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Lutheran Services in America
CHAPLAINS' NETWORK

Caring Connections

An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling

Discovering Evidence-Based Chaplaincy

The Purpose of Caring Connections

Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling is written by and for Lutheran practitioners and educators in the fields of pastoral care, counseling, and education. Seeking to promote both breadth and depth of reflection on the theology and practice of ministry in the Lutheran tradition, *Caring Connections* intends to be academically informed, yet readable; solidly grounded in the practice of ministry; and theologically probing. *Caring Connections* seeks to reach a broad readership, including chaplains, pastoral counselors, seminary faculty and other teachers in academic settings, clinical educators, synod and district leaders, others in specialized ministries and — not least — concerned congregational pastors and laity.

Caring Connections also provides news and information about activities, events and opportunities of interest to diverse constituencies in specialized ministries.

Scholarships

When the Inter Lutheran Coordinating Committee disbanded a few years ago, the money from the "Give Something Back" Scholarship Fund was divided between the ELCA and the LCMS. The ELCA has retained the name "Give Something Back" for their fund, and the LCMS calls theirs "The SPM Scholarship Endowment Fund." These endowments make a limited number of financial awards available to individuals seeking ecclesiastical endorsement and certification/credentialing in ministries of chaplaincy, pastoral counseling, and clinical education.

Applicants must:

- have completed one [1] unit of CPE.
- be rostered or eligible for active roster status in the ELCA or the LCMS.
- not already be receiving funds from either the ELCA or LCMS national offices.
- submit an application, along with a financial data form, for committee review.

Applicants must complete the Scholarship Application forms that are available from Judy Simonson [ELCA] or Bob Zagore [LCMS]. Consideration is given to scholarship requests after each application deadline. LCMS deadlines are April 1, July 1 and November 1, with awards generally made by the end of the month. ELCA deadline is December 31. Email items to Judith Simonson at *jsimonson@aol.com* and to Bob Zagore at *Bob.Zagore@lcms.org*.

Has your email address changed?

Please notify us of that change by re-subscribing at *lutheranservices.org/newsletters#cc*.

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News, Announcements, Events: E-mail items to Judith Simonson at *jsimonson@aol.com* or Bob Zagore at *Bob.Zagore@lcms.org*

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Call for Articles

Caring Connections seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight with the wider community. We want to invite anyone interested in writing an article to please contact one of the co-editors, Diane Greve at *dkgreve@gmail.com* or Lee Joesten at *lee.joesten@gmail.com*. Specifically, we invite articles for the upcoming issue on the following themes:

2019.3 The Future of Faith-based Health Care;
2019.4 Racial and Social Justice in our Ministries

Have you dealt with any of these issues? Please consider writing an article for us. We sincerely want to hear from you! And, as always, if you haven't already done so, we hope you will subscribe online to *Caring Connections*. Remember, a subscription is free! By subscribing, you are assured that you will receive prompt notification when each issue of the journal appears on the *Caring Connections* website. This also helps the editors and the editorial board to get a sense of how much interest is being generated by each issue. We are delighted that the number of those who check in is increasing with each new issue. Please visit *www.lutheranservices.org/newsletters#cc* and click on "Click here to subscribe to the *Caring Connections Journal*." to receive automatic notification of new issues.

Editorial

Diane Greve

EVERY CHAPLAIN, CERTIFIED EDUCATOR AND PASTORAL COUNSELOR I KNOW wants to provide their very best ministry for the sake of their patients, families and staff. But what does "best ministry" look like? What are "best practices?" How do we know?

In 1992–93, I was enrolled in the CPE residency at the University of Minnesota Hospital and Clinics. Our supervisors at that time, Ken Siess and Linda Campbell, required all their residents to engage in primary research. We had to determine our research question, review the literature, develop a research proposal and methodology, go through the IRB process to gain permission to work with the patients, have the findings quantified and do the interpretation. We wrote up a report of our research and our findings and, finally, made a presentation at the hospital. Our question was *"What do hospital patients in a university hospital setting expect from the chaplain's visit?"* In 1994, the University of Minnesota Hospital CPE Center won the ACPE Research Center of the Year for our work.

While we learned many things in this process, what I am most aware of is that this was 25 years ago. Chaplaincy research by Lutherans is not new! Several certifying groups require chaplains to have some amount of research literacy and, in turn, that their chaplaincy practice would be informed by the research being done in the field.

This issue of *Caring Connections* focusses on such best practices. How are Lutheran chaplains drawing from the literature to develop best practices in their ministries of chaplaincy and clinical education. Some are working with their inter-disciplinary colleagues to conduct primary research. Others are learning to review the literature that applies to their ministry and determine how it might inform their approach to chaplaincy. I hope that the following articles by our Lutheran colleagues will inspire us and help us to provide the best possible care to our people. In this issue, you will find:

- **George Handzo** provides a look at changes in healthcare along with the challenges and opportunities for chaplaincy care.
- **Paul Galchutt** writes about his path to becoming a Transforming Chaplaincy research fellow and how that has opened new insights and possibilities.
- **Russell Myers** collaborated with his EMS colleagues to conduct research that would inform how best to serve the first responders in his care.
- **Steve Rice** describes his three stages of experience with Evidenced Based Spiritual Care and what he learned through his research about loneliness.
- **Nancy Wigdahl** tells of her qualitative research regarding leadership among chaplains.

- **Brian Heller** proposes conducting research with parish pastors to explore the benefits of having units of CPE prior to entering parish ministry.
- **Brian Earl** ponders the benefits and limitations of utilizing evidence-based practice in chaplaincy and some of his own tensions between science and faith centered practice.
- **Dana Schroeder** describes the research focus within the CPE residency curriculum at Advocate Aurora Health System.

As you read these articles, you may find yourself asking if chaplains are faith professionals working in a health care context or partners in health care with a specialty in faith and spirituality. You may also wonder how any of this applies to those of us in long term care or corrections. I will leave that to your pondering… What might the best practices be in those settings as an inter-disciplinary team member? And how would you know?

Zion Conference is happening September 26–29, 2019. Information is located in the back pages of this issue. Registration will be $200. You will also find forms there to nominate a chaplain, pastoral counselor or clinical educators for the Christus in Mundo award. Give that serious consideration.

One of our colleagues, **Dennis Kenny**, has been honored with the ACPE Distinguished Service Award. You will find that article toward the back of this issue.

We would like to hear from you, our readers. In future issues, we would like to print your responses whether you agree or disagree with the articles. We welcome your emails. Please write to Diane Greve *dkgreve@gmail.com* or Lee Joesten *lee.joesten@gmail.com*, the co-editors of *Caring Connections*.

May your review of these articles inspire your own best practices in your ministry.

The Changing World of Health Care Chaplaincy: Challenges and Opportunities

George Handzo

ONE OF THE MANY ACHIEVEMENTS WE CAN BE PROUD OF as Lutherans in the United States is that we have a very long and very consistent commitment to trained, professional chaplaincy in health care. Even as I came out of seminary in the early 1970's, one needed to take at least one unit of CPE to graduate. Health care chaplains were heavily supported at the national level of our church bodies and Lutheran hospitals, led by Lutheran General in Park Ridge, Illinois (now Advocate Aurora Health System), were among the national leaders in integrating spiritual care and chaplaincy into health care—a position that Advocate Aurora still maintains. So, our Lutheran history in the ministry of chaplaincy is one of leadership.

That said, health care in the US has changed a great deal, mostly for the better. And, the pace of change has accelerated. Those health systems and disciplines, including chaplains, who think they can continue to practice as they have in the past, quickly will not be practicing. There is a lot of change and much of it is painful as it upends the ways we have offered spiritual care and chaplaincy for generations.

At the risk of telling you all something that you already know, here are a few of the major changes:

- Health care is (finally) moving from being doctor-centered to being patient-centered.
- Palliative care has emerged as the paradigm for much of how health care is delivered. Increasingly, it is officially defined as being the model of treatment for everyone with "serious" illness, thus covering most of the patients that chaplains serve.
- The health system is moving from "volume to value." This means, in short, that health care providers no longer are paid for the number of procedures and tests they do but for the outcomes achieved.
- Health care is increasingly an outpatient business. Currently, Memorial Sloan-Kettering Cancer Center, where I directed spiritual care for some years, does outpatient bone marrow transplants. Most patients of MSK never see an inpatient bed.

There is a lot of change and much of it is painful as it upends the ways we have offered spiritual care and chaplaincy for generations.

These changes have some serious implications for chaplaincy. On the positive side, all of the models for palliative care posit a chaplain as a member of the team. In the Joint Commission standards for Advanced Certification in Palliative Care, a chaplain is required as a member of the team in order for the site to be certified. The

National Consensus Project Clinical Guidelines for Quality Palliative Care (NCP) that is the major driver of practice for both the Joint Commission and the Centers for Medicare and Medicaid continues to strengthen the mandate for spiritual care and chaplaincy. The 4th edition issued in late 2018 says that palliative care and hospice teams should have a "paid professional chaplain" on the team. This was also the first edition of the guidelines in which chaplains were active contributors. Over 90 organizations nationwide, including a number of the chaplaincy associations, have endorsed the guidelines. The bottom line is that the demand signal for chaplains is a great deal stronger.

The other driver of this trend is the prominence of patient-centered care and the patient's voice in the health care process. The simple truth is that patients and their caregivers value chaplains and, while some occasionally throw us out, many more welcome us.

No longer does the economy of health care allow hospitals to have chaplains simply because it is "the right thing to do."

The problematic side of these changes is that chaplaincy is being held to the same standards of performance as other disciplines. No longer does the economy of health care allow hospitals to have chaplains simply because it is "the right thing to do." Like all other disciplines, we have to demonstrate value. Thus, volume metrics on which we have depended, like number of patients seen, are losing currency. They need to be replaced by outcome measures that relate to reimbursable value. The problem is that we do not have much to replace them with. We do have current studies concluding that chaplains can raise patient satisfaction scores. Studies have also demonstrated that meeting spiritual and religious needs can lower use of aggressive care at the end of life and thus lower hospital costs. Even there, we know very little about which chaplaincy interventions lead reliably to these outcomes.

The NCP guidelines, while supporting chaplains on the team, also have very specific requirements for what chaplains will be held accountable for including a thorough, documented spiritual assessment. The chaplain is designated as the spiritual care specialist on the team and is presumed then to have the skills and knowledge to fulfill their role. This model is fully spelled out in the book, *Making Health Care Whole,* by Christina Puchalski and Betty Ferrell.

Thus, while chaplains are seen as very valuable members of the team, they also need to be accountable for demonstrating that value. A couple years ago, I attended a palliative care case presentation at a major conference. The case clearly involved spiritual issues but apparently no chaplain was involved. After the presentation, I asked the presenter why she didn't involve a chaplain. Her answer was, "I don't call a chaplain any more because he writes the same chart note on every patient." Whether we like or agree with this reasoning or not, the fact is that, in the perception of the physician, the chaplain was not accountable and did not practice in a way that added value to the care provided by the team.

So what has all this done to best practice in health care chaplaincy? Consensus is developing in the field of professional chaplaincy care around several best practices. Our discipline is becoming a multipath, referral service based on processes which identify patients with spiritual or religious need and prioritize chaplain visits according to that need and its impact on other treatment processes and outcomes.

In current best practice, chaplains visit patients of all faiths selected according to specific protocols and are assigned to specific locations or service lines, generally selected for their strategic importance to the institution. Thus, the decisions about where chaplaincy resources are allocated need to involve institutional administration and show alignment with institutional strategic objectives. Certainly service lines, normally including palliative care, are prioritized over others such that chaplains may round with some teams every day and only visit other units when a patient is referred. Even when a chaplain is assigned to a unit or service line, best practice dictates that the choice of patients to see is decided by an agreed upon priority list. Increasingly, the highest priority is those patients referred because of documented spiritual need. Patients who desire to see a chaplain but who do not have documented spiritual distress have a much lower priority. All of this is obviously a big change from the past practice of seeing all patients just because they are on your nursing unit.

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A major resource challenge for chaplains and others is the increasing assumption that all services are now presumed to be offered in the same way across all settings of care. Thus if the chaplain is assigned to the palliative care team and that team has an outpatient clinic as well as inpatient beds, all members of the team including the chaplain are to be available in both settings. If home-based palliative care is also offered, the delivery systems become even more stretched. Most chaplains have been slow to develop workable models to meet this challenge. Doing spiritual care virtually using applications such as Zoom and Facetime is increasing and seemingly being received well by patients.

Screening for spiritual needs, taking spiritual history as part of routine history and physicals, and completing spiritual assessment at all stages of the patient's process is increasingly valued. Even though the chaplain may only execute the assessment segment, the chaplain is responsible for teaching and integrating the other two components. To achieve this goal, the chaplain needs to be conversant with the latest literature in the field. Research on spiritual screening tools, for instance, is proliferating.

Furthermore, while visiting patients and families is at the center of what chaplains do, as the spiritual care specialists in the institution, their expertise must be leveraged to educate other disciplines in spiritual care, to help the institution

develop and implement policies and programs that improve patient experience, and be involved in research and quality improvement. Increasingly, chaplains are reporting to patient experience officers. Thus the skills and knowledge chaplains need is expanding. For example, federal palliative care rules mandate that if your institution provides palliative care and has pediatric patients, it must offer those patients palliative care. This means the palliative chaplain can be called upon to cover pediatric as well as adult patients.

All of these changes are driving how professional health care chaplains are expected to practice. Simply going to a nursing unit and checking with staff to determine who should be seen has largely been replaced by screening and referral protocols. Documentation, data reporting and quality improvement are more frequently required and take time. Communication with the interdisciplinary team including attendance at team meetings and rounds are now generally expected. Most of all, the expectation that chaplaincy is untouchable because we are simply a service that every hospital offers is unrealistic and runs the risk of our very existence being called into question.

Years ago, a senior administrator said to his managers in a meeting that those, who in five years expect to be doing their jobs the same way they are doing them now, will not be here to see it. That prophecy continues to be true. Chaplaincy does have value and contributes to our institution's mission and even its bottom line. Patients do value us. However, if we do not demonstrate that value and align those contributions with the goals and strategies of the institution, we will be replaced or just left out.

We have many opportunities. I feel very optimistic about the continued and even increasing integration of spiritual care as a contribution to patient care. The only barrier I see to this growth is our own reticence to change and our resistance to the demands being made on us.

The Rev. George F. Handzo, BCC, CSSBB is widely regarded as one of the foremost authorities on the deployment and practice of professional healthcare chaplaincy.

As Director of Health Services Research and Quality at HealthCare Chaplaincy Network and President of Handzo Consulting, Rev. Handzo oversees projects devoted to the strategic assessment, planning and management of chaplaincy services and to developing the evidence for the efficacy of chaplaincy care. Rev. Handzo has authored or co-authored over 70 chapters and articles on the practice of spiritual care and chaplaincy care.

He is a past president of the Association of Professional Chaplains which in 2011 awarded him the Anton Boisen Professional Service award, its highest honor. He serves on the Geriatrics and Palliative Care Committee of the National Quality Forum the Distress Guidelines Panel of the National Comprehensive Cancer Network and the Advisory Board of the Palliative Care Quality Network. He is a Certified Lean Six Sigma Black Belt.

The Rev. Handzo is a graduate of Princeton University and Yale University Divinity School and is a rostered minister of Word and Sacrament in the ELCA.

The Formation of a Chaplaincy Researcher

Paul Galchutt

LIKE MANY, MY INTRODUCTION to health care chaplaincy occurred through the Evangelical Lutheran Church in America's (ELCA) requirement that one basic unit of Clinical Pastoral Education (CPE) be completed as an ordination requirement. Unlike some of my peers, I was drawn like moth to a flame toward a health care chaplaincy specialization. The opportunity and privilege to support and be a source of healing for patients, family and staff members had much appeal then and continues to animate my desire to serve.

I, in fact, pursued the possibility of completing a chaplain residency subsequent to my last year at Luther Seminary (1995–1996) in St. Paul, Minnesota. I applied but declined the offer for two reasons. First, in addition to being drawn to health care chaplaincy specialization, I found much fulfillment in my congregational internship experience. At that time in my life, my internal tug was slightly greater to return to the congregation for word and sacrament service. The other reason, the ELCA requires that all ordination candidates fulfill a minimum of three years of service within a congregation before being able to pursue specialized ministry. I was a congregational pastor for seven years.

In the fall of 2003, I transitioned to a CPE residency at Northwest Community Hospital in the Chicago area. I entered the program discerning whether I would return to congregational work or begin a new path as a health care chaplain. My CPE experience enabled a growing self-awareness as well as the development of new pastoral care skills through practice-based learning. I look back on my year at NCH with much fondness for the relationships with my educators and peer group. A learning style prevalent for me throughout my chaplain residency (and that continues to carry me forward) was seeking to exercise the *cognitively intellectual aspects* of our vocation.

I couldn't get enough of some of the classic CPE readings such as Michael Kerr and Murray Bowen's, *Family Evaluation* or Edwin Friedman's, *Generation to Generation*. Family systems, over functioning, triangulation, emotional cut-off… being able to have language and concepts for understanding clinical experiences was attractive to me. One of my CPE educators used to jokingly threaten to take my books away for fear that I might be over-intellectualizing. I wish there was a means to measure how CPE curriculum has shifted over the last fifteen years and how these shifts have arguably mirrored those rapidly occurring within healthcare. While I have not

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reviewed ACPE competencies recently, I have observed a move toward educating chaplains with a little more "intellectualizing," especially related to research literacy.

With the completion of my chaplain residency, I began my first position in health care chaplaincy at St. Francis Hospital on the south side of Milwaukee. For three years I was gifted with talented colleagues as well as department directors that afforded me growth in the profession. One of the roles I took on during those three years was to become the system's bereavement coordinator. As part of this role, I would meet quarterly with the other bereavement coordinators in the greater Milwaukee area. Each time we met we would discuss a peer-reviewed article concerning grief and/or bereavement.

This discussion group and the process of retrieving those articles became my introduction to research and the significance of research informing chaplaincy practice. While I was not familiar with how to interpret odds ratios or how to have a sense of what inferential statistical test was being used for determining an association, I enjoyed the pull toward the results and findings as well as the tentativeness with which data was reported and claims were made. A detailed, measured sense of what could or could not be said about the work was evident. I began to have an inkling that there was not much chaplaincy research out there at this time.

I enjoyed the pull toward the results and findings as well as the tentativeness with which data was reported and claims were made.

My migration in health care chaplaincy took me back to my home state of Minnesota where I began working at the University of Minnesota Medical Center in 2007. My full-time position was split, half as the inpatient palliative care chaplain and half as a staff chaplain assigned to a medical surgical area. Similar to my position in Milwaukee, I was immediately aware that I was surrounded by two astute teams of clinicians — palliative care and chaplain colleagues.

Being a member of the palliative care team I was sucked a little deeper into the hole of research literacy. Once a month, the palliative care team hosted a journal club with its core team members along with rotating medical learners. Honestly, at first, I had no idea what a journal club was until I attended my first one. My interest in research, however, deepened a bit more with facilitating my first journal club. My naïve dive into the literature was with the recognition that I really did not know what being peer-reviewed meant and why that was important. It was only through taking a plunge and flailing a bit before I began to have a sense of why a scientific manuscript is constructed as it is.

Another experience which rapidly vaulted my learning was being summoned by Chuck Ceronsky, my chaplaincy director at that time, to create a spiritual assessment for palliative care. Aligning with this summons was my acceptance to participate in the Advocating for Clinical Excellence (A.C.E.) Project being sponsored by the National Cancer Institute. This initiative was created to strengthen the advocacy and

leadership skills of psycho-oncology professionals. A project proposal was required for acceptance. My project, a palliative care specific spiritual assessment, eventually led to my first ever poster presentation and then to the publication of a peer-reviewed article based on, in my case, the palliative spiritual assessment (Galchutt, 2013) that was created.[1] This assessment was later updated in 2016 in a non-refereed article.[2]

The real fun, though, of engaging the work of spiritual assessment occurred when presentations and dialogues were hosted with my chaplaincy team members about the spiritual assessment I had begun using in palliative care. This assessment was offered to department colleagues to be *the* spiritual assessment template used for all chaplaincy progress notes moving forward. The dialogues were engaging. The best outcome from this process was, I believe, our growth as a team about how we understood and practiced the art of writing a progress note. This dialoguing process is detailed in the article mentioned above.

Thinking about spiritual assessment prompted reflections about the core of chaplaincy work and how we describe it in our notes.

Thinking about spiritual assessment prompted reflections about the core of chaplaincy work and how we describe it in our notes. I began to have my own internal conflicts with the code language chaplains often use with one another and which also appears frequently in our documentation. Some of these words or phrases are *presence, not having an agenda*, or a chaplain's favorite modifying word before the word listening as in *active* listening*, healing* listening *or reflective* listening. I am not in favor of using any of those expressions in chaplaincy documentation. I do not sense they are helpful for the interprofessional partners who, hopefully, read our chaplaincy documentation searching for relevant outcomes.

Another word, perhaps, which may stir the most dust among the readers of this publication, is that I am also opposed to describing health care chaplaincy work as *ministry* when talking with other non-chaplain health care colleagues. Let me explain. First, I see the work I do as a part of my call to Word and Sacrament ministry. I will explicitly affirm this belief when I am among those of an ecclesiastical persuasion outside of my chaplaincy context to explain what I do and why I do it. When with health care co-workers, however, I want to be recognized as a health care worker. True to Lutheran teaching on vocation, my call to ministry is no greater than theirs. In my almost fifteen years of chaplaincy, I have yet to hear a health care worker of any stripe describe their work to other health care workers as ministry. Instead, I hear talk about how their work is either research informed or has an evidence base behind it.

1 Galchutt, P. (2013). A Palliative Care Specific Spiritual Assessment: How This Story Evolved. OMEGA — Journal of Death and Dying, 67(1–2), 79–85. *https://doi.org/10.2190/OM.67.1-2.i*

2 Galchutt P. A Chaplaincy Scope of Practice Note: The Evolution of a Specific Palliative Care Spiritual Assessment. *PlainViews*. 2016; 13(12). A non-referred article is one that has not been peer reviewed.

I recognized health care chaplaincy was shifting toward an evolving research informed practice using a growing evidence base concerning chaplaincy care, and specifically, within the realms of religion, spirituality, and other connected areas of study. My clarity and hope for the recognition of this movement has been nurtured over the last two years through the privilege of becoming a Transforming Chaplaincy (TC) research fellow.[3]

I recognized health care chaplaincy was shifting toward an evolving research informed practice using a growing evidence base concerning chaplaincy care, and specifically, within the realms of religion, spirituality, and other connected areas of study.

The Templeton Foundation grant allowed for seventeen chaplaincy research fellows in two different cohorts to pursue a Master of Public Health (MPH) degree in order to learn research skills. The last two years as a Transforming Chaplaincy fellow have provided me with a new lens by which to see chaplaincy care. I have gained fluency in a new language allowing me to examine the existing research and to be involved in new investigations. In fact, TC's grant allowed for funding of small research projects for the fellows.

Consequently, I have been involved with two small projects sponsored by TC. The first involved seven focus groups with non-chaplain members of palliative care teams[4]. The research question, "what content is most helpful as well as missing from palliative chaplain progress notes," has generated data for possibly two manuscripts. One of the manuscripts will serve as my graduating capstone project for my MPH as well as be a chapter in a book published by Swiss chaplaincy researcher, Dr. Simon Peng-Keller of the University of Zurich. At the time of the submission of this essay, the other manuscript is in formation.

My other research project with a palliative care team involves a two-component intervention pilot to address burnout reduction and is still in the process of data collection. One of the two components involve my longtime co-facilitator, Michael Finch, APRN, with interdisciplinary expressive writing groups. Finch, the Lead Advanced Practice Provider with palliative care at University of Minnesota Health, Fairview, has worked with an inpatient palliative care team located in the upper midwest. This team participated in six expressive writing groups for this first component. Another partner on this project, Kate Roth, MS, LP, an Organizational Development and Learning specialist, has facilitated the other component: Workplace Engagement Sessions (WES). At the core of WES is the reality that burnout is not the

3 "Transforming Chaplaincy is a think tank with a mission to promote research literacy in chaplaincy to improve patient outcomes." See their website at *www.transformchaplaincy.org*. Transforming Chaplaincy (TC) received a $4.3 million grant funded by the Templeton Foundation awarded to TC's co-directors, George Fitchett, PhD, DMin, and Wendy Cadge, PhD. Fitchett is a chaplain, an educator with the Association of Clinical Pastoral Education, and a researcher (epidemiologist) connected with Rush University in Chicago. Wendy is sociologist, researcher, and professor at Brandeis University near Boston.

4 My moderating/analysis partner and co-author with the focus groups has been my longtime chaplain colleague, Judy Connolly, DMin, BCC.

fault of individuals. There is a critical structural, organizational component. WES was designed to address this aspect of burnout.

Connections with TC has opened doors for me to other opportunities as well. I have been fortunate to connect with leaders in palliative care, Christina Puchalski, MD, and Betty Ferrell, RN, PhD. I have been included as faculty in a new and growing initiative, Interprofessional Spiritual Care and Education (ISPEC). ISPEC is vital to chaplaincy, spiritual care and its essential connection to interprofessional health care partners. In response to a case study I wrote that is slated to be published as a chapter in a book later this summer concerning chaplaincy involvement in decision making, I am privileged to present this case in February at the International Chaplain Case Study Conference hosted in Amsterdam, Netherlands. Lastly, I will present on the focus group research mentioned above in June while in Florida for the Association of Professional Chaplains and TC Capstone Conference.

While I do not have a map for the journey of my future, I am confident our future in health care chaplaincy will involve the continuum of research — from literacy to the opportunity of conducting original research. I look forward to being a companion with you on this road.

Paul was a palliative chaplain for ten years at the University of Minnesota Medical Center, a facility of the Fairview Health System. He has been a healthcare chaplain for nearly fifteen years. He is completing his Masters in Public Health at the University of Minnesota, is a Transforming Chaplaincy research fellow, and is faculty for the Interprofessional Spiritual Care Education Curriculum (ISPEC).

Evidence-based chaplaincy in EMS

Russell Myers

THE PAST DECADE HAS BROUGHT AN INCREASE in the calls for evidence-based chaplaincy practice.[1] A related development has been an interest in outcome-oriented chaplaincy.[2] The wellbeing initiative at Allina Health Emergency Medical Services is an example of how this can be done. Our original research has provided evidence that informs our chaplaincy practice; still to be done is the work of measuring the impact of the chaplains' care.

Since 1993 I have served as chaplain for Allina Health, based in Minneapolis, Minnesota. I was a full-time staff chaplain at United Hospital in St Paul, Minnesota for fourteen years, and then for eight years split my time between the hospital and Allina Health Emergency Medical Services. I left the hospital in the fall of 2015, when the EMS position increased to full-time. In January of this year my FTE reduced to .6, and I now have a colleague who shares the position on a .4 FTE basis.

The role of the EMS chaplain is to support the paramedics, EMTs and dispatchers who provide 911 emergency response (Advanced Life Support or ALS) as well as scheduled transportation (Basic Life Support or BLS). Our "customers" for the ALS/911 calls are the people who live, work and visit the communities we serve. Customers for BLS/scheduled transportation are the hospitals and their patients — people who need skilled care while being moved from one facility to another (for example, patients needing an ambulance to take them from a hospital to a long-term care center). Dispatchers have both internal and external customers. In addition to communicating with ambulance crews, dispatchers engage over the phone with distraught callers, providing a calming voice and instructions for how to give care until the ambulance arrives.

EMS professionals serve in a job with a lot of emotional weight. Some is the cumulative stress of caring for people in need. Some is the stress that comes with a critical incident. A routine call suddenly becomes urgent. The sights, sounds and smells associated with an emergency call may linger for some time. A call that feels ordinary for one paramedic can trigger unexpected memories and associations for another, becoming a critical incident.

EMS professionals serve in a job with a lot of emotional weight. Some is the cumulative stress of caring for people in need. Some is the stress that comes with a critical incident.

The chaplains' approach to this position is one of proactive relationship building. We do that by riding with ambulance crews and sitting with dispatchers on a regular basis. A guiding principle for me has been "the time of a crisis is not the time for

1 Fitchett, George, Kelsey B. White and Kathryn Lyndes, eds. *Evidence-Based Healthcare Chaplaincy: A Research Reader.* London: Jessica Kingsley. 2018 ISBN: 978-1-78592-820-8

2 Ibid, page 146

us to be exchanging business cards." That is, we need to know each other ahead of time, so that when the inevitable high-stress calls come, the dispatchers, paramedics and EMTs know who we are and why we are reaching out to them. Transparency is essential to the relationship; there is no hidden agenda. The "why" of this job is "because we care." Employees know that I am contacting them because we all know this is a challenging field to work in, and we as an organization care about the wellbeing of our people.

This was a new position when I started twelve years ago. I wondered how I would determine who had experienced a difficult call and how to prioritize them. Together with my colleague Al Kleinsasser, chaplain at a neighboring EMS agency, we turned to the leaders of our organizations for guidance in determining which types of calls were most likely to cause distress, and used their "Top 10" to develop standard operating procedures for when we want leaders to notify the EMS chaplain.[3] This was the beginning of the journey to create an evidence-based EMS chaplaincy practice.

Employees know that I am contacting them because we all know this is a challenging field to work in, and we as an organization care about the wellbeing of our people.

The journey led to two IRB-approved studies. The first was a survey study initiated by me and led by Lori Boland, the epidemiologist who coordinates research at Allina EMS. Using validated survey instruments, we conducted a cross-sectional survey among Allina dispatchers, EMTs and paramedics to evaluate professional burnout and an extensive list of potential risk factors. One of the instruments used in the Wellbeing study was the Critical Incident History Questionnaire. As noted in the Boland paper, "Survey respondents indicated that they perceived Critical Incidents (CI) involving children to be among the most difficult to experience and cope with. All seven of the pediatric incident types presented in the survey had very high average severity ratings, and accounted for seven of the top eight event types rated most difficult to cope with (Table 3, page 991).[4] This is evidence, provided by our own clinicians, that pediatric calls are among the most difficult calls they get.

By itself, this was not new. It came as no surprise that calls involving children are challenging. "Consistent with our findings and irrespective of methods or geography, studies universally report that calls involving children or persons personally or professionally known to the crew are among the most disturbing. Unique to the current study, however, was an examination of incident severity rating by parental status. We hypothesized that emergency responders with children might

3 Myers R., Kleinsasser A. *EMS chaplains provide spiritual support for providers and staff.* Journal of Emergency Medical Services. 2013;38(9):58-91
https://www.jems.com/articles/print/volume-38/issue-9/features/ems-chaplains-provide-spiritual-support.html

4 Boland, L. L, Kinzy, T. G, Myers, R. N, Fernstrom, K. M, Kamrud, J. W, Mink, P. J, & Stevens, A. C. (2018). *Burnout and Exposure to Critical Incidents in a Cohort of Emergency Medical Services Workers from Minnesota*. Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 19(6). *http://dx.doi.org/10.5811/westjem.8.39034* Retrieved from *https://escholarship.org/uc/item/1wn2k7ng* Boland, page 991

find pediatric CIs more distressing because of mental and emotional transference of the situation to children in their own lives, but our findings did not support any difference in perceived severity by parental status.[5]"

In other words, it doesn't matter if the provider is a parent or not. Pediatric calls can be distressing to *anyone*. Informed by this evidence, I adapted my chaplaincy practice to place a high priority on follow-up contacts to all paramedics, EMTs and dispatchers who were involved in Code 3, lights-and-sirens, emergency transports of patients who are children. Our research team also conducted a follow-up focus group study to further delve into what specific elements of pediatric calls contribute to distress.

The findings have been published in two peer-reviewed papers, to date. The first, *Burnout and Exposure to Critical Incidents in a Cohort of Emergency Medical Services Workers from Minnesota*[6] provides quantitative data on EMS providers' exposure to critical incidents. The second one, *Emergency Medical Services Provider Perspectives on Pediatric Calls: A Qualitative Study*[7] summarizes the qualitative information gleaned from the follow-up focus groups. I encourage readers to follow the links to those articles.

A next step in this process has been to identify and refine the referral sources. I get referrals from supervisors and managers, informing me of high-stress calls involving children (as well as referrals for follow ups based on other criteria). Sometimes employees will contact me directly, on behalf of a co-worker or to request support for themselves. Another source of information about calls involving pediatric patients is the use of an automated notification program, set up through the communications center. Using key words, the First Watch program generates short email reports, informing me of calls that meet the established criteria. (See image above.)

FIRST WATCH

Incident Information

Call Information		Call Disposition	
Dispatch Reason:	Transfer/Interfacility/Palliative Care	Disposition:	
		Transport Mode:	Lights and Sirens
Response Mode:	Lights and Sirens	Encounter #:	
Type of Service Requested:	Interfacility Transfer (Unscheduled)	Type of Destination:	Hospital
		Destination Name:	CHILDREN'S HOSPITAL ED (Fax) - MINNEAPOLIS
Level of Service Provided:			
Location Type:	Health Care Facility (clinic, hospital, nursing home)	Destination Address:	From **AHEMS** From **AHEMS**, From **AHEMS** From **AHEMS** From **AHEMS**
Address:	4050 COON RAPIDS BLVD NW er 3 COON RAPIDS, MN Anoka		
		Destination Decision:	Patient's Physician's Choice
		Turnaround Delay:	
Mass Casualty:	No		
Incident Date:			
Incident #:			
Response #:			
PCR #:			

Incident Times

Time Dispatch Notified:	04/08/2016 17:23:00	Unit #:	636
Time Unit Notified:	04/08/2016 17:28:06	Unit Role:	Critical Care Ground Transport
Time Enroute:	04/08/2016 17:28:27	Unit Call Sign:	636
Time Arrived Scene:	04/08/2016 17:35:32	Begin Odometer:	

The chaplaincy program at Allina EMS is integrated with the Provider Well Being Council, a broader company initiative to provide support for the wellbeing of our employees. Others engaged in aspects of this work are Employee Assistance Program (EAP) providers, supervisors, managers and directors, and employee co-workers. Coming initiatives will include a therapy dog, education and training, and a peer support team.

5 Boland, page 991

6 Boland, page 993

7 Jessica N. Jeruzal, Lori L. Boland, Monica S. Frazer, Jonathan W. Kamrud, Russell N. Myers, Charles J. Lick & Andrew C. Stevens (2019) Emergency Medical Services Provider Perspectives on Pediatric Calls: A Qualitative Study, Prehospital Emergency Care, *https://www.tandfonline.com/eprint/pBhwJkZ5KRnP2NDjdHc6/full*

Unlike our chaplain colleagues in other healthcare settings, our primary focus is not on the patients. This is workplace chaplaincy. And as noted above, we have yet to do the work of measuring the impact of the chaplains' care. Our study did not include measures of chaplaincy care or measures relevant to the Wellbeing care provided by others.

In many ways, discovering the evidence upon which to focus the work of the EMS chaplain has been the easy part. Measuring its effectiveness will be a greater challenge, one that we are building into the work of the Provider Well Being Council.

Suggested reading:

Fitchett, George, Kelsey B. White and Kathryn Lyndes, eds. *Evidence-Based Healthcare Chaplaincy: A Research Reader*. London: Jessica Kingsley. 2018 ISBN: 978-1-78592-820-8

Roberts, Stephen B., ed. *Professional Spiritual & Pastoral Care: A Practical Clergy and Chaplain's Handbook*. Woodstock, VT: Sky Light Paths. 2012 ISBN-13: 978-1594733123, especially chapter 30, "Health Care Chaplaincy as a Research-Informed Profession"

Stewart-Darling, Fiona. *Multifaith Chaplaincy in the Workplace*. London: Jessica Kingsley, 2018. ISBN: 978-1-78592-029-5

Swift, Christopher, Mark Cobb and Andrew Todd, eds. *A Handbook of Chaplaincy Studies: Understanding Spiritual Care in Public Places*. Burlington VT: Ashgate, 2015. ISBN: 978-1-4724-3406-7, especially chapter 5, "Developing Practice-Based Evidence"

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AHA! My Discovery of Evidence-Based Spiritual Care

Steven D. Rice

TO SET THE "STAGE," this article is informed by reading the research on evidence-based chaplaincy and by my 32-year journey into as a professional chaplain in spiritual care.

My goal in writing this article is to arouse the reader to be inspired by the excitement that has seized me. During my three plus decades in chaplaincy, many chaplain colleagues have conducted compelling research that has resulted in an emphasis today on "best practices" in spiritual care. When our work is grounded in "best practices," we have the opportunity to be high-quality, evidence-based, professional providers of whole-person spiritual care for our patients, our families and our staff.

The opportunities inherent in being a chaplain could be described as participating in live theater with lots of people in the front row with you or with lots of people on stage with you. When I am mindful enough to stop, look and listen with purpose to the live theater … I can genuinely see the perspiration, the heavy breathing, the joys, the confusions, the fears, the love, the panic, the passions, the regrets, the acceptance, the alienations, the forgiveness, the anger, the tear-filled eyes, and the "aloneness" an individual may experience with their feelings … as they live out their story. The difference in this analogy…we are not acting.

Chaplaincy Experience ~ Stage One: 1987 – 1994

After graduating from seminary in 1972, I served three Lutheran congregations between 1972 and 1987. After leaving the second and before going to the third congregation, I eagerly participated in four units of CPE in New Orleans. Upon completion of CPE, I accepted a call to a congregation in Colorado Spring as part of a ministry team. In addition to the expected pastoral responsibilities, I was also excited to be asked to develop chaplaincy outreach programs in the many multi-family apartment/condo units surrounding the church. This would be my first experience in developing chaplaincy programs outside the traditional chaplaincy settings.

The opportunities inherent in being a chaplain could be described as participating in live theater with lots of people in the front row with you or with lots of people on stage with you.

Then, in April 1987, Lutheran Social Services of Central Ohio offered me their newly established position as Director of Chaplaincy for the agency. Enthusiastically, I said "Yes!" My job description: initiate, establish and supervise contract chaplains serving in local medical and nonmedical facilities.

I quickly discovered there were very few written materials on the development of chaplaincy in non-traditional contexts. My own naivete led me to believe that all I needed to do was to explain to the management the importance of spiritual care for employees in these non-traditional settings. I knew management would be excited to welcome a chaplain into their company! After all, who didn't want their employees to be well physically, emotionally and spiritually!

However, in response to my presentation for chaplaincy services, management acknowledged the idea sounded good, but it did not seem practical because the employees "are busy their whole shift." In reality, management would have welcomed a chaplain from LSS ... but they did not want to pay for a chaplain "to lead Bible studies and prayer." I quickly realized there was something I did not understand about the workplace. Additionally, the three major hospitals in Columbus had robust pastoral care departments and CPE programs. The directors were not interested in contracting chaplains. The fact was, initially, we made no inroads establishing and supervising contract chaplains serving in local medical and nonmedical facilities.

In reality, management would have welcomed a chaplain from LSS . . . but they did not want to pay for a chaplain "to lead Bible studies and prayer."

I visited and re-visited the seminary library in town and searched the *Journal of Pastoral Care and Counseling* in order to find better information about chaplains in the business world and in long-term health care communities. The studies being done were primarily for hospitals and CPE programs. I found no useful material for establishing contract chaplains that applied to my targeted settings.

Early in 1988 I shared my failures and frustrations with a friend who was a sales person and a member of the Lutheran church my family attended. I think he could see my perspiration. After listening to my frustrations, he told me that his fifteen years of sales experience had taught him a very important concept. "It is more about the relationship you establish than the product you want to sell." His advice: First, if possible, get to know the person in charge of making decisions for the company or facility. In the process of establishing a trusting relationship, I would learn the *needs* of the company. "After establishing the relationship," he said, "you will be able to determine how your chaplaincy program can meet some of their needs."

AHA! "Oh, I need to think in terms of *need*-based chaplaincy, not *location*-based chaplaincy!"

By the end of 1988, LSS had chaplain contracts for part-time chaplains in the city hospice, in a smaller, independent hospital, within a woman's prison and with Goodwill Industries (a workplace). After 6 years we had six part-time chaplains in various traditional and nontraditional settings meeting the spiritual *needs* of employees and residents!

I have never forgotten the "aha!" moment of *need*-based chaplaincy sent from God through a friend in early 1988!

Chaplaincy Experience ~ Stage Two: 1994 – 2009

In June 1994, I left LSS after accepting an offer to be the first full-time hospice chaplain for Riverside Methodist Hospital (Ohio Health) in Columbus, Ohio. I brought with me six years of experience from the City of Columbus hospice where I had served as the contract chaplain for LSS.

The need-based chaplaincy "aha moments" continued. In 1995 a hospice nurse and I presented "Hospice 101" to a group of 20 college students at the Ohio State University Department of Allied Medicine. In that classroom I had my first hands-on experience with research. As part of my presentation, I asked each student to complete a sentence on an index card. I explained their answers were confidential and that I would look at their responses after class.

Before reading on, I invite you to complete this sentence for yourself: "That which I fear the most in life is to be . . ."

Before reading on, I invite you to complete this sentence for yourself: "That which I fear the most in life is to be ..." I watched as some immediately finished the sentence and folded the card for me to collect, while others pondered the question and slowly wrote their answers.

I expected a wide variety of responses but was surprised and shocked by the uniformity of the responses! Of the twenty unsigned cards I received, 80% of the respondents completed the sentence with the words "alone, lonely, loneliness, separated from, by myself" and a few other descriptive words for "alone." I did not know it at the time, but this initial research would follow me for the next 25 years! And, what I learned by gathering this data has influenced me as a chaplain and as a human being in identifying the needs of a large percentage of fellow human beings.

As a full-time hospice chaplain from 1994 until 2009, I collected over 600 unsigned cards and more data using the same existential question with the addition of requesting information about the respondent's gender and age. Combining all the data, sixty-three percent of males and females, of all ages, competed the sentence with a reference to being alone. However, the age of the respondents revealed that ... while the responding words were different ... the fear of loneliness in one's life situation was universal:

- **Under** age 55: Sixty-five percent of the total responders answered with "alone" or a synonym for "alone".
- **Over** age 55: Twenty-two percent of respondents made references to "being alone" while a majority of those over age 55 wrote their fear was being "unable to care for myself" and "losing control of my faculties" or other phrases conveying the same type of fear. I have always felt the words, thoughts and

feelings for those over 55 years old, were another way of communicating the fear of "loneliness" from "helplessness" in one's life situation.

Chaplaincy Experience ~ Stage Three: 2009-2019

In 2009 I transferred within OhioHealth from Riverside Methodist Hospice to Riverside Methodist Hospital to work in oncology and with the start-up palliative care program. Every day, as a member of the Palliative Care Team, I meet individuals who have received devastating news about their health or prognosis. I have learned over and over just how important it is for individuals to be given a safe person with whom to name their feelings and describe their thoughts.

Today, what I have learned about "loneliness," through research and through experience, is integrated into my spiritual care assessment of patients and family members. When I hear a sentence that involves, "I feel so …", I stop, look and listen for more. I want to give the individual plenty of time to further clarify or describe what they are feeling. Using data gathering from my survey and learning more about evidence-based research has allowed me to be a needs-based chaplain for not only our patients and family, but also for our staff colleagues.

Using data gathering from my survey and learning more about evidence-based research has allowed me to be a needs-based chaplain for not only our patients and family, but also for our staff colleagues.

In my first years as a chaplain, few individuals were writing about research, evidence and best practices in spiritual care. The early pioneers in chaplaincy remind me of the California gold miner who, armed with a pickax and shovel, looked for and often found precious nuggets or flakes of gold that kept them attentive to their work. The pickax and shovel worked for decades, but they have been replaced by more sophisticated models to uncover new veins of gold flakes and nuggets.

Decades ago, as chaplains, we did our best to be high-quality, professional providers of whole-person spiritual care for individuals, their families and the staff. But little of our chaplaincy work was grounded in evidence-based research. Today evidence-based research and experience provide a firm foundation for utilizing "best practices" when we provide need-based, whole-person spiritual care as a professional member of a care team, no matter what "stage" we are on.

My work happens to be with a hospital-based palliative care team. However, every chaplain is in a unique position and setting in which to offer individuals and groups need-based spiritual care by stopping, looking and listening. Today there are many individuals, who, through their earnest, powerful, and enthusiastic research, are devoting themselves to uncovering and communicating evidence-based research with you and with me that can positively impact our work, our ministry with other human beings.

I would encourage you to read the evidence-based research. It will continue to transform us as chaplains. May each of us have those "aha moments" that inform the essence of our callings as chaplains in our own settings.

Steven D. Rice, MDIV, BCC, ACP, was born in Los Angeles and lived in Southern California until beginning his journey into the ministry through the Concordia system of the LCMS. He graduated from Concordia Seminary, St. Louis in 1972.

He is married to Patricia, a graduate of Concordia River Forest, Chicago. They have two children, two children-in-law and four grandchildren. Steve enjoys photography, traveling and the theater. Steve and Patricia especially enjoy supporting the arts by attending all of the performing arts productions in which their grandchildren are involved. He reports the best time to get great pictures of the stage productions are during the final rehearsal. Steve is now rostered in the ELCA.

Chaplain as a Leader in Healthcare Organizations

Nancy Ruth Wigdahl

THE FOCUS OF MY SEMINARY EDUCATION was parish ministry. The faculty prided themselves on teaching students how to preach using good text criticism and exegesis. Greek was foundational to all the courses that followed. It seemed that any sort of relational and leadership skills was deemed to be instinctive. Clinical Pastoral Education was a mysterious and feared elective that was not required at that point in the theological education of students preparing for ministry in the former American Lutheran Church.

Eight years of parish ministry lead me to more years of preparation to be a CPE educator, which, I discovered, was often paired with a management role within a healthcare organization. Somehow, the fuzzy image of the chaplain simply holding the hand of a patient struggling amid a life crisis became a ruse. While I felt more than adequate in being a bedside chaplain, my role in the board room and administrator's office was murky. Informally, I saw models of leadership in my parish ministry colleague and in fellow chaplains and educators, but it seemed to be a game of trial and error and pure chance. The relational skills learned in CPE were an asset but leadership skills were haphazard. Managers did not always seem to be leaders and there were leaders who were not managers. The behaviors of administrators were mysterious and illogical and I wanted to understand them in order to better work with them.

Confounding leadership experiences lead me to enroll in a Master's program in organizational leadership at St. Catherine University in St. Paul, Minnesota. This program provided me much of the experiential and conceptual learning about leadership that I had been craving for the past twenty-five years of ministry. For me, the models of female leadership that I experienced in that program were very important. Furthermore, the collegial relationships that I experienced in the course of that program with leaders from a broad spectrum of organizations, not only healthcare, were significant to my continued development as a leader.

While I felt more than adequate in being a bedside chaplain, my role in the board room and administrator's office was murky.

Culminating my learning in the program, I wrote a thesis on my qualitative research project that focused on the chaplain as a leader in healthcare organizations. My research explored 1) the current role and practice of certified spiritual care providers who serve in healthcare settings; 2) the skills and knowledge certified spiritual care providers identified as leadership competencies; and 3) recommendations as to how spiritual care providers may receive clinical training that

goes beyond a traditional supportive stance to a proactive involvement as an ethical and enduring leader in healthcare.

My plumb line for discerning personal best leadership practice were drawn from the book, *The Leadership Challenge* by J. Kouzes and B. Posner (2007) and included:

- Model the Way: finding your voice by clarifying your personal values and setting an example by aligning actions and values.
- Inspire a Shared Vision: envision a future of possibilities and enlist others in this vision.
- Challenge the Process: seek innovative ways to change, grow and improve, and to take risks.
- Enable Others to Act: foster collaboration and strengthen others by shared power.
- Encourage the Heart: show appreciation for individual excellence and celebrate the values and victories by creating a spirit of community.

These characteristics are mirrored in the *Common Standards for Professional Chaplaincy* (2004) and the *Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students* (2004). Therein, one finds encouragement for spiritual care professionals to advocate for changes in their institutions that honor spiritual values and promote healing, and that provide expertise and counsel to other health care professionals in advocating for best practices in care.

My Research Process

In order to gain a concrete picture of the current practice of chaplains, my research consisted of nine interviews with persons currently serving as certified chaplains in acute care hospital settings. Each of the interviewees had been certified as a healthcare chaplain for a minimum of one year. All were certified in the Association for Professional Chaplains; one was also dually certified in the National Association of Catholic Chaplains. I conducted these interviews and analyzed the data utilizing the long qualitative interview approach described by G. McCracken, *The Long Interview* (1988).

I passionately believe that chaplains regularly demonstrate competencies that could easily be categorized as leadership at the same time that they may be reluctant to claim identity as a leader in the healthcare setting.

My potential bias in this research could have been fueled by the fact that I have long-term familiarity with both the field of chaplaincy and long-term collegial relationships with peers of the interviewees. I was also aware that I passionately believe that chaplains regularly demonstrate competencies that could easily be categorized as leadership at the same time that they may be reluctant to claim identity as a leader in the healthcare setting.

Emerging Themes

A number of significant themes surfaced amid these interviews; these themes were related to Kouzes and Posner's personal best leadership practices. All interviewees volunteered authenticity or the closely related concept of integrity as important characteristics of spiritual care providers serving as leaders in health care settings. Sometimes the idea of authenticity came out when an interviewee was talking about an admired leader or as they empowered members of the healthcare team to assume leadership or as they engaged in conversation with the interdisciplinary team about their role as a chaplain. Other chaplains related the development and use of voice as related to authenticity. Modeling was also named as being important to their leadership.

Another theme mentioned by interviewees was vision: vision expressed by flexibility amid institutional changes and strategic planning or vision in the image of leader as midwife. One chaplain spoke of two chaplains whose longevity and wisdom served to inform much of the leadership of a department.

One chaplain couched the process of challenge in their understanding of the chaplain as a counter-cultural figure in the hospital by infusing heart and spirit especially relative to the technical, objective climate of the hospital.

The theme of challenging the process was expressed by chaplains incorporating innovative practices of music, designing a new chapel, incorporating walking meditation, and using a prophetic voice. One chaplain couched the process of challenge in their understanding of the chaplain as a counter-cultural figure in the hospital by infusing heart and spirit especially relative to the technical, objective climate of the hospital.

Enabling others to act was a theme expressed by interviewees relative to collaboration with others in the establishment of support groups. Collaboration and enabling others were also expressed in how chaplains made connections with the rest of the hospital, designing patient care plans with the interdisciplinary care team, serving on wellness committees, listening and not complaining as well as encouraging staff to bring forth their concerns in ways that result in action.

Encouraging the heart as expressed by expecting the best of self and others and recognizing good performance was exemplified by such practices as offering the nursing staff a self-care basket or helping nurses deal with the kind of emotional intensity in difficult situations or inviting the interdisciplinary staff to process personal stressors that are impacting their daily work.

A most curious response to my recruitment letter was at least three chaplains who said that they were willing to speak to me while offering a gentle protest that I might be better off speaking with the manager of the department because that is the person who really provides the leadership. When I posed this scenario to the

interviewees for their response, one chaplain identified that it is challenging for chaplains to identify with and hold chaplains accountable for leadership positions. In the identity fog of chaplaincy, chaplains may often struggle to define themselves in the secular setting of the hospital. Chaplains are usually rostered and maintain a membership covenant in their denomination at the same time that they are employed by hospital organizations that also beg their allegiance, resulting in potential identity conflict.

Recommendations

Amid this research, the identify formation of chaplains became a central issue for me. In my concluding recommendations, I named that it is important to help chaplaincy students become aware of the experience of being a marginal or liminal figure in the hospital. My recommendation was to not only facilitate awareness of this identity dilemma but to also give chaplaincy students the tools to manage themselves amid this marginal, countercultural existence. Helping chaplains to become familiar with and experience their liminal position as the norm in the hospital setting will give chaplains the foundation to more easily claim parity with the rest of the interdisciplinary care team.

Helping chaplains to become familiar with and experience their liminal position as the norm in the hospital setting will give chaplains the foundation to more easily claim parity with the rest of the interdisciplinary care team.

I also recommend providing education for chaplain students regarding the conceptualization of leadership dynamics. Chaplains may come with master's level theological education that may give them religious language to describe their role, such as pastor, priest and prophet. However, chaplains also need secular language to describe their role. With the aim of defining themselves and of educating other healthcare professionals, they need language that will help people from other disciplines to understand the chaplain's role and function.

This also prompts the understanding of the chaplain as translator. A significant role of the chaplain is to be a supportive presence that also reminds patients that they are more than their diagnoses. At the same time, this orientation to patients may make chaplains reluctant to attend to their own professional interests. Chaplains also need to support their own interests by defining their meaning and value of their work to hospital administrators and leaderships, in essence, translating theological language in secular terms.

Interestingly, I found that as I interviewed chaplains and they had the opportunity to articulate what it is that they do, they began to more readily claim their identity as a leader. Regardless of whether they were a staff chaplain or a manager, understanding the leadership nature of their behaviors seemed to help them to assert their perception of self as leader. I encourage chaplains to access courses and training that help them to both understand and implement leadership. Time and

experience were significant to the development of leadership as well as the need for conceptual awareness of leadership.

Leadership by Chaplains Today

In the nine years since I conducted this research, I have observed that many CPE programs have instituted a focus on leadership in their residency programs. Granted, a mere ten week focus on self as leader and chaplain affords a very basic taste of the potential leadership opportunities in the hospital setting. I also find that chaplain managers have divergent views of supporting the development of chaplains as leaders. I do believe that there is opportunity for a closer examination and comparison of the leadership behaviors and authority dynamics of the chaplaincy department manager and staff chaplain. The role and impact of mentors is also an important consideration relative to the formation of leadership skills and identity of chaplains.

I am encouraged that certified chaplains do name, demonstrate and describe behaviors that are classified as leadership. The training of chaplains should include not only the identity development of chaplain as leader but also include the exploration and practice of strategies that equip the chaplain to provide leadership as a care team member. A working knowledge of leadership concepts will also help the chaplain to define themselves in both their judicatory and the healthcare setting.

Nancy Wigdahl, an ELCA rostered minister of word and sacrament, has recently retired from a position as an ACPE Certified Educator with Fairview Health Services, Minneapolis. She spends a good bit of her time volunteering for ACPE Certification and Accreditation besides enjoying the freedom of a flexible schedule. Nancy also serves on the editorial board for Caring Connections.

The Pastor as Shepherd and Counselor — Why CPE Matters in the Parish

Brian Heller

"WHY ARE YOU GOING TO DO THAT PROGRAM ANYWAYS?"

I got that question a lot at seminary after I told my classmates that I was going to take an extra year out of seminary to participate in a clinical pastoral education (CPE) residency at a local hospital. To be honest, I even asked myself that question a few times. After all, I thought I would be ministering only within a parish setting, not becoming a chaplain. However, after completing my residency and being a pastor in a small parish for almost two years, the benefits of CPE for the parish pastor are crystal clear to me.

To begin with, CPE provides the seminary student with experiences they won't find anywhere else. In my seminary education, we were required to take only one quarter of pastoral counseling. In my own experience of that course, about 5 of the 10 weeks covered premarital counseling. This left counseling those who are suicidal, suffering from drug addictions, and other issues crammed into those last 5 weeks. On top of that, none of the course involved "hands on" training. Everything was theoretical. However, CPE gives students the opportunity to experience all of these things (and more!) on a routine basis. During my CPE residency, I was still taking some courses at seminary. During that year, it wouldn't be uncommon for me to be ministering to a family whose 14-year-old daughter just died at 4 AM, and then be sitting in a liturgics class at 7:30 AM. Clinical Pastoral Education allows students to experience the stress of intense ministry and how to handle that stress in a productive and healthy way. And yes, parish pastors do experience the stresses of ministry. This is something that a 10-week seminary course simply cannot accomplish.

Additionally, CPE provides a safe place for students to learn and test new pastoral care and counseling skills that they've been taught. This is actually what drew me into CPE in the first place. During my vicarage year of seminary, a woman came to me for counsel after finding out her husband was cheating on her. Two weeks after visiting with me, she attempted suicide. Completely distraught, I went into my vicarage coordinator's office at seminary to withdraw from seminary. This professor was the one that convinced me to stick it out, but to add CPE to my seminary education. I couldn't be more thankful. CPE taught me new pastoral skills that I would never have acquired anywhere else. Before CPE, I didn't even know what a verbatim was. Though intimidating at first, gifts like verbatims and self-reflections

Clinical Pastoral Education allows students to experience the stress of intense ministry and how to handle that stress in a productive and healthy way.

that CPE provides help the student develop personally and pastorally. Not only does your CPE supervisor provide feedback, but your classmates, often from different denominations and religions, do as well. CPE provides the parish pastor with a plethora of experience and insight he/she simply won't find anywhere else.

In a conversation with a classmate of mine, he lamented that he had been present for about six funerals in the past two months, but he didn't really know how to effectively minister to the family. Thankfully, on the other hand, CPE provided me, on a weekly basis, with the opportunity to be with the families of loved ones who had died. Each of those moments of pastoral care were critiqued giving me opportunities to learn and improve. Real life experiences provide real life growth — this is what CPE is all about. The clinical method of learning (i.e. learning by doing) is at the heart of the CPE experience. Without CPE, many parish pastors find themselves in a trial-by-fire situation, trying out different techniques when the stakes are high, such as counseling a couple when their marriage is on the rocks.

Taking CPE provides students a context to practice their pastoral care skills in a "safe place" with professional feedback and support that they can carry with them throughout their entire ministry.

In my own experience as a parish pastor, the majority of my ministry has involved some type of counseling. In my first two months of serving my current parish, our small town was ravaged by a tragic accident involving a semi-truck striking a six-year-old boy. Within an instant, the town flooded the local parishes, looking for help, looking for someone to be present with them in their grief. No doubt many parish pastors across the country find themselves in similar circumstances.

Taking CPE provides students a context to practice their pastoral care skills in a "safe place" with professional feedback and support that they can carry with them throughout their entire ministry. Whenever I know a difficult situation is coming up, I may go back and look through a number of verbatims I have written. I look specifically at the comments that my supervisor and peers wrote me and apply them appropriately in those situations.

Perhaps the best reason for a parish pastor to take the plunge into a CPE course is that it helps the pastor develop their own self-awareness. "What's going on within me? Why am I reacting this way to this situation?" These questions are *so* important to the parish pastor as he/she is faced with a multitude of interpersonal relationship issues and, unfortunately, conflicts. Being able to identify what is going in one's self stops one from making a rash comment during a heated voter's meeting or spewing off a mouthful in an email to a parishioner that shouldn't be sent. For many people, CPE allows them to get to know themselves and explore their history and experiences that comprise who they are. With such personal growth, professional and pastoral growth are bound to follow.

As a prospective PhD student at Concordia Theological Seminary in Ft. Wayne, Indiana, it is my goal to scientifically demonstrate the need for parish pastors to take CPE. I want to evaluate the pastoral effectiveness/competency between CPE trained and non-CPE trained clergy.

In summary, CPE is an invaluable program to be utilized, not only by those aspiring to be chaplains, but by anyone called to pastoral ministry. This opportunity can fill in the experiential gaps between leaving seminary and arriving at one's first parish, and it can contribute to a minister's personal and professional development. Speaking personally, had it not been for the many challenges and blessings that I was awarded during my own CPE experiences, I would not be the person or pastor I am today.

The Rev Brian Heller is a graduate from Concordia University Chicago (2011) and Concordia Theological Seminary (Masters of Divinity- 2016, Masters of Sacred Theology- 2018). He completed three units of CPE at Lutheran Hospital in Ft. Wayne, Indiana. Brian then completed a fourth unit of CPE through an electronic, extended unit designed and administered by Lutheran Senior Services in St. Louis, MO. During this time, he received extensive experience in ministering to a diverse group of people and situations. In the Spring of 2017, Brian received a call to serve in the Northern Illinois District of the Lutheran Church- Missouri Synod. Currently Brian serves as the sole pastor of Holy Trinity Lutheran Church in Walnut, Illinois and as a volunteer chaplain at Perry Memorial Hospital in Princeton, Illinois. He resides in Walnut with his wife, Jennette, son, Isaac, and daughter, Carly.

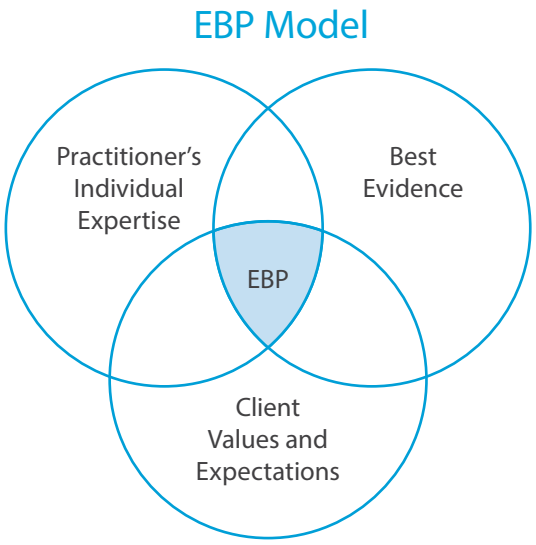
A Brief Rationale for Including Scientific Research in Chaplaincy

Brian Earl

AS A CHAPLAIN FELLOW in an interprofessional research-focused fellowship, I have become very interested in how to integrate research into chaplaincy practice. Even in my limited experience in pastoral ministry and chaplaincy ministry I know this can be a charged topic. There are people in favor of the inclusion of research, some that are opposed, and all manner in-between.

I believe there are some strong reasons to incorporate research into our pastoral care and chaplaincy practice. In this article, I want to share a brief rationale for including research while acknowledging some tensions and limitations.[1]

In the Veterans Administration (VA), a conversation about scientific research often involves discussing evidence-based practices (EBP). What is evidence-based practice? The American Psychological Association describes it this way: Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.[2] See the EBP model diagram pictured here.[3] This second definition is specific to spiritual care. "Evidence-based spiritual care is the use of scientific evidence on spirituality to inform the decisions and interventions in the spiritual care of persons.[4]"



Some may wonder, "why concern ourselves with what scientific research has to say about our pastoral care practice?" Before answering that question, however, there is a more fundamental question that needs consideration: How do we know what is good pastoral care?

First and foremost, the foundation of good pastoral care is revealed to us by God in Scripture. There are numerous texts describing and prescribing good pastoral care. Yet, even with all of these texts there are plenty of practical gaps to fill in. Let me give some examples based on a few verses that deeply inform my practice. In John 13:34, Jesus says "A new commandment I give you: Love one another. As I have loved you, so you

1 Much of the theoretical basis of my argument, which is the first part of this article, is taken from an online presentation by George Fitchett entitled, *Evidence-Based Chaplaincy: Oxymoron? Mistake? No-Brainer?"*

2 APA Policy Statement on Evidence-Based Practice in Psychology, 2005.

3 Fitchett G. *Evidence-Based Chaplaincy Care: Oxymoron? Mistake? No-Brainer*? Online Webinar for VA CPE Chaplain Trainees. Vol. Online2018.

4 O'Connor J "Is Evidence based Spiritual Care an Oxymoron?" *Journal of Religion and Health.* 2002;41(3).

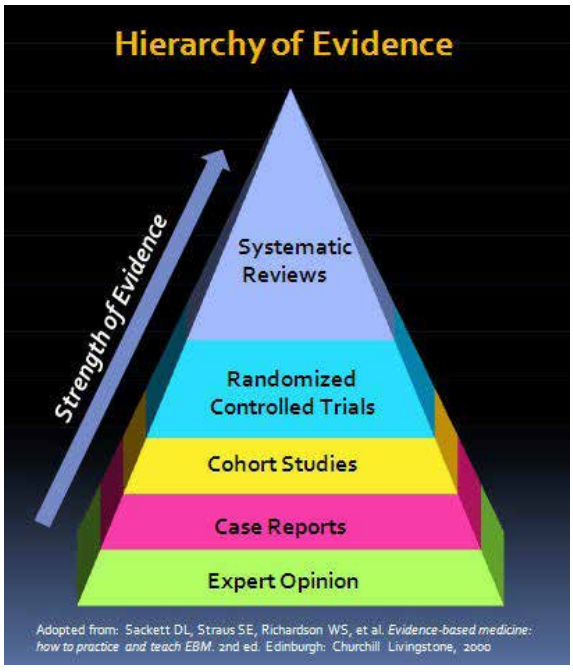
must love one another." In Romans 12:15, Paul tells us to "Rejoice with those who rejoice. Weep with those who weep." These two verses form two of the fundamental principles of my chaplaincy pastoral care: love and empathy. From these verses I take it that good pastoral care involves love and empathy. Yet, there are plenty of practical questions that remain unanswered: how exactly do I rejoice with those who rejoice in a pastoral care encounter? Hug, shout, sing or high five? Along with weeping do I say anything else? If so, what? If someone is not weeping or rejoicing, how do I empathize with them? The list could go on.

How then shall we fill these gaps of everyday details of pastoral care where God is silent, in the *adiaphora*? Here are some of the ways:[5]

- Tradition: We have done it this way in the past.
- Policy: This is the way we are supposed to do it.
- Education: This is they way we were taught to do it.
- Personal Experience/ Trial and Error: I tried several ways and this one works best.
- Intuition: Doing it this way feels right.

We all use some combination of these ways to inform us of good pastoral care. We were taught from a combination of these methods in our seminary education and chaplaincy training.

However, not all the methods are equally helpful or valid. Some of these methods are better than others. For example, intuition may steer us rightly or wrongly. Everyone has some amount of personal experience. A person's experience is generally considered increasingly trustworthy the more expertise and experience they have.



In the world of scientific evidence not all knowledge is equal. How knowledge is acquired is important. Just as we have a hierarchy of knowledge — Scripture being on top — so, too, scientific evidence has a hierarchy. See the diagram: *the hierarchy of evidence*. The weakest evidence is on the bottom and the strongest evidence is at the top. We are all familiar with expert opinion. Case reports are reports about particular instance of clinical care (i.e. a verbatim). Cohort studies are studies involving groups of people. Random Clinical Trials are trials where people are randomly assigned to intervention that is being tested or to a group not receiving the

5 Fitchett G presentation identified in footnote #3 above.

tested intervention called a control group. It is randomized to remove the placebo effect and any potential biases of provider or recipient. At the top of the hierarchy are systematic reviews. These are reviews of large numbers of research studies and articles which summarizes overall findings. In short, the greater number of independent sources showing the same evidence the stronger the evidence and the connected claims.

Scientific research and empirical evidence are a set of tools and knowledge that we can use to inform our care. This knowledge is not used to prove or disprove the Biblical foundation of our practice. Instead these tools and this knowledge help fill in the practical gaps in our practice. We are already using extrabiblical means to inform our practice; so, why not look to scientific research as well?

Scientific research and empirical evidence are a set of tools and knowledge that we can use to inform our care. This knowledge is not used to prove or disprove the Biblical foundation of our practice. Instead these tools and this knowledge help fill in the practical gaps in our practice.

Here are three benefits I have found in integrating scientific research into my chaplaincy practice and pastoral care.

First, when scientific research and evidence-based tools and skills are used on the Biblical foundation, powerful pastoral care can occur. Here are two personal examples. When I was 16 years old, I joined a Bible study group that was going through Robert McGee's *Search for Significance*. McGee is a professional counselor who is the founder of Rapha — a recognized Christ-centered healthcare organization. In this book McGee works to bring people's sense of identity and self-worth in line with Scripture. To do this he uses several psychotherapeutic tools from the Cognitive Behavioral Therapy (CBT) modality, which is a recognized EBP. He uses these tools to help bring peoples sense of self-worth, identity, forgiveness and sense of hope for change in line with God's Word. This book, used in conjunction with this Christ-centered group, helped me to heal emotionally; see my tremendous worth as a child of God in a way I hadn't before; and, experience the forgiving power of the Gospel in deep personal ways. At the time I didn't know that what McGee was using was CBT tools; or what Evidence Practices were; or that CBT was an EBP. Nonetheless, I benefited from McGee's implementation of research into his Christian psychotherapeutic practice. This book and the related group experience have since then served as a powerful tangible example of how extrabiblical tools and research could be used toward the godly end of good pastoral care. In fact, it is a formative experience in my spiritual journey that fuels my own pastoral care practice now.

Fast forward to my current chaplaincy care with the integration of the EBP of Motivational Interviewing (MI). MI is a modality focused around understanding, working with and fueling a person's own motivation to make positive life changes.

Research shows that MI is associated with helping people make positive changes.[6] MI has helped me learn some practical tools to join someone as they consider making positive changes in their life: for example, from addiction to recovery or in spiritual disciplines.

This modality closely mirrors a lot of chaplaincy practice and values: respect for the individual, empathy, and working with someone rather than working above them. Therefore, I think it is worthwhile for all spiritual care providers to become aware of and even just briefly being trained in MI, though further explanation and exploration of MI is a topic for another article.

If I am to work and serve in this world, it behooves me, at bare minimum, to understand how my colleagues think.

The second benefit I have gained from integrating research into my clinical practice is greater cultural competency, leading to connection and collaboration. Searching, studying and implementing research has been helpful to me in understanding my teammates. In my outpatient clinic I am the only chaplain. This means the rest of my colleagues are functioning from the empirical medical model. This model is a combination of what they were taught and what is their policy. If I am to work and serve in this world, it behooves me, at bare minimum, to understand how my colleagues think. If I were a chaplain in Japan, I would seek to understand my colleagues' and clients' culture and language; not to throw away my own culture or language but to join them, serve them and work with them. If I understand how they think and speak then I can connect with them in their work and world. This, in turn, could lead to collaboration and greater ends than simple parallel work. For example, this research integration has led to my participation in interprofessional publication, conferences, presentations and patient care.

In addition, as I better understand and participate in this culture, I can celebrate and honor our shared values and hopes. For example, the desire to provide helpful and substantive care is surely in line with our faith. I do not want to provide pastoral care because 'it feels right' or simply because 'this is how we've always done it.'

The third benefit for research integration is better advocacy for spiritual care. As I become familiar with addiction and chaplaincy research, I have been able to connect with my colleagues and better advocate for integration of religion and spirituality in medical treatment, and for my services and my clients' spiritual needs. As stated before, the language of most of my colleagues is that of evidence

6 In referring to Motivational Interviewing, I drew from several sources including:
- Rubak S, Sandbaek A, Lauritzen T and Christensen B. Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract.* 2005;55(513):305–312.
- McKenzie KJ, Pierce D and Gunn JM. A systematic review of motivational interviewing in healthcare: the potential of motivational interviewing to address the lifestyle factors relevant to multimorbidity. *J Comorb* 2015;5:162–174.
- Lawrence P, Fulbrook P, Somerset S and Schulz P. Motivational interviewing to enhance treatment attendance in mental health settings: A systematic review and meta-analysis. *J Psychiatr Ment Health Nurs*. 2017;24(9-10):699–718.

and research. Some have been skeptical or hesitant of chaplaincy because a perception that our work has no evidence to back it up or that religion and spirituality are not relevant to healthcare. These perceptions are false. There is evidence to back up the value of chaplaincy.[7] There is even more research evidence to back up the value of religion and spirituality. Consider a systematic review by Harold Koenig of over 3000 articles dealing with religion and spirituality (r/s) and health outcomes.[8] Koenig found that "a majority of studies report significant relationships between r/s and better health." He concludes, "The research findings, a desire to provide high-quality care, and simply common sense, all underscore the need to integrate spirituality into patient care." Knowledge of this research gives me greater ability to advocate for the spiritual care of my patients in the language most familiar to my colleagues.

It is possible that scientific people and people of faith can be at odds. However, opposition is not the only relationship that science and faith need to have.

Though there are strong reasons for inclusion of research into spiritual care, there are some tensions and limitations. Here are a few limitations I have encountered and how I am working through them.

One, as mentioned above, the EBP culture has some values in line with our Christian values. It also has values that are in contrast to the Christian faith. For example, the emphasis and prioritization on clinical results in EBP can be in tension with our primary calling to be faithful. We cannot ever fully guarantee positive results when working with people. For example, we cannot count Jeremiah's ministry as 'bad ministry' or 'unfaithful' because his ministry did not result in the positive results of preventing the exile.

Two, another aspect of the EBP emphasis on empirical evidence can be at tension with our looking to the supernatural. A prevalent narrative in our day is that science and faith are at odds. It is possible that scientific people and people of faith can be at odds. However, opposition is not the only relationship that science and faith need to have. It has been helpful to me to understand some alternate relationships such as separate and complementary.[9] Science deals with what is empirical: measurable, testable and repeatable. Our faith primarily deals with a transcendent revelation in the past. One cannot empirically test things of the past, let alone the transcendent. Thus, science and faith are of different spheres of knowledge, both important. It is also true that many scientists of faith find their empirical knowledge bolsters their

7 Cunningham CJL, Panda M, Lambert J, Daniel G and DeMars K. Perceptions of Chaplains' Value and Impact with Hospital Care Teams. *J Relig Health*. 2017;56(4):1231-1247.

8 Koenig HG. Religion, spirituality, and health: the research and clinical implications. *ISRN Psychiatry*. 2012;2012:278730.

9 Ian Barbour's 4 models of the interactions of science and religion has been a helpful framework for many people on this topic. See his 1966 book: Issues on Science and Religion or numerous summaries online.

faith in the revealed God in Christ.[10] Thus science and faith can be complementary. A more nuanced and robust view of the relationship between faith and science is invaluable for us as pastoral care providers.

Three, a tension I sense in myself as I immerse myself in research is that I can potentially lose some of my humble reliance on God rather than myself. As professional skill, knowledge, training, experience and successes increase they may fuel a sense of pride or self-reliance. I'm reminded of Deuteronomy 6 (especially verse 12) and Joshua 24:1–14 where God reminds Israel not to forget who brought them from slavery, to Canaan and brought them victory in the promised land. I suspect the potential dangers of prideful, self-reliance and forgetfulness are not unique to chaplaincy and scientific research.

Thus science and faith can be complementary. A more nuanced and robust view of the relationship between faith and science is invaluable for us as pastoral care providers.

Last, I think there is a tension in this debate on EBP and research that lies at the heart of chaplaincy: the tension between medical and spiritual. I am not a doctor or psychologist. Nor am I a parish pastor. Yet, because I use some tools from both professions, I occupy an in-between space. Some days I have a clear sense of my role in these two spaces. Other times I wonder — am I leaning too much toward psychology? Other times I wonder, have I entered too far into a role as pastor or educator? Perhaps this clarity comes in time and some of my colleagues have already figured it out.

Though the comparison is not exact, this tension reminds me of the tension of saint and sinner. I am at the same time saint and sinner trying to navigate in the middle of these two realities. If I emphasize one too much over the other, I can fall into some theological or practical pitfalls. I cannot avoid this tension. It is a reality of Christian living. So, acknowledgement and awareness of both is vital for faithful living as a Christian. Likewise, I think awareness and acknowledgement of both parts of my professional identity as a chaplain is vital. I'm not sure I can avoid the tension. The same goes with the issue of research implementation in my practice. I will have some tensions and struggles navigating between the worlds of medical and pastoral, between empirical and supernatural, between tested and revealed. This tension is no reason not to implement research. Instead it is a present reality I deal with regardless of research.

At the end of the day, as the clinical world moves toward EBP and research, we, too, can in good faith in Christ move this way. The foundation of our pastoral care is a calling from the God who came down to us revealed through scripture. On top of

10 See the online talk by biophysicist and Christian, Alister McGrath entitled, "Overcoming the Faith and Science Divide." I found it to be a helpful introduction into a more complicated and complementary view of science and faith. John Lennox, a professor emeritus at Oxford, is a great speaker on the interface of science and faith. Several of his talks can be found online as he shares how science has positively influenced his faith. Also, see Werner Heisenberg, pioneer of quantum mechanics, the Heisenberg Uncertainty Principle, and a practicing Lutheran.

this foundation we can build robust pastoral care practices using tools and knowledge from scientific research in order to care for the people God brings us to serve. We could even conduct our own research. Of course, there are tensions that we will need to navigate in this world of the empirical as we cling to the supernatural Source of All Life. As we walk this path of pastoral care, may the peace of God that transcends all understanding guard our hearts and minds in Jesus the Messiah.

Rev. Brian Earl MDiv, BCC is currently serving at the VA Connecticut Health Care System in West Haven, CT, where he is the first chaplain fellow to be a part of the VA's Interprofessional Advanced Fellowship in Addiction Treatment. In that position he is working to provide spiritual care to those struggling with addiction, equip others to do to the same, and further advance the field of spirituality and addiction treatment. He graduated from Concordia Seminary, St Louis in 2009. Before being called to chaplaincy in 2015, Brian served as pastor of Centennial Lutheran Church in Superior, NE. All the while he continues to have love of evangelism and art.

Brian and his wife Christa (engineer, entrepreneur and linguist) have one son, Ezekiel, and two cats—Mouse and Mojo. They are enjoying exploring the northeast through biking, hiking, camping, traveling, dining and singing.

Teaching Research Informed Practice in a CPE Residency

Dana Schroeder

"*The challenges faced by ministers – from hospital and nursing home chaplains to parish pastors — can be positively impacted by research and evidence informed practice.*" Rene Brandt

ACPE CERTIFIED EDUCATOR RENE BRANDT has been supervising CPE interns and residents at Advocate Lutheran General Hospital since 2001. Ordained in the Presbyterian Church USA, Rene's passion for excellence in ministry and pastoral education comes through in her quiet but forceful way of speaking. Rene looks at the challenges faced by ministers across a wide spectrum with a pastor's heart and a researcher's eye. Though her context is the clinical setting of a level one trauma center in a bustling Chicago suburb, Rene's energy for "research informed practice" is expansive.

Rev. Brandt, along with her colleagues at the other hospitals offering residency programs in the Advocate Aurora Health System CPE Center[1], has used a "Curriculum on Research Informed Practice" for three years. Growing out of grants written by Rev. Brandt and the Rev. Janet Maclean, also an ACPE Certified Educator, the intention was to move away from the idea of residents *doing* research to focus more on helping them become research-informed practitioners. In addition, the initiative was seen as a way to bring the many hospitals in the system together — to integrate them more fully.

The Advocate Aurora program seeks to prepare CPE residents to be research-informed in their ministry practice by:

The intention was to move away from the idea of residents *doing* research to focus more on helping them become research-informed practitioners.

- Teaching them how to find and analyze research articles
- Fostering integration of new insights into pastoral practice
- Forming habits of reading articles, assessing relevancy and adapting their practice.

The curriculum includes lectures on "Why Research Matters," "Medical Terminology," "Library Resources," "Research Methodology: Terms, Design, Statistics," and "Research Ethics." Residents are taught how to conduct a literature review and how to write a case study.

1 Advocate Health Care in Illinois and Aurora Health Care in Wisconsin came together in April, 2018 to form Advocate Aurora Health.

Information is shared through readings, seminars, Journal Club, and the application and demonstration of learning. This includes an exam on analyzing a research article, a literature review of a topic relevant to the resident's pastoral care and a case study exploring care provided. There is also a student final presentation.

The program lecturers include CPE Educators, a Vice President of Mission and Spiritual Care in the Health System, a research librarian and published researchers. Readings and resources include articles from the early days of research in Pastoral Care through to the most recent work being produced in the field.

A research informed practice can lead to spiritual care professionals thoughtfully determining how best to use the limited resources of personnel and time.

The Advocate Aurora research curriculum includes basic training about the types of research one might encounter — for example, learning the difference between qualitative and quantitative research. But the focus is always on building the habit of staying current with what is happening in our profession. A research informed practice can lead to spiritual care professionals thoughtfully determining how best to use the limited resources of personnel and time.

The program takes place at the various hospitals in the health system, as well as through Skype meetings and the use of the most current Telepresence technology. Residents from every hospital in the system gather virtually for lectures, presentations, conversation and consultation. Within their peer groups, they select and present articles to all system residents.

"We are equipping our graduates to find what they need," says Brandt. Regular meetings via telepresence afford a learning community that sometimes approaches 25 people. In that setting, participants have the opportunity to read peers' work and the work of other professionals. The intention is to, as Brandt says, "build the habit of reading and talking about what is read."

By the end of their residency year, all Advocate Aurora Health System CPE residents are required to demonstrate a level of research literacy consistent with current APC and ACPE standards. To that end, residents complete an exam on research terminology as well as read and analyze journal articles relating to their clinical pastoral encounters.

The Rev. Sally Miller, a Certified Educator Candidate who is utilizing the curriculum for the first time this year, says simply, "It is about staying current. Sharing with a larger community, looking at theory and practice together with colleagues in ministry is an enriching and energizing experience."

At their own site, residents present literature reviews to peers, practicing the skills learned through various lectures and interaction with the system librarian and a variety of researchers.

Utilizing their own clinical work experiences, residents all create and present a case study to their peer groups for feedback and critique. The free, collegial sharing of information and insight is a key component in the program's success.

The hope is that participants develop, over the course of their residency year, habits of mind and practice that can potentially be useful throughout their ministry careers.

Recently, Miller's resident group hosted the system-wide research presentation day. Together they chose an article and then utilized a rigorous critical summary technique to prepare for the presentation. They agreed at the outset that they felt the article they had chosen was "flawed," and they addressed their concerns about it to the larger community. According to Miller, "The articles aren't perfect and needn't be to be useful."

Working with both a critical and curious attitude, the resident-presenters and their peers around the system participated in a lively and informative conversation. As the presenters were both directive and flexible, the conversation was spacious enough that all their peers had the opportunity to participate.

The energy in the room and throughout the virtual community was very evident. At the conclusion of the hour, Rev. Miller's group took time for collective, intentional debriefing and reflected on their experience of the process. Utilizing the classic CPE "action/reflection" model of learning, they delighted in the experience of both leading and participating in a lively discussion. The residents drew various connections to their ministry and their ongoing learning, as well as to the possible implications of their growing research-informed practice.

Using a research informed approach to the challenges faced by ministers across a wide spectrum, not just hospital chaplains, the Advocate Aurora Health System CPE Residency program seeks to equip graduates for more effective ministry wherever they may be. The belief is that faith leaders who are generative, connected, creative and energized are better able to keep ministries vital and relevant.

According to Rev. Brandt, "We chaplains and all ministers need to find ways to be less siloed. We need ways to share our work together. God has given us the gift of intellect and curiosity. Research and thoughtful analysis of what is happening are good things."

Rev. Dana C. J. Schroeder, has been a Certified Educator and Staff Chaplain at Advocate Good Samaritan Hospital in Downers Grove, Illinois in the west suburbs of Chicago since the summer of 2015. He has been married to Lynnette since 1984 and they have two adult children, Christopher and Emily. Both Dana and Lynnette are ordained ELCA ministers of word and sacrament serving in ministries of chaplaincy. In their free time they explore Chicago and love the live music scene — especially jazz. They also enjoy the outdoors, escaping to the country to hike and canoe whenever possible.

News, Announcements, Events

Dennis Kenny Recognized for Service

The following article appeared in the March 11, 2019 issue of ACPE This Week. *Dennis is a rostered word and sacrament minister in the ELCA.*

ACPE is proud to announce that their member, Rev. Dr. Dennis Kenny, ACPE, has been named the 2019 Distinguished Service Award (DSA) honoree. The DSA is awarded for long, outstanding service and leadership to the association.

Dennis was born and raised in Detroit, Michigan which he considers his hometown or "my city." After high school he attended Capital University in Columbus, Ohio, a university affiliated with the Lutheran Church. Dennis received a Bachelor of Arts degree in Sociology. After college he stayed in Columbus and attended Lutheran Theological Seminary, where he received his Master of Divinity degree.

He pursued his interest in integrating theology and sociology by enrolling in the Masters of Sacred Theology degree program at Andover Newton Theological Seminary, Boston, Massachusetts. He participated in CPE in the Andover Newton Cluster. He continued to study in Andover Newton's Doctor of Ministry degree program and graduated cum laude with an emphasis on Psychology and Pastoral Counseling. He participated in further units of CPE at Harper Hospital, Detroit, Michigan, and the University of Michigan Hospital, Ann Arbor, Michigan.

He returned to Detroit to serve as a Chaplain/Educator at Lutheran Social Services, where he provided pastoral care to a home for the aging, supervised volunteers, developed curriculum, and oversaw the pastoral care work of the agency. He was then called to use his gifts to serve as an Associate Pastor of Salem Memorial Lutheran Church in Detroit. There he had the full range of pastoral responsibilities for this 400-member congregation.

With his calling to be an ACPE Certified Educator, Dennis accepted a position as the Director of Pastoral Care at Ypsilanti Regional Psychiatric Hospital, Ypsilanti, Michigan. There he ministered as the Protestant Chaplain to over 900 psychiatric patients in different stages of mental illness. Dennis managed a department of six chaplains and supervised two levels of CPE. He reported to the CEO and functioned as trainer for management.

After a few years Dennis accepted a position as the Manager of Pastoral Ministry at McAuley Health Center, Ann Arbor, Michigan, a 650 bed multi-institutional health care center. There he ministered to patients and staff, served as a liaison between CPE and medical education and nursing education programs, and participated in the management matrix. He supervised staff chaplains, CPE staff, and CPE residents.

During his years at this hospital Dennis served as Regional Director of the East Central Region ACPE.

Dennis had an opportunity to serve as the Director of Pastoral Care at the California Pacific Medical Center, San Francisco, California and decided to move to the west coast. He ministered to patients and staff, managed the department, supervised staff chaplains, and supervised three levels of CPE. While there he became the Founding Director of the Institute for Health and Healing and eventually was appointed the Direct of Integrative Clinical Education & Spirituality.

In 2006 Dennis returned to the Midwest and served as the Director of Spiritual Care and Healing at Cleveland Clinic Health Systems, Cleveland, Ohio. He directed the spiritual care department and co-directed the Healing Services program. He retired from the Cleveland Clinic in 2014. During his tenure there Dennis served again as Regional Director of the East Central Region ACPE until 2017.

It is with great honor that ACPE recognizes him with the 2019 Distinguished Service Award.

In Times Such as These Zion 2019

ZION 2019 will gather on the beautifully wooded campus of University of St. Mary of the Lake in Mundelein, a north suburb of Chicago. The dates for Zion are September 26 through 29. The theme around which we gather is "IN TIMES SUCH AS THESE."

We find ourselves in troubling and uncertain times.

The national healthcare system in which many of us serve does not work well, is extraordinarily expensive, and the certainty of reimbursement is tenuous. Healthcare corporations are realigning in anticipation of a future not clearly seen, leaving their employees anxious about their roles, responsibilities, accountability, and job security.

Our society has been shaken by the dramatic demise of the myth of a post-racial America. We are newly aware of two Americas – one black and one white. We have experience greater suspicion toward the "other" who has made a home among us and greater hostility toward the "stranger" outside our borders.

The open secret of sexual abuse, exploitation, and devaluation has exploded and the shock waves continue to reverberate in politics, arts, sports, health care, entertainment, business, and religion. The "#MeToo" movement confronts not only overt behaviors, but also long-standing biases.

The many societal issues which impact us in times such as these are compounded by a loss of safe space for and civility in our public discourse. There is little consensus on facts, less on truth. That which is repeated most often and most loudly is accepted as normative. Social media serves as an echo chamber which confirms already held prejudices. Families, friendships, and even congregations are divided as people are no longer able to dialogue with one another.

It is in times such as these that we as chaplains, pastoral counselors, and certified educators are called to serve. We are "front-line Church" impacted through the people to whom we minister, through the institutions we are called to serve, and personally as members of this society. How shall we understand the issues which trouble us? Where do we see Christ at work in these uncertain times? Are there unique insights we might gain from our own Reformation tradition, born and nurtured in equally troubling and uncertain times? How might we best serve clients, patients, students, and families in this context? What can we teach the Church about the world we are encountering on the front line?

In light of the theme there will be three keynote speakers this year addressing Woman and Justice, Racism and Reaction, and Healthcare and Health. The Rev Kathie Bender Schwich, the senior officer for Mission and Spiritual Care in the newly-formed Advocate-Aurora health care system will address healthcare. The other keynotes will be confirmed shortly. The Reverend Peter Nafzger, Assistant Professor of Practical Theology at Concordia Seminary, will serve as the Bible Study leader. The Reverend Lee Joesten, retired CPE supervisor, will serve as liturgist and the Reverend Elizabeth Palmer, book editor for *Christian Century*, will serve as homilist for the Saturday evening service which will follow the banquet and Christus in Mundo presentations. Please submit your nominations for this prestigious award by using either of the two nomination forms at the end of this issue of *Caring Connections*. The possibility of a visit to the Illinois Holocaust Museum in Skokie is being explored and there will be quiet time to take in the serenity of the St. Mary of the Lake campus.

Please put a hold on these dates, **September 26–29, 2019,** and watch for further information.

Evangelical Lutheran Church in America
God's work. Our hands.

Sisters and Brothers in Ministry:

The following are the procedures for nominating an ELCA colleague in chaplaincy, pastoral counseling and/or clinical education to be considered for the **Christus In Mundo (Christ in the World) Award.** Two people from the ELCA will be selected for this honor. The awards will be given at the **Zion XVII Conference, September 26-29, at the University of St Mary of the Lake, Mundelein, Illinois.**

Please fill in the form below. On an attachment, in approximately 250 words, state the qualities of the nominee and give examples of the person's ministry that distinguish this person as making significant, sustained contributions in the field of chaplaincy, pastoral counseling and/or clinical education within the ELCA and beyond. Contact the nominee and (a) gain his/her consent to be nominated, and (b) request a copy of the person's resume to accompany this nomination.

Nominee's information

Nominee's Name: _____ Title: _____

Address: _____

Place of Ministry *(if applicable)*:

_____

Home Church: _____

Personal Phone: _____ Work Phone: _____

Email Address: _____

Years in the Ministry: _____ Spouse: _____

Your information

Your Name: _____ Signature: _____

Address: _____

Personal Phone: _____ Work Phone: _____

Email Address: _____

Describe the nominee's association with you. _____

_____

_____

_____

ALL NOMINATIONS MUST BE RECEIVED BY JUNE 1, 2019.

Please return this form, the attachment, and the resume to:

John E. Schumacher, BCC
6241 West Eddy Street
Chicago, IL 60634
email: *jesjms@att.net*
phone: 773-283-4336

LCMS Specialized Pastoral Ministry
CHRISTUS IN MUNDO AWARD
Nomination Form

The following are the procedures for nominating an LCMS colleague in chaplaincy, pastoral counseling, and/or clinical education to be considered for the Christus In Mundo (Christ in the World) Award. Two people from the LCMS will be selected for this honor. The awards will be given at the Zion XVII Conference, September 26 – 29, Mundelein, Illinois.

Please fill in the form below. On an attachment, in approximately 250 words, state the qualities of the nominee and give examples of the person's ministry that distinguish this person as making significant, sustained contributions in the field of chaplaincy, pastoral counseling, and/or clinical education *within the LCMS and beyond*. Contact the nominee and (a) gain his/her consent to be nominated, and (b) request a copy of the person's resume to accompany this nomination.

Nominee's Name _____ Title_____
Address_____
Place of Ministry (if applicable) _____
Home Church_____
Personal Phone_____ Work Phone _____
Email Address_____
Years in the Ministry_____Spouse_____

*Your Name*_____*Signature*_____
*Address*_____
*Personal Phone*_____ *Work Phone* _____
*Email Address*_____

Describe the nominee's association with you.
_____
_____
_____

Please return this form, the attachment, and the resume to

LCMS Specialized Pastoral Ministry
spm@lcms.org
1333 S. Kirkwood Road
St. Louis, MO 63122.
Fax: 314-996-1124.
Phone: 800-248-1930, ext. 1388, or 314-996-1388.

All nominations must be received by June 1, 2019.