

Professional Chaplaincy: Its Role and Importance In Healthcare

Editors: Larry VandeCreek
Laurel Burton

©The Association of Professional Chaplains
©The Association for Clinical Pastoral Education
©The Canadian Association for Pastoral Practice and Education
©The National Association of Catholic Chaplains
©The National Association of Jewish Chaplains
This project was funded by a grant from the Bristol-Myers Squibb Foundation.

Summary

This paper describes the role and significance of spiritual care and is the first joint statement on this subject prepared by the five largest health-care chaplaincy organizations in North America representing over 10,000 members. As a consensus paper, it presents the perspectives of these bodies on the spiritual care they provide for the benefit of individuals, health-care organizations and communities.

Throughout this paper, the word *spirituality* is inclusive of *religion*; *spiritual care* includes pastoral care. Spiritual caregivers in healthcare institutions are often known as *chaplains* although they may have different designations in some settings, i.e. *spiritual care providers*. The paper contains four sections.

1. The Meaning and Practice of Spiritual Care

This first section describes *spirit* as a natural dimension of all persons and defines the nature of spiritual care. With the basic premise that attention to spirituality is intrinsic to healthcare, the paper establishes their relationship and outlines the various environments in which it is provided.

2. Who Provides Spiritual Care?

Professional chaplains provide spiritual care and this section describes their education, skills and certification.

3. The Functions and Activities of Professional Chaplains

This section delineates the typical activities of professional chaplains within healthcare settings, focusing on their care of persons and their participation in healthcare teams.

4. The Benefits of Spiritual Care Provided by Professional Chaplains

The materials here describe how professional chaplains benefit health-care patients and their families, staff members, employing organizations, and communities.

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) in the U.S. states, "Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values." A Canadian accreditation agency makes similar statements. Such regulations, and efforts to meet them, flow from the belief that attention to the human spirit, including mind, heart and soul, contribute to the goals of health-care organizations.

Section I: The Meaning and Practice of Spiritual Care

Spirit is a natural dimension of every person. Reflecting on the ancient word *Spirit*, May (1982) writes, "Spirit implies energy and power." The word *Spirituality* goes further and describes an awareness of relationships with all creation, an appreciation of presence and purpose that includes a sense of meaning. Though not true generations ago, a distinction is frequently made today between spirituality and religion, the latter focusing on defined structures, rituals and doctrines. While religion and medicine were virtually inseparable for thousands of years, the advent of science created a chasm between the two. The term *spirituality* is a contemporary bridge that renews this relationship. In this paper, the word *spirituality* includes *religion*; *spiritual care* is inclusive of *pastoral care*. Those who provide spiritual care in healthcare settings are often known as *chaplains* although in some settings they may be described as *spiritual care providers*.

Spirituality demonstrates that persons are not merely physical bodies that require mechanical care. Persons find that their spirituality helps them maintain health, cope with illnesses, traumas, losses, and life transitions by integrating body, mind and spirit. When facing a crisis, persons often turn to their spirituality as a means of coping (Pargament, 1997). Many believe in its capacity to aid in the recovery from disease (McNichol, 1996) and 82 percent of Americans believe in the healing power of personal prayer (Kaplan, 1996), using it or other spiritual practices during illness.

Persons frequently attend to spiritual concerns within religious communities through the use of traditional religious practices, beliefs, and values that reflect the cumulative traditions of their religious faith. They may pray, read sacred texts, and observe individual or corporate rituals that are particular to their tradition. Religious beliefs may encourage or forbid certain behaviors that impact healthcare.

Others focus their spirituality outside traditional religious communities and practices. All, however, share deep existential needs and concerns. Many persons both inside and outside traditional religious structures, report profound experiences of transcendence, wonder, awe, joy, and connection to nature, self, and others, as they strive to make their lives meaningful and to maintain hope when illness strikes. Support for their efforts is appropriately thought of as spiritual care because their search leads to spiritual questions such as Why do I exist? Why am I ill? Will I die? and What will happen to me when I die? Institutions that ignore the spiritual dimension in their mission statement or daily provision of care increase their risk of becoming only "biological garages where dysfunctional human parts are repaired or replaced" (Gibbons &

Miller, 1989). Such "prisons of technical mercy" (Berry, 1994) obscure the integrity and scope of persons.

Spiritual Care: Its Relationship to Healthcare

1. Healthcare organizations are obligated to respond to spiritual needs because patients have a right to such services.

Regulatory and accrediting bodies require sensitive attention to spiritual needs. As the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO, 1998) makes clear, "Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values." The Canadian Council on Health Services Accreditation (1999) states, "When developing the service plan, the team considers the client's physical, mental, spiritual, and emotional needs. The team respects the clients' cultural and religious beliefs and enables them to carry out their usual cultural or religious practices as appropriate." In an effort to fulfill such mandates as well as honor their own values, healthcare institutions create 'patient rights' statements in which they pledge to provide sensitive attention to the dignity, culture, beliefs, practices, and spiritual needs of all patients, their caregivers, and hospital personnel. Such attention flows from the belief that care of the body alone cannot be effective if the mind, heart, and soul are ignored.

Healthcare professionals increasingly recognize that patients want holistic approaches to their well-being. For several years, Harvard cardiologist Herbert Benson, has conducted popular biannual educational events for healthcare professionals that explore spirituality and healing in medicine. Following intensive research, he (1999) wrote, "I am astonished that my scientific studies have so conclusively shown that our bodies are wired to (be) nourished and healed by prayer and other exercises of belief." Professional chaplains respect and respond to patient values and beliefs, encouraging a more holistic approach to healthcare.

2. Fear and loneliness experienced during serious illness generate spiritual crises that require spiritual care.

While it is a biological event, serious illness frightens patients and isolates them from their support communities when they need them most. Losses such as physical and cognitive capacities, independence, work or family status, and emotional equilibrium, along with the accompanying grief, can seriously impact their sense of meaning, purpose, and personal worth.

Professional chaplains address these crises through spiritual care that emphasizes transcendence and enhances connections to support communities, thus aiding healing and recovery. They listen for the impact of medical information on patients and families, uniquely facilitating an understanding of the technical language of medical professionals.

3. Spiritual care plays a significant role when cure is not possible and persons question the meaning of life.

Compassion and comfort become important foci of care when illness is chronic or incurable. Approaching death can engender serious spiritual questions that contribute to anxiety, depression, hopelessness and despair. Professional chaplains bring time-tested spiritual resources that

help patients focus on transcendent meaning, purpose, and value.

4. Workplace cultures generate or reveal the spiritual needs of staff members, making spiritual care vital to the organization.

Mitroff and Denton (1999), in a groundbreaking study of spirituality in organizations, emphasize that employees do not want to compartmentalize or fragment their lives and that their search for meaning, purpose, wholeness, and integration is a constant, never ending task. Other consultants (Henry & Henry, 1999) write about the importance of individual and organizational stories that help healthcare employees cope with their stress. Such stresses are a concern for organizations that recognize employees as their most valuable resource. Professional chaplains are skilled in eliciting stories that "evoke self-understanding and creativity, and sometimes ... bring light to the paths we travel in life" (Henry & Henry, 1999).

Spiritual care contributes to a healthy organizational culture. Professional chaplains, moving across disciplinary boundaries, serve as integral members of healthcare teams as they care for staff members themselves who experience the stress of patient care. Chaplains not only help staff members cope, but empower them to recognize the meaning and value of their work in new ways.

5. Spiritual care is important in healthcare organizations when allocation of limited resources leads to moral, ethical and spiritual concerns

Difficult ethical dilemmas regularly arise in today's highly technological healthcare systems, i.e. decisions to withdraw aggressive treatment. Unavoidably, such decisions interact with personal values and beliefs of all involved. Professional chaplains, who are frequently members of Ethics Committees, provide spiritual care to staff members as well as patients and families affected by these complex issues.

Healthcare Settings for Spiritual Care

Professional chaplains provide spiritual care in a variety of healthcare settings, including but not limited to the following:

- Acute care
- Long-term care and Assisted living
- Rehabilitation
- Mental health
- Outpatient
- Addiction treatment
- Mental retardation and developmental disability, and
- Hospice and palliative care

Section II: Who Provides Spiritual Care?

A variety of persons may provide patients with basic spiritual care, including family members, friends, members of their religious community, and institutional staff members. Their local clergyperson may also offer spiritual care from their specific tradition by providing supportive counsel and appropriate rites. The professional chaplain does not displace local religious leaders, but fills the special requirements involved in

intense medical environments (Gibbons & Miller, 1989). They complement these leaders by joining their respective resources "to assure that faith continues to have a prominent place among the healing resources available to all persons" (Mason, 1990). Congregants highly value the spiritual care provided by their local clergypersons (VandeCreek & Gibson, 1997).

Many religiously active persons do not notify their local clergy of their hospitalization (Sivan, Fitchett & Burton, 1996; VandeCreek & Gibson, 1997). Additionally, many patients do not have a religious community to which they can look during healthcare crises. In one study, only 42 percent of hospital patients could identify a spiritual counselor to whom they could turn, and many of them had not talked to their local religious leader about their situation (Sivan, Fitchett & Burton, 1996). For others, attention from their spiritual counselor is limited by being in a hospital far from home (VandeCreek & Cooke, 1996), by patient concerns about privacy or confidentiality, or a fear that their own religious leader would not understand or be supportive.

Professional chaplains offer spiritual care to all who are in need and have specialized education to mobilize spiritual resources so that patients cope more effectively. They maintain confidentiality and provide a supportive context within which patients can discuss their concerns. They are professionally accountable to their religious faith group, their certifying chaplaincy organization, and the employing institution. Professional chaplains and their certifying organizations demonstrate a deep commitment and sensitivity to the diverse ethnic and religious cultures found in North America. An increasing number of professional chaplains are members of non-white, non-Christian communities and traditions.

Professional chaplains are theologically and clinically trained clergy or lay persons whose work reflects:

- Sensitivity to multi-cultural and multi-faith realities
- Respect for patients' spiritual or religious preferences
- Understanding of the impact of illness on individuals and their caregivers
- Knowledge of healthcare organizational structure and dynamics
- Accountability as part of a professional patient care team
- Accountability to their faith groups

In North America, chaplains are certified by at least one of the national organizations that sponsor this paper and are recognized by the Joint Commission for Accreditation of Pastoral Services.

- Association of Professional Chaplains (approximately 3,700 members)
- Association for Clinical Pastoral Education (approximately 1000 members)
- The Canadian Association for Pastoral Practice and Education (approximately 1000 members)
- National Association of Catholic Chaplains (approximately 4000 members)
- National Association of Jewish Chaplains (approximately 400 members)

Whether in the United States or Canada, acquiring and maintaining certification as a professional chaplain requires:

- Graduate theological education or its equivalency

- Endorsement by a faith group or a demonstrated connection to a recognized religious community
- Clinical pastoral education equivalent to one year of postgraduate training in an accredited program recognized by the constituent organizations
- Demonstrated clinical competency
- Completing annual continuing education requirements
- Adherence to a code of professional ethics for healthcare chaplains
- Professional growth in competencies demonstrated in peer review

Section 3: The Functions and Activities of Professional Healthcare Chaplains

The activities of professional chaplains include diverse interactions with patients and families, professional staff, volunteers, and community members. While no one chaplain can or need perform every function, they can be classified as follows:

1. When religious beliefs and practices are tightly interwoven with cultural contexts, chaplains constitute a powerful reminder of the healing, sustaining, guiding, and reconciling power of religious faith.

2. Professional chaplains reach across faith group boundaries and do not proselytize. Acting on behalf of their institutions, they also seek to protect patients from being confronted by other, unwelcome, forms of spiritual intrusion.

3. They provide supportive spiritual care through empathic listening, demonstrating an understanding of persons in distress. Typical activities include:

- Grief and loss care
- Risk screening - identifying individuals whose religious/spiritual conflicts may compromise recovery or satisfactory adjustment
- Facilitation of spiritual issues related to organ/tissue donation
- Crisis intervention/Critical Incident Stress Debriefing
- Spiritual assessment
- Communication with caregivers
- Facilitation of staff communication
- Conflict resolution among staff members, patients, and family members
- Referral and linkage to internal and external resources
- Assistance with decision making and communication regarding decedent affairs
- Staff support relative to personal crises or work stress
- Institutional support during organizational change or crisis

4. Professional chaplains serve as members of patient care teams by:

- Participation in medical rounds and patients care conferences, offering perspectives on the spiritual status of patients
- Participation in interdisciplinary education
- Charting spiritual care interventions in medical charts

5. Professional chaplains design and lead religious ceremonies of worship and ritual such as:

- Prayer, meditation, and reading of holy texts
- Worship and observance of holy days
- Blessings and sacraments
- Memorial services and funerals
- Rituals at the time of birth or other significant times of life cycle transition
- Holiday observances

6. Professional chaplains lead or participate in healthcare ethics programs by:

- Assisting patients and families in completing advance directives
- Clarifying value issues with patients, family members, staff and the organization
- Participating in Ethics Committees and Institutional Review Boards
- Consulting with staff and patients about ethical concerns
- Pointing to human value aspects of institutional policies and behaviors
- Conducting in-service education

7. Professional chaplains educate the healthcare team and community regarding the relationship of religious and spiritual issues to institutional services in the following ways:

- Interpreting and analyzing multi-faith and multi-cultural traditions as they impact clinical services
- Making presentations concerning spirituality and health issues
- Training of community religious representatives regarding the institutional procedures for effective visitation
- Training and supervising volunteers from religious communities who can provide spiritual care to the sick
- Conducting professional clinical education programs for seminarians, clergy, and religious leaders
- Developing congregational health ministries
- Educating students in the health care professions regarding the interface of religion and spirituality with medical care

8. Professional chaplains act as mediator and reconciler, functioning in the following ways for those who need a voice in the healthcare system.

- As advocates or "cultural brokers" between institutions and patients, family members, and staff
- Clarifying and interpreting institutional policies to patients, community clergy, and religious organizations.
- Offering patients, family members and staff an emotionally and spiritually "safe" professional from whom they can seek counsel or guidance.
- Representing community issues and concerns to the organization.

9. Professional chaplains may serve as contact persons to arrange assessment for the appropriateness and coordination of complementary therapies.

Patients increasingly demonstrate interest in healing from many

sources not represented within the traditional healthcare disciplines. Many of these complementary healing traditions are grounded in the world's religious traditions and chaplains may utilize or make a referral for commentary therapies such as:

- Guided imagery/relaxation training
- Meditation
- Music therapy
- Healing touch

10. Professional chaplains and their certifying organizations encourage and support research activities to assess the effectiveness of providing spiritual care.

While many chaplains serve in settings with little interest in conducting research, others are employed by centers with a research mission. Increasingly, chaplains attend to research in the following ways.

- Developing spiritual assessment and spiritual risk screening tools
- Developing tools for benchmarking productivity and staffing patterns that seek to increase patient and family satisfaction
- Conducting interdisciplinary research with investigators in allied fields, publishing results in medical, psychological, and chaplaincy journals
- Promoting research in spiritual care at national conventions

Section 4: The Benefits of Spiritual Care Provided by Professional Chaplains

The work of professional chaplains offers distinct benefits to the four components of any healthcare delivery system: the patients and their family members, the professional healthcare staff, the organization itself, and the community within which it resides. These benefits are increasingly demonstrated by empirical research studies.

A. Benefits for Patients and Families

Six research areas are summarized here that describe the benefits of attention to the spirituality for patients and family members.

1. Supporting Religious/Spiritual Beliefs and Practices

- A growing body of research demonstrates the health-related benefits of religious and spiritual beliefs and practices. A recent meta-analysis of data from 42 published mortality studies involving approximately 126,000 participants demonstrated that persons who reported frequent religious involvements were significantly more likely to live longer compared to persons who were involved infrequently (McCullough, Hoyt, Larson, Koenig & Thoresen, 2000).
- In a study of nearly 600 older, severely ill, medical patients, those who sought a connection with a benevolent God, as well as support from clergy and faith group members, were less depressed and rated their quality of life as higher, even after taking into account the severity of their illness (Koenig, Pargament, & Nielsen, 1998).
- In a study of 1,600 cancer patients, the contribution of patient reported spiritual well-being to quality of life was similar to that associated with phys-

ical well-being. Among patients with significant symptoms such as fatigue and pain, those with higher levels of spiritual well-being had a significantly higher quality of life (Brady, Peterman, Fitchett, Mo, & Cella, 1999).

Conclusion: These, and other studies, demonstrate that religious faith and practice impact emotional and physical well-being. Professional chaplains play an integral role in supporting and strengthening these religious and spiritual resources.

2. The Importance of Religious/Spiritual Coping during Illness

- Religious coping, although related to non-religious coping, is distinct and makes unique contributions to the coping process. Religious and non-religious coping are not functionally redundant (VandeCreek, Pargament, Belavich, Cowell, & Friedel, 1999; Pargament, Cole, VandeCreek, Brant, & Perez, 1999).
- A study of older adults found that more than half reported their religion was the most important resource that helped them cope with illness (Koenig, Moberg, & Kvale, 1988).
- In another study, 44 percent of the patients reported that religion was the most important factor that helped them cope with their illness or hospitalization (Koenig, Hover, Bearon, & Travis, 1991).
- In a study of women with breast cancer, 88 percent reported that religion was important to them and 85 percent indicated it helped them cope (Johnson & Spilka, 1991).
- Similarly, 93 percent of women in a study of gynecological cancer patients reported that religion enhanced their sense of hopefulness (Roberts, Brown, Elkins, & Larson, 1997).
- A study with breast cancer outpatients reported that 76 percent had prayed about their situation as a way to cope with their diagnosis (VandeCreek, Rogers, & Lester, 1999).
- Studies demonstrate that spiritual well-being helps persons moderate the following painful feelings that accompany illness: anxiety (Kaczorowski, 1989), hopelessness (Mickley, Soeken, & Belcher, 1992; Fehring, Miller, & Shaw, 1997), and isolation (Feher & Maly, 1999). Many patients expect chaplains to help them with such distressing feelings (Hover, Travis, Koenig, & Bearon, 1992).
- Pargament (1997) cites many additional studies that demonstrate the importance of religious and spiritual coping for persons dealing with illness.

Conclusion: Persons turn to spiritual resources during illness and other painful experiences, finding them helpful. Professional chaplains are trained to encourage helpful religious coping processes.

3. Responding to Spiritual Distress

- Studies point to the importance of spiritual distress, that is, unresolved religious or spiritual conflicts and doubts. This distress is associated with decreased health, recovery, and adjustment to illness (Berg, Fonss, Reed, & VandeCreek, 1995; Fitchett, Rybarczyk, DeMarco, & Nicholas, 1999; Fitchett, 1999a; Fitchett, 1999b).

Conclusion: Professional healthcare chaplains play an especially important role in identifying patients in spiritual distress and helping them resolve their religious or spiritual problems, thus improving their health and adjustment.

5. Caring for Families

- Often family members experience similar or more intense distress than their hospitalized loved ones. In some studies, patients have indicated that one of the most important chaplaincy functions is helping their family members with feelings associated with illness and hospitalization (Carey, 1973; Carey, 1985).
- In one study, 56 percent of the families identified religion as the most important factor in helping them cope with their loved one's illness (Koenig, Hover, Bearon, & Travis, 1991).
- In another study, family members rated spiritual care from chaplains more highly than patients (Vandecreek, Thomas, Jessen, Gibbons & Strasser, 1991).
- Compared to those whose spiritual needs were not being met, caregivers of Alzheimer's patients who worshiped regularly and who felt their spiritual needs were being met reported greater well-being and decreased stress (Burgener, 1999).

Conclusion: Families rely on religious and spiritual resources to cope with the high levels of distress during a loved one's illness. A chaplain's care for family members has a positive impact.

6. Patient and family satisfaction with the spiritual care provided by chaplains

- Studies indicate that as many as 70 percent of patients are aware of one or more spiritual needs related to their illness (Fitchett, Burton, & Sivan, 1997; Moadel, Morgan, Fatone, Grennan, Carter, Laruffa, Skummy, & Dutcher, 1999).
- Studies of patients in acute care hospitals indicate that between one third and two thirds of all patients want to receive spiritual care (Carey, 1985; Fitchett, Meyer, & Burton, 2000).
- When chaplains help a patient's family, the patient is more likely to choose that institution again for future hospitalization (Gibbons, Thomas, Vandecreek, & Jessen, 1991).
- A large study (Vandecreek & Lyon, 1997) of patient and family member satisfaction with the activities of chaplains showed that:
 - A large majority of patients were highly satisfied with the spiritual care provided by professional chaplains.
 - The satisfaction with chaplaincy services by family members was even higher than that reported by patients.
 - The chaplain's visits "made the hospitalization easier" because the visit provided "comfort" and helped the patient relax.
 - The chaplain helped patients "get better faster" and enhanced their "readiness to return home" because the visits helped them feel more hopeful.

Conclusion: Patients and family members are frequently aware of their spiritual needs during hospitalization, want professional spiritual attention to those needs, and respond positively when attention is given, indicating that it influences their recommendation of the hospital to others.

B. Benefits for Healthcare Staff

Healthcare professionals, including physicians and nurses, sometimes

experience stress when working with patients and family members. This stress has increased recently because economic changes have led to fewer staff members providing care for more seriously ill patients. Chaplains can provide sensitive, supportive spiritual care to these patients and their families for extended time periods, thereby allowing other professionals to attend to other duties.

Professional chaplains play an important role in helping staff members cope with personal problems. Their supportive consultation can enhance morale and decrease staff burnout, thus reducing employee turnover and the use sick time. One study reports that 73 percent of Intensive Care physicians and nurses believe that providing comfort for staff is an important chaplain role, and 32 percent believe chaplains should be available to help staff with personal problems (Sharp, 1991).

C. Benefits for Healthcare Organizations

The services of professional healthcare chaplains benefit healthcare organizations in at least nine ways.

1. Chaplains help healthcare organizations meet patient expectations for competent, compassionate spiritual care services, thus enhancing the image of healthcare organizations. In an age of high technology medicine, brief hospitalizations, and shortened contacts with physicians and other health professionals, chaplains offer one of the few opportunities for patients to discuss their personal and spiritual concerns.
2. Chaplains who are certified as chaplaincy education supervisors through the national professional organizations conduct certified programs for religious leaders and laypersons seeking certification. Since participants in academic quarter-length programs usually do not receive stipends, their clinical services being free to the institution. (Students in one-year clinical pastoral education residencies typically receive a small stipend). Such programs increase the amount of spiritual care available at low cost to institutions.
3. Chaplains establish and maintain important relationships with the community clergy.
4. Chaplains play an important role in mitigating situations of patient/family dissatisfaction involving risk management and potential litigation. When patients or their caregivers become angry or threatening, professional chaplains can mediate these intense feelings in ways that conserve valuable organizational resources. Their presence can serve as a vehicle for reducing risk and potential litigation.
5. Chaplains can reduce and prevent spiritual abuse, acting as gatekeepers to protect patients from unwanted proselytizing. Codes of professional ethics stipulate that chaplains themselves must respect the diverse beliefs and practices of patients and families.
6. Chaplains help patients and family members identify their values regarding end-of-life treatment choices and communicate this information to other healthcare staff. Clarifying values and improving communication can reduce expensive, unwanted care (Daly, 2000).
7. Chaplains help organizations develop their mission, value, and social justice statements that promote healing for the body, mind and spirit. Especially for faith-based healthcare organizations, they promote mission awareness and enhancement.

8. Chaplains assist healthcare organizations in fulfilling a variety of accreditation standards, including those associated with patient's rights for spiritual care and support.

9. Spiritual care provided by chaplains is cost efficient. The only published chaplaincy cost study reported that the services of professional chaplains range between \$2.71 and \$6.43 per patient visit (VandeCreek & Lyon, 1994-1995). Additionally, approximately three quarters of HMO executives surveyed reported that if spirituality (expressed through personal prayer, meditation and other spiritual and religious practices) can have an impact on well-being, then it can helpfully impact cost containment (Yankelovich Partners, Inc., 1997).

D. Benefits for the Community

Healthcare institutions are increasingly sensitive about their relationship to the community and chaplains make unique contributions by providing many community services. These include:

- Leadership and participation in community wellness programs.
- Leadership of support groups to help members of the community cope with loss or crisis and live with illness.
- Leadership and participation in community responses to crisis and disaster including airline disasters, weather emergencies, and acts of violence.
- Participation in a continuum of spiritual care that emphasizes connections to local clergy and faith groups, home health and hospice workers.
- Guidance and support for parish nurse programs and other congregationally supported programs that enhance the health of community members.
- Establishing educational programs for parish/synagogue volunteers who will engage in lay spiritual visitation and support for faith group members.
- Maintaining active relationship with local clergy associations.
- Providing community educational seminars on topics of spirituality, loss and illness, and coping with crisis.

Conclusions

During the turmoil of healthcare reform, decision-makers are constantly searching for ways to provide optimal patient services within financial constraints. They seek to retain quality caregivers and maintain positive relationships within the organization and community. Professional chaplains respond to these concerns in unique ways, drawing on the historic traditions of spirituality that contribute to the healing of body, mind, heart, and soul.

References

Benson, Herbert. (1999). *Timeless Healing*. N.Y.: Scribner, p. 305.

Berg, Gary E., Fonss, N., Reed, A. J. & VandeCreek, L. (1995). The Impact of Religious Faith and Practice on Patients Suffering From a Major Affective Disorder: A Cost Analysis. *The Journal of Pastoral Care*, 49(4), pp. 359-363.

- Berry, Wendell. (1994). *A Parting. Entries: Poems by Wendell Berry*. New York: Pantheon Books, 11.
- Brady, Marianne J., Peterman, A. H., Fitchett, G., Mo, M., & Cella, D. (1999). A Case for Including Spirituality in Quality of Life Measurement in Oncology. *Psycho-Oncology*, 8(5), 417-428.
- Burgener, Sandy C. (1999) Predicting Quality of Life in Caregivers of Alzheimer's Patients: The Role of Support from and Involvement with the Religious Community. *The Journal of Pastoral Care*, 53(4), 433-446.
- Canadian Council on Health Services Accreditation. (1999). *Achieving Improved Measurement (AIM) Program*. 430-1730 St Laurent Blvd, Ottawa, Ontario, Canada, K1G 5L1. Sections 13.3 & 14.9.
- Carey, Raymond G. (1973). Chaplaincy, Component of Total Patient Care? *Hospitals: Journal of the American Hospital Association*, 47(14), 166-172.
- Carey, Raymond D. (1985). Change in Perceived Need, Value and Role of Hospital Chaplains. In Lawrence E. Holst (Ed.) *Hospital Ministry: The Role of the Chaplain Today* (New York: Crossroad Publishing Company), pp. 28-41.
- Daly, G. (2000). Ethics and Economics. *Nursing Economics*, 18(4), 194-201.
- Feher, S. & Maly, C. (1999). Coping With Breast Cancer in Later Life: The Role of Religious Faith. *Psycho-Oncology*, 8(5), 408-416.
- Fehring, Richard J., Miller, J.F., & Shaw, C. (1997). Spiritual Well-Being, Religiosity, Hope, Depression, and Other Mood States in Elderly People Coping With Cancer. *Oncology Nursing Forum*, 24(4), 663-671.
- Fitchett, George, Burton, L. A., & Sivan, A. B. (1997). The Religious Needs and Resources of Psychiatric In-Patients. *Journal of Nervous and Mental Disease*, 185(5) 320-326.
- Fitchett, George, Rybarczyk, B. D., DeMarco, G. A., & Nicholas, J. J. (1999). The Role of Religion in Medical Rehabilitation Outcomes: A Longitudinal Study. *Rehabilitation Psychology*, 44, (4), 333-353.
- Fitchett, George. (1999a). Screening for Spiritual Risk. *Chaplaincy Today*, 15(1), 2-12.
- Fitchett, George. (1999b). Selected Resources for Screening for Spiritual Risk. *Chaplaincy Today*, 15(1), 13-26.
- Fitchett, George, Meyer, P. & Burton, L. A. (2000). Spiritual Care: Who Requests It? Who Needs It? *The Journal of Pastoral Care*, 54(2), 173-186.
- Gibbons, James L. & Miller, S.L. (1989). An Image of Contemporary Hos-

pital Chaplaincy. *The Journal of Pastoral Care*, 43(4), 355-361.

Gibbons, James L., Thomas, J., VandeCreek, L., & Jessen A. K. (1991). The Value of Hospital Chaplains: Patient Perspectives. *The Journal of Pastoral Care*, 45(2), 117-125.

Henry, L.G. & Henry, J.D. (1999). *Reclaiming Soul in Health Care*. Chicago: Health Form, Inc. 52.

Hover, Margot, Travis, J. L. III, Koenig, H. G., & Bearon, L. B. (1992). Pastoral Research in a Hospital Setting: A Case Study. *The Journal of Pastoral Care*, 46(3), 283-290.

Johnson, Sarah C. & Spilka, B. (1991). Coping with Breast Cancer: The Roles of Clergy and Faith. *Journal of Religion and Health*, 30(1), 21-33.

Joint Commission on Accreditation of Healthcare Organizations. (1998). *CAMH Refreshed Core*, January, RI1.

Kaczorowski, Jane M. (1989). Spiritual Well-Being and Anxiety in Adults Diagnosed with Cancer. *The Hospice Journal*, 5,(3-4), 105-116.

Kaplan, Marty. (June 24, 1996). Ambushed by Spirituality. *Time Magazine*, 62.

Koenig, Harold G., Moberg, D. O., & Kvale, J. N. (1988). Religious Activities and Attitudes of Older Adults in a Geriatric Assessment Clinic. *Journal of the American Geriatrics Society*, 36, 362-374.

Koenig, Harold G., Hover, M., Bearon, L. B., & Travis, J. L. III. (1991). Religious Perspectives of Doctors, Nurses, Patients, and Families. *The Journal of Pastoral Care*, 45(3), 254-267.

Koenig, Harold G., Pargament, K. I., & Nielsen, J. (1998). Religious Coping and Health Status in Medically Ill Hospitalized Older Adults. *Journal of Nervous and Mental Disease*, 186(9), 513-521.

Koenig, Harold G. (1999). *The Healing Power of Faith* (New York: Simon and Schuster).

Mason, Edna. (1990). The Changing Role of Hospital Chaplaincy. *Reformed Liturgy and Music*, 24(3), 127-130.

Matthews, Dale A., McCullough, M. E., Larson, D. B., Koenig, H. G., Swyers, J. P., & Milano, M. G. (1998). Religious Commitment and Health Status: A Review of the Research and Implications for Family Medicine. *Archives of Family Medicine*, 7, 118-124.

May, Gerald. (1982). *Care of Mind/Care of Spirit*. San Francisco: Harper and Row, 7.

McCullough, Michael, Hoyt, W., Larson, D., Koenig, Thoresen, C. (2000). Religious Involvement and Mortality: A Meta-Analytic Review. *Health Psychology*, 19(3), 211-222.

McNichol, T. (1996). The New Faith in Medicine. *USA Today*, April 7, p.4.

Mickley, Jacqueline R., Soeken, K., & Belcher, A. (1992). Spiritual Well-Being, Religiousness and Hope Among Women with Breast Cancer. *Image: Journal of Nursing Scholarship*, 24(4), 267-272.

Mitroff, Ian & Denton, E. (1999). *A Spiritual Audit of Corporate America: A Hard Look At Spirituality, Religion, and Values in the Workplace*. San Francisco: Jossey-Bass Publishers.

Moadel, Alyson, Morgan, C., Fatone, A., Grennan, J., Carter, J., Laruffa, G., Skummy, A., & Dutcher, J. (1999). Seeking Meaning and Hope: Self-Reported Spiritual and Existential Needs Among an Ethnically-Diverse Cancer Patient Population. *Psycho-Oncology*, 8(5), 378-385

Pargament, Kenneth. (1997). *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford Publications.

Pargament, Kenneth, Cole, B., VandeCreek, L., Brant, C., & Perex L. (1999). The Vigil: Religion and the Search for Control in the Hospital Waiting Room. *Journal of Health Psychology*, 4(3), 327-341.

Roberts, James A., Brown, D., Elkins, T., & Larson, D. B. (1997). Factors Influencing Views of Patients with Gynecologic Cancer About End-of-Life Decisions. *American Journal of Obstetrics and Gynecology*, 176, 166-172.

Sharp, Cecil G. (1991). The Use of Chaplaincy in the Neonatal Intensive Care Unit. *Southern Medical Journal*, 84(12), 1482-1486.

Sivan, A., Fitchett, G., & Burton, L. (1996). Hospitalized Psychiatric and Medical Patients and the Clergy. *Journal of Religion and Health*, 35(1), 11-19.

VandeCreek, Larry, Thomas, J., Jessen, A., Gibbons, J., & Strasser, S. (1991). Patient and Family Perceptions of Hospital Chaplains. *Hospital and Health Services Administration*, 36(3), 455-467.

VandeCreek, Larry & Lyon, M. (1994/1995). The General Hospital Chaplain's Ministry: Analysis of Productivity, Quality and Cost. *The Caregiver Journal*, 11(2), 3-13.

VandeCreek, Larry & Cooke, B. (1996). Hospital Pastoral Care Practices of Parish Clergy. *Research in the Social Scientific Study of Religion*, 7, 253-264.

VandeCreek, Larry & Lyon, M. (1997). Ministry of Hospital Chaplains: Patient Satisfaction. *The Journal of Health Care Chaplaincy*, 6(2), 1-61. (Also in book form: (New York: Haworth Press, 1997).

VandeCreek, Larry & Gibson, S. (1997). Religious Support from Parish Clergy for Hospitalized Parishioners: Availability, Evaluation, Implications. *The Journal of Pastoral Care*, 51(4), 403-414.

VandeCreek, Larry, Pargament, K., Belavich, T., Cowell, B. & Friedel, L. (1999). The Unique Benefits of Religious Support During Cardiac Bypass Surgery. *The Journal of Pastoral Care*, 53(1), 19-29.

VandeCreek, Larry, Rogers, E., & Lester, J. (1999). Use of Alternative Therapies Among Breast Cancer Outpatients Compared with the General Population. *Alternative Therapies*, 5(1), 71-76.

Yankelovich Partners, Inc. (1997). *Belief and Healing: HMO Professionals and Family Physicians*. Report Prepared for the John Templeton Foundation.

Contributors to The White Paper

The following persons were appointed by their organizations to draft the Paper:

Representing the Association of Professional Chaplains:

Carl Anderson, Downer Grove, ILL.

George Fitchett, Chicago, ILL.

Representing The Association for Clinical Pastoral Education:

Maxine Glaz, Fraser, CO*

Mark Jensen, Winston-Salem, NC

Representing The Canadian Association for Pastoral Practice and Education:

Tim Frymire, Winnipeg, CANADA

Phyllis Smyth, Quebec City, CANADA*

Representing The National Association of Catholic Chaplains:

Steven Ryan, Los Angeles, CA

Michele Sakurai, Beaverton, OR

Representing The National Association of Jewish Chaplains:

Zahara Davidowitz-Farkas, New York, NY

Seth Bernstein, Worcester, MA*

*Unable to attend the group meeting of writers.

The board members of the five sponsoring organizations approved the final draft of this Paper on November 9, 2000 at a joint meeting in Nashville, TN. They are:

The Association of Professional Chaplains

Carl Anderson, Downers Grove, IL

Judith Blanchard, Portland, ME

Robert Kidd, Houston, TX

Karen Ballard, Greenville, NC

Paul B. Janke, Sacramento, CA

Theodore Lindquist, Madison, WI

Stephen L. Mann, Baltimore, MD

Dick D. Millspaugh, Columbia, MO

Timothy Little, Sacramento, CA
 George F. Handzo, New York, NY
 Elizabeth Jackson-Jordon,
 Rockingham, NC

Mary Moore, Marietta, GA
 Roderick J. Pierce, Houston, TX
 Mary Whetstone-Robinson,
 Columbus, OH

The Association for Clinical Pastoral Education

Orwoll O. Anderson, Fall Creek, WI
 J. Paul Balas, Gettysburg, PA
 Verlin E. Barnett, Jr., Akron, OH
 Yvonne M. Boudreau, Orange, CA
 James V. Corrigan, San Diego, CA
 JoAnn M. Garma, New Orleans, LA
 James L. Gibbons, Park Ridge, IL
 Theodore E. Hodge, Louisville, KY
 Janet L. Humphreys, Louisville, KY
 Janet T. Labrecque, Minneapolis, MN
 Dan A. McRight, Miami, FL
 Irvin Moore, Jr., Cincinnati, OH
 Duane F. Parker, Riverside, RI

Charles F. Pieplow, Birmingham, AL
 Lee Ann Nolan Rathbun, Dallas, TX
 Harlan E. Ratmeyer, Albany, NY
 Cornel G. Rempel, Mount Gretna, PA
 William D. Russell, Chesterfield, MO
 Sally A. Schwab, Saint Joseph, MO
 Teresa E. Snorton, Decatur, GA
 D. James Stapleford, Wichita, KS
 Donald A. Stiger, Chicago, IL
 Elizabeth Stroop, Chapel Hill, NC
 Henry Douglas Watson, Newport News, VA
 Linda Wilkerson, Dallas, TX
 Patricia A. Wilson-Robinson, Tacoma, WA

The Canadian Association for Pastoral Practice and Education

Margaret Cobbold, Toronto, ON
 Neil Elford, Edmonton, AB
 Martin Frith, Toronto, ON
 Bill James-Abra, Stratford, ON

Dale Johnson, Vancouver, BC
 Cynthia M. Morneault, Pierrefonds, QC
 Phyllis Smyth, Quebec, QC

The National Association of Catholic Chaplains

Joan Bumpus, Indianapolis, IN
 Liam C. Casey, Hartford, CT
 Jane M. Connolly, Astoria, PA
 Mary Anne DiVincenzo, Fresno, CA
 Joseph J. Driscoll, Milwaukee, WI
 Virgine Elking, Kettering, OH
 Eileen F. Grimaldi, West Seneca, NY
 James H. Kunz, Rochester, MN
 Richard M. Leliaert, Riverview, MI

Mary Lou O'Gorman, Nashville, TN
 Hubert P. Polensky, Ontario, OR
 Ellen K. Radday, Arlington, VA
 Farroel A. Richardson, Portland, OR
 Stephen R. Ryan, Los Angeles, CA
 Charlene A. Schaaf, Colorado Springs, CO
 Nancy A. Siekierka, Irving, TX
 Jane Smith, Fulton, MO
 Patricia M. Walsh, San Gabriel, CA

The National Association of Jewish Chaplains

Mitchell Ackerson, Baltimore, MD
 Cecille Allman Asekoff, Whippany, NJ
 Sandra Rosenthal Berliner, Melrose
 Park, PA

Stephen D. Roberts, New York, NY
 Solomon Schiff, Miami Beach, FL
Zev Schostak, Commack, NY

Seth L. Bernstein, Worcester, MA
 Zahara Davidowitz-Farkas, Norwalk, CT
 Shimon Hirschhorn, Riverdale, NY
 Steven Kaye, Denver, CO
 Lowell S. Kronick, New Hyde Park, NY
 Tom Liebschutz, Rockville, MD
 Beverly W. Magidson, Albany, NY
 Seymour Panitz, Rockville, MD

Julie Schwartz, Atlanta, GA
 Sam Seicol, Brookline, MA
 Marion Shulevitz, New York, NY
 Stephen Shulman, Riverdale, NY
 Barbara J. Speyer, Los Angeles, CA
 Bonita E. Taylor, New York, NY
 Michael Wolff, Quebec, Canada
 David J. Zucker, Aurora, CO