Archbishop Kelly Named NACC National Episcopal Advisor

The Most Reverend Thomas C. Kelly, OP, Archbishop of Louisville, has been named the new Episcopal Advisor of the National Association of Catholic Chaplains.

In announcing the appointment of Archbishop Kelly, NACC President Eugene J. McGlothin, OSB, said, “We are very happy to welcome Archbishop Kelly as our new Episcopal Advisor. He comes to us with an excellent background in health care as well as long experience with the various committees within the National Conference of Catholic Bishops (NCCB).”

Among the positions and appointments Archbishop Kelly has held are: Associate General Secretary, United States Catholic Bishops’ Conference, 1971-77; General Secretary, United States Catholic Bishops’ Conference, 1977-1982; Secretary, NCCB, 1982-1985; member, Board of Directors, Catholic Health Association, 1985-1991; member, Commission on Catholic Health Care Ministry, 1987; Episcopal Liaison, National Catholic Conference of Airport Chaplains, 1987-1989. Currently, he is serving as Chairman, Bishops’ Advisory Committee, Catholic Committee of the South, and is on the Administrative Committee, NCCB. Since 1982 Archbishop Kelly has been serving as Chancellor and Trustee of Bellarmine College in Louisville, Kentucky and as Chairman, Catholic Conference of Kentucky.

He has served as Archbishop of Louisville since 1982.

Archbishop Kelly received a Doctorate in Canon Law in 1962 from the Pontifical University of St. Thomas Aquinas (Angelicum) in Rome. He has subsequently been awarded six honorary doctorate degrees. He entered the Order of Preachers (Dominicans) in 1951 and took his solemn vows four years later; he was ordained a Priest in 1958.

Archbishop Kelly succeeds Bishop Leroy Matthiesen, Bishop of Amarillo, who recently completed two terms. Our gratitude to Bishop Matthiesen for his faithful service, and a warm welcome to Archbishop Kelly.
We Must Actively Proclaim What We Do

Eugene J. McGlothlin, OSB
NACC President

I surely hope all of you read the article in the January 19, 1996 issue of NCR, headlined, “Chaplains Can Help with Ultimate Issues.” It made me very proud of our members who so eloquently explained the role of Chaplains — Fr. Joe Driscoll, Rick Erickson, and Sr. Judith Carron, as well as Sr. Jean deBlois and Jack Glaser.

The article in NCR was in response to the publication of the findings of a study called “SUPPORT,” which stands for “Study to Understand Prognoses and Preferences for Outcome and Risks of Treatment.” The conclusions of the study, published in the Journal of the American Medical Association (November 22/29, 1995), were that physicians either did not understand, did not ask about, or disregarded the wishes of patients regarding their treatment and care at the end of life. The study also concluded that physicians failed to adequately monitor patients’ pain.

The SUPPORT study repeatedly documented that communication between physicians and their seriously ill patients was poor, and that even when specially trained nurses were included to facilitate communication, their intervention failed to improve the communication and decision making at the end of life. The JAMA study was featured in the last issue of Vision, including a reprint of the JAMA editorial about the study.

The article in NCR pointed out that

We have to become interested in researching what we are doing, putting it in language and literature that the other professionals we work beside will understand.

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March 1996 Vision
The Making & Shaking of Words

Rev. Joseph J. Driscoll
Executive Director

In a recent op-ed article in the New York Times, Thomas Friedman described the tortuously slow process of the U.N. International Criminal Tribunal’s investigation into the massacre in Rwanda. He notes that the inquiry into the approximately 500,000 deaths in April of 1994 is being conducted by a team of 35 investigators and 10 prosecutors.

In his story, Friedman narrows the focus of this overwhelming slaughter to one village, Kibuye, unspeakably beautiful with its natural cover and undeniably horrible underneath the earth, where it is estimated the remains of 4,000 people lie.

The author further narrows his lens in identifying a key dilemma that is tearing at the social fabric of the Rwandan people as this slow search and count continue day by day. In his conversations with many of the villagers, there emerges a strong sense that the investigation is too long and they want to exact justice and to do so now.

Friedman struggles with this question: Will such a tribunal make a difference? He concludes that the search and the count, bodies and evidence, will be worth it if even only 200 perpetrators are prosecuted in the end.

Slow, careful, clear documentation metes a far superior justice than the unbridled hatred and revenge that seem to ebb and flow in this tribal land. Whether a tragedy of a nation such as Rwanda, or an ordinary day in the life of a chaplain, the call of the wild gets tamed when we slow down and work hard with the count of words and the meaning of numbers so vital to good communication.

The travails of good communication start very young. In fact, we know from the literature that communication begins in the womb, and most probably even before that formative space. The subsequent articulation of intuited, felt experience is a life-long task that rocks both babes in arms and older folks in homes. It seems we are always trying to find the right words to match an experience. At our best, we probably come closest in the stumbling of poetry, though we may be fooled into thinking it is in the firm posture of science.

I remember Joan Chittister once describing an old proverb from the rabbinic literature. It went something like this: "Shake a sentence vigorously until all the words fall out, and then you are left with the meaning."

But before we shake a sentence, we must struggle to hang words together that can make sense to those around us. This challenge, I believe, is at the workbench of attempting to speak of matters spiritual in an objective, understandable medium. Hence, as our allied health care professionals utilize assessment tools and research instruments to validate their contribution to the wellness of others, so, too, we must engage in a common language that is understood by all.

The resistance comes as strong as our refusal to even attempt to speak the local language when visiting another country. I had a friend who was the exception to the rule. When he and his wife planned a trip abroad, they would sit down and learn the Spanish, Italian or Greek a year or so before their departure to that given country. Most of us, however, are intimidated, feel awkward and embarrassed when we leave the security of our own native tongue. And yet we are often told that even the attempt to speak the language brings appreciation and a willingness to help the struggling communication.

There are three common objections that one often hears around this resistance to documentation and/or research. The first is the issue of confidentiality. In one sense it is to our credit that we pause and struggle with this issue, for it can never be taken lightly. Shirley Nugent, our Standards Chair, articulates for me the clearest criteria in grappling with the whole issue of confidentiality. The questions one needs to ask are as follows: 1) what is it that I feel needs to be shared? 2) who is it with whom I want to share this information? And 3) why do I want to share

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it? The answers to these questions will provide some good assurance of boundaries that are so necessary for all of us in health care who are engaged in a privileged relationship.

The record- and note-keeping of others on the health team is likewise confidential. Can we expect access to others' notes and not be willing to share our own in our common interest to offer the best possible care for a patient and her or his family? Assessment, documentation and research will raise this important question, and yet, the physician, nurse, etc., are likewise bound by these principles.

A second objection is in the protest that it is not possible to quantify what we do. Unlike other more "scientific" disciplines, ours is more difficult, some say impossible, to put into words. This special issue of Vision will hopefully help us to see that it is possible to hang words together that would carry lots of meaning if shaken out later. An exciting part of looking at these various tools for spiritual assessment is the vast differences in approach, and yet each brings a different angle or perspective to the whole. We can and must quantify what we offer in the health care setting.

I am reminded of a recent conversation with Margot Hover, one of our NACC members and a leader in pastoral and spiritual care research. Margot, with a wonderful gleam in her eye, bottom-lined the "why" of research. She said, "Jesus counted." After a smiling pause, she reminded me of the multiplication of loaves, the sending off of the seventy-two and other such moments.

A third objection is in the complaint that paperwork takes away my time with the patients, clients or parishioners. Join the chorus on this one. Is this not one of the most often-voiced complaints of all members of the team? Certainly there is some truth to this objection, as indeed with the others. However, what good can come out of my careful, skilled "paperwork" which will directly benefit not only this particular individual but others as well?

I am brought back to the SUPPORT study recorded in the Journal of the American Medical Association last November which documents the major communication difficulties between physicians and patients and families around end-of-life issues. The results of this study, it seems, position us with a unique opportunity to evidence the vital role of the chaplain in this area of health care. We need to join researchers in designing a study, putting forth certain hypotheses, facilitating the process and documenting the results.

The NACC is seriously behind some of the other professional pas-

As our allied healthcare professionals use assessment tools and research instruments to validate their contribution . . . so, too, we must engage in a common language that is understood by all.

toral care, counseling and education organizations in targeting research as an essential area of focus. We have some members who are involved in research, but there is not the concerted effort and priority which it seems would offer support and motivation to others.

Perhaps we could use the regional structure and invite leadership there to identify some chaplains in a particular center/network to conduct a defined research project. Some monies could be set aside to assist the researchers with the view that the results could be published for the benefit of the entire membership. We could likewise honor these chaplains or supervisors with a research award for their endeavors.

It also seems important that we focus on education for research in our national and regional assemblies. Likewise, there seems a need to develop strategies to partner with others in this endeavor, i.e., universities, local, state and federal agencies, insurance companies, etc.

Whatever the medium of communication, the chart, the notes, or the research project, the outcome is better communication of who we are and what we bring to the care of patients, clients and families. At times the work of paperwork will be tedious and may not seem gratifying. And yet, there could be a moment when my documentation can make the difference. A few years back, a tragic suicide happened in a facility and the institution was being sued for millions of dollars. A chaplain's note in the chart was the only documentation that gave evidence that this was not a case of neglect and that neither the physician nor the facility were responsible in this instance. Can you imagine how valued the chaplain of that institution was after that intervention?

The work of paperwork — recording, counting, analyzing — leads to a clear communication that can set direction and can have a powerful impact in life and death circumstances — be it in the killing field in Rwanda or the dying beds of terminal patients.

Our written word may not seem immediately applicable, but we will never know who may come by and shake those words and discover the meaning for oneself or indeed the whole human family.
Pastoral Research: A Story About What and Why

An Interview with Margot Hover, D.Min.

Rev. Joseph J. Driscoll
Executive Director

Editor's Note: The following interview was granted to Executive Director Joe Driscoll by Margot Hover, D.Min., at her office at The HealthCare Chaplaincy, Inc. (HCI) in New York City. Previously, she served as the Coordinator of Research at Duke University Medical Center in Durham, North Carolina. At the end of April, she will be installed in her new position at HCI, where she is a Chaplain to the Adult Day Hospital and an ACPE Supervisor. She is now supervising four residents: a male Episcopal Deacon, a Muslim woman, an orthodox (male) rabbi, and a reconstructionist woman rabbi who lives at the Ronald McDonald House and serves as a chaplain there. Margot is also the Convenor of the ACPE Research Network.

Margot is an NACC-certified chaplain who served us for several years as the Chair of the Marketing Committee. She is the author of eight books, including Caring for Yourself When Caring for Others, and more than 60 published articles. Her newest book, All Our Tears, is in preparation at Twenty-third Publications. Margot is the single, adoptive mother of two children. Her hobbies are writing and music (bagpipe).

Margot Hover, D.Min.

I was employed closed, I went to Dallas Parkland Hospital, where I started a program in decedent care. It entailed counting everything — counting how many infants died without family, counting how many people picked up non-valuable belongings, counting everything. And it was exacting. I think we had three logs at the time, including the only complete death log in the hospital.

The thing I was proudest of about the program was that it was pastoral through and through. When I trained students and chaplains to do those procedures, I always said that every piece of paper that we filled out, and every number we handled had a pastoral reason for it. If it didn't, we had no business doing it, because it was time- and energy-consuming.

All that record keeping paid off pastorally, as patterns started to emerge. For instance, at Parkland at that time, most of the patients were indigent. They didn't have money to make two or three trips to the hospital to pick up this or that, or to sign this or that paper. At the time the business office was open only during the day. When I realized how many people died during the night, and how many of those people had valuables and non-valuable belongings with them, I took those numbers to the business office and made a good case for them to stay open 24 hours a day.

Q Margot, how did you get into the whole area of research?

A I got into research through pastoral care; that has been an important beginning for me. I did pastoral care as most of us do, by relying on my intuition. When the Department of Pastoral Care at the University of Mississippi where
Since chaplains were filling out paper work, anyway, I got the policy put through that whenever the next of kin came to claim belongings, they were instructed to go first to the Chaplains' office. We had a chaplain available 24 hours a day. Then the chaplain would go with the relative to the business office to serve as a witness to their getting those belongings. That was a legal issue.

What I was more concerned with, however, was giving pastoral care to all the people who had been touched by the death of a loved one, especially if they hadn't been able to get there at the time of death. A relative may have been really stolid through the whole process, for example. Often it was when they would receive, sometimes a wedding ring, sometimes a billfold with family pictures, the sort of things that a dying person would leave, that their grieving really burst forth. I was convinced that the best person to handle that with them adequately was a chaplain. That was where we needed to be. So my paying attention to the numbers, and fiddling around with them until a pattern emerged, really alerted us to a pastoral need that we had never thought of before.

That is what research does. It makes us aware of things in a new way. Larry VandeCreek says that you learn through research what you can't learn intuitively, what you don't learn any other way. After we had been teaching research for nearly seven years at Duke University Medical Center, this last spring when the residents reported on their year-long research project, Jack Carroll, a sociologist over at the Divinity School who helped to mentor the process, said how impressed he was because it was clear that they had learned a great deal. They had uncovered some really startling insights about their ministry specialties and had confirmed some others. He said that the research process by itself represented not just learning a new skill but a whole paradigm shift for pastors.

It helped me to hear that because there was an awful lot of resistance to chaplains doing research back in the beginning — as though to try to document or support with numbers what you were doing was “interfering with the free-flowing of God's grace.” It has been a paradigm shift for most of us, although we are more open to that now than we used to be.

So that is how I got into research. After three years at Parkland, I was asked to set up a program in pastoral research at Duke. But the point that should be emphasized is that I got into research through pastoral work.

That is a moving story, Margot. Thank you for telling about your experience at Parkland. Can the ordinary chaplain be involved in research? If

Research makes you aware of things in a new way. You learn through research what you can't learn intuitively . . . can't learn any other way.

so, what steps are necessary for a chaplain to embark on a research project?

The answer to the first question is yes. The story I like to tell is that I did a presentation on studies on prayer for a group of physicians and other healthcare professionals from around the state. I was very anxious about giving the presentation. These people were all researchers, and I suspected they did not think of themselves as particularly religious. At the end of the session, they asked me to lead them in prayer, which nearly blew me out of the water. As we were walking out of the room and they were giving me feedback on my presentation, I mentioned how anxious I had been. The doctor who was right next to me said, “Why be anxious? You're among friends, and besides, research is simply a story about what and why. It helped me to see research in that light. Research really is a story about what and why. And since chaplains are experts in storytelling and story-
I know that it sounds trite to say that Jesus counted, but somebody in the Bible counted, otherwise how would we know how many people were in each of the tribes? What difference does it make how many people got bread and fish that day? Why is “sense,” our sensory details, so important? “Go tell John what you have seen, that the blind see,” and so on. That’s collecting data. It must have been important. It’s one way of learning, in that case, about Jesus. Look at the data. It’s one way of learning about our work, of course. So that’s what I mean about the trite, “Jesus counted.”

I want to emphasize that research should be looked at not as a way of competing with other disciplines, but as a way of establishing and maintaining our professionalism and our expertise in the areas of spiritual assessment, crisis management, grief care, religious ritual, and the other areas that are our particular concern. The purpose of research is to increase our knowledge in our field.

It’s really important for chaplains to read research, and to read it intelligently. All too often, they either don’t read research at all, or assume that if something is in print, it’s true, or if it’s a research article with numbers in it, it’s true, and that can’t be the case at all. So just learning some easy steps to read a research article is important. Being able to read and critique research articles and to understand the research processes are tools that any chaplain ought to have as a matter of competence. They are as much tools of our trade as being able to listen sensitively and to pray with patients.

The book I recommend that is helpful to start reading research is Research in Pastoral Care and Counseling (Journal of Pastoral Care Publications, 1994). The first part on “Quantitative Approaches” is a revision of Larry VandeCreek’s 1988 Research Primer for Pastoral Care and Counseling (which is out of print), and the second part, by Merle Jordan, is on “Qualitative Approaches.” Chaplains already do research. When we do verbatims and process them, that is qualitative research. We just don’t think of it in those terms. Quantitative research emphasizes objectivity; you do everything you can to remove yourself from what you are testing. Qualitative research means that you attempt as much as you can to join the other person, to climb into their skin and to lift up questions you both look at, but you look at them from the context of the other person. You try to ask the same questions of everybody in the sample. That’s an attempt at a patient is here? Let’s see, is it his right foot, or his left foot?” So, if we think that a doctor should document, and we don’t, aren’t we saying that a patient’s spiritual journey and spiritual healing, or spiritual well-being, is less important than the physical well-being?

Just in terms of charting, for example, it can be done simply. At Sloan-Kettering, a really fine system of charting has been worked out with a crack-and-peel sticker that has a checklist on it, and the chaplain simply checks off the services provided, fills in their name and beeper number and sticks it on the chart page in the progress note. Then if anybody on the team wants to know more, they give the chaplain a call.

That kind of record-keeping — and that’s what documentation is — has a couple of benefits. The first is that it establishes us as equal members of the healthcare team, equal with everyone else. Secondly, it’s a source of information about the patients. Or a group of patients, if we’re talking about a study. It supports needs, or makes a case for needs.

A common objection to both documentation and research in spiritual care is the difficulty, some might even say impossibility, of objectifying spirituality and spiritual issues. How would you respond?

On the one hand, I want to say “nonsense,” and on the other hand, I want to say “yes, it is hard.” But nurses don’t have any trouble quantifying or objectifying spirituality and spiritual issues. Look in the data bases for nursing literature. If you look under the search word spiritual, you’ll find that nurses have done hundreds and hundreds of research projects in spirituality. We didn’t want to do it, so nurses began doing it. And that has given them some credibility in the area of spiritual care.
It is my opinion that nurses, especially parish nurses, pose the greatest threat to chaplains. There are places where chaplain positions have been lost because they say that nurses are giving spiritual care.

I don’t like to view us as competing, but nurse researchers have been able to look at issues in spirituality like the one that dovetails with what I’ve been doing — hopefulness. In objectifying qualities and attributes of hopefulness, they look at how things like a nurse’s mannerisms affect that, or how a doctor’s relationship impinges on hopefulness. What does it do to a patient’s depression to be able to talk to a doctor or nurse about their feelings, or — as Harold Koenig at Duke explored — whether it was helpful or even appropriate to talk with a patient about prayer, or about a patient’s spiritual or religious values, and what effect that had on the doctor-patient relationship. I think it’s nonsense that you can’t objectify spiritual issues. But it takes a lot of talking with colleagues and a lot of sorting through. Nurses are doing that.

When I used to teach English and vocabulary, the kids would say, “I know what that word means; I just can’t explain it.” Then I would say, “Then you don’t know what the word means.” So when people say, “I know what hopefulness is, I just can’t define it.” Well, nonsense! Then you don’t know what it is. How can you help someone develop something when you don’t know what it is, if you don’t know what you are looking for or what you are heading toward, or what you would like to lead someone to? I believe you can separate and define elements of particular spiritual issues.

I would like to refer NACC members to the recent book of readings in pastoral research edited by Larry VandeCreek, Spiritual Needs and Pastoral Services: Readings in Research. (Journal of Pastoral Care Publications, 1995). It has some excellent research articles. It includes an article, for example, on a study done at Duke. In our research we noticed we got very few referrals from physicians, who had little or no contact with us. Almost all of our referrals came from nurses, most of whom had had some contact with chaplains in that hospital. As a result, we started looking at ways that chaplains could make themselves better known to physicians. We began encouraging students and staff there in pastoral care to maximize their relationship with physicians, to go out of their way to attend rounds, to talk with physicians when they could, and to see themselves as able to provide care, not only to nursing staff, but also to physicians.

I would also like to refer NACC members to Larry Dossey’s books, Meaning and Medicine, and Healing Words. These books are full of research studies that deal with spirituality and pastoral care.

Research increases our knowledge in our field. We learn how to approach patient needs, expectations and apprehensions better.

Margot, you just mentioned Spiritual Assessment as one of the priorities for pastoral research. As you know, in this issue of the Vision we are focusing on Spiritual Assessment. What would you look for in evaluating or developing a useful spiritual assessment tool?

If you had to name three priorities for pastoral research today, what would they be?

The number one priority for pastoral research is to network and begin dialogue in depth with other disciplines. I’ve said this all along. One of the biggest benefits of our doing pastoral research is that it makes our expertise available to our colleagues in other disciplines, and it forces us to hear what they have to say that impinges on our work.

The second priority is spiritual assessment: what spiritual assessment is, and how to do it well, in each of the particular settings that we serve. A third priority for pastoral research — in healthcare, which is where we are usually talking about pastoral research — is an enormous challenge. What is the role and nature of spirituality in each one of the particular diagnoses? For example, what is the effect or the interplay between a patient’s spirituality and their diagnosis and treatment? I think looking at that would give us some ideas of when and how to intervene.

I didn’t have a chance to do this at Duke, but there’s some interest at Sloan-Kettering in researching the effect of pastoral visits on hopefulness and depression in cancer patients during the time when they are getting chemotherapy. If we see, for example, that it has no effect, then we might want to put our resources into the area of cardiology. And when is the best time to provide pastoral care there? Since a chaplain can’t be there all the time, or with every patient, where are the needs, documentably, most acute?

Can you give us one or two examples of pastoral research that produced results that have proved beneficial?
Does it communicate clearly to the personnel who will be using it? If the tool is so complicated that the chaplain won't use it, or if the terminology entered in the chart is so esoteric that it is not understandable to the other members of the health care team, then the tool is useless.

JCAHO, on a rapidly increasing basis, is looking at the role of spirituality in restoring and maintaining health, and the role of the chaplain in assessing that and providing appropriate interventions. That is another reason why spiritual assessment must now be a high priority.

Q **Do you have any ideas how we as an organization could help facilitate more pastoral research?**

A One way is by supporting and nurturing research that is done by members. Some of the regions in ACPE — for example, the North Central region — give grant money to people who submit proposals to do research. A really fine beginning study, simple but very well done, was done by some people there, Shelly Bergstrom and Patricia Guilbeault, and it won the Researcher of the Year Award last year for ACPE. It had to do with what factors are important in a student's selection of a CPE center. Most of us would have guessed that a student is attracted to a particular center if it offers a stipend, if it provides housing or free meals, or if it is situated in a good location for the student. What they found was that the most important factor, or one of the most important factors, was whether the prospective student liked the supervisor. That study was nurtured and supported not just with money, but by people who heard about it — people who do research, like George Fitchett — and reached out and supported them while they were working on it.

Another way to foster research is by publicizing and giving recognition to research that is being done in the field, particularly by our members. I suggest a regular column in the Vision, and giving recognition to people who do research. As Convenor of the ACPE Research Network, I am really grateful that we get the opportunity to present the awards that we give each year at the convention banquet because people pay a lot of attention to that. People who are doing research naturally are motivated, at least in part, by the possibility of getting some recognition for it.

A third way is by encouraging people to join groups that are already supporting pastoral research. Of course, I would also encourage people to join the ACPE Research Network. It's $10 a year, and members get the Network News. The Newsletter is an excellent way to get involved in research, because it offers a way to share ideas and connect with others who are doing similar work.

Larry VandeCreek almost seven years ago. I had admired his writing, and when I met Larry at one of the conventions, I said I'd like to do a project with him, and we ended up being able, through our networking, to do a two-site study. You can always do that. It's a really easy and fun way of getting your feet wet in doing a research project, by helping somebody else do theirs, and doing it in two places. That halves the work and doubles the results, in addition to building the experience of the researcher.

Another way we could facilitate beginning research is to encourage members to replicate earlier studies. For instance, they might contact the author of a study published in the Journal of Pastoral Care, telephone the researcher, and ask if she or he would be open to sharing materials and information about the process. Generally, researchers are more than happy to do so, since the networking is rewarding and the credibility of their study supported.

It is really fun and valuable to network with anyone who will stand still long enough to talk. It is in that process that people dialogue about important issues and share information, insight, and enthusiasm. My students are always amazed that even well-known authors are generous with their time and pleased to answer questions about their research, assuming that the caller has taken the time to read their articles thoroughly and is ready to ask focused, intelligent questions.

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March 1996/VISION
The 7 x 7 Model for Spiritual Assessment: An Introduction

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(Editor’s Note: George Fitchett, an ACPE Supervisor and the current editor of the Journal of Supervision and Training in Ministry, is considered a leading scholar and authority on Spiritual Assessment. For this special section of the Vision we invited him to contribute this article and include the bibliography of his published work. The article was previously published in the ACPE Research Network Newsletter.)

Background: The 7 x 7 model for spiritual assessment is based on the following assumptions:

1. Spiritual assessment is an important part of the process of providing spiritual care. It provides the basis for a spiritual care plan and for communication and accountability about the spiritual care we provide.

2. Spiritual assessment is not the same as spiritual screening or triage. Spiritual screening refers to the methods we use to identify persons who request spiritual care, or for whom more careful spiritual assessment should be completed. Spiritual screening can be done by any trained interviewer, and does not require a pastoral care specialist. Spiritual assessment is a more careful review of the spiritual needs and resources of a person. As such, it is more time-consuming and requires greater expertise.

3. Being more intentional about our spiritual assessments does not require that we replace empathic, open-ended pastoral conversations with a list of questions from a survey. Our model for spiritual assessment can shape the way we listen and respond in our pastoral conversations. It can also provide the framework for our efforts to summarize what we learned about a person after we have finished our conversation with them.

4. Spiritual assessment is an ongoing process. Our first assessment may be based on limited knowledge about a person, but as we become better acquainted with them we have an opportunity to develop a more comprehensive assessment and to revise our previous assessment.

5. The spiritual dimension of life can best be described by a model which deals with beliefs, behavior, emotions, relationships and practices. We call this a multi-dimensional approach to spiritual assessment. It can be contrasted to one-dimensional models. For example, a model which describes what church a person is a member of, or a model which describes a person’s beliefs about God.

6. The 7 x 7 model employs a functional approach to spiritual assessment. A functional approach to spiritual assessment is concerned with how a person finds meaning and purpose in life and with the behavior, emotions, relationships and practices associated with that meaning and purpose. The functional approach to spiritual assessment can be contrasted to a substantive approach. The former inquires in an open-ended way about a person’s ultimate concern. An example of the latter would be to ask whether or not a person believes in God. In a spiritually pluralistic context, such as a hospital, the functional approach to spiritual assessment is preferable. It offers a greater possibility that a person can share their spiritual story in their own terms versus having to organize their story around the ideas of one particular substantive religious-spiritual world view or another.

7. The spiritual dimension of life affects and is affected by other dimensions of life. Spiritual assessment must be undertaken in the context of a multi-disciplinary holistic assessment.

The 7 x 7 Model for Spiritual Assessment. The 7 x 7 model for spiritual assessment has two broad divisions: 1) a holistic assessment and 2) the multi-dimensional spiritual assessment. This is illustrated in Figure 1.

Figure 1. The 7 x 7 Model for Spiritual Assessment

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<th>SPIRITUAL ASSESSMENT</th>
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<td>Belief and Meaning</td>
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<td>Psychological Dimension</td>
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<td>Spiritual Dimension</td>
<td>Authority and Guidance</td>
</tr>
</tbody>
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Holistic Assessment. Our holistic assessment looks at six dimensions of a person’s life.

A. The Medical Dimension. What significant medical problems has the person had in the past? What problems do they have now? What treatment is the person receiving?

B. The Psychological Dimension. Are there any significant psychological problems? Are they being treated? If so, how?

C. The Family Systems Dimension. Are there at present, or have there been in the past, patterns within the person’s relation-
ships with other family members which have contributed to or perpetuated present problems?

D. The Psycho-Social Dimension. What is the history of the person’s life, including place of birth and childhood home, family of origin, education, work history and other important activities and relationships. What is the person’s present living situation and what are their financial resources?

E. The Ethnic, Racial or Cultural Dimension. What is the person’s racial, ethnic or cultural background? How does it contribute to the person’s way of addressing any current concerns?

F. The Social Issues Dimension. Are the present problems of the person created by or compounded by larger social problems?

Spiritual Assessment. Our spiritual assessment looks at seven dimensions of a person’s spiritual life.

A. Belief and Meaning. What beliefs does the person have which give meaning and purpose to their life? What major symbols reflect or express meaning for this person? What is the person’s story? Do any current problems have a specific meaning or alter established meaning? Is the person presently or have they in the past been affiliated with a formal system of belief (e.g., church)?

B. Vocation and Obligations. Do the person’s beliefs and sense of meaning in life create a sense of duty, vocation, calling or moral obligation? Will any current problems cause conflict or compromise in their perception of their ability to fulfill these duties? Are any current problems viewed as a sacrifice or atone-
ment or otherwise essential to this person’s sense of duty?

C. Experience and Emotion. What direct contacts with the sacred, divine, or demonic has the person had? What emotions or moods are predominately associated with these contacts and with the person’s beliefs, meaning in life and associated sense of vocation?

D. Courage and Growth. Must the meaning of new experiences, including any current problems, be fit into existing beliefs and symbols? Can the person let go of existing beliefs and symbols in order to allow new ones to emerge?

E. Ritual and Practice. What are the rituals and practices associated with the person’s beliefs and meaning in life? Will current problems, if any, cause a change in the rituals or practices they feel they require or in their ability to perform or participate in those which are important to them?

F. Community. Is the person part of one or more formal or informal communities of shared belief, meaning in life, ritual or practice? What is the style of the person’s participation in these communities?

G. Authority and Guidance. Where does the person find the authority for their beliefs, meaning in life, for their vocation, their rituals and practices? When faced with doubt, confusion, tragedy or conflict, where do they look for guidance? To what extent does the person look within or without for guidance?

References

Books


Articles


Tapes
Spiritual Care Guides: Common Language the Key

Department of Pastoral Care  
Providence Hospital  
Holyoke, Massachusetts

Language is the basis of all communication. Within any particular group a common vocabulary is developed over time to ensure accurate communication. In Spiritual Care we have lagged behind other professional disciplines in this regard.

From examining the charting practices of many other disciplines, I found that most disciplines follow a pattern in their charting. This pattern went beyond the obvious S.O.A.P. (Subjective Objective Assessment Plan) or A.P.I.E. (Assessment Plan Intervention and Evaluation). Certain phrases, wordings, and subject matter were repeated. An idea was born: Why not use that vocabulary of words and phrases, and a common structure so that our staff would not have to invent, or reinvent what would be said each time they sat down to record their interventions?

The Guides, printed normally on cards, 4.25" x 6.75", front and back, pocket-sized for convenience (reproduced here at 100%), offer a standard language for use in medical record communication. The Guides can also be used to provide data to substantiate our work quantitatively and qualitatively. This model has brought direction and focus to the Quality Improvement process, to our spiritual assessments and to the task of patient charting.

I began developing the Spiritual Care Guides with a view toward integrating patient assessment, charting and quality improvement. At first, these seemed very disparate objectives, but led to development of an Assessment Guide (Figures 1 and 2). Patient intervention codes are recorded by the chaplain for each patient following each of the four categories: Type of Contact, Support System Involvement, Issues Raised, and Interventions Provided. The framework allows for statistical and clinical data collection and serves as the basis for assessment and charting. The number totals are collected daily and form the basis for quality improvement studies.

The first two categories each receive one code per contact. Type of Contact allows tracking of our involvement with other disciplines and the acuity of our patients. By coding the Support System Involvement we document our interactions with patients, family members and staff.

The third category, Issues Raised, allows tracking the subject matter of the interventions. Often, more than one area is raised. All areas raised are recorded.

With the Interventions Provided section, we code all interventions that we offered. This section focuses us more intentionally on the work of spiritual care in a time-crunched environment.

These coded words then form the basis for medical record charting. The outgrowth of this is shown in Figures 3-5. Our facilities have chosen the Problem, Intervention, and Outcome (P.I.O.) model for charting. Those who use another model can use the same language fit into the proper form. (Assessment and Plan can be combined under Problem. Our goal in developing a standard form for our documentation was to provide clear, meaningful documentation that facilitated communication and optimal patient care.

The form of our entries is consistent throughout our department to ensure one standard. Our department is identified on the first line along with the Type of Contact for quick identification of referrals. Each section of P.I.O. begins on a new line to enhance readability. For each section of the P.I.O. the Guides give standard examples of chart entries to use as a starting point for charting.

To facilitate the use of spiritual language and avoid medical and psychological language, the Guides finish with a list of Spiritual Care Words (Figure 6). This helps identify our unique place on the healthcare team.

These Guides are a tool that can be used in many settings to facilitate the communication of the spiritual needs of people. May these Guides serve as a catalyst for growth. May they be used for God’s glory.

If you want more information about the Guides, contact Rev. Stanley D. Arnold, M.Div., Department of Pastoral Care, Providence Hospital, 1233 Main Street, Holyoke, MA 01040.

<table>
<thead>
<tr>
<th>EXAMPLE:</th>
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<tr>
<td>120195</td>
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<tr>
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</table>

March 1996/VISION
### Figure 1
Arnold's Pocket Spiritual Care
Assessment Guide ©1995

<table>
<thead>
<tr>
<th>AD</th>
<th>Advanced Directive</th>
<th>P</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>CA</td>
<td>Critical Admission</td>
<td>R</td>
<td>Referral</td>
</tr>
<tr>
<td>CD</td>
<td>CoDe</td>
<td>S</td>
<td>Sacramento/Service</td>
</tr>
<tr>
<td>CN</td>
<td>CoNsult</td>
<td>T</td>
<td>Therapy/Counseling</td>
</tr>
<tr>
<td>D</td>
<td>Death</td>
<td>VF</td>
<td>Visit Follow-up</td>
</tr>
<tr>
<td>O</td>
<td>Outpatient</td>
<td>VI</td>
<td>Visit Initial</td>
</tr>
</tbody>
</table>

**SUPPORT SYSTEM INVOLVEMENT**

- **P**: Patient Only
  - G: Group Work
  - F: Family Only
  - N: Newborn, Pediatric
  - S: Staff - Dr., Nrs., SW
- **P+F**: Pt & Family Separately
  - S: Staff - Dr., Nrs., SW
  - SO: Significant Other(s)

**ISSUES RAISED**

- **AD**: Addiction
  - FI: Family Issues
  - AG: Alienation from God
  - FN: Financial
d- **ALC**: Local Church
  - GA: Grief Anticipatory
  - GS: Grief Subsequent
- **ADN**: DeNomination
  - SF: Suffering
- **AEC**: Ethnic Community
  - MN: Meaning of Illness
- **AX**: Anxiety
  - MT: Medical Treatment Issues
- **CA**: Cancer
  - SE: Spiritual Energies (see BACK)
- **CD**: Concept of Death
  - SF: Suffering
- **ET**: Ethics
  - SO: Spiritual Growth
- **FQ**: Faith Questions
  - SGS: Spiritual Growth Statement

**INTERVENTIONS PROVIDED**

- **AS**: Assessment
  - MT: Music / Art Therapy
- **BS**: Brainstorming
  - OEP: Open-Eyed Prayer
- **C**: Crisis
  - PA: Patient Advocacy
- **CR**: Conflict Resolution
  - PC+: Parish Contacted
- **EE**: Existential Encounter
  - PR: Prayer
- **EM**: Empowerment
  - RC: Reality Checking
- **F**: Facilitation
  - RF: Reframing
- **FC**: Family Council
  - RH: Referral In House
  - ROH: Referral Out House
- **GI**: Guided Imagery / Meditation
  - RGI: Reconnect I (C/S, G, P, H)
- **GW**: Grief Work
  - SD: Spiritual Direction
- **HP**: Health Promotion / Wellness
  - SS: Staff Support
- **HB**: Hope Building
  - SSE: Social Skill Enhancement
- **INF**: Information
  - TT: Therapeutic Touch / Message

**LIFE'S SPIRITUAL ENERGIES**

**Bold Terms**

- Meaninglessness
- Misery
- Chaos
- Curse
- Brokenness
- Foolishness
- Bondage
- War
- Dread
- Despair
- Ingratitude
- Helplessness
- Apathy
- Revenge
- Arrogance
- Faithlessness
- Guilt-Shame
- Greed
- Denial
- Injustice
- Aloneness
- Indolence

**Notes**

- Fullness of Life
- Joy
- Creativity
- Blessing
- Pursuing Healing, Recovery & Integration
- Wholeness
- Wisdom
- Freedom
- Peace
- Courage
- Hope
- Gratitude
- Power
- Compassion
- Mercy
- Humility
- Faithfulness
- Grace
- Charity
- Awareness
- Justice
- Intimacy
- Discipline

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**March 1996/VISION**
**Figure 4**

**Intervention summary**

- ADdiction issues: Faith Questions
- CANcer issues: Family Issues
- EThtics issues of XX: Grief Issues of XX (lost/looming XX, XX died)
- spiritual concerns of XX: Treatment Issue of XX (disengagement, 2nd opinion)
- Nash Life's Spiritual Energies

Facilitated discussion with XX (Patient, Spouse, Wife, D, S)
Facilitated discussion of what Patient's wishes would have been if able to make them known
Provided XX: (See Interventions/Provided)
Contacted (name) at Patient/Family request for PC support
Enabled mobilization of XX's resources (Patient & family's)

Allowed ventilation of feelings. Patient stated, "I feel so alone." "Where is God?" "Why is this happening." (Quote Patient)

**O: Outcome**

What is the situation at the end of intervention? Was need met? Did plan change? Include follow up plans.

- Patient/Family expressed decreased
- Further discussed XX: XX resolving. (See Issues Raised)
- Spiritual Energies
- Patient's status changed to DNR
- Pastoral Care's involvement
- Will visit again XX (in 2 days) to discuss XX. (See Issues Raised)

No further identified needs at this time. Will follow as needed.

**Figure 5**

**Commonly Needed Chart Entry Examples**

**ADVANCED DIRECTIVE**

P: Patient/Family requested help in preparing Advanced Directives / Health Care Proxy

I: Discussion included topics in Thinking About Your Preferences material which was provided to Patient along with the hospital's proxy form. XX discussed feelings.

O: Proxy filled out and placed in chart. O: Patient said will take home and discuss further.

**DNR - ETHICS**

P: Patient/Family facing treatment decisions needing ethics clarification

I: Facilitated discussion with XX (names)

O: Dr. XX talked with XX. Patient made DNR

**DEATH**

P: Patient dying/XX died

I: Arranged meeting

O: Family thankful for PC's involvement

**SUBSTANCE ABUSE**

P: Attend group XX

I: Discussion centered around Step XX. Patient expressed XX

O: Will follow as needed to discuss XX.

*Arnold's Pocket Spiritual Care Charting Guide* 6196S (card 7)

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**Figure 6**

**PASTORAL CARE WORDS**

Abandoned
Angry
Anxious
Avoided
Blessed
Broken
Busted
Calm
Cared for
Confronted
Condemned
Confused
Curled
Discouraged
Disciplined
Discouraged
Encouraged
Felt
Gazed
Gazed
Given
Helped
Humbled
Honored
Judged
Lauded
Loved
Loved
Mourned
Ousted
Ousted
Praised
Powerful
Prepared
Resilient
Rejoiced
Rested
Rewarding
Secured
Screwed
Spiritual
Successful
Tranquil
Tried
Tribald
Tender
Touched
Trusted
Unburdened
Victorious
Willing

March 1996/VISION
TQM-Shaped Tool Increases Medical Staff Referrals

Chaplain Adrienne Zervos
Saint Joseph Medical Center
Joliet, Illinois

St. Joseph Medical Center Joliet, Illinois, implemented Total Quality Management in the Spring of 1991. This is a philosophy that continually places the pursuit of improvement by defining needs and expectations of its customers by empowering all partners-in-care to achieve their best. Concurrently the NACC and CHA were challenging their members to begin to develop a means of spiritual assessment that documented focused spiritual need, method, intervention and evaluation.

The Pastoral Care Department at St. Joseph's was invited to participate in a pilot TQM team in which a specific problem was identified and resolved through a seven-step story process. The TQM course led the team to the development and implementation of its first Spiritual Assessment Tool (SAT). The creation of the SAT involved education, research, and much team consensus. The team assimilated several SAT samples to serve our particular needs. Spiritual language was seen as problematic and resolved by formulating standard definitions.

The Spiritual Assessment Tool is currently used in all areas of our medical center. Department policy indicates that chaplains will assess and document on all patients receiving extensive pastoral care as well as to nursing and physician referrals. In addition the SAT is utilized when patient conditions change, i.e., "Code Blue," DNR and organ donation discussions.

By implementing the TQM method, the Pastoral Care team learned that it could be an essential part of the holistic health care team. We understood that our interventions indeed could be put into words so that other medical disciplines could comprehend. We became more aware to minister in a focused manner. This focus resulted in identifying spiritual concerns and addressing those concerns that promoted healing. In addition we gained professional confidence in documentation that has led to responsibility and accountability.

One of the visible successes of the SAT is the increase of referrals from the medical staff. Pastoral Care is included in all new patient nursing assessments and specific nursing Care Maps. Our SAT has strengthened the link in the chain of integrated health care. The continued use of the SAT demonstrates that chaplains indeed do make a vital contribution to patient, family and medical staff. Our SAT has empowered our professionalism both institutionally and professionally by demonstrating in a credible way that we are the visible sign of Christ's healing ministry.

![Gathering the Data](image)

Each word that reads vertically on the form above, from Prayer through Withdrawal, is defined on the reverse side of the form. (Example: Spiritual Discussion - "conversation around issues that pertain to God or religious matters.") If you would like a photocopy of these definitions, please contact the Editor.

<table>
<thead>
<tr>
<th>Referred by:</th>
<th>Pastoral Service</th>
<th>Feelings Dealt With</th>
<th>Support System</th>
<th>Other</th>
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Assessment:

Treatment:

Intervention:

Evaluation:

Additional Referral:

Special Concerns:

(Blank) (Chaplain's Signature)

Yellow - Pastoral Care

Write - Medical Records

March 1996/VISION
Chaplains Carry Cards, Chart on Computer

System Based on A PIE

Dave Corcoran, Chaplain
Loyola University Medical Center
Maywood, Illinois

From their very first visit, chaplains are using their assessment skills — whether they visit patients and families in the hospital, outpatient clinic, home or hospice. Chaplains have spiritually sensitive ears that listen for the “feeling words” patients use in telling their stories. From these words a chaplain assesses the major stressors in each patient’s life, where the person is hurting, and what is the source of that pain. To help people, the chaplain also needs to discover what support systems patients have and what sources of meaning and hope have helped them in the past.

Chaplains at Loyola University Medical Center (in Maywood, Illinois) have designed a convenient, laminated card to take along with them on their daily rounds. (See sample assessment card, copyrighted by Loyola University of Chicago and reprinted here with permission.) We developed this assessment card over several months to remind us of some frequently encountered stressors, sources of support, and sources of meaning and hope for patients and families.

Our whole Pastoral Care reporting system was developed to use the existing computer-based charting system, which is owned and copyrighted by Alltell Information Services (Healthcare Division, 200 Ashford Center North, Atlanta, GA 30338). Our system was based on the nursing diagnostic tool, A PIE, i.e., ASSESSMENT, PLAN, IMPLEMENTATION, and EVALUATION. And our charting notes are printed automatically — along with other ancillary services — and placed in the patients’ charts daily by the unit secretaries.

If a patient stays in the hospital at least a week or makes ongoing visits as an outpatient, the chaplain can continue the initial assessment with:

PLAN — for example, encourage verbalization of stressors, encourage the person to discover links between illness and stressors in life, encourage the person to verbalize possible ways of accepting and dealing with whatever cannot be changed.

IMPLEMENTATION — for example, visit patient once or twice or three times a week; contract with patient to address a specific issue.

EVALUATION — the chaplain looks for outcomes, such as change in acuity, the person’s increased involvement in own healing process, person’s recognition that the meaning system improved outlook, person’s articulation of connection between emotional and spiritual well-being.
Chaplains use the assessment card to do an initial assessment as they make their daily rounds. Chaplains only use the full computer-based spiritual assessment tool, based on APIE, when they are working with a patient for a longer time.

**What we have learned:** We do some ASSESSMENT on nearly every patient. The full PLAN, IMPLEMENTATION, and EVALUATION steps are charted less often. But charting is an indication to the medical and nursing staff that chaplains are documenting their role in the healing process as an integral part of the medical team.

We have also learned that we need some automatic way for the computer system to total the hours spent by chaplains, and we would hope to build this feature into any new system. We would also stress the importance of providing adequate training to your pastoral care staff members, so that they feel comfortable using this computer tool. It is also essential to work closely with the hospital's computer staff in developing and using the system.

**What has proved successful:** This document is a good means to fulfill JCACHO expectations for outcome. Being able to choose and penlight for most of the items on any available computer eliminates time spent searching for the chart and then either typing or writing a note for the chart.

**What to avoid:** Avoid noting any personal sharing that would betray the confidence and respect due to the patient's verbalizing confidential information.

When chaplains from other hospitals asked what we were doing for assessment, we passed on our ideas to them, and they have shared the results with other hospitals. The following commentary is an example of one such hospital's evaluation of this assessment tool.

If you are interested in using our assessment tool or have any questions concerning it, please call the Pastoral Care Department of Loyola University Medical Center, (708) 216-9056.

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**Tool Compatible with Our Computer Screens**

Dian Korb  
Director, Pastoral Care  
St. Elizabeth Hospital  
Belleville, Illinois

After a JCACHO review three years ago, the nurse reviewer suggested that Pastoral Care needed to start documenting more, since the log books gave evidence of valuable information for the medical team to evaluate the patients. After a year of much research and collaboration with the Pastoral Care staff to find materials appropriate for charting on our Health System's computer (FAMIS), I was thrilled to find Loyola's spiritual assessment tool to be compatible with our penlight computer screens.

With permission to use the information, we sat down with our computer analyst and revised some of the screens to fit our needs, maintaining the APIE form. We also gathered several other screens from one of our own system's hospitals, St. Mary's in Decatur, and incorporated them into the 16 screens.

Our staff was always hesitant to document on the patient record, for fear of revealing too much information and violating confidentiality. But using the Loyola screens, the pastoral care department felt at ease with the broader terms set in nursing language, with the direct documenting to the patient chart via the computer, and with the ability to chart on any computer terminal throughout the hospital.

The chaplains realized that they had always charted "in their heads" implicitly as they listened for feelings and resources, but now they could explicitly chart with a feeling of confidence and checklist-style screen, which moves very quickly and avoids the cumbersome pulling out of the patients' chart on the unit.

Since the 10 chaplains in our department have been charting, referrals have increased from the nurses and social workers as they become more aware of the importance of spiritual care in the patient and family treatment.

Initial and follow up Assessment, Plan, Implementation, and Evaluation includes the following title screens:

- Patients' Major Stressors
- Support Systems
- Religious Practice
- Relationship with God
- Perception of God
- Sources of Hope and Strength
- Effect of Illness on Spirituality
- Patient's Present Mood
- Family Relationships
- Physical Condition
- Chaplain Plan; Sacraments
- Advance Directives
- Organ Donations
- Spiritual Support to Patient and Family (including prayer, counseling, and pre-op visit).

Most screens list a variety of one or two words to choose from (10-15) describing each category. All the screens were approved by the nursing development staff before being initiated into the system.

Our Spiritual Assessment tool has been in effect for a year, and the Joint Commission is returning December 12-15 this year. We are anxious to hear their response to our improvement, thanks to the networking of Dave Concoran at Loyola and Agnes Kohlbeck at St. Mary's, Decatur.

Because of the Loyola copyrights, we do not supply copies of the screens for this article; however, we would be open to questions on our process if you call Dian Korb at (618) 234-2129, ext. 1166.
Promising Computer Tools Challenge Our Visioning

Tom Helmick
Chaplain/Director of Pastoral Care
St. Alexius Medical Center
Bismarck, North Dakota

In the first month of use, I have found our new computer spiritual assessment tool an easy and comprehensive way of documenting essential areas of patient spiritual assessment without compromising any areas of confidentiality.

This spiritual assessment tool (see computer screen form on page 19) is one of a number of multi-disciplinary patient assessments in our Clini-Com computer system. Computer entries are made either by using a penlight or by typing in the appropriate numbers. Computer printouts are placed in the patient's chart.

The process of beginning a spiritual assessment form to be made into a computer screen began by Chaplaincy compiling a list of the kinds of needs we were meeting, various forms of chaplain interventions, and various patient responses to these interventions. The work we had done on interdisciplinary plans of care was very helpful here, since these plans listed many of these topics.

Next, a list including all these items was brought to the nursing department that is coordinating the computer nursing assessment. It was decided that the spiritual assessment would appear as a separate page within the nursing assessment. Multiple revisions were made with chaplains reviewing each revision. Finally, the screen was in the computer and in operation.

Nursing response has been very positive. The nurses appreciate chaplains charting as nurses do. The specific spiritual assessments are also helpful to them in considering the holistic care of their patients. The response of the other chaplains is "guardedly optimistic," with a key factor being their individual comfort with computer use in general.

Laptop Computer Assessment Program

I heard Gary Berg talk about his computer assessment program at a program entitled, "Spiritual Care: Does It Make a Difference?" at Mayo in November, 1994. I have used his program successfully with patients, family, staff and physicians. Of the assessment tools I have used in the past, this one holds the greatest promise for me in terms of helping the user assess his/her spiritual strengths and weaknesses. The most common response I have received from patients about the assessment is, "Thanks for offering this to me. This was interesting and has given me a lot to think about."

As a chaplain, I find this instrument gives me a range of topics on which to relate with the patient. It provides a broad base for considering some of the spiritual dimensions of a person's hospitalization.

I have received from a couple of physi-

(Editor's note: Tom Helmick, Chaplain/Director of Pastoral Care, submitted several assessment tools that his department at St. Alexius Medical Center in Bismarck, ND, has used. One is an interdisciplinary team report that is now being used in psychiatry. One is a computer assessment program developed at the medical center that has just been put into place (see chart form on next page).

Another tool, described but not shown here, is based on a computer assessment tool developed by Chaplain Gary Berg in St. Cloud, Minnesota. He is Chief of Chaplain Service at the Veterans Administration Medical Center there. His copyrighted software program is available from Living Water Software, 1203 7th Avenue North, St. Cloud, MN 56303 (612) 253-3437, the cost is $99 and includes a manual.

The patient/user answers a number of questions on a laptop computer, using a 5-point Likert scale (No. 1 might be "never.") The process usually takes 15 to 20 minutes. The numerical scoring system in the program not only indicates where interventions are most needed for the individual, but it also facilitates research using a group of patients. Chaplain Margot Hover, D.Min., used this assessment program in her research at Duke University Medical Center.

Chaplain Berg wrote an article describing his method, "The Use of the Computer as a Tool for Assessment and Research in Pastoral Care," which was published in the Journal of Health Care Chaplaincy, Vol 6 (1) 1994. Berg is also the senior researcher of a study published in the latest issue of the Journal of Palliative Care (Winter 1995, Vol. 49, No. 4 pp. 359ff), entitled "The Impact of Religious Faith and Practice on Patients Suffering from a Major Affective Disorder: A Cost Analysis." Berg used his computer program to gather the data. The principal finding in this study, he writes on page 363, is that spiritual injury, particularly in the form of meaninglessness and a sense that life is unfair, contributes to an increased LOS (Length of Stay). These two bear the strongest correlation with increased hospital costs. "This finding reinforces and provides empirical evidence that the absence of meaning is a core disfigurement of the soul that is at the heart of much suffering and illness."

March 1996/VISION

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cians some very positive responses to this Chaplain Service Computer Assessment. As a result, a kidney care physician, a clinical psychologist and I will propose a research study to study the correlation between spirituality and perceived quality of life in hemodialysis and home-dialysis patients. I will use this program for an assessment of the patient’s spiritual strengths and weaknesses.

In a task force meeting about care at the end of life, an emergency room physician talked about addressing the meaning of life and death questions with patients diagnosed with chronic long-term diseases, such as congestive obstructive pulmonary disease, congestive heart failure and end-stage renal disease. Through discussion of patient expectations of possible medical interventions within their own philosophy of life and death, the physician felt that a great deal of failed medical interventions could be avoided. He saw this computer assessment as one tool that would provide an indicator of the patient’s meaning of life, and the importance of spirituality and religion.

When I reflect on what we’ve learned and what’s proved successful, I have learned as much about ourselves as chaplains, and how we define our role and our need to communicate with other hospital disciplines, as I have learned about the mechanics of spiritual assessment. I believe that the use of an assessment tool requires a radically different look at the patient and at pastoral care than most of us have been used to. It requires a belief that the spiritual components of illness can be assessed, and ideally are communicated to the team, and that they do not belong only to the realm of mystery that is open to God and the chaplain alone.

The use of assessments also requires a commitment to take the time with them, to join the ranks of nursing, medicine and the allied health fields, all of whom are committed to charting as a part of their professional duties. It requires, thirdly, a view of the patient in a continuum of care, and not someone who needs to be seen only within 24 hours of admission. It requires, then, a mindset that includes follow-up visits that are based on the needs assessed.

My experience tells me that these are challenges to the present views and background of most of us as chaplains, placing the frontier of assessment in our revisioning rather than in any assessment instrument.

---

**Spiritual Assessment Computer Screen**

Chart Date/Time:
01 Pre op 02 Follow up 03 Dialysis 04 Referral

Needs Met:
08 Spiritual 09 Emotional 10 Social

Spiritual/Psychosocial Needs Assessed:
11 Unable to assess [cf. comment]
12 Patient doing well. No spiritual needs assessed
13 Good family support

Interventions:

40 Listened 41 Anointing of the Sick 42 Ethical Guidance 43 Clarified values 44 Clarified faith 45 Referral to

Responses:
50 Relieved 51 Consulted with RN 60 Improved 61 Worse 62 Grateful 63 Improved 64 Confident 65 Withdrawal

Comment:

"Compar" Revised 10/27/95

March 1996/VISION

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Spiritual Assessment: Check-off Form
User Friendly

Chaplain Rita McShea, Director
Pastoral Care Services
St. Anthony’s Medical Center
St. Louis, Missouri

Over the past seven years at St. Anthony’s Medical Center in St. Louis, Missouri, we have utilized a variety of formats for spiritual assessment. The one-page, two-sided format presented on this page is the one that we currently use.

We have found it to be beneficial for patients and chaplains alike. As you can see, we have gone to a format that is predominately a check-off list with a space provided for narrative about the patient’s progress. This format is user-friendly and serves as a guide for the chaplains following a particular patient.

We have in-serviced the department and have worked with individual chaplains to make the format the most functional. It is the best we have had thus far. ■

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FASTORAL CARE SPIRITUAL ASSESSMENT
ST. ANTHONY’S MEDICAL CENTER
ST. LOUIS, MO 63128

Denomination:

Church/Temple:
Minister Visiting: Yes ___ No ___
Sacraments/Anointing of the Sick: Yes ___ Date Received ____________
Declined ___
Durable Power of Attorney: Y ___ N ___

Admitting Diagnosis: ____________________________

---

Types of Contact:
Initial Contact ___
Pre-surgical Contact ___
Family Consultation ___
Physician Referral ___
Nurse Referral ___
Other Referral ___
Durable Power of Attorney ___
Left Card/Brochure ___

---

Statements or behaviors that may be indicative of spiritual strengths and/or needs:

Acceptance___ Lacks Support___
Supportive relationships___ Anxious___
Hopeful/Sacraments___ Anxiety___
Prayerful___ Irate___
Sense of meaning/purpose___ Self-blame___
Grief/Loss___ Apathetic___
Isolation___ Fearful___
Express physical pain___
Spiritual distress___
Decisional conflict___
Body image issues___

---

Current Support System:
Family___ Church___ Friends___ Agency___ Institution___

Patient and/or family chief concern: ____________________________

Follow-up: Yes ___ No ___ Reason:

---

CARE PLAN: Contact Church/Synagogue ___
Chaplain Visits: Daily ___ Twice Weekly ___ Weekly ___ Fax ___

Interventions:
___ Assist pt. with search for meaning/self-worth
___ Explore Coping Mechanisms
___ Explore Spiritual Issues/Resources
___ Facilitate Discovery and Verbalization of Feelings
___ Facilitate Ethical Decision-Making (i.e., end-of-life, pain management)
___ Facilitate Person Autonomy
___ Facilitate Reconciliation
___ Link Pt./Family with Spiritual/Emotional Resources
___ Prayer/Ritual/Sacraments
___ Provide Support to Patient/Family
___ Explore Grief/Loss Issues
___ Discuss Durable Power of Attorney
___ Other Spiritual Concerns

---

PAGE 2 FASTORAL CARE SPIRITUAL ASSESSMENT

Identified spiritual/emotional concerns:
___ Acceptance
___ Ability to find meaning/purpose
___ Develop Effective Coping Skills
___ Forgiveness/Reconciliation
___ Ethical Decision Making
___ Hopefulness
___ Awareness and Expression of Feelings
___ Patient/Family Sense of Connectedness with Spiritual/Emotional Resources
___ Personal Empowerment
___ Identified Specific Grief and Loss Issues
___ Identified Other Spiritual Issues
___ Identified Spiritual Strengths/Resources
___ Awareness of Pastoral Presence/Services
___ Other

Patient Progress Report (Date, Time, Narrative, Signature/Title):

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March 1996/VISION

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Side 2. Progress report lines continue to the bottom of the page.
Intentional Spiritual Care —
A Self Assessment Model

Charles Topper
Associate Professor of Counseling
St. Joseph College
West Hartford, Connecticut

In our attempt to incorporate spiritual assessment as part of pastoral care, we need to examine our own practice of pastoral care. First of all, what are the tasks of pastoral care? Secondly, in which tasks do I spend the majority of my time in pastoral care? Since most of us have been thoroughly trained in the psychological aspects of pastoral care, we more easily carry out the helping relationship focus of pastoral caring. We facilitate a patient focusing on his/her concerns and feelings. At times we need to also remind ourselves of the spiritual focus of pastoral care. The following is a model for the chaplain to use in assessing his/her own focus of pastoral care and to encourage his/her own growth in spiritual care.

Many of us in our CPE training saw and experienced the model showing us the difference between, firstly, a friendly visit and, secondly, a pastoral helping visit. This model adds to that paradigm a third and fourth area of focus: thirdly, spiritual care and fourthly, pastoral acts and rituals.

Look at the following model below and assess what kind of pastoral care do you use and when? Does most of your pastoral care focus in one area? Use the model to help you intentionally choose and perhaps expand the types of pastoral care to more frequently include spiritual care.

I have used this model of pastoral care in my supervision of graduate students and in my work as a hospital chaplain. It enables me to be more reflective and intentional about what type of care I am giving, especially spiritual care. You will notice that there are arrows going back and forth between the four focuses of care. These arrows point out that one does not necessarily move chronologically from one through four. One area integrates the other and they all intertwine. Use the area that is most appropriate at the time for your patient in your situation.

I find that one of the best ways to involve the patient in spiritual care is for the chaplain to have one or two open ended questions that he/she might use. An example might be to ask the patient if he/she has any religion and how this relates to his/her present situation in the hospital.

Four Focuses of Pastoral Care

**First Focus — Social**
A Friendly Pastoral Social Visit
(What is happening?)

Focus on
- external subject
- sharing experiences
- people in general
- religion
- being pleasant, positive
- entertaining

**Fourth focus — Ritual Care**
Relationship of Presence
(Can we pray?)

Focus on
- prayer
- scripture
- symbols (sacramentals)
- laying on of hands
- sacraments

**Second Focus — Helping, Comfort**
A Pastoral Helping Relationship
(How are YOU doing?)

Focus on
- the person
- the person sharing self
- the person sharing concerns
- how this particular person thinks and feels

**Third focus — Spiritual Care**
Spirited Relationship
(How are you and God doing?)

Focus on
- the person’s idea, relationship with God
- need of healing, forgiveness
- sense of God’s love
- significant religious practices
- sense of strength and hope
- state of health and beliefs
- faith support system
Calvary Hospital, Bronx, New York, is a 200-bed hospital providing palliative care to people who are terminally ill with cancer. Sixteen chaplains (full or part time) provide 24/7 coverage. As many as 30 persons receiving home care are also served by a chaplain. Recently, our patients have arrived sicker and their stays have been shorter. While the average stay is close to a month, 20 percent live no more than three days. Family members and friends may visit 24 hours a day and thus present a significant opportunity for ministry.

Patient/families are visited on the day of admission for an initial orientation and assessment. A one-page “Initial Assessment” form is currently in use to chart this contact. Pastoral staff find the checklist format easy to process. Brief notes may also be added to it. Interdisciplinary staff have found this to be a useful tool for learning about a patient’s religious/spiritual background.

A second, more extensive assessment form using direct questions was developed for piloting at the end of January. It is an adaptation of a previously piloted computer-based questionnaire (answered by the patient), which we found very helpful for some, but too demanding for most of our patients, who are often very weak and frail. Rather than having patients fill out the questionnaire themselves, we are now asking the questions directly, which seems to be an expeditious approach to identifying spiritual values as well as spiritual concerns, distress or despair.

We project a third element to translate this information into an assessment/plan centering around spiritual pain, using a vocabulary specific to pastoral care.

All these forms will be an integral part of the interdisciplinary medical record.

---

### Calvary Hospital, Bronx, NY

#### PASTORAL CARE ADMISSION NOTE

**Initial Assessment**

| SOURCE | PATIENT | Interviewer: ____________________________
| FAMILY | __________ |
| FRIEND | __________ |

<table>
<thead>
<tr>
<th>PATIENT APPEARS:</th>
<th>non-responsive</th>
<th>disoriented</th>
<th>non-verbal</th>
<th>pain</th>
<th>anxious</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>responsive</td>
<td>oriented</td>
<td>verbal</td>
<td>comfortable</td>
<td>calm</td>
<td>confused</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RELIGION:</th>
<th>Lutheran</th>
<th>Methodist</th>
<th>Mormon</th>
<th>Pentecostal</th>
<th>Presbyterian</th>
<th>Protestant</th>
<th>Roman Catholic</th>
<th>7th Day Adventist</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>AME</td>
<td>Baptist</td>
<td>Judaic</td>
<td>Episcopal/Anglican</td>
<td>Hindu</td>
<td>Islamic</td>
<td>Jehovah’s Witness</td>
<td>Jewish</td>
<td>Adding:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPRESSED NEEDS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting issues:</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td>____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINISTRIES OFFERED/REQUESTED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. n.</td>
</tr>
<tr>
<td>Sacrament of the Sick</td>
</tr>
<tr>
<td>Communion</td>
</tr>
<tr>
<td>Spiritual Conversation</td>
</tr>
</tbody>
</table>

---

**REFFERAL**

| __________ |
| __________ |
| __________ |

**PATIENT/FAMILY EDUCATION:**

| 24-Hour Coverage | how to reach chaplain |
| range of services | sacraments/worship |
| support groups | brochure(s) |

**NOTES:**

| ____________________________ |

**PRIORITY ACTION:**

| ____________________________ |

**CHAPLAIN’S PLAN:**

Date: __________

| ministers as required | frequent visits |
| suggest sacraments | offer support |
| suggest support groups | offer support |
| spiritual assessment | meet with family |
| other (specify): | |
The instrument published here is designed to assist chaplains in developing a plan of care for extended care and high-risk patients and to track spiritual issues addressed with them. Information regarding religious affiliations, etc., is obtained during an initial interview. During this interview the chaplain begins to develop a sense of the patient's spiritual needs.

On this form, spiritual issues are noted on the horizontal lines by a small, intersecting vertical line with the date written above it. Movement toward health and wholeness is recorded over a period of time. This is indicated by additional vertical lines with the date of subsequent interviews.

The reverse side of the sheet, Side 2, is used to record a brief account of the patient's experiences and the chaplain's pastoral plan. This plan is used to develop goals and interventions which are then entered into the interdisciplinary patient care plan.

This instrument is incorporated into the assessment section of the patient chart. It is helpful because it provides an ongoing record of patient issues and the patient's movement along a continuum. It also provides the chaplain with an ongoing record of his/her work.

A disadvantage is its length. The form takes time to complete. Diligence is needed to keep it updated. It does not work well with transitional patients since it is somewhat time dependent. However, it could be a helpful tool in discharge planning when making referrals to patients' home congregations or other spiritual supports in the community.

The words used on the form to describe spiritual issues are based on the work of Roy B. Nash, of Springfield, Illinois. (For further information about the concepts he describes as "Life's Spiritual Energies," see pages 13-14 in this issue of VISION.)

### Personal and Confidential

**Spiritual Profile**

<table>
<thead>
<tr>
<th>Chaplain</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Name</td>
<td></td>
</tr>
<tr>
<td>Faith Backgnd</td>
<td>Denomination</td>
</tr>
<tr>
<td>Church</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Religious Practices Desired:</td>
<td></td>
</tr>
<tr>
<td>Worship Services</td>
<td>Bible Study</td>
</tr>
<tr>
<td>Prayer/Meditation</td>
<td>Mass</td>
</tr>
<tr>
<td>Sacraments</td>
<td>Faith Discussion Group</td>
</tr>
<tr>
<td>Contact Pastor</td>
<td></td>
</tr>
</tbody>
</table>

#### Spiritual Issues at Present Time

<table>
<thead>
<tr>
<th>Dread</th>
<th>Courage</th>
<th>Injustice</th>
<th>Justice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atonement</td>
<td>Unity</td>
<td>Despair</td>
<td>Hope</td>
</tr>
<tr>
<td>Helplessness</td>
<td>Power</td>
<td>Apathy</td>
<td>Compassion</td>
</tr>
<tr>
<td>Bondage</td>
<td>Freedom</td>
<td>Revenge</td>
<td>Mercy</td>
</tr>
<tr>
<td>Guilt</td>
<td>Charity</td>
<td>War</td>
<td>Peace</td>
</tr>
</tbody>
</table>

**Major Life Events/Current Experiences**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Wholeness</th>
<th>Mercy</th>
<th>Joy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaningless</td>
<td>Fullness of Life</td>
<td>Anger</td>
<td>Humility</td>
</tr>
<tr>
<td>Curse</td>
<td>Blessing</td>
<td>Ingratitude</td>
<td>Gratitude</td>
</tr>
<tr>
<td>Foolishness</td>
<td>Wisdom</td>
<td>Denial</td>
<td>Awareness</td>
</tr>
<tr>
<td>Guilt</td>
<td>Grace</td>
<td>Faithfulness</td>
<td>Faithfulness</td>
</tr>
</tbody>
</table>

Pastoral Plan

Additional Comments

Follow-Up Care
Training Volunteers for Spiritual Assessment

Rev. Fred Shilling and
Lucille Theroux, CSJ
Region II

(Editor’s note: Lucille Theroux, CSJ is a chaplain at Albany Medical Center in Albany, New York, and Rev. Shilling, now pastor at Gilead Lutheran Church in Brunswick, New York, is the former Director of Pastoral Care of Albany Medical Center.)

“Well,” she reported, “Really, all I seem to do is listen.” Margaret, a faithful Eucharistic minister, was responding to her parish experience during a “Ministry Refresher Day” at St. Rita’s Parish. Margaret, like many parish and institution-based volunteers, comes with a hunger to grow in ministry skills. One of the ways in which these skills can be developed is through the use of a modified form of spiritual assessment.

At the beginning of a workshop session, each participant is encouraged to prepare a card and to envision either a personal experience of illness or a person with whom they have ministered in illness.

<table>
<thead>
<tr>
<th>Significant Others</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiritual Resources</td>
<td>Meaning</td>
</tr>
</tbody>
</table>

This schematic presents a format for a basic spiritual assessment which can present a fairly complete “picture” of the person met in ministry.

**Significant Others.** Volunteers doing home visits or initial contacts in institutional settings find it helpful to determine the persons, living or deceased, who are the supports of a person who is ill. Pictures on the wall, handmade cards from children or grandchildren can be conversation starters for this information. Mention of a parish, local congregation, pastor, or parish minister can be clues for the kind of connection a person has with a “spiritual home.”

**Setting.** The room or even the limited space in a hospital is another source of important information in ministry. A person at home surrounded by mementos and treasured objects can be in a situation very different from that of the person with not even a single card or photograph in the limits of a nursing home or hospital room. Someone who has had to enter an institution in order to receive necessary care also finds this setting extremely significant.

**Meaning.** How does an individual view his or her present condition? Someone confined at home for a definable period of convalescence will have a perspective very different from that of the person who knows this is the final stage of a terminal illness. Another may view an injury or illness as a turning point, marking the passage from independent living to a more confined and limited lifestyle.

**Spiritual Resources.** The authors have found that this is the category which takes some time to develop and understand but which can be a very effective starting point for ministry. Again, the presence of Scriptures, a rosary, or some devotional objects might be obvious starting points for discussion. However, with some encouragement, other resources — nature, music, different forms of prayer, the presence of flowers, loved scenes and experiences — may surface or be reconsidered.

Working in many different ministry settings, the authors have found that this simple diagram is an effective tool for introducing the notion of spiritual assessment. The tool can also be of benefit to experienced chaplains. No matter what particular form an institution mandates for spiritual assessment, the simple structure outlined here offers a schematic for approaching the basic areas of assessment.

Margaret and others like her, who see their role as “only listening,” may learn that to really listen, to truly hear the story is one of the greatest gifts we can offer. The Margarets in our ministries and in ourselves can truly listen with the heart and help the storyteller hear the Voice of the Spirit at work.

**Do You Have a Unique Spiritual Assessment Tool?**

The response to the Vision’s request for examples and descriptions of Spiritual Assessment Tools was gratifying. There were more submissions than space permits. The tools that were chosen for publication are the ones that best lent themselves to space considerations and ease of reproduction in the Vision format.

If you know of an outstanding tool that you think is useful and innovative and has proven to be beneficial, especially if it is used in a setting not covered in this issue, please contact the Vision Editor and tell us about it for consideration for future publication.
BOOKS REVIEWS

Two New Books on Ethics Recommended

C. Rosemary Marmouget
Region IX

Making Moral Choices: An Introduction

Mark Miller, CSSR (Mystic, CT: Twenty-Third Publications), 1995, 87 pages, paperback, $9.95.

Just a few days ago, as I was dutifully driving my daughter to her part-time job at the mall, I caught a few brief lines from a rap song. Although this is not my style in music, I was intrigued by one line. The rapper said something to the effect, “Who will teach us right from wrong?”

Traditionally, it has been the church, parents and school teachers who begin to form the values and morals of the children. In today’s society, however, many no longer attend church, come from broken and troubled families or attend schools that are overcrowded and unmanageable. Who will teach them right from wrong?

Rev. Mark Miller is a Canadian Redemptorist priest and director of the Redemptorist Bioethics Consultancy for Western Canada. He has served as a bioethicist for St. Paul’s Hospital in Saskatoon, as well as a teacher for Newman Theological College in Edmonton and St. Mary’s College in Calgary.

Father Miller writes to teach today’s youth a very complicated subject by utilizing an interestingly simple and easily understood command of our language. He is able to present universally appealing examples to illustrate morality, conscience formation and decision making. He speaks to those factors that influence our values and morals such as customs, culture, civil law and faith.

Father Mark invites the young reader to process, reason and deduce their own moral and ethical decisions. This book does not attempt to lecture or force one’s own value system, but rather, each set of reflection questions is designed to initiate and stimulate one’s own reasoning ability, thus causing them to formulate moral decisions through their own developed conscience.

As a chaplain in the field of mental health, I plan to use Father Mark’s book when working with troubled youth in a group setting. I would like to recommend Making Moral Choices to other chaplains working with teenagers and young adults in health care, parish settings, or as a springboard to teaching basic moral reasoning to others.

I enjoyed very much reading Father Mark’s book and can appreciate his efforts and gift, to take what could have been an overwhelmingly complicated subject and creating a manageable teaching tool.

Christian Ethics

Judith Caron. (Mystic, CT: Twenty-Third Publication) 1995, 250 pages, paperback, $14.95

An unfinished tapestry provides a creative background from which Judith Caron inspires her readers to look at the pattern of their ethical and moral decision making. She is able to entice us to look beyond the final beauty of the decision itself to the philosophy, theology and psychology that became the threads gently worked by the weaver’s hand.

Christian Ethics takes an interdisciplinary look at what constitutes one’s ethical decisions. Judith Caron’s own Judeo-Christian background, along with being an educator, hospital chaplain and a psychotherapist, influences her own thoughts on the subject. However, she is sensitive to other major religions and cultures.

I found this book to be well organized and easily followed. Judith provides us with outlines, charts, and case studies. She provides questions for reflection and discussion as well as those for research.

I would recommend Judith Caron’s Christian Ethics to any chaplain looking for further study in how ethical decisions are made by individuals and societies. I would also suggest this as an excellent teaching or discussion tool for departments wanting to challenge or broaden their ethical vision.

(Editor’s note: Rosemary Marmouget is the Chair of the NACC Planning and Marketing Committee. She formerly was Certification Chair of Region IX.)

In Memoriam

Please remember in your prayers:

Sr. Mary Maurice Burst, DC, of Region XI, who died December 25, 1995, at the age of 70. An Emeritus member, she was a certified chaplain who served at O’Connor Hospital and O’Connor Hospice in San Jose, California. A Sister in her religious community who notified the National Office of her death wrote, “Her membership in your organization was important to her. I know she is praying for you. Please pray for her.”

Brother Charles R. Dennis, OP, 65, of Ashland, Oregon, who was a certified chaplain at Rogue Valley Medical Center in Medford. He died December 9, 1995, of brain cancer that metastasized.

Sr. Mary Ellen Oldham, RSM, 64, who died December 14, 1995. She was residing in Cedar Rapids, Iowa. She served Region IX as Secretary in the late 1980s. At the time of her recertification in 1991, she was a Pastoral Associate at St. John’s Regional Health Center in Springfield, Missouri.
Positions Available

SUPERVISOR/COORDINATOR of CPE

Spohn Hospital, Corpus Christi, TX - CPE Supervisor sought to provide a summer CPE unit at Spohn Hospital in Corpus Christi, TX (May 28-August 9, 1996). Spohn is an Off-Site of Santa Rosa Health Care’s USCSC/CCA-accredited CPE program. Member, Incarnate Word Health Services, Spohn Hospital has hosted two previous summer CPE units; its facilities provide wide variety of clinical and educational opportunities for CPE. Qualifications: a Roman Catholic (NACC/ACPE certified) with particular sensitivity to Hispanic, Anglo and Asian cultural mix of this area. Stipend and housing/boarding provided. Contact Mrs. Mary Davis, CPE Supervisor, Santa Rosa Health Care, 519 W. Houston St., San Antonio, TX 78207, (210) 704-2181; or FAX: (210) 704-3686.

Genesis Medical Center, Davenport, IA - Opportunity for a CPE Supervisor/chaplain to assist in supervision and operations of Pastoral Care Department. Position requires M.Div. or equivalent, ordination or profession in a religious order. Dual supervisory certification by NACC and ACPE preferred; will consider individual currently in process. Three to five years of hospital experience required. Genesis is a 505-bed, 2 campus, acute care facility located on the Mississippi River. Comprehensive salary and benefit package. Call or send resume to: Human Resources, Genesis Medical Center, 1227 E. Rusholme St., Davenport, IA 52803; (319) 383-1313.

St. Elizabeth’s Medical Center, Boston, MA - A 454-bed tertiary care center and a major teaching and research hospital, a member of Christian Health Care System, and affiliated with Tufts University School of Medicine seeks a CPE Supervisor for center which is accredited by ACPE and USCC. Seeks a Director of Clinical Pastoral Education who is excited and challenged by a vision of training spiritual care providers for the 90’s. Director will be responsible for coordinating summer, weekend, and extended basic CPE units, as well as supervisory training. Competitive salary and benefit package. Position 40 hours, start date: Sept. 1, 1996. Resume to: Karen Cleaves, Human Resources, St. Elizabeth’s Medical Center, 736 Cambridge Street, Boston, MA 02172.

MerciCare Medical Center, Fargo, ND - MerciCare Medical Center, including a 380-bed tertiary care hospital, seeks a full-time CPE Supervisor/Chaplaincy Services Coordinator to direct CPE programs and provide leadership for spiritual care service, education and counseling for individuals, families, staff and community. Qualifications: if ordained, ecclesiastical endorsement; if not ordained, a MA in Theology, M.Div., or equivalent. Minimum of two years pastoral care, counseling and CPE supervision with demonstrated leadership skills. Send resume and reference to Mona Loken, Recruiting/Employee Manager, MerciCare Medical Center, 720 4th St. N., Fargo, ND 58122; 800-437-4010 Ext. 2508. AA/EOE.

DIRECTOR, PASTORAL CARE/SERVICES

St. Marys Hospital Medical Center, Madison, WI - A 350-bed acute care facility located in Madison, Wisconsin, is seeking a full-time Director of Pastoral Care. Primary responsibilities are to initiate, plan and develop programs and to assist in providing Pastoral Care to patients, families and employees. The candidate should have three to five years previous hospital experience as a chaplain. Experience as a Director is desirable. Certification by NACC or College of Chaplains required. Please request the required application form from: St. Marys Hospital Medical Center, Personnel Department, 707 S. Mills Street, Madison, WI 53715; (608) 258-6625, or 1-800-236-6101; A Member of the SSM Health Care System; AA/EOE.

Mt. Carmel Medical Center, Pittsburgh, PA - A modern 188 bed acute patient care hospital, located in a progressive university town of 26,000 people in Southeast Kansas, seeks Catholic Director, Pastoral Services. This position will consist of being a Director part-time and a Staff Chaplain the other half. Candidate must be NACC/COC certified with demonstrated managerial and staff chaplain experience. Excellent salary and benefit package. Send resume to: Sister Cheryl Sylvester, Mt. Carmel Medical Center, Centennial & Rouse, Pittsburgh, KS 66762. EOE.

St. Elizabeth Hospital, Elizabeth, NJ - A 229-bed acute care teaching hospital in Elizabeth, New Jersey, has immediate opening for Director of Pastoral Care. We seek innovative individual who can direct and coordinate pastoral care services to patients, families and staff. Position requires Master’s degree in Theology/Spirituality, CPE certification. NACC/COC certification, minimum 3-5 years previous administrative health care experience and at least 2 years experience in hospital chaplaincy. Send cover letter and resume to: Mary Anne Purcell, Employment Manager, St. Elizabeth Hospital, 225 William Street, Elizabeth, NJ 07207. EOE.

Good Samaritan Regional Medical Center, Phoenix, AZ - Director of Religion and Pastoral Care. A 650-bed Level I Trauma Center seeking an individual to direct pastoral care ministry and educate patients, families, staff and the community. Qualifications include a Master’s in Theology/Ministry from an accredited Theological School or a Ph.D. Requires ordination and ecclesiastical endorsement along with 3-5 years as a certified Clinical Supervisor with the ACPE. Involvement in professional organizations a plus. Please submit resume to: Personnel/Recruitment, 1441 North 12th Street, Phoenix, AZ 85006. Phone: 1-800-395-0465. FAX: (602) 495-4674. EOE.

COORDINATOR OF PASTORAL CARE

Our Lady of Victory Missionary Sisters, Huntington, IN - We are seeking Coordinator of Pastoral Care. This position includes providing help to the Victory Noll staff and sisters in dealing with grief and loss, being available to listen to the sisters’ concerns and counseling them about the aging process, transition and loss. Will work in collaboration with the nursing staff, local living coordinators and administrator. Also collaborates with liturgist and chaplain in providing celebrations of the sacraments of reconciliation and anointing of the sick. Requirements: CPE and some related experience. Salary and benefits commensurate with position and experience. Send/fax cover letter and resume by April 15 to Personnel Director, Box 109, Huntington, IN 46750; phone/fax (219) 356-0628.

CHAPLAIN

St. Joseph’s Manor, Trumbull, CT - A 297-bed facility, run by the Carmelite Sisters for the Aged and Infirmon, is currently seeking a Staff Chaplain to join our Pastoral Care team. The incumbent of the position is responsible for assisting residents, families and

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staff to accept all aspects of the resident's condition and to incorporate their experience into their individual faith development. Qualified candidates should have NACC or COC certification or a combination of Bachelor's degree in Theology, Religious Studies or other related areas and one year of clinical experience in health care ministry. Please send resume to: Personnel Department, St. Joseph's Manor, 6448 Main Street, Trumbull, CT 06611-2078. EOE.

- St. Marys Hospital Medical Center, Madison, WI - A 350-bed acute care hospital is seeking a Chaplain to join our active ministry program. ACPE training and NACC or College of Chaplains certification required. Please request required application form from: St. Marys Hospital Medical Center, Personnel Department, 707 S. Mills Street, Madison, WI 53715; (608) 259-5566; 800-236-6101. Member, SSM Health Care System. AA/EOE.

- St. Mary Medical Center, Long Beach, CA - A progressive, Patient-Focused Care 556-bed acute and general care hospital seeks a high energy individual for our full-time Catholic Priest Chaplain. Position will provide pastoral care to our patients, families and 2000+ staff; sacramental ministry; crisis intervention, and ethical consultation regarding treatment/care. Qualified candidates will have recent healthcare experience, ecclesiastical endorsement and team-player attitude. Exceptional interpersonal communication skills and a minimum of 2 CPE units. NACC/COC certification and conversational Spanish abilities highly preferred. St. Mary is located 10 blocks from the ocean in Long Beach and recently received our Accreditation with Commendation from JCAHO. Contact S. Mary McCluskey, Dir. of Pastoral Care at (310) 491-9676 for more information or FAX resume to (310) 491-9272.

- Mercy Hospital, Iowa City, IA - A 234-bed regional health center is seeking a self-directed individual to provide spiritual and emotional assistance to patients and family members. The successful candidate will promote good communication and cooperation within the Pastoral Care department; be available on an on-call basis for emergency spiritual needs; visit new admissions to inform patients of pastoral services; attend meetings, assist in the distribution of Holy Communion; assist with sacramental preparations and provide pastoral care to those in need on the assigned nursing units. Applicants must possess strong religious convictions and demonstrate sensitivity and concern for the sick, as well as a deep respect for all religious beliefs. Bachelor degree or combination of education and religious and social experience is necessary. Certified membership in the NACC is required. A minimum two years related hospital experience preferred. Letter of introduction, professional accomplishments and resume should be sent to: Human Resources Dept., Mercy Hospital, 500 East Market St., Iowa City, Iowa 52245, EOE.

- St. Francis Hospital and Medical Center, Topeka, KS - Named one of top 100 hospitals in the nation, our 378-bed tertiary care facility seeks a full-time Priest Chaplain. Position provides spiritual and emotional care to patients, families and staff through presence, prayer and counseling. Position requires a Roman Catholic priest, with minimum of 4 CPE units and Bachelor's degree with study focus including theology, scripture, psychology and Christian ethics. Prefer at least 2 years pastoral ministry experience in hospital or church ministry. Apply to: Karen Morris, Human Resources, St. Francis Hospital and Medical Center, 1700 SW 7th St., Topeka, KS 66606, 800-444-2954.

- Saint Francis Medical Center, Cape Girardeau, MO - A 264-bed acute care center is seeking a full time SISTER CHAPLAIN to join a six-member staff. One unit CPE required. Share weekend and on-call duties. Responsibilities include spiritual, psycho-social/emotional support to patients, families, hospital staff and community outreach. Excellent working conditions, with enthusiastic support of Administration. Saint Francis Medical Center is located approx. 100 miles south of St. Louis and 150 miles north of Memphis. We offer an excellent salary and comprehensive benefits package which includes interviewee expenses, relocation assistance, health and dental insurance, 100% tuition reimbursement, life and disability insurance, as well as retirement plan and other benefits. For more information, please call or send your resume to: Saint Francis Medical Center, Linda McVay, Human Resources, 211 St. Francis Drive, Cape Girardeau, MO 63703; (314) 339-6109.

- St. Elizabeth Hospital, Elizabeth, NJ - A 329-bed acute care teaching Catholic hospital, seeks a CERTIFIED Hospital Chaplain to minister in its team-oriented Pastoral Care Department consisting of Sisters, Priests, Protestant Minister and Rabbi. Successful candidate must possess certification (NACC/COC) or pending interview. Strong background in theology and counseling required. Responsibilities: providing spiritual and emotional support to patients, families and staff. Send cover letter and resume to Mary Anne Purcell, Employment Manager, St. Elizabeth Hospital, 225 Williamson Street, Elizabeth, NJ 07207. EOE.

- Marian Center of Saint Paul, St. Paul, MN- Is seeking a part-time Staff Chaplain. We are a 150 bed facility providing Skilled Care, Assisted Living and Board and Care Services. Will work with residents, families and staff of all denominations, providing emotional and spiritual support and sacramental and liturgical services. This position requires a Divinity degree or equivalent, 4 units CPE and certification by NACC. May be ordained or lay minister. Chaplaincy experience preferred. Send resume to Katie Lamkin, Human Resources, Marian Center of Saint Paul, 200 Earl Street, St. Paul, MN 55106.

- St. John Hospital and Medical Center, Detroit, MI - A 607-bed facility sponsored by Sisters of St. Joseph, has immediate opening for full-time ordained Roman Catholic chaplain/priest to join our Pastoral Care team. Candidate must have previous hospital chaplaincy experience, be committed to functioning as a team member, and be interested in exploring new roles in pastoral care. There will be involvement in development of clinical roles and multidisciplinary integration, as well as possibility for providing spiritual care in the outpatient setting. EOE. Send resume to Human Resources, St. John Hospital and Medical Center, 22101 Moross Road, Detroit, MI 48236; (313) 343-3988.

CPE PROGRAMS

- St. Camillus Health Care Campus, Wauwatosa, WI - Camillian Brother Stephen E. Braddock, OS Cam., Ph.D, has announced the development of a Clinical Pastoral Education (CPE) program at St. Camillus Health Care Campus in Wauwatosa, Wisconsin. The program will offer students opportunities to specialize in ministry to geriatric patients, persons with dementia and persons infected and affected by HIV/AIDS. Extended 25 week units are scheduled April 29, 1996 to October 19, 1996 and October 28, 1996 to May 2, 1997. An intensive 10 week program is planned for summer of 1997. For further information or to apply for any of these programs, please contact Kate Sullivan, Director of CPE, at (414) 259-6575.
March

18 Copy Deadline
   May Vision

April

5 Good Friday
   Office Closed

7 Easter Sunday

15 Deadline for Information
   Update for Membership
   Directory

22 Copy Deadline
   June Vision

May

1-4 ACPE Annual
   Conference
   Buffalo, NY

10-12 Finance
   Planning/Marketing
   Meeting
   Milwaukee, WI

27 Memorial Day
   Observance
   Office Closed

30- NLC Meeting
    June 2 Milwaukee, WI