nice vignette about the chaplain-patient interaction. In the third paragraph the assessment and plan were documented together. Because the assessment was the last thing documented and was grouped together with the plan of care, it made it difficult for the healthcare team to sort out exactly what the chaplain was attempting to communicate. To address this communication issue, the training manual provides a format to make it seamless for chaplains to accurately and cogently communicate to colleagues the spiritual aspect of persons.

The fourth goal of the training manual is to incorporate spiritual care plans into overall medical care plans for holistic healing. Historically at MultiCare chaplains would
document something like chaplain to follow as available for the spiritual care plan. It is a passive care plan and tells the care team nothing about what the patient needs in terms of spiritual/religious care while they are in hospital. The training manual addresses areas where chaplain could have a more active voice and play a vital role in aligning spiritual and medical care plans with patients’ values and life goals beyond medical care.

**Components of the Training Manual**

The components of the training manual are arranged around the goals of the manual discussed above. The first section of the manual outlines the current ministry challenges for the chaplain department at MultiCare Health System (see Appendix A, page 109). The next section, Recognizing Spiritual Themes is comprised of two related parts (see Appendix page 117). The first part works through key theories from the social sciences that chaplains regularly use which form a framework for doing spiritual assessments. The theories highlighted are attunement theory, total pain theory, narrative theory, trauma informed care, grief theory, attentive listening and theory of emotion. The second part of this section lays out the HARP-M model of spiritual assessment. The mnemonic HARP-M stands for hope, autonomy, relationships, peace and meaning. The mnemonic is designed to help chaplains recognize broad spiritual themes that patients may describe to chaplains in an array of situations beyond overtly religious contexts.

For ease of use the manual arranges the five spiritual themes into charts. Each chart is headed with the name of the spiritual theme: hope, autonomy, relationships, peace, or meaning. The left column of the chart is titled spiritual intensity and each theme
is examined on a scale moving from spiritual well-being at the top of the scale to spiritual despair at the bottom of the scale. Under the second column is a description what the assessed area might look like at that intensity level. The third column identifies possible related emotions that might be expressed on the surface of this spiritual theme alerting the chaplain to deepen the conversation to identify the spiritual root. The fourth column gives examples of what a patient might say if they are dealing with a certain spiritual theme at a certain intensity level. The aim of these charts is to equip chaplains to recognize spiritual themes toward accurate spiritual assessments so that patients’ spiritual needs are honored in their medical care.

The second section of the manual entitled Responding to Spiritual Needs/Strengths addresses gaps around intervention skills and helps chaplains respond appropriately to what they assess (see Appendix A, page 139). It aims to educate chaplains on a range of possibilities for intervention strategies. It outlines sensitive questions chaplains might ask to probe deeper into the themes. It also helps chaplains understand and use facilitation skills to promote more reflection by patients to get to the spiritual heart of the matter for holistic healing. This section adds two columns to the charts found in the previous section. The first added column lists suggested responses/interventions that match the theme and intensity. The next column includes intended outcomes the chaplain might aim for as they assist the patient in moving toward wholeness and healing.

The third component of the training manual is titled Recording Patients’ Spiritual Narratives in the EMR; it lays out a cogent document format so that chaplains can clearly
record their spiritual assessment, intervention and care plan (see Appendix A, page 149). It aims to improve on the previous documentation model by streamlining the format to make it easier for the healthcare team to find the information they may need. For example, it moves the spiritual assessment as a single line to the top of the note instead of being buried in the third paragraph as it was before. At MultiCare when doctors review the patient notes from the day before, they have the medical note at the center of the screen and the interdisciplinary notes as thumbnail screens running along the right side. In the previous documentation format, the spiritual assessment was too far down in the note to be seen by the doctors. By moving the assessment to the top of the note the patient’s spiritual needs are easily seen giving more opportunity for them to be considered in their medical care.

The documentation model the training manual introduces is arranged around the acronym RAIN which stands for reason for visit, assessment of spiritual needs/strengths, intervention, and next steps. This model highlights spiritual assessment as a single line, such as patient describes spiritual distress related to hope, and then immediately under that describes the spiritual needs and strengths in narrative format. This serves as a guide to the healthcare team to know how to support the patient and how the spiritual pain might affect the total wellbeing of the patient. In this way the spiritual aspect of the patient is clearly documented and is then easily understood by the entire healthcare team. This understand can then lead to the creation of comprehensive care plans for whole person care.
The fourth section of the manual goes into more detail about spiritual care plans and is titled Restoring *Imago Dei*: Spiritual Care Plans (see Appendix A, page 152). The focus of this section is to help chaplains understand where medical care and spiritual care intersect so that the patient’s spirituality is incorporated into the over plan of care. Additionally, this section helps chaplains be more active in affirming the power of spirituality to assist patients in finding hope and meaning in their illness. This section helps chaplains create care plans that demonstrate the effectiveness of spiritual care in healing. It assists them in understanding how to clearly communicate in the medical chart so that the patient’s spiritual concerns and values become integrated into their overall plan of care. In this way, *imago dei* is restored to modern medicine for holistic healing.

The fifth section of the manual contains two case studies for chaplains to practice recognizing spiritual themes, responding to those needs, and then recording their care plans in the medical record (see Appendix A, page 154). It offers a note template so that chaplains can gain experience in how the documentation model functions to help make recording what they assess easier to record. The case studies can help chaplains pull the pieces previous sections together and see how the components of the training manual work together to form a cogent, comprehensive spiritual assessment, pastoral intervention and documentation model for holistic healing in modern healthcare settings.

The entire manual is formed to be contextually sensitive in at least three ways. First it is sensitive to the spiritual needs of patients who suffer with silenced voices in modern healthcare settings. The training manual equips chaplains to hear, respond and document patient voices in their medical records. Where the medical record normally
obscures the humanity of the patient, recording only the physical symptoms of their
disease, chaplains can insert another aspect of their personhood that is equally valid to
their healing. This serves the patients and brings back an essential healing resource for
whole person care. Patients then have their voices heard and their agency supported.

Another way the manual is contextually sensitive is that it helps clinician-patient
relationships be more bilateral. Including the spiritual and social aspects of patients in
their medical record supports compassionate medical practices. By ensuring that the
patient is seen and understood foremost as a person, it will foster human-to-human
connections in a complex healthcare system with powerful competing forces that work to
erode compassion. Finally, it is contextually sensitive in that it supports chaplains in their
ministry and addresses training gaps that are barriers to their work. The chaplains at
MultiCare want to become spiritual care experts. However, their past training on how to
do this is minimal. This training manual and the spiritual assessment workshop built to
implement it serve to mitigate these gaps.

**Target Population**

The target population for the training manual are the chaplains who serve at
MultiCare Health System. These chaplains are made up of six salaried chaplains, twelve
per diem chaplains and two CPE residents. They serve in the six acute care MultiCare
hospitals in the Puget Sound Region of Washington State. They are made up of nine
women and eleven men. One chaplain comes from a non-Christian faith background and
the rest come from Protestant Christian faith backgrounds. One chaplain is of African
American descent and the rest are of Caucasian descent. They range in age from twenty-eight to sixty-eight years old. Seven are board certified chaplains and three are in process of being board certified. The others have yet to pursue certification and are being encouraged to take this step.

**Intended Impact for the Target Population**

The intended impact for this population is three-fold. One intended impact is that chaplains would grow in the skills they need to provide expert spiritual care and document their work effectively. A second intended impact is that as chaplains grow in their ministry skills that their confidence level in their ability to provide effective pastoral care would grow. As their skill and confidence grow, the third intended impact is that they would meaningfully integrate into healthcare teams to foster holistic healing and compassionate care for the sick.

**Growth in Skill-level**

The first intended impact of this ministry initiative entails the ability of chaplains to effectively assess the spiritual needs and strengths of the patient. It includes the ability to approach each patient encounter with sensitivity to religious issues especially given the demographics related to religion in the cities MultiCare serves. Because there are many people who do not belong to a faith community, or who are described as “dechurched,”

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the assessment and documentation model is designed with broad spiritual categories in mind so that chaplains can also serve all patient populations with fidelity. It also includes the skill set to move beyond simply responding to the patient at the emotional level. It involves a deepening of pastoral listening that can trace the emotion to the spiritual root and provide targeted healing interventions that support spiritual healing. Finally, the skills set entails helping chaplains refine how they tell the patient story in the electronic medical record to raise the likelihood of chaplain notes being read and used by the interdisciplinary team. As they grow in these skills, the hope is that after they care for the patient that they would then be competent in using the new documentation format to clearly and concisely chart the spiritual encounter in language the entire healthcare team can understand.

Growth in Confidence

As chaplains use the new model and become experts at spiritual assessment, a second intended impact of the manual is that they would grow in confidence in their role. A major contributor to chaplains’ role ambiguity and lack of integration on healthcare teams has been chaplains’ lack of confidence about where they fit on the care team. There is a current interest in how to bring spirituality back into medicine and we must step into this opportunity. Being confident in our role and owning our expertise in spiritual assessment is a vital way to demonstrate our value to the healthcare system.
Full Integration on Healthcare Teams

A final intended impact is that as chaplains grow in confidence that they would become meaningfully integrated into the healthcare teams with which they serve. As they speak more confidently about the spiritual and social issues important to patients, and how these issues profoundly intersect with medical care, they will emerge as leaders in how to bring spirituality back to medicine. In this way they will serve as prophetic witnesses for the benefit of everyone who groans under modern healthcare’s oppressive systems.
CHAPTER 5:
IMPLEMENTATION AND ASSESSMENT

This chapter will discuss the steps taken to implement the training manual. The implementation was devised as a phased roll out strategy for two main reasons. First it was to give chaplains time to embrace a new vision for their role. Second it was to help them experience success in integrating a new assessment, intervention and documentation model into their practice for ministry transformation. The assessment of the manual consists of data gathered from pre-implementation and post-implementation surveys completed by the chaplains. The comparative results of the surveys will be discussed and interpreted for future ministry focus in the department. For ongoing assessment of the success of the ministry initiative a quality assurance protocol will be used. This will consist of chaplain self-reporting about their charting, check-ins at monthly one-on-one meetings, ongoing chart reviews by the department director, and training at quarterly staff meetings.
Implementation of the Manual

The first phase of the roll out strategy for the new manual took place in the third quarter of 2019 during department quarterly meetings. At this time the new RAIN documentation format was introduced and explained. Along with the new documentation format the HARP-M assessment model was introduced. It was explained to the chaplains that while they were free to use the assessment model that fit their ministry style best, everyone in the department was required to use the documentation format to standardize chaplain chart notes. As the new documentation model was beginning to be used, chaplains were encouraged to work together with their site teams to share successes and difficulties in implementing the new documentation model and to share the feedback with me. This gave me an opportunity to adjust and incorporate their feedback before the finished manual was rolled out. It also gave time for the chaplains to be familiar with the format and language of the HARP-M assessment model before they received the training manual to make incorporation of a new assessment a smoother transition.

At the fourth quarter department meetings, a copy of the training manual was given to each chaplain. At that time a brief overview was offered so that chaplains understood the layout and structure of the manual. The spiritual theme charts were discussed and an explanation about how to use them was given. A sample case study was discussed, and a group chart note was completed so that the chaplains were able to see how all the components of the training manual work together and could be useful for their work. At this meeting the chaplains were invited to take the manual and use the
model for one month and to be prepared to discuss questions, concerns and feedback with me in our January one-to-one meetings.

Each month I meet with every chaplain individually to provide time for them to debrief and offer any coaching they might need. For the month of January, we also discussed the training manual. I gathered information from them about what was working well and where they still had questions. I also elicited feedback about what would be helpful to include in our February Spiritual Assessment Workshop. I took all the feedback I received from the chaplains and designed a workshop around their learning needs.

The final phase of the training manual implementation was a three-hour Spiritual Assessment Workshop. The workshop was built around learning needs and goals identified by the chaplains in our January discussion so that the workshop was relevant and timely. In order to carry out the workshop I needed several resources. The first resource was to secure meeting rooms at Auburn Medical Center, Tacoma General Hospital and Good Samaritan Hospital. The dates for the workshops were planned around when meeting rooms were available as meeting space in hospitals is a challenge to find. Next, I created a PowerPoint presentation to align with the components of the training manual. The time for the workshop was used for instruction with interactive learning.

The first section of the workshop was made up of two parts that looked at assessment in general. The first part of the introductory section highlighted the difference between giving a description of a situation and assessing a situation. For this, I invited the chaplains to describe and assess a character from a Disney movie. This helped
demonstrate the higher-level thinking skills that assessment involves. It clearly demonstrated that assessing the spiritual issues beneath the behavior or emotion led to pastoral interventions that get to the heart of the spiritual pain for healing.

In the second part of the introductory section we looked at how spiritual assessment is understood by disciplines other than chaplains. For example, nursing has an entire nursing diagnosis category around spiritual distress. It is broken out into things like spiritual alienation, spiritual anxiety, spiritual guilt, or spiritual despair. Social work also has also developed spiritual assessment questions, mainly related to patient autonomy. Even doctors have an interest in spiritual assessment and have developed several tools to assist them in knowing what is important to the patient spiritually, and how it might intersect with medical care. The learning point was to help chaplains understand that we are not the only ones interested in this topic and to invite them to reflect on what we can learn from other disciplines. It was also to help them consider what these other disciplines might want to know about the spiritual needs of patients. This information helps chaplains write chart notes that are helpful to their colleagues.

Next the workshop successively focused on each component of the training manual. First it focused on recognizing spiritual themes, then it moved to responding to spiritual themes, and finally it discussed what restoring *imago dei* in medical contexts might look like. For each of these steps there was a similar pattern for interactive learning. The pattern was to introduce the topic of the section and then demonstrate the learning activity. After the introduction and demonstration by me, the chaplains worked in small groups to engage in the activity to understand the concept in a deeper way.
At the conclusion of the interactive learning activity, we looked at the documentation tip sheet I created and then practiced documenting the chart note as a group. After the group demonstration the chaplains were invited to write this part of their note. The table below summarizes the learning activity and documentation practice point that relates to each component of the manual.

Table 1: Training Manual Components with Related Learning Activity

<table>
<thead>
<tr>
<th>Component of Training Manual</th>
<th>Learning Activity</th>
<th>Documentation Practice Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizing Spiritual Themes</td>
<td>Identify the Spiritual Theme and Intensity: Each chaplain pair is given two card decks. On one deck the intensity scale is written. The other deck has one of the five spiritual themes written one the card. A chaplain pulls one card from each deck and tells a story with that intensity and that theme. The other chaplain practices assessing what they are hearing.</td>
<td>On the note practice template, the chaplains document their spiritual assessment.</td>
</tr>
<tr>
<td>Responding to Spiritual Needs/Strengths</td>
<td>Mix and Match: Each chaplain pair receives a set of index cards. On one set are written interventions. On the other set are written intended outcomes. They find an intervention and intended outcome to fit the story they just heard.</td>
<td>Document the intervention(s) and intended outcome(s) on the practice note template.</td>
</tr>
<tr>
<td>Restoring Imago Dei</td>
<td>Identifying Categories: Each pair of chaplains is given cards that can fit under one of three categories: “Religious,”</td>
<td>Document the spiritual care plan on the practice note template.</td>
</tr>
</tbody>
</table>
“Interpersonal,” or “Intrapersonal.” They read the card and decide what category it is under.

Assessment of the Manual

In August 2019, prior to beginning the implementation of the training manual, the chaplains participated in a survey to self-assess where they stood in terms of spiritual assessment skills. Eighty-eight percent of the chaplains completed the survey designed and delivered via Survey Monkey. They were invited to rate themselves on a sliding scale that ranged from zero to one hundred percent. The questions were arranged around the themes of knowledge base about spiritual assessment, skill-level in carrying out spiritual assessments, and confidence in professional competencies. The table below summarizes the questions and pre-survey and post-survey results.

Table 2: Pre-Implementation and Post-Implementation Survey Results

<table>
<thead>
<tr>
<th>Survey Question and Assessment Theme</th>
<th>Pre-Survey Result</th>
<th>Post-Survey Result</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge-How knowledgeable do you feel in describing the pastoral intervention you delivered in your visit?</td>
<td>79%</td>
<td>88%</td>
<td>+9%</td>
</tr>
<tr>
<td>Knowledge-Beyond praying with patients, how well versed are you in the variety of pastoral interventions you regularly use?</td>
<td>81%</td>
<td>84%</td>
<td>+3%</td>
</tr>
<tr>
<td>Skill-Do you have specific spiritual assessment models that you regularly use during patient visits?</td>
<td>FICA, Pruyser, RIOAP, FACT</td>
<td>FICA, HARP-M, Groves</td>
<td>Chaplains narrowing their focus in their</td>
</tr>
<tr>
<td>SDAT, Groves</td>
<td>chosen assessment models.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skill</strong>-How competent do you feel in making a pastoral/spiritual diagnosis of spiritual distress and/or spiritual wellness of a patient?</td>
<td>84%</td>
<td>87%</td>
<td>+3%</td>
</tr>
<tr>
<td><strong>Confidence</strong>-How equipped do you feel in recognizing spiritual themes during pastoral conversations?</td>
<td>83%</td>
<td>89%</td>
<td>+6%</td>
</tr>
<tr>
<td><strong>Confidence</strong>-How confident do you feel in your ability to describe spiritual distress in everyday language?</td>
<td>85%</td>
<td>89%</td>
<td>+4%</td>
</tr>
</tbody>
</table>

**Interpretation of Survey Data**

I chose to group the survey questions around the themes of knowledge, skill and confidence to gather data about where the chaplains saw themselves in terms of professional functioning before and after the implementation of the training manual. The themes for the questions are in direct relation to the goals of the training manual. Across all three themes there was a twenty-seven percent net gain of self-perceived growth in these three areas.

The knowledge questions assessed chaplains’ perceptions about pastoral interventions they might use. This area saw a net gain of twelve percent. The first question asked how they perceived their ability to describe the interventions they employed in a visit, and this reflected the largest gain of all the areas assessed at nine percent. While chaplains gained the ability to describe the interventions used, they rated
themselves lower on the number of interventions they know how to use, at three percent. This suggests that on-going training plans in spiritual assessment needs to include education about effective chaplain interventions.

The second set of questions was arranged around the theme of skill. The skill section saw a net gain of five percent. In this area the chaplains were asked if they had a spiritual assessment model they regularly used, and if they did, which one. The pre-survey results showed that chaplains used several different spiritual assessment models; they were not committed to a specific one. The post-survey results showed the number of named models reduced by 50 percent. The second question around skill was meant to measure their perception of how their chosen model works for them. This area saw a gain of 3 percent. While the number of named models saw a reduction in number, the perception of how these models function went up. This suggests that chaplains are narrowing their focus on which model works best for them, and having found a model that is effective, they are investing in how to deepen their practice with their identified model. Several of the chaplains have adopted the HARP-M model of assessment. Further training around how to deepen their skill in spiritual assessment and determining the efficacy of their model could be a profitable future focus for department training.

The third set of questions revolved around chaplains’ self-perception of their confidence level before and after the implementation of the training manual. Overall, their confidence level grew by 10 percent. The first question asked them to consider their confidence in making a spiritual assessment, and this area saw a net gain of 6 percent. The second question asked about their confidence in documenting their spiritual
assessment in plain, normative language, and this saw a gain of 4 percent. This data suggests that chaplains are growing in their confidence in how to carry out a spiritual assessment and are lagging in their confidence in their ability to describe the assessment. The gap between knowledge and confidence is bridged by opportunities to practice the new skill. Because of this, our department will engage in regular training to assist chaplains in honing their skill set so that their confidence in carrying out spiritual assessment is supported.

The data also shows that in terms of documenting the chaplains grew in their knowledge of how to describe their interventions by 9 percent, but in their confidence in how to document spiritual assessments it grew by only 4 percent. This suggests that the gap between knowing how to document and feeling secure in documenting is continuing to evolve. From this data I will use a strengths-based feedback model when coaching chaplains on the new documentation format as they grow in this new skill area. The data also shows that while the chaplains rated their growth in knowledge at 12 percent, and growth in confidence at 10 percent, they rated their growth in skill lower at only 5 percent. Again, this points to a training opportunity to invite chaplains to continue to practice this new skill set so that they feel fully equipped to carry out this essential ministry function. This could be an area of focus for another Spiritual Assessment workshop planned for fall of 2020.
Degree of Application in Ministry Context

One hundred percent of the chaplains are using the new documentation format. They report that the format makes it easier for them to truly access what is going on spiritually for the patient and helps them chart in a clear, concise manner that the rest of the healthcare team can easily understand. The chaplain team is also reporting that they finally have language to describe what they do. Instead of using chaplain shorthand terms, such as ministry of presence, they can now unpack that phrase to describe what they are doing in everyday language so that their role and function are more transparent to other team members. There is some anecdotal evidence that as their role becomes more transparent to other team members that they are becoming more integrated into their teams.

For example, one of the chaplains who serves in a cancer centers reported an interaction with a physician. The physician had read the chaplain’s note about a patient who had recently been diagnosed with an aggressive form of cancer. The prognosis for the patient was poor, at about a 1 percent chance treatment would be successful. The patient was pursuing treatment despite the low odds and against the advice of the physician. The physician was confused and after reading the chaplain’s note assessing the patient around the spiritual themes of hope and relationship, the physician approached the chaplain to get some guidance on how to navigate a therapeutic alliance with the patient. It was the chaplain’s note that led to a larger conversation about the values of the patient. Currently, instead of an adversarial relationship between physician and patient, there is a
respectful alliance. There is also a holistic care plan in place for this patient respecting her life goals beyond the scope of medicine.

**Ongoing Assessment Plan**

There are several things that make up the ongoing assessment plan. The foundational ongoing plan will be chart reviews by me and feedback in real time. In our electronic medical record system, Epic, there is a way to run reports on every patient a chaplain has seen, and so completing chart reviews for each chaplain is a realistic assessment methodology. The chaplains welcome the feedback and understand that this is part of the quality improvement in documentation that the entire department wants to achieve. One chaplain even stated that she hopes MultiCare becomes known for our assessment, intervention and documentation model to help other departments who may also want to improve their ability to assess and describe their work for holistic care of patients.

As an extension of the chart review and feedback in real time, I will also be adding a check in with each chaplain about their charting at our monthly one-on-one meetings. Chaplains will be invited to bring a chart note they would like to discuss. It could be something they are proud of or something with which they are struggling. This will sustain an on-going dialogue and will also help create individual professional growth plans for each chaplain. Another aspect of the ongoing assessment will be to incorporate mini training sessions at our quarterly department meetings. This will entail presenting a case study and then working with the chaplains to write a corporate chart note. This will
allow for interactive discussion among the chaplains, the opportunity for various viewpoints to be heard and revisions and improvements to be made as needed.

**Table 3: Sample Rubric for Ongoing Feedback and Quality Improvement**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was RAIN format followed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there a clear assessment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was patient’s story told in clear, concise, normative language?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were the intervention and intended outcomes appropriate for assessed need/strength?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there a care plan? Was it followed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengths and Growth Areas:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Another piece of the ongoing assessment is to flesh out each theme in our department newsletter *Flourish*. The newsletter comes out every other Friday and is intended to provide ongoing education for the chaplains. The last several editions have been on the theme of hope. The next editions will work through aspects of autonomy. This pattern will continue until all the elements of the HARP-M assessment model have been discussed. At the end of this series there will be a follow up spiritual assessment workshop to address any areas the chaplains identify where they may need additional training. This assessment will be made via Survey Monkey and in one-on-one monthly meetings.
SUMMARY AND CONCLUSION

This section will provide a summary of the outcomes of implementing the training manual. It will also cover a synopsis of the insights gained from this ministry focus project. Next it will discuss implications of this ministry initiative for the future of the ministry at MultiCare Health System. This section will conclude with suggestions for how this ministry initiative could intersect with the larger Christian community.

Outcomes

Overall the outcome of this ministry initiative has been fruitful. Several factors related to the objectives and goals of the training manual point to this success. The first factor which points to the success of the ministry initiative is seen in the Survey Monkey results. The positive net gain in all areas measured demonstrates the positive impact of implementing the training manual. Additionally, the chaplains are also reporting that the new model is helping them understand their work more fully. For example, one chaplain reported, “I finally understand what I am doing; I wish I’d had this manual in CPE.” Another reported, “This documentation model helps me when I’m in the room with the patient, I know what to look for and helpful ways to respond.”

These are only two examples of several the chaplains have offered showing that they are stepping into a more clearly defined role. As stated previously, historically the chaplain role has been ambiguous on healthcare teams, and so has been underutilized or very narrowly defined. Chaplains at MultiCare are now embracing a clearly defined role.
As chaplains lean into their increased knowledge base and feel equipped to apply it in a variety of patient care situations, their confidence is growing. This has led to a positive feedback loop in which they were able to experience efficacy in their work. It also led to the rest of the healthcare team noticing and understanding the essential role that spirituality plays in healing. As the central role chaplains play in holistic healing is becoming more widely recognized, chaplains are being utilized to the top of their scope of practice. Their role is not seen narrowly, unnecessary or in purely religious terms. Because of this, *imago dei* is being restored to medicine and holistic care plans are being utilized.

**Insights**

The insights gained from this intuitive are twofold. The first insight is about how language impacts culture, and the second is about the response of healthcare professionals. It was informative to observe the change toward spiritual care when chaplains started to use language in a new way. In the short time they have been documenting in the medical chart in a clear, concise way there is evidence that it is having a positive impact for whole person care. As the patient’s story became more accessible to the healthcare team in language they could understand, the team was very receptive to figuring out ways they could incorporate patient preferences into care plans. Chaplains had been telling the patient’s story all along. However, many of the salient points were buried deep in the note and the healthcare team was unable to decipher how these important aspects of the patient intersected with medical care. With the new
language the spiritual aspect of the patient is more easily understood by the care team and are being used for whole person care. In other words, the language chaplains use matters a great deal. By using language our healthcare colleagues can grasp the patient’s voice is being heard, their agency is respected and patient-clinician partnerships flourish.

The second insight is related to healthcare professionals. It was wonderful to witness the transformation in the attitude of the care team toward the patient when they really understood the patient story and perspective. Rather than judging them, or standing at a distance, they were able to join them in more human-to-human encounters. For example, there was a chaplain who was working with a care team in one of our hospitals, and the patient they were caring for was facing a dire outcome. The family of the patient would not accept the prognosis and demanded that full aggressive medical measures continue to be used. This resulted in moral distress within the care team. It also resulted in anger toward the family.

However, when the care team read the chaplain’s note, they understood the spiritual struggle of the family. As a result of knowing the story more fully and understanding some past medical experiences the family was carrying into the current experience, the care team understood and honored their grief and fear. In knowing the human story, the care team was able to unite around the family and support them as they made the difficult decision to transition to full comfort measures. The doctor stated, “I never realized that the family didn’t just need more education about the prognosis, they needed time to grieve.” Not only do chaplains now bridge the communication gap between patients and the healthcare team in the medical record, they also function to
build trust in a modern healthcare system that can be alienating. They are making a way for holistic care plans to be formed and carried out.

**Future Implications of Ministry Initiative**

There are four future goals that could grow from this ministry initiative. The first is changing how patients are assessed for spiritual needs on admission to the hospital. The second is forming interdisciplinary focus groups for discussions about spiritual assessment and the new documentation model. The third has to do with building interdepartmental partnerships to support holistic care at a system level, and possibly reaching out to local faith communities to support ongoing holistic care.

**Spiritual Screen on Admission**

Currently when patients are admitted to the hospital they are asked, “Do you want to see a chaplain?” By asking this question MultiCare fulfills the obligation to offer spiritual care to all patients. However, because this question only identifies the patients who self-select a chaplain visit, it misses some patients who may benefit from a chaplain visit and yet would not choose one. In the future, I would like to implement the spiritual screening process developed by George Fitchett at Rush University (see Appendix B, page 156). In this spiritual screening process, the patient is asked a brief series of questions to identify the patients that may be struggling with religious or spiritual issues.

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This process allows for self-selection and generates a referral to a chaplain for patients who may not say they want to see a chaplain but who are experiencing spiritual/religious struggle. In this way patients who are at risk spiritually, and who may not self-select to see a chaplain, can be seen and a spiritual assessment carried out. This will support holistic healing leading to better overall health outcomes for patients.

Interdisciplinary Focus Groups

Another future ministry implication that could grow from this project is that of forming interdisciplinary focus groups to gather their feedback on our new documentation model. Since the chaplains work very closely with the Palliative Care team in the hospitals, this could serve as the first focus group. The thrust of the focus group would be to have an open discussion about the new documentation model and find out what is helpful to them and what could be refined. After consulting with the Palliative Care team, I would then like to expand the focus groups to include staff from the Intensive Care Unit, our physician hospitalist group, and our psychiatric units for additional feedback on the documentation model. As feedback is gathered from other disciplines, chaplains can incorporate what is learned from these focus groups to improve their communication skills. With improved communication, the gap that has existed between disciplines will be closed to support holistic care of patients. An extension of this ministry implication is that I have joined a work group through Transforming Chaplaincy. The goal of this work group is to identify normative language that chaplains
can use when charting in Epic so that patients’ voices are clearly heard in the medical chart. This group is still in the formation process and work is yet to begin.

Interdepartmental Collaboration

A third future ministry implication involves moving toward collaboration with two other business units within MultiCare. The first is building an alliance with our education services department. The second is working on a project with the Chief Medical Officer at Auburn Medical Center to build faith-based community partnerships.

The first interdepartmental partnership is with The Center for Health Equity with the goal of enhancing the required annual education cultural competence module to include spirituality as an essential component of culturally competent care. Currently the computer-based learning module covers language, race, working with people who are deaf and language use choices for the bariatric population. The module does not cover anything related to how religious preferences or requirements might intersect with medical care. For example, issues pertaining to blood and blood products or dietary obligations could be included as common religious issues that may arise in hospital settings. Currently if there is a patient who avoids certain foods for religious reasons the only way to ensure that food will not show up on their meal tray is to put it in as an allergy. This serves to enforce the notion that a patient is reduced to physical reactions and not that the avoidance of the food is set in a much larger meaning structure. Integrating spiritual issues into the annual educational module could raise awareness about the ways in which spirituality intersects with medical care. I am actively in
conversation with the team from the Center for Health Equity and we will be adding a section on spirituality and health for annual education for all employees for 2020.

The second interdepartmental partnership has already begun. Currently I am in discussions with the Chief Medical Officer (CMO) at Auburn Medical Center. We are working on a proposal to present to an alliance of pastors who serve congregations in Auburn, Washington with the aim of improving population health. This potential partnership between the churches of Auburn, Washington and Auburn Medical Center could focus on how spirituality supports wellbeing in people living with chronic health conditions. It could also work to find faith-based supports for underserved populations for greater wellbeing in these patients. This partnership could develop critical relationships with various faith communities to help them support their congregants, perhaps resulting in regular clergy visits to hospitalized patients. It could also serve to raise awareness for staff at MultiCare about how health disparities and social determinants of health affect the populations MultiCare serves. In addition to the initiative discussed above, the CMO and I are exploring what it would take to bring narrative medicine groups to the physicians at Auburn Medical Center.

**Suggestions for Intersection with Larger Christian Community**

This ministry initiative project offers opportunities for the larger Christian community. First, the healthcare system can be incredibly difficult to navigate, and this could be an opportunity for the Christian community to reengage with medicine in a more proactive way. For example, by understanding the alienation patients face when they deal
with the healthcare system, churches could offer support and encouragement of these parishioners. This could be in individual pastoral care situations, or it could take the shape of a programmatic form, such as spiritually focused support groups, especially for those living with chronic illness.

An illustration of this is found in how Methodist Healthcare and several churches in Memphis, Tennessee are partnering to address population health. The healthcare system and a network of churches in the city have worked together to improve the health of the population. They serve as model of what a renewed partnership between the Church and medicine could look like. Here is what they have done.

Since 2006, the Congregational Health Network (CHN) has equipped over 450 Memphis churches—one-third Church of God in Christ, one-third National Baptist, and the rest a combination of AMC, Christ of Christ, and United Methodist churches—to promote the physical health of their congregants, many of whom have not social or economic access to Memphis’s award-winning healthcare. Each pastor selects a volunteer liaison in the church, who connects fellow members to a ‘navigator’ in one of the local hospitals. Together, the liaison and navigator walk the church members through appointment, medical documents, after care, and other details that would otherwise prove daunting…CHN’s success goes to show, in part, that creating a sustainable health care model in the United States will require more than upping coverage for the uninsured.  

Another implication of this ministry project for the wider church community is that it can invite churches to help people as they prepare for death. Historically the church was of great support as people prepared for their death. As part of the original hospice movement in Europe, the church took special interest in and active care of those who were dying. With this ethic of care of the dying a guide book was published that

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contained “an ingenious collection of wisdom with the bold name *Ars Bene Moriendi*, or the Art of Dying Well.”³ Over time, as the Western church moved with the rest of society into a culture that denies death, this practice of the church was lost. This coupled with faulty, or weak, theologies of suffering can lead to a void in guidance from the Church at the end of life. For example,

in a study of 68 ethnically diverse advanced cancer patients, belief in miracles, seeking guidance from God, and spiritual coping were associated with a preference for resuscitation, ventilation, and hospitalization in near-death scenarios. In a study from the trauma literature, over half of the respondents believed that God could heal a critically injured patient even when the physician stated that medical futility had been reached. Religious copers may choose medically aggressive therapies because they believe God could use the therapy to provide healing. Alternatively, patients may seek aggressive therapies because they hope that God might miraculously intervene while the patient’s life is being prolonged through intensive medical care.⁴

This is not to say that the choices religious people make around end of life decisions are inappropriate. It is to say that at this significant time in the life of its members that the Church is often silent. This leaves people without important guidance and support as they navigate a healthcare system that is alienating and minimizes or ignores essential aspects of their personhood. The Church could play a vital role in healing at the critical juncture of spirituality and health. The Church has a vital role to play both when people are living with chronic illness, as is shown in the Memphis

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³ Ibid.
example, and when people are preparing for death, as is shown in the example of the early church.
APPENDIX A
TRAINING MANUAL

TABLE OF CONTENTS

SECTION I:
INTRODUCTION: CURRENT MINISTRY CHALLENGES 109

SECTION II:
RECOGNIZING SPIRITUAL THEMES 117

SECTION III:
RESPONDING TO SPIRITUAL NEEDS/STRENGTHS 139

SECTION IV:
RECORING PATIENTS’ SPIRITUAL NARRATIVE IN EMR 149

SECTION V:
RESTORING IMAGO DEI: SPIRITUAL CARE PLANS 152

SECTION VI:
CASE STUDIES 154

BIBLIOGRAPHY 157
INTRODUCTION

This section of the training manual defines the context for the new ministry strategy. It examines several factors related to the challenges that chaplain face as they seek to serve patients in a healthcare system that can minimize the essential role spiritual plays in the lives of patients. At the same time modern healthcare systems can undervalue the contribution chaplains make which in turn negatively impacts holistic patient care. The three main challenges to chaplaincy at MultiCare Health System are elucidated below.

Current Ministry Challenges

In evaluating our program there are three core ministry challenges before us:

1. To demonstrate value to the healthcare system we serve
2. To fully integrate into healthcare teams with whom we collaborate
3. To bridge the communication gap about the spiritual aspect of patients

One way we can meet each of these challenges is described by George Fitchett when he says “in an environment where the lingua franca is research, we need to be able to demonstrate what we contribute [and] that begins with careful charting and evaluations by chaplains.”¹

Below is a very brief outline of how a spiritual assessment, intervention and documentation model, that is our careful charting, can address various aspects of the

ministry challenges with which we are faced. Each of these will be fleshed out in the remainder of this training manual.

Challenge 1: Demonstrating Value

In 2003 the Joint Commission on Accreditation of Healthcare Organizations, JCAHO, wrote that

patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. JCAHO Associate Director of Standards Interpretation explained that the Commission ‘expects you to conduct a spiritual assessment of every patient in every healthcare setting to determine how a patient’s religion or spiritual outlook might affect the care he or she receives.’

Chaplains can demonstrate their value by gaining competency as the spiritual care experts on healthcare teams by conducting spiritual assessments in line with this accreditation requirement. To unpack what this means in practice, we’ll begin by defining each word in this phrase.

The word “spiritual” is defined as “that aspect of persons which is a dynamic and intrinsic aspect of humanity through which individuals seek meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.”

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The chart below outlines fundamental aspects of spirituality.4

<table>
<thead>
<tr>
<th>Essential Attributes of Spirituality</th>
<th>Existential</th>
<th>Relational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involves a search for meaning/purpose</td>
<td>Object of relationship lies beyond physiological, psychological or social domains of life</td>
<td></td>
</tr>
<tr>
<td>Something that provides meaning/purpose</td>
<td>Object is transcendent, a life-force, energy</td>
<td></td>
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</tbody>
</table>

Spirituality can overlap with religion. Religion can facilitate human spirituality and give the expression of spirituality specific shape and meaning. Religion can provide tradition and institutional practices to help answer the deep spiritual questions of life. The diagram below illustrates where religion and spirituality overlap, showing how each meet needs and answer questions that are essential to human flourishing.5

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The next word in the phrase “spiritual assessment” is the word “assessment.” The Oxford dictionary records that the root word “assess” comes from the Latin word “assidere” which means to ‘sit by.’ When chaplains sit by a patient to carry out a spiritual assessment, what is it exactly they are doing? Here an insight about assessment from the educational field may offer further understanding. Stiggins writes, “if assessments of learning provide evidence of achievement for public reporting, then assessments for learning serve to help students learn more. The crucial distinction is between assessments to determine the status of learning and assessments to promote greater learning.” He makes a key differentiation between assessment of learning and assessment for learning. Assessment of learning looks backwards and uses items such as testing to measure this kind of learning. Assessment for learning looks forward and uses items such as learning goals and learning plans to help students toward greater learning.

As chaplains assess spirituality and how it is functioning for the patient, they are using both types of assessment.

Assessment of spirituality—in this type of assessment chaplains are looking at the patients past and current spiritual status. Chaplains screen for spiritual pain to see where the patient might be struggling and where they may be in distress. Chaplains also examine things such as how a patient has used spiritual practices in the past to help them

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8 Ibid.
cope and what resources they have that could serve as a source of strength/meaning. This is a place that one of the spiritual history tools could be used.

Assessment for spirituality—In this aspect of assessment chaplains are looking for ways to promote spiritual health in the patient for future wellbeing. They work to craft a spiritual care plan to support spiritual growth and spiritual health. In conducting a spiritual assessment, chaplains examine how the patient’s spirituality has functioned for them in the past and how it is functioning for them in the present (assessment of). They also determine how to help support the patient’s spirituality going forward (assessment for) to support spiritual wellbeing and holistic healing. For example, if a patient expresses spiritual struggle related to their image of God as angry and punishing them, a spiritual care plan could be formed to assist the patient in exploring and resolving this struggle for greater spiritual peace and well-being going forward.

Knowing that our healthcare system is mandated to conduct spiritual assessments, one concrete way to demonstrate value is to become specialists at conducting and recording accurate and thorough spiritual assessments. We can be the resident experts in helping our organization meet this standard and in supporting whole person care.

Challenge 2: Integrating on Healthcare Teams

Because the chaplain role has historically been ambiguous in clinical settings, our role has become narrowly defined as mainly relating to death or to overt religious activities. For example, one study found that while nurses, physicians, and social workers indicated it was important to refer patients to chaplains for end-of-life issues, they thought it much less important to
make referrals for issues related to treatment, pain and depression, and anxiety and anger...This may be because many healthcare professionals do not see a link between physical symptoms and spiritual issues, and as such they tend to treat these issues as medical or emotional as opposed to spiritual...most healthcare professionals would not think to connect unresolved grief, chronic anxiety or demoralization with unresolved spiritual issues. These differences in perspective among the disciplines may partly reflect disparate views regarding the chaplain’s role.

Careful documentation of our broad range of interventions can help our colleagues understand that we have much more to offer patients in terms of holistic healing than interventions limited to dealing with death or prayer. In this way we can become more integrated into the interdisciplinary care team contributing to holistic healing for our patients.

Challenge 3: Bridging the Communication Gap

Acknowledging and identifying the emotions patients convey to us is an important part of our work. However, if the spiritual assessment stops there it can translate poorly into clinical communication. Extrapolating from the numerous spiritual assessments (spiritual histories) developed by physicians such as FICA10 and HOPE11 we


can conclude that many physicians are interested in the spiritual aspect of their patients and how it relates to their medical care.

We can close this communication gap by working to document the spiritual aspect of our patients along with our chaplain interventions in language that makes sense to our clinical colleagues so that patients are seen as people in a holistic way, not as just a medical problem to be solved. This will contribute to holistic healing for the patient and help the staff connect to their patients in meaningful ways. As McCormick reflects,

> When illness threatens the health, and possibly the life of an individual, that person is likely to come to the physician with both physical symptoms and spiritual issues in mind…through these two channels, medicine and religion, humans grapple with common issues of infirmity, suffering, loneliness, despair, and death, while searching for hope, meaning, and personal value in the crisis of illness.”

Considering this truth, “the desire for a new form of medicine is real and deep. People today are not ready to give up scientific progress and all that it has to offer, but they rightly sense the need for more. Their desire is spiritual. They want a form of medicine that can heal them in body and soul.” With a foot in both the world of medicine and in the world of religion/spirituality, healthcare chaplains are uniquely placed within the context of modern healthcare culture to help birth this new form of medicine.

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Working within the culture we can help fashion a transformed way to practice medicine while also addressing our three core ministry challenges. By recognizing spiritual themes in what our patients are telling us, responding to it with intentional chaplain interventions that promote holistic healing and recording it in ways our clinical colleagues can understand we can bring about a medicine that sees patients, not with the detached “medical gaze”\textsuperscript{14} prevalent in modern medicine. We can evoke a medical culture that instead sees hospitalized persons with renewed vision, in their human fullness, with the compassionate gaze of God.

RECOGNIZING SPIRITUAL THEMES:  
BEARING WITNESS TO THE SPIRITUAL ASPECT  
OF HOSPITALIZED PERSONS

In thinking through the act of recognizing spiritual themes, the “doing” part of our work, it is first essential to review the theories that lay the groundwork for the “being” part of our work. It is important to consider who we are as we enter the room as chaplains and how that relates to our ability to foster a relationship-based context that invites patients to share their narratives from which spiritual themes can emerge.

Grounding Theories: The Person of the Chaplain

There are several theories that help build human connection and invite dialogue so that patients are free to share aspects of themselves that can otherwise be silenced in modern medical culture. These grounding theories represent ways of being for the chaplain and provide a relational orientation for interaction with the patient. Chaplains often bear witness to human suffering and to the spiritual aspect of the personhood of patients that has been minimized or ignored by modern medicine. It is essential that chaplains are persons who can hold sacred space for patients to share their spiritual narratives.

The theories discussed are attunement theory, total pain theory, narrative theory with an acknowledgement to trauma informed care, grief theory, and a focus on attentive listening. It will conclude with a discussion on the role of emotions in helping chaplains recognize spiritual themes in patient narratives as a basis for appropriate and effective spiritual care.
Attunement Theory

This theory comes from the work of Daniel Stern who observed infants and their mothers. In his work he took special note of how the quality of emotional interactions between mothers and infants affected how much or how little the infants felt understood.

Of special importance, Dr. Stern believes, is a sort of attunement in which mothers somehow let their infants know they have a sense of the infants' feelings. If a baby squeals in delight, for instance, the mother might give the baby a gentle shake. In that interaction - which mothers and infants go through about once a minute while actively engaged with each other - the main message is in the mother's more or less matching the baby's level of excitement…If you just imitate a baby, that only shows you know what he did, not how he felt," said Dr. Stern. "To let him know you sense how he feels, you have to play back his feelings in another way. Then the baby knows he is understood.¹

This theory applies to the work of chaplains because it is imperative that we communicate to patients with all of who we are that we are attuned to them, right here, right now in the present moment. We want to communicate through body language, tone and word that they have a safe space to say what they need to say and that they will be heard and understood without judgment. “Attunement is literally being ‘in tune’ with someone else’s emotional states. It’s [the] ability to be present emotionally in such a way that the [other person] feels understood, accepted and mirrored.”²

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² Gabor Mate, In the Realm of Hungry Ghosts: Close Encounters with Addiction (Toronto: Knopf, 2008), 238.
As patients feel safe, they can share their story of illness which can threaten personal integrity and be profoundly dysregulating. Attunement theory tells us that a personal encounter with an emotionally attuned person can foster safety and connection.

Total Pain Theory and the Spiritual Aspect of Persons

The concept of “total pain” was introduced by Dame Cecily Saunders after she noticed that even though all the physical needs of dying people were being met, that they were still suffering. In response to this “she introduced effective pain management and insisted that dying people needed dignity, compassion, and respect, as well as rigorous scientific methodology in the testing of treatments…Saunders introduced the idea of ‘total pain,’ which included the physical, emotional, social, and spiritual dimensions of distress.” 3 This well-supported theory of total pain informs our care in that we are looking for those aspects of pain that are spiritual in nature. It tells us that holistic healing depends on having these spiritual needs adequately addressed. Using her question, “How are you within?” can help chaplains address inner issues that may be causing spiritual, emotional and/or relational pain that may otherwise go unaddressed.

Narrative Theory

Psychotherapists who write about neurobiology agree that narrative seems to foster the horizontal integration of the left and right hemispheres of the brain…the left brain provides linear organization, logical interpretation of material, and the drive to understand cause and effect. But the material itself, the ‘stuff’ of

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 autobiographical memory, linked with emotions, relationships, and coherent contextual meanings, comes from the right brain.4

Narrative integrates the left and right hemispheres of the brain, but narrative is not reduced to a biological process. There is also a social aspect to narrative that is accomplished as the patient shares their narrative with the chaplain. The integration happening inside the person in the presence of a regulating, attuned chaplain is a healing intervention. With this intervention items such as “existential concerns, connectedness with God, community, faith, anger at God, others, conflicted belief system, despair, loss, grief, shame, isolation, religious concerns, and spiritual struggle…and also their hopes and dreams”5 can be examined and discussed for clarity and meaning.

As chaplains invite storytelling one task “is to help pick up on the right-brain messages that are being transmitted outside the [patient’s] awareness and reflect this right-brain information back to [them] in order to make possible a larger more inclusive narrative…to include the silent wisdom of the right.”6 Their right brain wisdom can be lost in very painful situations. In those circumstances when pain to too great for us to bear, we block its journey into consciousness and into words, dissociatively trapping it in our bodies and in the lower regions of the right brain, where the survival-oriented flight/fight/freeze defense mechanisms are organized. However, we still need to make sense of our experiences, so we create substitute narratives, often self-critical, to help us understand what is happening beneath our awareness. This is often our only option at the time, but it means that

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4 Patricia A DeYoung, Understanding and Treating Chronic Shame A Relational/Neurobiological Approach (New York: Routledge, 2015), 102.


6 DeYoung, Understanding and Treating Chronic Shame A Relational/Neurobiological Approach, 102.
our pain cannot be metabolized. It also means that we end up living half a life, inhabiting our minds and the critical stories we were told or came to believe, but not our bodies.\(^7\)

A feeling of disintegration, dissociation or even disembodiment can be the lived experience for people who are searching for meaning. Sharing their story fosters the left-right brain integration that needs to occur for them to re-inhabit their body and make meaning from their experiences. This in turn can contribute to a sense of personal coherence and social connectedness that is essential to holistic healing and wellbeing.

Arthur Frank in his book *The Wounded Storyteller*, writes that illness creates “narrative wreckage” in a person’s life and therefore illness calls for stories to repair the damage that is done by becoming ill.\(^8\) He highlights the importance of giving patients the opportunity to tell their story when he writes,

> the medical redefinition of conversation between physician and patient as a clinical task, for example, as ‘history taking,’ works to suspend normal conventions of politeness and thus to legitimate interruptions...[which are] ‘basically attempts to curtail storytelling by patients’ [because] ‘the story may not contribute to the doctor’s cognitive process of reaching a diagnosis.'\(^9\)

He then goes on to point out that the interrupted life of the patient is further interrupted when they attempt to express their story of illness. He writes that many people do not want to hear these kinds of stories because they are full of pain, longing and unfilled dreams. He says that “the stories are uncomfortable, and their uncomfortable quality is all

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\(^7\) Daniela Sieff, *Understanding and Healing Emotional Trauma Conversations with Pioneering Clinicians and Researchers* (New York, NY: Routledge, 2015), 47.


\(^9\) Ibid.
the more reason they have to be told. Otherwise, the interrupted voice remains silenced.**10**

Frank outlines three stories of illness. They are the restitution narrative, the chaos narrative and the quest narrative. He writes that healthcare culture works to make all narratives into a restitution narrative, that is a movement toward recovery. While this is an important narrative meant to instill hope, Frank warns that it may overlook the suffering of the person who wants healing and is not yet there. The second narrative he reviews is the chaos narrative. He writes that “those living in chaos are least able to tell a story, because they lack any sense of a viable future. Life is reduced to a series of present-tense assaults.”**11** The third type of narrative he describes is the quest narrative in which the patient is searching for a style for their illness that does not result in a diminished life.

A fourth illness narrative to be considered for our work is that discussed by Robert G. Mundle in his article, “The Spiritual Strength Story in End-of-life Care: Two Case Studies,” is the spiritual strength narrative. He explains

My clinical work as a hospital chaplain has revealed to me a kind of ontological narrative structure with a decidedly spiritual and/or religious focus that I call a ‘spiritual strength story’…I propose that a “spiritual strength story” has five defining characteristics: (1) it is brief; (2) it is ontological; (3) it uses symbols and metaphors; (4) it is a “big story” or meta-narrative with a positive spiritual and/or religious focus; and, most conspicuously of all, (5) it repeats. Cultivating awareness of the “spiritual strength story” in clinical relationships can help to improve the quality of inter-professional patient-centered care and understanding,

**10** Ibid, 58.

**11** Ibid, XV.
especially in the reflexive, embodied and relational practice of palliative and end-of-life care.¹²

These are only four examples of story types we might hear as we care for patients. There are many others as well. The important concept to remember is the central place narrative plays for humans in making meaning, experiencing integration and finding hope.

Trauma Informed Care

An important caveat to narrative theory is understanding its place in trauma informed care. Persons who have experienced trauma may not be able to engage in narrative processes. For these patients it is essential that a safe and trusting environment is established because healing is fostered in safe relationships. If patients feel unsafe it could potentially re-traumatize a person making it difficult for them to receive the care they are seeking. Chaplains can play a role in supporting patients’ spiritual wellness by recognizing trauma and by communicating about it to the care team.

Communicating well about the patient’s trauma to the care team can help them refrain from the judgmental question “What’s wrong with you?” and instead ask the compassionate question “What happened to you?” with the implied following question “How can I help?” The following principles are essential to creating a sensitive and contextual approach to trauma informed care:

**Patient empowerment**: Using individuals’ strengths to empower them in the development of their treatment;

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Choice: Informing patients regarding treatment options so they can choose the options they prefer;
Collaboration: Maximizing collaboration among health care staff, patients, and their families in organizational and treatment planning;
Safety: Developing health care settings and activities that ensure patients’ physical and emotional safety; and
Trustworthiness: Creating clear expectations with patients about what proposed treatments entail, who will provide services, and how care will be provided.13

In her classic work, *Trauma and Recovery*, Judith Herman writes that “because traumatic syndromes have basic features in common, the recovery process also follows a common pathway. The fundamental stages of recovery are establishing safety, reconstructing the trauma story and restoring the connection between survivors and their community.”14 Janina Fisher has adapted Judith Herman’s principles and explains them this way:

**Stage 1: Safety and Stabilization: Overcoming Dysregulation**
As a first step, you must first learn to comprehend the effects of trauma: to recognize common symptoms and to understand the meaning of overwhelming body sensations, intrusive emotions, and distorted cognitive schemas. The achievement of safety and stability rests on the following tasks:
- Establishing bodily safety: e.g. abstinence from self-injury.
- Establishment of a safe environment: e.g., a secure living situation, non-abusive relationships, a job and/or regular income, adequate supports.
- Establishment of emotional stability: e.g., ability to calm the body, regulate impulses, self-soothe, manage post-traumatic symptoms triggered by mundane events. The goal of this stage is to create a safe and stable ‘life in the here-and-now,’ allowing you to safely remember the trauma, rather than to re-live it.

**Stage II: Coming to Terms with Traumatic Memories**
At this stage, the focus is to overcome the fear of traumatic memories so they can be integrated, allowing appreciation for the person you have become as a result of the trauma. In order to metabolize (not just verbalize) memories, you may make


14 Judith Herman, *Trauma and Recovery the Aftermath of Violence-From Domestic Abuse to Political Terror* (New York: Basic Books, 1992), 3.
use of EMDR or other mind-body therapies. Pacing ensures that you don't become ‘stuck’ in avoidance or overwhelmed by memories and flashbacks. Since ‘remembering is not recovering,’ the goal is to come to terms with the traumatic past.

**Stage III: Integration and Moving On**

You can now begin to work on decreasing shame and alienation, developing a greater capacity for healthy attachment, and taking up personal and professional goals that reflect post-traumatic meaning-making. Overcoming fears of normal life, healthy challenge and change, and intimacy become the focus of the work. As your life becomes reconsolidated around a healthy present and a healed self, the trauma feels farther away, part of an integrated understanding of self but no longer a daily focus.15

In providing care for patients living in the aftermath of trauma chaplains can help support them during their hospitalization so that they are not re-traumatized by the hospital experience which can be bodily invasive and disempowering. Helping the rest of the care team understand that something terrible and tragic has happened to this person can engender compassion and sensitive care practices that will contribute to healing.

**Grief Theory**

As patients tell their stories it is essential to remember that the majority of people chaplains visit are experiencing some level of loss. Being grounded in your grief theory and able to work with it in the context of patient care is essential to help patients navigate the difficult and complex journey of grief. Here we will discuss Worden’s Grief Theory which he describes as “four tasks of mourning”:16

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**Worden’s Task 1: To Accept the Reality of the Loss.**

This task is accomplished through things such as spending time in the room with their deceased loved one, planning and attending funeral or memorial services and/or burial or internment. It is also accomplished as the griever learns to talk about the person who died in past tense. It also involves evaluating what the relationship meant. Chaplains assist with this in facilitating storytelling at the time of death. It is important to remember that hospitalized persons can also experience more subtle forms of loss. Helping people identify ambiguous losses is critical because when these are left unacknowledged and unnamed it can lead to disenfranchised grief which can usher in a whole host of spiritual maladies.

**Worden’s Task 2: To Work Through the Painful Impact of Grief**

This task is centered around facing a complex and sometimes confusing range of emotions a person deals with as they attempt to reconcile the loss and integrate it into their life. This can be even more complicated with the ambiguous losses related to illness, unmet expectations for healing and lost dreams due to health issues.

Rather than attempting to identify all the emotions of grief that one may experience and need to work through, Worden’s model acknowledges that each person and each loss will mean working through a range of different emotions. From sadness, fear, loneliness, despair, hopelessness, and anger to guilt, blame, shame, relief, and countless others, there are many emotions a griever contends with. What is important in this task is acknowledging, talking about, and understanding these complex emotions in order to work through them. The danger, of course, is denying one’s feelings and avoiding them. This tendency can be exacerbated by society’s discomfort with the feelings that accompany grief, so the griever may feel like they shouldn’t feel or acknowledge these difficult emotions.17

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Worden’s Task 3: To Adjust to an Environment in Which the Deceased is Missing

This task may be accomplished outside the hospital or we might encounter patients who are working on this task of grief from a loss prior to hospitalization. Recognizing when people are working on this task can help us form pastoral interventions to help them with this adjustment. “This task requires developing the necessary skills to move confidently forward in the altered environment – internal, external, and spiritual.”

Worden’s Task 4: To Find an Enduring Connection with the Deceased While Embarking on a New Life

The gist of task four is this – to find an appropriate, ongoing connection in our emotional lives with the person who has died while allowing us to continue living. Like the other tasks, this can mean varying things to various grievers. But it often means allowing for thoughts and memories, while beginning to meaningfully engage in things that bring pleasure, new things, or new relationships…This last task can take a long time and be one of the most difficult to accomplish.

For the more ambiguous losses related to illness this can mean helping the patient work toward healing and peace finding a full life even with a body that continues to present them with health challenges.

Attentive Listening

As chaplains sit in relationship with patients and assess where they are spiritually a large part of the work is attentive listening. In his book The Lost Art of Listening Michael Nichols writes,

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19 Ibid.
The essence of good listening is empathy, which can be achieved only by suspending our preoccupation with ourselves and entering into the experience of the other person. Part intuition and part effort, it’s the stuff of human connection. A listener’s empathy---grasping what we’re trying to say and showing it---builds a bond of understanding, linking us to someone who hears us and cares, and this confirms that our feelings are legitimate and recognizable. The power of empathic listening is the power to transform relationships. When deeply felt but unexpressed feelings take shape in words that are voiced and come back clarified, the result is a reassuring sense of being understood and a grateful feeling of shared humanness with the one who understands.\textsuperscript{20}

Robert Kidd states that “the \textit{sacred work} of spiritually supportive listening is called for when healing, strengthening, or guidance is needed…in such healing interactions, the speaker feels more valued and respected and experiences an emotional completeness unrealized in other forms of discourse.”\textsuperscript{21} He then goes on to offer some foundational responses for effective listening summarized in the chart below.\textsuperscript{22}

<table>
<thead>
<tr>
<th>Type of Response to Demonstrate Listening</th>
<th>Description of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Responses</td>
<td>Literal repetition-this response is most useful when the speaker emphasizes a word or phrase. Care needs to be taken so it does not become parrot-like. Example, a patient states “I am so shocked that Dad died.” The Chaplain says, “You are shocked about his death.” Reflecting-this response sensitively captures the emotion behind the words and restates it to help the patient integrate emotion. Patient says, “I am so angry that I missed my son’s birthday because I’m in the hospital again.” Chaplain says, “It’s upsetting and discouraging when your health challenges make you miss important family events.”</td>
</tr>
</tbody>
</table>

\textsuperscript{20} Michael P. Nichols, \textit{The Lost Art of Listening} (New York: Guilford Press 2009), 10

\textsuperscript{21} Roberts, Donovan, and Handzo, eds., \textit{Professional Spiritual and Pastoral Care a Practical Clergy and Chaplain's Handbook}, 92.

\textsuperscript{22} Ibid., 94-102
| Facilitating Responses | Paraphrasing-This response takes a small part of the narrative and rewords it to help the patient hear their own narrative in a new way for further integration. Patient might say, “The doctor said that Mom is not going to wake up, but we know that she’s a fighter.” Chaplain might say, “It’s hard to reconcile what the doctor says with what you know of your mom.”  
Summarizing-This is useful when the patient gives a lot of information, moving from topic to topic and then back again. For example, a patient has talked for 45 minutes about a wide range of topics. Chaplain might say, “Thank you for sharing so much of your story with me. I’m wondering, how does your faith help you with what you’re going through?”  
Facilitating Responses | Open-ended questions-intentional use and contextualized to fit the larger conversation and aimed at getting to the heart of the matter for integration; not fact-finding mission  
Buffering-these types of responses help soften what could otherwise be difficult or sensitive expressions of emotion. These help the speaker not feel overly exposed in the conversation. Examples include, “this may be difficult to discuss…” or “I wonder if you have considered…”  
Understatement/Euphemism-notice when speakers use a veiled way of expressing difficult or taboo topics such as death, sexuality, anger or in some cases fear or sorrow. Using the words for “death” the family uses such as “pass away,” or “crossed over” can keep the conversation moving and demonstrate understanding.  
Tell-Me-More/Minimal Encouragement-Make sure the tell-me-more is used to move the conversation spiritually as it can become listener directed. “Could you say more about…” “Help me understand…” Minimal encouragement responses are very brief interjections to let the speaker know the listener is tracking and interested in what the speaker is sharing. “Please go on…”  
Intense Interaction Responses | Calling Attention-This highlights something that the listener notices such as tears, body language, something/someone unmentioned to uncover spiritual pain.  
Hovering-this response is used when the speaker hovers over a topic without really landing. While respecting boundaries and comfort level of the speaker the chaplain could help the speaker land on a painful topic, and then allow the patient to move away and then with sensitivity, bring back again. |
There are two factors that could be barriers to attentive listening. The first potential barrier is how a chaplain modulates parallel processes that may occur during the visit. The other potential barrier is how chaplains regulate their own emotion. Listening to the story of another person can trigger personal memories of past painful experiences. It is important for the quality of one’s listening to be aware of the internal processes and emotions that may be stirring and how they can impact pastoral care.

The Spiritual AIM is an assessment and intervention model that harnesses the chaplain’s self-awareness of their parallel process to move the chaplain deeper into listening and understanding what the patient may be saying. This model is helpful in that it guides the chaplain in how to use their own parallel process in service to the healing of the patient. Rather than getting stuck in the patient process, the chaplain can instead use it to inform a healing intervention. The following chart recaps their thinking.23

<table>
<thead>
<tr>
<th>Patient’s Spiritual Theme</th>
<th>Chaplain May Feel</th>
<th>Chaplain Embodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning and Direction</td>
<td>Mental fogginess, confused in following patient’s story</td>
<td>Guidance</td>
</tr>
<tr>
<td>Self-worth, belonging to community</td>
<td>That patient is attempting to be caregiver for chaplain or that patient is putting chaplain on a pedestal</td>
<td>Community</td>
</tr>
<tr>
<td>Reconciliation/to love and be loved</td>
<td>Drawn into a triangle. That patient could be easily alienated by the chaplain.</td>
<td>Prophetic/Truthteller</td>
</tr>
</tbody>
</table>

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The second factor that could be a barrier to attentive listening is how the chaplain regulates their emotion in response to what the patient says or to the situation at hand. If the chaplain presents as anxious or not attentive then this attitude will adversely affect the healing possible in the relationship. Marie Dezelic created the following diagram for understanding emotional regulation processes. It can be a tool for chaplains to use in considering how they respond in certain situations and how this might impact the care they are able to offer.24

When chaplains can present with a non-anxious presence, they can communicate openness and welcome for the patient to share what it is they need to say. In a recent study, patients identified three themes that were helpful to them from chaplain interventions. The identified themes were “being heard and understood, feeling there is a place for ‘not having a solution,’ and feeling there is a place for ‘that which cannot be

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said.”25 By cultivating an attuned presence, and by nurturing space inside themselves and within the relationship chaplains can hold space for the patient to be heard. Chaplains can maintain inner stillness in remembering that the chaplain’s “primary role is not to provide answers but to listen in a way that helps [them], and [the speaker] listen for what God is saying.”26 Chaplains bear witness to patient’s pain and stand in solidarity with them.

The Role of Emotions

In creating a safe relational environment using these grounding theories chaplains can journey with patients and help them explore their emotional reactions to experiences of life. No matter which theory of emotion underlies their practice, chaplains can help patients understand how their emotions connect to their relationship with God/spiritual things, with themselves and with others. “Emotions are the cry of the soul. They expose what we are doing with the sorrow of life and in turn reveal what our heart is doing with God.”27 It is my belief that emotions reveal deeper spiritual themes. Dan Allender and Tremper Longman go as far as stating that “every emotion is a theological statement.”28


28 Ibid., 34
Emotions are expressed outwardly and are deeply rooted in our questions and beliefs about God and spiritual things. In the chapter “Inspiring Hope” in the book *Professional Spiritual and Pastoral Care A Practical Clergy and Chaplain’s Handbook*, Dr. Glenn Robitalle writes,

Effective spiritual care recognizes the central place emotion plays in spirituality…when faith is healthy, the believer engages the God Presence/transcendence as life-giving, life-affirming and benevolent. The outcomes of such faith are strengthened resolve to face the uncertainties of life and access to the strengths of one’s faith in time of difficulty. When faith is unhealthy, the God Presence/transcendence is cast as severe, exacting, malevolent, and/or indifferent. In such cases, beliefs interfere with the believers’ capacity to cope and significantly add to the challenges being faced. Assessing this connection between affect and beliefs is the primary role of spiritual care. Until one follows the emotional trail to this spiritual antecedent, spiritual care is little more than a shot in the dark.29

Acknowledging the essential role emotions play in spirituality, the next pages will explore five spiritual themes that may underlie emotion. Taken together these five themes comprise the HARP-M model of spiritual assessment. They are Hope, Autonomy, Relationships, Peace, and Meaning. In the charts that follow each theme is examined on an intensity scale moving from spiritual well-being to spiritual despair. The first column of the chart is the assessment domain of how the patient is coping in relation to the theme. The second column is a description of the assessed area. The third column identifies possible related emotions and the fourth column contains examples of what a patient might say. The aim of these charts is to offer a range of possibilities for what may

be happening in the interaction and to help guide chaplains so that they are better equipped to recognize and respond to spiritual needs.

### Spiritual Theme: Hope/Transcendence/Sacred

<table>
<thead>
<tr>
<th>Spiritual Intensity</th>
<th>Description</th>
<th>Emotions</th>
<th>Patient May Say…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well being</strong></td>
<td>Meaning beyond circumstance; Focus is on ultimate hope; Anchored/Deeply connected to transcendent values (God, nature, family, beauty, etc.)</td>
<td>Expectation of good future, Inner peace, Forward looking/planning, Gratitude</td>
<td>God will take care of me, My family is always there for me, I am confident…</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Life promoting self-narratives that live in the reality of the here and now while envisioning a better future</td>
<td>Mostly positive expectation, Some apprehension realizing that things could turn out differently than expected</td>
<td>God will help me (“won’t give me more than I can handle”), I can get through this, Better days are coming</td>
</tr>
<tr>
<td><strong>Spiritual Pain/Struggle</strong></td>
<td>Negative feelings about the future; Decreased motivation to change things; low expectations of what future holds</td>
<td>Fear based/Anxious, Disappointed/downhearted, Confused, Betrayed</td>
<td>It will never get better, I feel like giving up, Sighing/resignation to situation, Why would God do this/allow this?</td>
</tr>
<tr>
<td><strong>Spiritual Distress</strong></td>
<td>Patient’s view of their future as limited and they do not see ways to improve their future. They feel powerless to make it better</td>
<td>Dread/Discouraged, Overwhelmed, Agitated, Afraid—could manifest as anger</td>
<td>I can’t/ It is too late now, I have no future, God/other does not care about me, I can’t pray anymore</td>
</tr>
<tr>
<td><strong>Spiritual Despair</strong></td>
<td>Patient has lost beliefs in their systems of meaning and lost trust in transcendent values and/or in God. Negative view of future.</td>
<td>Doom/ Terrified/ Numb, Powerless, Abandoned, Despondent/desolate</td>
<td>God has abandoned me, I am alone/No one can help me, I have no hope (attachment, mastery, or survival threatened or missing), I have lost my faith</td>
</tr>
<tr>
<td>Spiritual Intensity</td>
<td>Description</td>
<td>Emotions</td>
<td>Patient May Say…</td>
</tr>
<tr>
<td>--------------------</td>
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<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Well being</strong></td>
<td>Able to live congruent with self-identity and carry out vocational purposes of life</td>
<td>Competence/Mastery Secure Confident Peaceful</td>
<td>Define life in terms of vocation/what they do Speak in present tense in how they live their purpose and exercise free choice toward personal goals</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Still able to carry out many of life tasks/vocation independently and sees a future that will present challenges and feels that they have the resources to meet those when they come</td>
<td>Some sadness, mostly acceptance of life’s changes Stability Trust</td>
<td>This is hard for me… I still can… I’ve adapted…</td>
</tr>
<tr>
<td><strong>Spiritual Pain/Struggle</strong></td>
<td>Sees self-identity disintegrating while still able to fulfill many important tasks and engage in important relationships in a meaningful way. Sees that the future may present challenges they can’t overcome.</td>
<td>Grief Insecure Uncertain Discouraged</td>
<td>I used to… I feel myself aging… Before I was sick… I miss being able to…</td>
</tr>
<tr>
<td><strong>Spiritual Distress</strong></td>
<td>Sees self-identity and choice disintegrating while unable to fulfill important tasks or engage in important relationships to fulfill their perceived purpose. Life completion tasks thwarted.</td>
<td>Defeated Empty Alienated Lonely</td>
<td>How will I live without…? (role, function, person) What am I going to do now? No one visits me anymore…</td>
</tr>
<tr>
<td><strong>Spiritual Despair</strong></td>
<td>Sees self-identity disconnected from life purpose and unable to retrieve prior sense of vocation and/or meaning Unable to maintain sense of unique identity; negative self-image</td>
<td>Worthless Inadequate Powerless Shame or Guilt Hopelessness</td>
<td>I’m a burden… I can’t/won’t… I have no purpose… No one cares what I think…</td>
</tr>
</tbody>
</table>
### Spiritual Theme: Relationships/Belonging/Community

<table>
<thead>
<tr>
<th>Spiritual Intensity</th>
<th>Description</th>
<th>Emotions</th>
<th>Patient May Say….</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well being</strong></td>
<td>All levels of relational systems-self, others, God, nature intact and thriving. Deep sense of interconnectedness Connects with healthy boundaries</td>
<td>Generosity, Joy/Humor, Openness</td>
<td>Expresses gratitude for key relationships in life. Accepts others and self openly. Deeply rooted in faith relationship with God.</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Most relationships are intact and healthy. May exhibit some needs for reconciliation/reconnection with important relationships and willing to do the work necessary to repair them.</td>
<td>Grief, Hope</td>
<td>Describe some brokenness in a relationship and their openness to work toward reconciliation accepting their responsibility in the relational brokenness</td>
</tr>
<tr>
<td><strong>Spiritual Pain/Struggle</strong></td>
<td>Brokenness in key relationships. Unwilling or unable to accept personal responsibility. Unable or unwilling to reconcile and/or forgive. Or might be self-blaming.</td>
<td>Lonely, Self-Protective, Detached</td>
<td>Lament loss of companionship. Describe self in self-depreciating or over inflated language</td>
</tr>
<tr>
<td><strong>Spiritual Distress</strong></td>
<td>Feels cut off from community and senses that they are somehow unacceptable to others. Loss of sense of connection to important social/faith aspects of life. Anger and unforgiveness toward others.</td>
<td>Empty, Crushed spirit, Dissatisfied, Abandoned</td>
<td>May describe relational brokenness by blaming others. Unable to take responsibility for their part in brokenness. “Why would God allow this…?”</td>
</tr>
<tr>
<td><strong>Spiritual Despair</strong></td>
<td>Withdrawn and refuses to accept help. Disconnected from self, others, God Self-isolating behaviors</td>
<td>Alienated, Defensive</td>
<td>No one wants to be near me… I don’t need anyone… God does not care about me…</td>
</tr>
<tr>
<td>Spiritual Intensity</td>
<td>Description</td>
<td>Emotions</td>
<td>Patient May Say…</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Well being</strong></td>
<td>Deep sense of inner calm and contentment irrespective of external stress. Lives live consistent with deeply held values.</td>
<td>Serenity, Contentment</td>
<td>All is well… I have deep trust that God will see me through…</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Ability to name outer stressors and regain grounding in the transition/change/stress. Grieves appropriately the losses/changes of life to move forward with hope.</td>
<td>Trust, Hope, Reconciled</td>
<td>I have the coping skills to manage I have faced hard things before, and I’ll be ok</td>
</tr>
<tr>
<td><strong>Spiritual Pain/Struggle</strong></td>
<td>Outer stressors threaten to overcome normal coping. Willing to engage in resiliency or spiritual practices to mitigate stress and find peace</td>
<td>Anxious, Confused, Shocked</td>
<td>I don’t know how I’ll deal with this… “What if” statements</td>
</tr>
<tr>
<td><strong>Spiritual Distress</strong></td>
<td>Outer stressors have overwhelmed normal coping strategies and a person experiences spiritual disequilibrium that causes them to question God’s love for them.</td>
<td>Bewildered, Overwhelmed</td>
<td>Why didn’t God stop…? Statements about “unfairness” of God Frustration/anger at God</td>
</tr>
<tr>
<td><strong>Spiritual Despair</strong></td>
<td>Life stressors have completely overwhelmed ability to cope and person despairs of ever being at peace feeling God has forsaken them and withdrawn love/comfort from them and they are unable to regain God’s favor.</td>
<td>Misery, Hopeless, Spiritually empty</td>
<td>Self-defeating language God has forsaken me Effort to find peace/connect with God seems useless</td>
</tr>
<tr>
<td>Spiritual Intensity</td>
<td>Description</td>
<td>Emotions</td>
<td>Patient May Say…</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
<td>----------</td>
<td>-----------------</td>
</tr>
<tr>
<td><strong>Well being</strong></td>
<td>Global and situation belief systems congruent. Person able to understand how life is fitting together and feels empowered to move through the world with integrated belief systems.</td>
<td>Curious, Exploring, Discerning</td>
<td>This is what I envisioned, God has led me here</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Global belief system threatened by the current situation. Person working through discrepancy with operative systems of faith/hope/transcendence intact.</td>
<td>Uncertain, Hopeful, Courage</td>
<td>I don’t understand, I never saw this coming, I can figure out how to cope</td>
</tr>
<tr>
<td><strong>Spiritual Pain/Struggle</strong></td>
<td>Global belief system overwhelmed by current situation. Person having difficulty reconciling global beliefs with what is happening to them in current context.</td>
<td>Puzzled, Troubled, Isolated from faith beliefs, Wavering trust</td>
<td>My faith never taught me this, I don’t know how to go on, I thought if I was “good” bad things would not happen to me</td>
</tr>
<tr>
<td><strong>Spiritual Distress</strong></td>
<td>Global belief systems are shaken, resulting in a time of spiritual uncertainty as either new belief systems emerge to replace old, or belief systems crumble considering the situation and the person is left spirituality adrift.</td>
<td>Bewildered, Fragmented, Dismayed</td>
<td>Why would God allow this?, Like Jacob I’ll wrestle with God until I understand, “Though he slay me, I’ll trust in Him” (Job)</td>
</tr>
<tr>
<td><strong>Spiritual Despair</strong></td>
<td>Person engages in maladaptive efforts to resolve the gulf between global and situational meaning resulting in loss of meaning structure</td>
<td>Stunned, Paralyzed, Anger/Apathy</td>
<td>I’ve turned my back on church, I stopped going to church and no one missed me, God abandoned me so I abandoned God</td>
</tr>
</tbody>
</table>
RESPONDING TO SPIRITUAL NEEDS/STRENGTHS:
SUGGESTED PASTORAL INTERVENTIONS

Recognizing spiritual themes in patient encounters, or assessment of, how the patient is using their spirituality, is foundational to formulating appropriate chaplain responses to the spiritual needs of patients. The Canadian Association of Spiritual Care identifies the following standards as useful guidelines for spiritually focused interventions:

1.4.1 Helps client evaluate role and function of spiritual/religious identity in their life.
1.4.2 Helps client to identify spiritual strengths, vulnerabilities, resilience and resources.
1.4.3 Facilitates exploration of a client’s sense of purpose and meaning in life.
1.4.4 Facilitates exploration of issues in relationships, moral distress and loss.
1.4.5 Facilitates contextualized meaning-making and sacred and religious interpretation.
1.4.6 Utilizes spiritual/theological/faith reflection in exploring and making meaning and in bringing the unconscious to the conscious understanding when it is safe and appropriate.
1.4.7 Fosters the client’s independence and responsibility within the care team.
1.4.8 Offers support and guidance for spiritual growth.
1.4.9 Strengthens relational connections and fosters experiences of community.
1.4.10 Enables reconciliation (e.g. conflict management, forgiveness)
1.4.11 Assists client in their own creative expression of spirituality.
1.4.12 Provides or facilitates prayer, rituals, rites, ceremonies, and services.
1.4.13 Leads or facilitates spirituality-focused themed groups, workshops and studies.¹

Another tool that chaplains can use to reveal the deeper spiritual narrative is the use of appropriate, sensitive well-timed questions. These are used with the intention of helping patients further explore their spirituality and assisting chaplains in understanding more fully the issues at hand. Questions are not used as a fact-finding mission, rather they

are used to help open the spiritual narrative and discover the heart of the matter. They can help elucidate the spiritual themes that may lie below the surface which need to be invited into the conversation so that emotional and spiritual healing can occur. The following questions have been tested in a recent study to find the most reliable questions for a brief spiritual assessment. I suggest that using these can help chaplains gain a sense of where the person is struggling and where their spiritual strengths lie.

- Do you struggle with the loss of meaning and joy to your life?
- Do you currently have what you would describe as religious or spiritual struggles?
- Are you at peace?
- Does your religion/spirituality provide you all the strength and comfort you need from it right now?
- Do you have any spiritual/religious concerns?²

Depending on the nature of the visit, a brief spiritual assessment might prove helpful to know which spiritual themes might require attention during the visit. The answers given by patients could reveal spiritual themes that may be trouble spots in need of intervention and support. The following charts contain each of the five spiritual themes with two additional columns. The first added column contains suggested responses/interventions. The next column includes intended outcomes to assist the patient in moving toward wholeness and healing.

<table>
<thead>
<tr>
<th>Spiritual Intensity</th>
<th>Description</th>
<th>Emotions</th>
<th>Patient May Say...</th>
<th>Suggested Response/Intervention</th>
<th>Intended Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well being</td>
<td>Meaning beyond circumstances; Focus is on ultimate hope; Authored/Deeply connected to transcendent values (God, nature, family, beauty, etc.)</td>
<td>Expectation of good future</td>
<td>God will take care of me My family is always there for me I am confident...</td>
<td>Explore with patient their future expectations Invite them to tell their life narrative that signifies hope</td>
<td>To ground patient in their faith/positive coping To anchor in productive spiritual practices for ongoing spiritual well-being</td>
</tr>
<tr>
<td>Coping</td>
<td>Life-promoting self-narratives that live in the reality of the here and now while envisioning a better future</td>
<td>Mostly positive expectation, Some apprehension regarding that things could turn out differently than expected</td>
<td>God will help me (&quot;won't give me more than I can handle&quot;) I can get through this After my .... life will be better</td>
<td>Structure pain points to assist with integration Affirm positive past coping strategies</td>
<td>To assist patient in facing faith for life/health promoting narratives To equip patient for future positive coping</td>
</tr>
<tr>
<td>Spiritual Pain/Struggle</td>
<td>Negative feelings about the future; Decreased motivation to change things; low expectations of what future holds</td>
<td>Fear based Anxious Disappointed/dowaned Confused Betrayed</td>
<td>It will never get better I feel like giving up Sighing resignation to situation Why would God do this allow this?</td>
<td>Explore from narratives/beliefs that may be life and hope limiting, damaging from practices</td>
<td>To help patient to articulate beliefs that are hurtful and identify helpful strategies to try in the future To help patient identify through how their faith is challenged by situation and moves toward reconciliation</td>
</tr>
<tr>
<td>Spiritual Distress</td>
<td>Patient's view of their future is limited and they do not see ways to improve their future. They feel powerless to make it better</td>
<td>Distressed/Disheartened Overwhelmed Agitated Afraid could manifest as anger</td>
<td>I can't! It is too late now I have no future God/disease does not care about me I can't pray anymore</td>
<td>Remain open and with sensitivity empower patient toward small steps of hope</td>
<td>To help patient verbalize feelings and actually partakes in small steps toward hope addressing factors of borne that are challenged</td>
</tr>
<tr>
<td>Spiritual Despair</td>
<td>Patient has lost beliefs in their systems of meaning and lost trust in transcendent values and/or in God. Negative view of future</td>
<td>Doom/ Terrified/ Numb Powerless Abandoned Despondent/ detached</td>
<td>God has abandoned me I have no hope (attachment/mystery, or survival threatened or loss) I have lost my faith</td>
<td>Use simple life promoting gestures Armed silence Compassion/ask</td>
<td>To facilitate trusting relationship (i.e., name how badly with chaplain (e.g. makes eye contact, focus on speaking) To help patient identify movements toward hope</td>
</tr>
</tbody>
</table>

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1 Anthony Scoli and Henry Billar, *Hope in the Age of Anxiety* (New York: Oxford University Press, 2009), 252.
## Spiritual Theme: Autonomy/Identity/Purpose/Dignity

<table>
<thead>
<tr>
<th>Spiritual Intensity</th>
<th>Description</th>
<th>Emotions</th>
<th>Patient May Say...</th>
<th>Suggested Response/Intervention</th>
<th>Intended Outcome Toward Healing</th>
</tr>
</thead>
</table>
| **Wellbeing**              | Able to live congruent with self-identity and carry out vocational purposes of life | Competence/Mastery  
Secure  
Confident  
Peaceful | Define life in terms of vocation/what they do  
Speak in present tense in how they live their purpose and exercise free choice toward personal goals | Assist patient in clarifying, refining goals of care  
To encourage patient to participate in care planning congruent with hopes and values  
To encourage ability to solve problems and actively engages in care life activities at level meaningful to patient |                                                                                               |
| **Coping**                 | Still able to carry out usual tasks/vocation independently and sees a future that will present challenges and feels that they have the resources to meet those when they come | Somber sadness, mostly acceptance of life’s changes  
Stability  
Trust | This is hard for me...  
I still can...  
I’ve adapted... | Identity strengths and help patient speak about past ways of coping, modification to these as needed | To restore sense of control around health challenges and ability to make decisions about their care  
To assist patient in verbalizing needs and appropriate reliance on others to receive help and meet needs |
| **Spiritual Pain/Struggle**| Sees self-identity/differentiating while still able to fulfill many important tasks and engage in important relationships in a meaningful way  
Sees that future may present challenges they can’t overcome | Grief  
Insecure  
Uncertain  
Discouraged | I used to...  
I feel myself aging...  
Before I was sick...  
I miss being able to... | Notice and identify ineffective coping  
Explore with patient areas of autonomy challenged by illness | To help patient lament losses, find courage to press on with renewed hope  
To facilitate discussion on how recent life stressors have overwhelmed normal coping strategies |
| **Spiritual Distress**     | Sees self-identity and choice disintegrating while unable to fulfill important tasks or engage in important relationships to fulfill their perceived purpose  
Life completion tasks thwarted | Defeated  
Empty  
Alienated  
Lonely | How will I live without...?  
(role, function, person)  
What am I going to do now?  
No one visits me anymore... | Assist patient in acknowledging losses and minimize their impact on patient  
Normalize feelings and help reframes | To enhanced coping  
To assist with renewed sense of empowerment to meet challenges  
To help patient work toward new meaning for positive coping |
| **Spiritual Despair**      | Sees self-identity disconnected from life purpose and unable to retrieve prior sense of vocation and/or meaning  
Unable to maintain sense of unique identity, negative self-image | Worthless  
Inadequate  
Powerless  
Shame  
Guilt  
Hopelessness | I’m a burden...  
I can’t own...  
I have no purpose...  
No one cares what I think... | Discuss self-concept and places where identity/vocation/purpose is threatened  
Facilitate reminiscence | To activate past sources of positive self-identity to aid in coping  
To use memories to reconnect to lost parts of self and remember contribution to world |
<table>
<thead>
<tr>
<th>Spiritual Theme: Relationships/ Belonging/ Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual Intensity</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
</tbody>
</table>
| Well being | All levels of relational system—self, others, God, nature intact and thriving. Deep sense of interconnectedness. Connects with healthy boundaries. | Generosity  
Joy/ Humor  
Openness | Expresses gratitude for relationships in life. Accepts others and self openly. Deeply rooted in faith relationship with God. | Facilitate reflection on meaningful relationships  
Identity relationships as source of strength | To help patient lean into relational support and deepen feelings of connection  
To help patient express how relationships support them |
| Coping | Most relationships are intact and healthy. May exhibit some needs for reconciliation/and willing to do the work necessary to repair them. | Grief  
Hope | Describe some brokenness in a relationship and their openness to work toward reconciliation accepting their responsibility in the relational brokenness | Assist patient in sharing their places of belonging/connection  
Elucidate points of pain/points of connection | To assist patient in identifying areas of support and/or concern  
To help patient identify internal resources to face difficult relational situations  
To affirm patient’s goal to move toward greater connection in significant relationships |
| Spiritual Struggle | Brokenness in relationships. Unwilling or unable to accept personal responsibility. Unwilling to reconcile and/or forgive. Or might be self-blaming. | Lonely  
Self-Protective  
Detached  
Abandoned | Lament loss of companionship  
Describe self in self-deprecating or coerced inflated language | Identify significant relational losses/tension  
Identify past and current sources of spirituality that may help in healing  
Surface inner narrative of self/other blame/hatred/unforgiveness | To assist in forgiveness process  
To help patient reconcile relationships for greater sense of connection to self/others/God  
To hear patient’s confession for healing |
| Spiritual Distress | Feels cut off from community and senses that they are somehow unacceptable to others. Loss of sense of connection to important social/faith aspects of life. Anger and unforgiveness toward others. | Empty  
Crushed spirit  
Dis satisfied | May describe relational brokenness by blaming others. Unable to take responsibility for their part in brokenness. “Why would God allow this…?” | Grief support around tangible and intangible losses due to broken relationships  
Attend to forgiveness needs | To affirm patient’s move toward taking responsibility for own part in brokenness  
To affirm patient’s move toward reconciliation in important relationships (self/others/God)  
Ritual as appropriate (confession/absolution) |
| Spiritual Despair | Withdraws and refuses to accept help. Disconnected from self, others. God  
Self-isolating behavior. | Alienated  
Defensive | No one wants to be near me…  
I don’t need anyone…  
God does not care about me… | Small life-giving gestures  
Affirm any movement toward chaplain, others  
Acknowledge painfalness of being alone  
Create community with patient | To assist with emotional expression  
To affirm patient’s desire to take first steps to reconnect with others, self, faith  
To notice and name patient’s move toward self-compassion |
<table>
<thead>
<tr>
<th>Spiritual Theme: Peace/Comfort</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spiritual Indensity</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Wellbeing</td>
</tr>
<tr>
<td>Coping</td>
</tr>
<tr>
<td>Spiritual Pain/Struggle</td>
</tr>
<tr>
<td>Spiritual Distress</td>
</tr>
</tbody>
</table>
## Spiritual Theme: Meaning

<table>
<thead>
<tr>
<th>Spiritual Assessment</th>
<th>Description</th>
<th>Emotions</th>
<th>Patient May Say...</th>
<th>Suggested Response/Intervention</th>
<th>Intradced Outcome Toward Healing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well Being</strong></td>
<td>Global and situation belief systems congruent. Person able to understand how life is fitting together and feels empowered to move through the world with integrated belief systems.</td>
<td>Curious, Exploring, Discerning</td>
<td>This is what I envisioned God has led me here</td>
<td>Facilitate conversation so that patient can reflect on life meanings</td>
<td>To ground patient in faith meanings systems that support health and wellbeing</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Global belief system threatened by current situation. Person working through discrepancy with operative systems of faith hope transcendence intact.</td>
<td>Uncertain, Hopeful, Courage</td>
<td>I don’t understand I never saw this coming I can figure out how to cope</td>
<td>Facilitate meaning-making Explore world view and theological constructs that support meaning</td>
<td>To help patient articulate situation and ways of living that are consistent with their deeply held meaning structures To honor patient’s confident decisions</td>
</tr>
<tr>
<td><strong>Spiritual Point/Struggle</strong></td>
<td>Global belief system overwhelmed by current situation. Person having difficulty reconciling global beliefs with what is happening to them in current context.</td>
<td>Puzzled, Troubled, Isolated from faith beliefs Wavering trust</td>
<td>My faith never taught me this I don’t know how to go on I thought if I was “good” bad things would not happen to me</td>
<td>Elaborate global and situational meaning discrepancies Help patient work through painful feelings when global and situation meanings don’t match</td>
<td>To allow for open discussions about conflicts or disturbances related to practice of belief system To assist patient in articulating feelings and clarifies direction To assist patient in making new meaning</td>
</tr>
<tr>
<td><strong>Spiritual Distress</strong></td>
<td>Global beliefs systems shaken, resulting in a time of spiritual uncertainty as either new belief systems emerge to replace old, or belief system crumbles considering situation and person is left spiritually adrift.</td>
<td>Bewildered, Fragmented, Dismayed</td>
<td>Why would God allow this? Like Jacob I’ll wrestle with God until I understand “Though he slay me, I’ll trust in Him” (Job)</td>
<td>Identify and acknowledge emotions to assist patient in clarifying meanings Surface theological expectations and how these relate to current situation</td>
<td>To discuss how long held beliefs about spiritual issues help/hinder meaning making To assist patient with reconciliation of meaning</td>
</tr>
<tr>
<td><strong>Spiritual Disagile</strong></td>
<td>Person engages in maladaptive efforts to resolve the gulf between global and situational meaning resulting in loss of meaning structure</td>
<td>Stunned, Paralyzed, Anger/Agathly</td>
<td>I’ve turned my back on church God abandoned me so I abandoned God</td>
<td>Provide grief support Name ambiguous losses Ritual as appropriate</td>
<td>To facilitate grief process for integration</td>
</tr>
</tbody>
</table>
Here are some examples of open-ended questions to elucidate spiritual themes:

Hope:
- What/Who helps you find hope now?
- Do you have spiritual practices that help you cope?
- Who/what sustains you during difficulty?

Autonomy/Purpose:
- How do your spiritual beliefs/practices contribute to your sense of purpose?
- How do you maintain your sense of identity/vocation as you deal with your situation?
- What are you doing now to continue to fulfill your life goals?
- How does your illness affect your sense of identity?
- What are the most important roles you’ve played in your life? What makes those stand out?

Relationships:
- How do you see yourself fitting into your important relationships?
- What are aspects of your community life (family, faith community) that are life affirming/or are harmful?
- Who supports you and helps you press on?

Peace/Comfort:
- How have you found peace in the past when dealing with difficulty?
- What troubles you most about being ill?
- What do you do to comfort yourself?

Meaning:
- What stories or metaphors help you understand who you are and why things happen?
- What/who gives your life meaning?
- What/if any rituals/sacraments help you find meaning in your life?
- How can I support your spiritual practices now?
### Sample Responses/Interventions

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Basic Facilitating</th>
<th>Existential Support</th>
<th>Religious Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledge</td>
<td>Grief/loss/adjustment/life transition support provided</td>
<td>Prayer</td>
<td></td>
</tr>
<tr>
<td>Addressed</td>
<td>Spiritual life discussed</td>
<td>Ritual</td>
<td></td>
</tr>
<tr>
<td>Ask guided questions (not fact finding)</td>
<td>Emotional stabilization</td>
<td>Sacrament</td>
<td></td>
</tr>
<tr>
<td>Assist</td>
<td>Spiritual struggles identified (pain, distress, despair)</td>
<td>Religious Items Provided</td>
<td></td>
</tr>
<tr>
<td>Assure</td>
<td>Established trust</td>
<td>Addressed religious/spiritual concerns</td>
<td></td>
</tr>
<tr>
<td>Attend</td>
<td>Values Explored/align care plan with patient values</td>
<td>Spiritual direction/counsel provided</td>
<td></td>
</tr>
<tr>
<td>Clarify</td>
<td>Supported patient’s loved ones</td>
<td>Faith affirmation</td>
<td></td>
</tr>
<tr>
<td>Cultivate</td>
<td>End of life concerns addressed</td>
<td>Discuss meaningful sacred text</td>
<td></td>
</tr>
<tr>
<td>Discuss</td>
<td>Life review</td>
<td>Support in crisis of faith</td>
<td></td>
</tr>
<tr>
<td>Elicit</td>
<td>Spiritual reminiscence</td>
<td>Perform blessing</td>
<td></td>
</tr>
<tr>
<td>Elucidate</td>
<td>Meditation /imagery/music</td>
<td>Congruence of religious belief examined</td>
<td></td>
</tr>
<tr>
<td>Empower</td>
<td>Uphold human dignity of patient</td>
<td>Image of God in healing/recovery/miracle</td>
<td></td>
</tr>
<tr>
<td>Encourage</td>
<td>Explore meaning of situation to patient</td>
<td>Spiritual practices to promote wellness</td>
<td></td>
</tr>
<tr>
<td>Enhance</td>
<td>Existential pain identified</td>
<td>Spiritual history explored</td>
<td></td>
</tr>
<tr>
<td>Examine</td>
<td>Discussed ultimate concerns</td>
<td>Explore spiritual/religious matters</td>
<td></td>
</tr>
<tr>
<td>Explore</td>
<td>Enable reconciliation</td>
<td>Assist patient in activating faith</td>
<td></td>
</tr>
<tr>
<td>Facilitate</td>
<td>Foster autonomy</td>
<td>Spiritual guidance</td>
<td></td>
</tr>
<tr>
<td>Identify</td>
<td>Connect to meaning</td>
<td>Spiritual counsel</td>
<td></td>
</tr>
<tr>
<td>Incorporate</td>
<td>Identify purpose</td>
<td>Theological reflection</td>
<td></td>
</tr>
<tr>
<td>Invite</td>
<td>Discussed ultimate hopes</td>
<td>Theodicy</td>
<td></td>
</tr>
<tr>
<td>Normalize</td>
<td>Discuss spiritual concerns</td>
<td>Identify conflicted meaning systems</td>
<td></td>
</tr>
<tr>
<td>Provide</td>
<td>Existential concerns addressed</td>
<td>Addressed negative religious coping</td>
<td></td>
</tr>
<tr>
<td>Reinforce</td>
<td>Breath work</td>
<td>Supported positive religious coping</td>
<td></td>
</tr>
<tr>
<td>Reframe</td>
<td>Music</td>
<td>Hymns from faith tradition</td>
<td></td>
</tr>
<tr>
<td>Strengthen</td>
<td>Art/Beauty</td>
<td>Devotional readings</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Poetry</td>
<td>Contact faith group</td>
<td></td>
</tr>
</tbody>
</table>
### Sample Intended Outcomes Toward Healing

<table>
<thead>
<tr>
<th><strong>Hope/Autonomy/Peace</strong></th>
<th><strong>Relationships</strong></th>
<th><strong>Meaning</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide/renew hope</td>
<td>To enhance social support/connection</td>
<td>To assist with meaning making</td>
</tr>
<tr>
<td>To tap into inner strengths/resources</td>
<td>To connect (reconnect) to faith community</td>
<td>To alleviate suffering</td>
</tr>
<tr>
<td>To help patient express trust/hope/confidence</td>
<td>Foster forgiveness (other/self)</td>
<td>To resolve spiritual concerns</td>
</tr>
<tr>
<td>To lessen anxiety/promote peace</td>
<td>To promote reconciliation (self/others/Divine)</td>
<td>For integration</td>
</tr>
<tr>
<td>To clarify values honored/care plan aligned with beliefs</td>
<td>To help conflict resolution</td>
<td>To move forward on healthy grief journey</td>
</tr>
<tr>
<td>To foster increased ability to cope</td>
<td>To mobilize spiritual support</td>
<td>To help make decisions to move forward with purpose</td>
</tr>
<tr>
<td>To ease spiritual distress</td>
<td>To assist investment in self/life/health outcomes with positive outlook</td>
<td>To honor meaning made congruent with faith/beliefs</td>
</tr>
<tr>
<td>To regain sense of control/purpose/agency/voice</td>
<td>To operate in healthy boundaries</td>
<td>To help find congruence/generativity</td>
</tr>
<tr>
<td>To meet core spiritual needs</td>
<td>To honor commitment to self-care</td>
<td>To illuminate faith/values in medical/ethical decision making</td>
</tr>
<tr>
<td>To assist patient to draw on spiritual resources to cope</td>
<td>To gain insight into relational needs/resources</td>
<td>To restore faith</td>
</tr>
<tr>
<td>To mitigate distress</td>
<td>To foster healthy relationship (self/others/God) restored</td>
<td>To reframed vocation</td>
</tr>
<tr>
<td>To help patient progress toward peace/hope</td>
<td>For reconciliation</td>
<td>To process thoughts/feelings for clarity</td>
</tr>
<tr>
<td>To help patient activate inner spiritual and/or emotional resources used for coping</td>
<td>To facilitate healthy boundaries</td>
<td>For sense of peace with situation/decision</td>
</tr>
<tr>
<td>To connect to sense of peace</td>
<td>To lessen isolation</td>
<td>For clarity</td>
</tr>
<tr>
<td>For encouragement</td>
<td>To help patient identify and state their needs</td>
<td>Toward new insight</td>
</tr>
</tbody>
</table>

**Spiritual theme**: relationship/belonging/community.

**Intervention and Intended Outcome Toward Healing**: Attended to relational distress to promote connection and support for spiritual wellbeing.
RECORDING PATIENTS’ SPIRITUAL NARRATIVES IN THE EMR: PROPHETICALLY SPEAKING INTO MEDICAL CULTURE FOR HOLISTIC HEALING

Charting is a vital component of developing inter-professional relationships, advocating for spiritual care in a clinical setting and most of all communicating essential information that other disciplines don’t have access to or are not listening for. When we chart, we are communicating to the clinical team...we avoid spiritual care jargon and articulate assessment and interventions in the clearest and most professional way.¹

After visiting with patients, having recognized and responded to their spiritual processes, it then comes time to record the encounter in their medical record. This is both a skill and an art because chaplains are translating a relationship-based, process-oriented human encounter into what could be seen as information gathering only, simply more data about the patient. The focus of chaplain documentation is on the spiritual, relational and emotional aspects of the person and should rarely include biomedical information. If it is included it is only for the purpose of helping the interdisciplinary team understand the spiritual aspects of the patient for whole person care plans to emerge.

Documenting serves the dual purpose of communicating to the clinical team what the spiritual needs and strengths of hospitalized persons are, and it demonstrates the broad range of chaplain interventions that contribute to wellness. When the care team sees how chaplains contribute to holistic healing this can lead to greater integration onto care teams. To move toward clarity in our department documentation we will use the RAIN acronym in our charting, outlined below.

¹ Kilts, “Spiritual Care and Assessment: Using Spiritual Care Assessment in Spiritual Health Therapy.”
<table>
<thead>
<tr>
<th>Documentation Domain</th>
<th>Guiding Questions</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for Visit</strong></td>
<td>Why was I in the room?</td>
<td>Met with patient per Epic order</td>
</tr>
<tr>
<td></td>
<td>Who/What brought me here?</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Spiritual Needs and Resources</strong></td>
<td>Which spiritual theme(s) did you recognize?</td>
<td>Assessment: Patient describes spiritual pain related to hope due to multiple challenges in living with chronic illness. Needs: Of note, she has had to miss out on several family and church activities in the last two months and she is fearful of what her future holds because she values social connection. Strengths: She is leaning into her faith practices of prayer and Bible reading to guide her as she deals with her difficulty.</td>
</tr>
<tr>
<td>Three methods for assessing:</td>
<td>What is the spiritual pain/distress?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Where are their internal/external sources of support?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How is the patient coping?</td>
<td></td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>What did I do in response to the spiritual needs/distress?</td>
<td>• Facilitated conversation to surface her emotions and clarify what is most important to her now. • Affirmed her faith practices for sustaining her spirit and helping her connect to hope.</td>
</tr>
<tr>
<td></td>
<td>What is your intended outcome for choosing to use the intervention?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What healing/spiritual movement do you want to foster?</td>
<td></td>
</tr>
<tr>
<td><strong>Next Steps</strong></td>
<td>What are spiritual needs of the patient to restore or maintain spiritual wellness?</td>
<td>• Contacted her faith community per her request. Transferring ongoing spiritual care to her pastor who will follow for ongoing spiritual counsel to address hope needs and assist with helping her stay active in her faith community and family concerns. • Patient desires to be as mobile as possible to participate in social activities.</td>
</tr>
<tr>
<td></td>
<td>What are patient expectations for follow up?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Faith community referral? Other referral?</td>
<td></td>
</tr>
</tbody>
</table>
Note Template for Practice

Reason for Visit:

Assessment of Spiritual Needs/Strengths:
➢ Your assessment appears first:

<table>
<thead>
<tr>
<th>Spiritual Assessment: (Example: Patient communicated spiritual _____ related to _____.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick reference: Wellbeing, resources exceed spiritual need; Coping, resources and need fairly equal; Spiritual Pain, resources slightly below spiritual need; Spiritual Distress-low resources and high spiritual need; Spiritual Despair-depleted resources and high spiritual need</td>
</tr>
</tbody>
</table>

Next address contextual factors correlated to needs and strengths written in narrative form. What is the spiritual story? What is important to the patient? Broad strokes, respectful, uphold human dignity. The story is still important. Not simply a description.

Needs (suffering/distress)-

Strengths (coping/support/inner resources/sources of meaning)-

Interventions/Outcomes (informed by assessment and linked to intended outcomes): What intervention did you use? For what outcome toward healing? Bullet point format

•

•

Next Steps: (informed by assessment and interventions. Was assessed need met? If yes, intervention complete. If not, what still needs to happen for holistic care? Intersection of spiritual care/medical care. If you say “will follow” ...add why you are following. What is the aim of the follow up for patient wellbeing and holistic care plan?)

•

•
RESTORING IMAGO DEI: SPIRITUAL CARE PLANS

This section offers an expanded discussion of the “N” in our RAIN documentation model as a vital component of our professional evaluations. The “N” is the place that our assessment, intervention and intended outcomes are formulated into a meaningful plan of care. The spiritual care plan is co-created with patients with their spiritual goals in mind and where assessment for takes center stage.

The “N” is future oriented and where we communicate patient expectations of on-going support, why the support is needed, and what patients may have committed to for their own spiritual well-being. If follow up is indicated if gives the next chaplain critical information to help them continue with the care plan so that the spiritual momentum flows unhindered. It also offers a vantage point to see the efficacy of our care over subsequent visits. Because it is co-created with patients it always leaves room for the direction to alter or change in future visits.

When we think of what a person may need for their spiritual health going forward, we are thinking along the lines of what would enhance their spiritual well-being and what resources and needs they have in terms of movement toward spiritual wellness. This includes areas where the patient is either ready to move, or is moving toward integration, and/or finding renewed purpose and meaning. It can include how they are reconnecting to hope, meaning, peace, forgiveness, self-confident decision making or faith practices.

It could also include information about what is still needed for the patient to find healing and detail the next step on their journey. This section is also an area where we
record any referrals made or requests for spiritual/religious resources. We can document that we have communicated with their faith community and that their faith community will now provide on-going support. We can also document that we have provided them with religious materials as they become more grounded in their own faith practices, taking responsibility for their spiritual health. We can also give recommendations for on-going care post-discharge such as grief support groups, or other community supports that might be the next step on their spiritual journey.

When spiritual care plans are in place and followed this can serve the dual purpose of supporting the patient’s well-being and helping the rest of the care team more fully understand chaplain care. It is a concrete way for our colleagues to follow the effectiveness of our spiritual care plans. It clarifies how the spiritual care plan complements and enhances the inter-professional care plans for patients. This plan is communicated to the rest of the care team so that the patient’s spiritual concerns, beliefs, values and/or religious practices become integrated into their overall plan of care. In this way whole person care is restored to modern medicine for holistic healing.

Example:

- **Next Steps:** Patient will reach out to daughter this afternoon and request to meet in hopes of reconciliation. Chaplain Services will follow up to provide on-going spiritual support around giving and receiving forgiveness for wellbeing and hope.
CASE STUDIES

Mrs. Lynn Millwood is a 75-year-old woman recovering from surgery to remove cancerous nodules from her lungs. The doctor has recently informed her there are metastases of the cancer, and that her prognosis is poor. Patient’s tone reveals veiled anger when she asks you, “Why has God done this to me? Is it because I haven’t gone to church? You also hear echoes of sadness and loss as she asks, “Or is it because I’ve been angry with my brother and haven’t spoken to him since Mom died?”

Recording Spiritual Care Encounters: How would you document this visit and care plan?

<table>
<thead>
<tr>
<th>Reason for Visit:</th>
<th>Why was I in the room?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizing Spiritual Themes</td>
<td>Who/What brought me here?</td>
</tr>
<tr>
<td>Spiritual Assessment:</td>
<td></td>
</tr>
<tr>
<td>Needs:</td>
<td>Which spiritual theme(s) did you recognize?</td>
</tr>
<tr>
<td>Strengths:</td>
<td>What is the spiritual pain/distress?</td>
</tr>
<tr>
<td>Needs:</td>
<td>Where are their internal/external sources of support?</td>
</tr>
<tr>
<td>Strengths:</td>
<td>How is patient coping?</td>
</tr>
<tr>
<td>Responding to Spiritual Needs/Strengths:</td>
<td></td>
</tr>
<tr>
<td>Intervention:</td>
<td>What did I do in response to the spiritual needs/distress?</td>
</tr>
<tr>
<td>•</td>
<td>Which interventions would you consider using? What is the purpose of choosing the intervention you did?</td>
</tr>
<tr>
<td>•</td>
<td>What healing/spiritual movement do you want to foster? What is your intended outcome for choosing to use the intervention?</td>
</tr>
<tr>
<td>Restoring Imago Dei:</td>
<td></td>
</tr>
<tr>
<td>What care plan might be developed with the patient?</td>
<td>Next Steps:</td>
</tr>
<tr>
<td></td>
<td>What will you record as spiritual needs of the patient going forward to restore or maintain spiritual wellness? (food, religious items, sacraments)</td>
</tr>
<tr>
<td></td>
<td>What are patient expectations for follow up? Faith community referral? Other referral?</td>
</tr>
</tbody>
</table>
Charles Painter is a 53-year-old man hospitalized for GI issues. He shares with you his feelings of disquiet and states “my life is going nowhere fast.” Charles has a high-profile job and is well respected in the community, and over the last few months he has felt increasingly empty and expresses that he just doesn’t see the point in it all anymore. How would you document this visit and care plan?

| Reason for Visit: | Why was I in the room?  
Who/What brought me here? |
|-------------------|------------------------|
| Recognizing Spiritual Themes | Spiritual Assessment:  
Which spiritual theme(s) did you recognize? |
| Hope/Transcendence/Sacred Autonomy/Identity/Purpose/Dignity Relationships/Belonging/Community Peace/Comfort Meaning | Needs:  
What is the spiritual pain/distress?  
Where are their internal/external sources of support?  
How is patient coping? |
| Responding to Spiritual Needs/Strengths: | Intervention:  
What did I do in response to the spiritual needs/distress?  
Which interventions would you consider using?  
What healing/spiritual movement do you want to foster?  
What is your intended outcome for choosing to use the intervention?  
What is the purpose of choosing the intervention you did? |
| Restoring Imago Dei:  
What care plan might be developed with the patient? | Next Steps:  
What will you record as spiritual needs of the patient going forward to restore or maintain spiritual wellness? (food, religious items, sacraments)  
What are patient expectations for follow up?  
Faith community referral?  
Other referral? |
APPENDIX B

RUSH RELIGIOUS STRUGGLE SCREENING PROTOCOL: A TOOL TO IDENTIFY RELIGIOUS/SPIRITUAL STRUGGLE

1. Is religion or spirituality important to you as you cope with your illness?
   - Yes
   - No

2. How much strength/comfort do you get from your religion/spirituality right now?
   - a. All that I need (go to question 3).
   - b. Somewhat less than I need.
   - c. None at all.
     * For answer b or c, thank patient and order chaplain consult

3. Would you like a visit from a chaplain?
   - Yes
   - No

Source: George Heltzer, RN, PhD, Rush University
TRAINING MANUAL BIBLIOGRAPHY


BIBLIOGRAPHY


