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Chaplain Spiritual Assessment and Its Efficacy for the Palliative Care Team at Roper St. Francis Healthcare: An Interdisciplinary-Phenomenologic Inquiry

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CHAPLAIN SPIRITUAL ASSESSMENT AND ITS EFFICACY
FOR THE PALLIATIVE CARE TEAM AT ROPER ST. FRANCIS HEALTHCARE:
AN INTERDISCIPLINARY-PHENOMENOLOGIC INQUIRY

A PROJECT

SUBMITTED TO THE FACULTY
OF THE M. CHRISTOPHER WHITE SCHOOL OF DIVINITY
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OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF MINISTRY

BY

YHANCO MONET

MAY 2017

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CHAPLAIN SPIRITUAL ASSESSMENT AND ITS EFFICACY
FOR THE PALLIATIVE CARE TEAM AT ROPER ST. FRANCIS HEALTHCARE:
AN INTERDISCIPLINARY-PHENOMENOLOGIC INQUIRY

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ABSTRACT

A qualitative phenomenological research methodology was designed and implemented to answer the question: what is it that chaplains assessed which is perceived as useful for the Roper St. Francis Palliative Care team? Twelve Palliative Care practitioners, representing diverse specialties, were interviewed and surveyed to answer the research question. Evidence suggested that spiritual care and chaplaincy assessments were perceived as relevant to the Roper St. Francis' Palliative Care praxis. However, the gathered data indicates that chaplains and Palliative Care practitioners would benefit from a more standardized/consistent spiritual assessment practice. A set of "Teaching Guidelines" and educational "Activities" was created with the goal of training chaplains in the art of doing Palliative Care spiritual assessments based on the research findings. A certified ACPE supervisor was interviewed about the viability and appropriateness of these "Teaching Guidelines" and "Activities." This professional educator enriched the educative proposal and validated its potential to train staff chaplains as Palliative Care practitioners.

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CHAPTER ONE

INTRODUCTION

a. STATEMENT OF NEEDS

In recent years, a lot has been written and researched about the relevance of religion and spirituality for patients of all kinds. More than one hundred spiritual assessment tools have been developed, and a group of them were validated scientifically. However, too few of them have been researched in the field of Palliative Care¹ chaplaincy and its clinical interdisciplinary contributions. It is the purpose of this research to expand the clinical knowledge of this modern pastoral specialty.

The present research inquiry was developed at Roper St. Francis Healthcare, in Charleston, SC. It intended to identify those aspects of spiritual assessments which were perceived as useful to the work of the local Palliative Care team. This research's intent was to transform the current state of ignorance regarding the value of Palliative Care spiritual assessments for the clinical team.

The research methodology was phenomenological in nature. The reason behind the methodology selection was simple. The best way of understanding the efficacy of spiritual assessment for the Roper St. Francis Palliative Care team was through the opinion of the PC practitioners.

¹ In order to reduce the amount of words used when referring to Palliative Care as a medical specialty, I will alternate using the full name of this medical discipline and its acronym "PC." Similarly, I will utilize the phrase Palliative Care chaplaincy or PC chaplaincy to refer to the specific ministry of the chaplain assigned to or involved with Palliative Care services. Throughout this paper, I will refer to Palliative Care as the relatively new medical specialty which goal is to provide pain and symptom management to any patient dealing with a chronic disease. This medical specialty provides care to patients and families at any stage of the disease process, and it does so through the interdisciplinary team which cares for the whole person.

To obtain relevant data, direct and indirect PC team members² were interviewed and surveyed around the topic of spiritual assessment. The acquired data was classified and compared considering various Palliative Care specialties,³ the literature that had been consulted, and the researcher's experience. The result of this comparison was translated to educational guidelines which will be endorsed to train chaplains on clinical spiritual assessments for Palliative Care. These guidelines were developed and presented to at least a supervisor certified through the Association of Clinical Pastoral Education.⁴ The purpose of this activity was to inquire about viable ways of including the research's educational guidelines into the Roper St. Francis Clinical Pastoral Education⁵ curriculum.

Empirical evidence demonstrated that this type of research is needed because clinical chaplaincy is still perceived as a non-core practice with little research done to validate its helpfulness.⁶ In my opinion, this perception is the product of the dated/unresolved conflict between faith and science which is contrary to the biblical and theological praxis of the Judeo-Christian worldview.

² Direct team members are those who work full time as members of the PC team. They were hired by Roper St. Francis Healthcare to provide PC services. Indirect team members are all the chaplains involved with the PC services. They work part time or PRN (as needed) for the PC team/program of this health care system.

³ Palliative Care doctors, nurse practitioners, social workers and chaplains.

⁴ ACPE. ACPE supervisors are the chaplains' educators.

⁵ CPE. In order to avoid so many words when referring to Clinical Pastoral Education, I will use the acronym "CPE" when referring to this educational discipline.

⁶ Christopher E. De Bono, "An Exploration and Adaptation of Antoin T. Boisen's Notion of the Psychiatric Chaplain in Responding to Current Issues in Clinical Chaplaincy" (PhD diss., University of St. Michael's College, 2012), 3.

The risk that this research presented was minimal. The probability and the magnitude of harm or discomfort anticipated were no greater than those ordinarily encountered in daily life. The potential risks of this research were minimized through the protection of participants' confidentiality.⁷ It did not represent a threat to patients or families because it was only focused on the anonymous, non-paid and voluntary participation of Palliative Care team members.

The problem of this research project was grounded on empirical evidence, gaps in literature research, and the researcher's experience as a Palliative Care chaplain. Empirical evidence demonstrated that chaplains at Roper St. Francis Healthcare who were involved with PC services struggle to document efficient spiritual assessments. Apparently, one of the reasons which supported such behavior was that staff members from other medical disciplines did not consult the chaplains' charting frequently enough. This perception caused chaplains to consistently lose motivation to document quality spiritual assessments. This reality negatively impacted the recertification process for the Roper Hospital PC program in 2014. At this time, the JACHO⁸ surveyor highlighted that the quality and consistency of PC chaplains' spiritual assessments were deficient. As a consequence, it negatively affected the JACHO surveyor's final report.

Reviewed literature demonstrated that not much research had been done to understand why clinical teams do not consult the PC chaplains' documentation on a regular basis. Locally, in the two years in which I had functioned as the chaplain

⁷ This section was taken from the IRB research template. This analysis is an IRB requirement of Roper St. Francis Healthcare which was recommended by Winnie Hennessy, PhD, RN, CHPN an IRB committee chair person.

⁸ Joint Commission on Accreditation of Healthcare Organizations

dedicated to Palliative Care at Roper Hospital, I had not found any chaplaincy research done on this topic. Nationally, most of the literature and research had focused on demonstrating the value of spirituality for patients, families, and staff members.⁹ In addition, national research had focused on developing and validating spiritual assessment instruments to support clinical practices.¹⁰ In my opinion, what researchers had consistently missed was the inquiry into how spiritual assessments were perceived as useful or not by other clinicians and PC practitioners. So far, those who had attempted to answer the previous question did it in a very general way. Perhaps psychiatric clinicians had been pioneers in the field of evidence-based practice research, incorporating spiritual assessments as an interdisciplinary, integrated and efficient practice. According to McGee and Torosian,

Numerous studies have shown spiritual health to correlate with both health and healing. To date, no inpatient psychiatric program to our knowledge has systematically integrated spiritual assessment and intervention into their program in order to promote clinical outcomes. When available, spiritual care is traditionally provided *ad hoc* to patients and family members without integration and coordination of their efforts with those of other clinicians.¹¹

⁹ Joint Commission. "Joint Commission on Accreditation of Healthcare Organizations. Evaluating your Spiritual Assessment Process." *The Source*. Volume 3, Issue 2 (February 2005). 6, http://www.professionalchaplains.org/files/resources/reading_room/evaluating_your_spiritual_assessment_process.pdf (Accessed May 16, 2015).

¹⁰ According to experienced chaplain Lori Hefner, there are nearly a hundred different spiritual assessment tools. See Lori Hefner, "Comparing and Discussing Two Spiritual Assessment Tools. Counseling Older Adults." *Counseling 820. Dr. Gloria Gregg* (April 3, 2008). 2, <http://www.lorihefner.com/spiritualAssessmentTools2.pdf> (Accessed May 16, 2015).

¹¹ Michael D. McGee, MD and Jennifer Torosian, MSN, "Integrating Spiritual Assessment into a Psychiatric Inpatient Unit," *NCBI, Psychiatry MMC* 3, no. 12 (Dec 2006): 60-64. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2945898/> (Accessed May 16, 2015).

Based on my PC chaplaincy experience, I believe that the above statement/problem is also true for PC chaplaincy. It supports the relevance and need of this research paper.

b. MINISTRY QUESTION

What is it that Palliative Care chaplains assess which is perceived as useful for the Roper St. Francis PC team? This was my research question. This question was relevant because its answer brought light to the phenomenon of inquiry. In general, clinicians are pragmatic, outcome-oriented practitioners with too little time to collect and analyze data. It was my hypothesis that PC chaplains were assessing spiritual issues which were not necessarily perceived as relevant enough for PC practitioners to consult chaplains' charts. I am aware that this was one among other possible hypotheses to consider in understanding this phenomenon. However, I believe it was a good place to start in trying to address this epistemological gap.

c. PROJECT SETTING

This project encompassed the group of three hospitals within the Roper St. Francis Healthcare system, located in the Charleston, SC area. It is a 657-bed hospital system, with perhaps the largest Palliative Care program in the state, including one inpatient PC service per hospital, one outpatient PC clinic, and one home-based PC practice. The current PC team is made up of five medical doctors¹², four nurse

¹² MDs.

practitioners¹³, and two social workers¹⁴ spread throughout the different services of the PC program.

This healthcare system has only one Pastoral Care department. It is integrated by one ACPE certified supervisor, one ACPE supervisory candidate,¹⁵ two clinical managers, six staff chaplains, five CPE residents, and a varied number of intern and extern chaplains. With the exception of the last group, the remaining chaplains provide spiritual care to PC patients and families.

d. PROJECT GOAL

The current project's goal was: to better understand what it was that Palliative Care chaplain assess which was perceived as useful for the Roper St. Francis Palliative Care team.

Among the possible outcomes of this project I gained: a) a phenomenological understanding of what PC team members found useful from PC chaplains' spiritual assessments; b) a phenomenological understanding of what it was that PC chaplains found useful from their spiritual assessments for the work and functioning of the PC team; c) an individualized perception of the research topic across disciplines¹⁶ involved with the PC services at Roper St. Francis Healthcare; d) an understanding of how different spiritual assessment models allowed chaplains to collect "useful/meaningful" information which contribute to the work, functioning and efficiency of the local PC

¹³ NPs.

¹⁴ SWs.

¹⁵ One of them is the department director and one is the Clinical Pastoral Education manager.

¹⁶ Physicians, Nurse Practitioners, Social Workers and Chaplains.

team; e) an understanding on how ACPE supervisors perceived the findings of this research and its potential use for PC chaplains' formation; and f) teaching guidelines were recommended to train PC chaplains in doing spiritual assessments which met the professional needs of the Roper St. Francis PC team.

e. RESOURCES

During the implementation of this research, Roper St. Francis Healthcare and its Palliative Care program were accredited through the Joint Commission, one of the most important accrediting health care institutions of the United States. All the Palliative Care direct members were accredited and licensed to practice within their specialty. Among the indirect PC team members, I, the researcher, was the only Board Certified Chaplain. The remaining chaplains practiced under the standards of quality and practice of the Association of Clinical Pastoral Education, maximum accrediting organization for Clinical Pastoral Education programs.

This research required the unpaid and voluntary participation of the target community members. Each participant donated one hour of their time to conduct the different researching activities. A meal or refreshments were offered to interviewees during the research activities. The recording equipment and physical spaces were borrowed from the Pastoral Care and Palliative Care departments respectively. The Pastoral Care department donated the researcher's time to develop the research's interventions.

In addition, multiples libraries were consulted such as: The Roper St. Francis Medical and Pastoral Care library; the Southern Baptist University library, the Gardner Webb University library and other online sources.

e. STATEMENT OF LIMITATIONS

The present research is limited by the nature and extension of the study, the composition and expertise of the target community, and their understanding of the questions asked. It is also limited by its phenomenological methodology, the researching tools utilized, and the researcher expertise in the field of Palliative Care and chaplaincy investigations.

CHAPTER TWO

RESEARCH METHOD AND LITERATURE REVIEW

a. METHODOLOGY

The methodology of this project was designed to address the research's project goal: to better understand what it is that chaplains assess which is perceived as useful for the Roper St. Francis PC team. With this purpose in mind, I worked with a group of resident chaplains, staff chaplains, and PC team members linked to Roper St. Francis Healthcare.

For the analysis part, I considered my personal experience as the Palliative Care Chaplain who worked with this team since June 2013. The research participants were chosen based on the fact that they were continually exposed to the PC work within Roper St. Francis Healthcare. These participants represented the main source of epistemological data for this research, in addition to what was established by the literature reviewed.

To continue, I must establish that qualified individuals: a) decided to participate voluntarily and anonymously in this research; b) have signed the research informed consent form; c) have been exposed to the work of chaplains and other PC disciplines for more than three months; and d) have been exposed to spiritual assessments as part of PC interdisciplinary work.

i. RESEARCH ACTIVITIES

In order to achieve the established goal, I proposed the following activity program:

Activity No. 1

Explanation and signature of the research consent form.

Means of Evaluation for Activity No. 1

A hard copy of the research consent form was signed and stored.

Activity No. 2

Every volunteer member of my target community was interviewed utilizing two sets of semi-structured interview questionnaires: one for chaplains and one for the Palliative Care team.¹⁷ The goal of this initial intervention was to access the most immediate, spontaneous and subjective response of participants around the topic of spiritual assessment and its usefulness to the Palliative Care team.

Means of Evaluation for Activity No. 2

The interviews were developed and recorded separately with each individual, ensuring their privacy while considering interviewees' answers, environmental conditions and body language responses to the questions. The obtained set of answers was triangulated, comparing individual and subgroup responses to better understand their perception regarding the research question. Such comparison was performed through a data content analysis based on the phenomenological methodology established for this purpose. The intent was to find patterns and inconsistencies in participant answers.

To validate the target community and the quality of their answers, a mix of three quantitative/qualitative indicators were developed: 1) five to ten PC team members participate in the interviews; 2) the sample comprises a diverse representation; and 3) the percentage of questions answered:

- b. At least two chaplains involved with PC services participated in the interview, answering 80% or more of the questions.
- c. From the two chaplains, at least one of them needed to be a chaplain resident, and the other one a staff chaplain.

¹⁷ See Appendices B and C.

- d. At least three PC team members representing two or more disciplines will participate.

The reason I chose a quantitative evaluation format instead of a qualitative one was because the idea of the project was to gather and compare responses to the interview questions in a non-biased manner. The evaluative emphasis I proposed for this activity was based on diversity. Such emphasis granted me access to relevant data, leading to more accurate conclusions. I foresee this research project as one of many more to come which should be developed to look into the topic. It is my assumption that the more research we, as chaplains, do in this topic, the more effective our practice of professional PC chaplaincy would be.

Activity No. 3

Next, I surveyed my target community, asking them to rate some of the most popular religious, spiritual and existential assessment models utilized within the US healthcare system, generated by the consulted literature. These models were: FICA (Spiritual History model), 7 x7 model (Spiritual Assessment model), and Dignity Conserving Therapy (Dignity/Existential Assessment model).¹⁸ The group of individuals surveyed rated¹⁹ the given assessment tools, focusing on the following questions: Which survey provided your discipline with the most useful data to perform your duties as a member of the PC team? Are you aware of any other assessment model which should be considered for this research inquiry? How would you rate it?

¹⁸ See Appendix D.

¹⁹ The spiritual assessment tools will be rated utilizing the numerical scale which goes from one to ten, in which 1 will represent the least useful spiritual assessment tool and 10 the most useful spiritual assessment tool.

Means of Evaluation for Activity No. 3

This activity was completed after acquiring more than five sets of spiritual assessment tools rated by individual participants.

Activity No. 4

Subsequently, each participant was interviewed a second time, taking into account the discipline and the sub-group they represented with regard to the reasons for their ratings. Then, obtained data was cross-compared by groups of participants, looking for common and non-common themes.

Means of Evaluation for Activity No. 4

This activity was considered successful after meaningful data was obtained. By meaningful data, I referred to the acquisition of information which allowed me to understand the target community's rating reasons, their thought processes, and/or rationale.

Activity No. 5

Following this, and based on the information acquired from Activities 2, 3, and 4, I established teaching guidelines to train CPE students and staff chaplains in the art of performing efficient spiritual assessments for the PC team.

Means of Evaluation for Activity No. 5

This activity was considered successful as PC spiritual assessment teaching guidelines were established based on the research findings from Activities 2, 3, and 4.

Activity No. 6

I presented the teaching guidelines to at least one ACPE certified supervisor to receive feedback about the research findings. I inquired about the viability and

appropriateness of using the recommended spiritual assessment teaching guidelines to train CPE students.

Means of Evaluation for Activity No. 6

This activity was considered successful once the consultation with the ACPE certified supervisor was documented.

Activity No. 7

The target community was surveyed a second and last time inquiring whether or not they perceived the research tools to be appropriate to gathering meaningful data pertinent to the topic of inquiry. Also, participants were surveyed about the researcher's ethics, and they were given the opportunity to comment about any other issue pertinent to the research and/or the researcher through free writing.

Means of Evaluation for Activity No. 7

Five or more second surveys were filled by research participants and stored according to the data gathering/storing procedures already established for this research.

Overall Project Means of Evaluation

This research project was completed and considered successful once I had gathered and documented meaningful conclusions and recommendations.²⁰ My hope is that the final results of this research could change the way PC chaplains at Roper St. Francis Healthcare think about spiritual assessments.

²⁰ In this project, meaningful conclusions and recommendations are understood as any learning obtained from the implementation of this project's activities.

ii. DATA STORING METHOD

The data storing method used consisted of electronically recording each individual interview in order to later transcribe relevant contents onto paper. Electronic recordings will be destroyed one month after the successful oral defense of the present research's final report. The interviews and surveys were classified according to the participant's role, the number of participants in that role, and the date. The classification was as follows: (Physician) "MD Participant No.-Date," (Nurse Practitioner) "NP Participant No.-Date," (Social Worker) "SW Participant No.-Date," (Chaplain Resident) "CR Participant No.-Date," (Staff Chaplain) "SC Participant No.-Date," (Certified CPE Supervisor) "CCPES No.-Date." In addition, as part of my data gathering-storing method, I utilized field notes which followed the same classifications noted above. These field notes were based on my observations, theoretical reflections, and methodological considerations.

iii. DATA ANALYSIS METHOD

The research data analysis method followed the process proposed by Hycner and recommended by Thomas Groenewald²¹ for phenomenological research. Essentially, this process established a series of five steps to examine the data:

1. Bracketing and phenomenological reduction.
2. Delineating units of meaning.
3. Clustering of units of meaning to form themes.

²¹ Thomas Groenewald, "A Phenomenological Research Design Illustrated," *International Journal of Qualitative Methods*, 3, no.1, article 4 (2004): 17.
https://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf (Accessed April 20, 2015).

4. Summarizing each interview.
5. Extracting general and unique themes from all the interviews and making a composite summary.²²

b. LITERATURE REVIEW

i. CHAPLAINCY

The Dictionary of Pastoral Care and Counseling defines chaplaincy as:

...the general activity performed by a chaplain, which might include crisis ministry, counseling, sacraments, worship, education, help in ethical decision-making, staff support, clergy contact and community or church coordination... Chaplaincy may be provided by an institution such as a general or mental hospital, prison, school or college, by a business organization, or the armed forces. Although many faith groups and institutions use “pastoral care” synonymously with “chaplaincy services,” some prefer to use “pastoral care” to refer to any service performed by either ordained or non-ordained persons, but reserve “chaplaincy services” for activities performed by ordained ministers, priests, or rabbis...²³

The same dictionary suggests that chaplaincy evolved to various specialized forms within the context of hospitals. Curiously, the *Dictionary of Pastoral Care and Counseling*, when referring to chaplaincy specialties, does not mention Palliative Care chaplaincy as one of them. This is perhaps because of the newness of Palliative Care as a clinical discipline or because, for some people, it is important that chaplaincy be perceived as a non-specialized discipline.²⁴ However, this is something that seems to be gradually changing in the more contemporary healthcare system and within the Association of Professional Chaplains. Actually, the only specialty specifically

²² Thomas Groenewald, 17

²³ Rodney J. Hunter, et al. *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 1990), 136.

²⁴ Ibid.

recognized by the APC beyond the chaplaincy certification is the Hospice and Palliative Care certification.

In the book *Paging God*, Wendy Cadge describes how chaplaincy is becoming different from what it used to be. Cadge said that hospital chaplaincy was transitioning from being a Catholic practice to being more interfaith and ecumenical. She noticed that the language used during religious services has changed. It is no longer heavily Catholic and seemed to follow more secular, institutional and ecumenical guidelines.²⁵ Essentially, Cadge highlighted how this clinical discipline changed for various reasons.

To this end, I can add the experience of Christopher De Bono, who researched and wrote about the modern context of hospital chaplaincy in North America. De Bono described chaplaincy as a progressively isolated and diminished professional practice. According to this author, this phenomenon was caused by, and at the same time was a consequence of: low referral rates to chaplaincy services, hospital budget cuts, and the belief that chaplaincy was not a core component of the patients care. De Bono also mentioned that hospital administrators trusted that social workers, clinicians and volunteer clergy members could meet patients' religious and spiritual needs. To his contextual assessment, De Bono added that professional chaplaincy was lacking scientific research and literature to support the presence, need and practice of clinical chaplaincy.²⁶

In response to this lack of research, multiple efforts were made by authors such as Clinebell, Doehring, Fitchett, Pargament, Dykstra, Koenig, Capps, Cooper-White,

²⁵ Wendy Cadge. *Paging God. Religion in the Halls of Medicine* (Chicago: The University of Chicago Press, 2012), 78-82.

²⁶ Christopher E. De Bono, 3-5.

Sperry, Farris, Cadge and Puchalski, among many others. Also, and more recently, on January 1, 2015, the Association of Professional Chaplains sent a letter announcing a change in its methodology for continuing education hours for Board Certified

Chaplains.²⁷ Essentially, APC said:

As part of its strategic plan, APC is working to transform the profession by creating research-literate chaplains who practice research-informed and, ultimately, evidence-based chaplaincy care for the benefit of those receiving care in various clinical settings. The profession is at a critical juncture; health care institutions are focusing on patient-centered outcomes, our fellow clinicians use and expect evidence-based practices, and chaplaincy largely lacks these components.²⁸

As De Bono said, this push for research comes within a context in which the meaning and value of chaplaincy is being questioned. This push comes with an identity crisis. Modern chaplains are no longer those who care only for the chapel or provide only Christian religious services and rituals. Modern chaplains do much more than that. They are members of healthcare clinical teams.²⁹ Chaplains provide more than religious services. They offer spiritual support to anyone who needs it, believers or not. Chaplains do crisis intervention and grief counseling, and they facilitate end-of-life³⁰ discussions, support groups, and decision-making processes. Modern chaplains are part of

²⁷ The acronym “BCC” will be used to reduce the total amount of words needed when referring to the certification of Board Certified Chaplain.

²⁸ Association of Professional Chaplains, e-mail message to author, January 9, 2015.

²⁹ Rodney J. Hunter, 136.

³⁰ Or, EOL.

Institutional Review Board³¹ Committees and ethics committees, just to mention a few of their other modern functions.

ii. PALLIATIVE CARE CHAPLAINCY

Kuebler defines Palliative Care as:

... comprehensive, specialized care provided by an interdisciplinary team to patients and families living with a life-threatening or severe advanced illness expected to progress toward dying and where care is particularly focused on alleviating suffering and promoting quality of life. Major concerns are pain and symptom management, information sharing and advanced care planning, psychosocial and spiritual support, and coordination of care.

... Palliative care extends the principle of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process. No specific therapy is excluded from consideration. An individual's needs must be continually assessed and treatment options should be explored and evaluated in the context of the individual's values and symptoms. Palliative care, ideally, would segue into hospice care as the illness progresses.³²

As an interdisciplinary medical discipline, PC team composition varies according to the program's characteristics and the setting's needs, emphasis, and institutional financial possibilities. Kuebler understands that the basic PC team is composed of a physician, nurse, social worker and other team experts as needed.³³ In my experience as a chaplain in South Carolina, I have observed that this basic/core model varies from hospital to hospital. I have found models in which chaplains and social workers are employed full-time while physicians work part-time and/or as needed. Some models mix

³¹ IRB.

³² Kim K. Kuebler, Mellar P. Davis and Crystal Dea Moore, *Palliative Practices. An Interdisciplinary Approach* (St. Louis: Elsevier Mosby, 2005), 6.

³³ Ibid, 11.

chaplains' and social workers' roles in the same job/position. Other models have nurses as the only full-time member while everyone else serves part-time or as needed.

As a discipline, hospital chaplaincy is older than PC, but PC chaplaincy is newer, because it did not precede the existence of PC as a medical specialty.³⁴ Perhaps one of the most important ways to differentiate these pastoral specialties is through the Standards of Practice for Professional Chaplaincy, developed by the Association of Professional Chaplains. Each of these Standards point to four different chaplaincy practices. One is very general and the remaining three are more specific/specialized. These Standards of Practice were written down in four different documents: 1) Standards of Practice for Professional Chaplaincy; 2) Standards of Practice for Professional Chaplains in Acute Care Settings; 3) Standards of Practice for Professional Chaplains in Long-Term Care; and 4) Standards of Practice for Professional Chaplains in Hospice and Palliative Care.³⁵

The above four documents refer to the Standards of Practice for Board Certified Chaplains. These documents agree that every BCC must address the same three standards sections, meet the same basic qualification requirements, and provide the Scope of Services.³⁶ Yet, there are significant differences between the Standards of Practice for Professional Chaplains in Hospice and Palliative Care and the standard practices for other

³⁴ PC was born 50 years ago in the UK as a medical specialty. See Kim K. Kuebler, Mellar P. Davis and Crystal Dea Moore, Xiii.

³⁵ To date, this is the only Certification offered by APC beyond Board Certified Chaplain (or, its acronym "BCC," as it will be referred to in order to avoid wordiness).

³⁶ See Appendix A.

chaplains. In my opinion, the difference is that there are more specific/detailed expectations for professional Palliative Care chaplains.³⁷

In my experience, what was established as Standards of Practice for Professional Chaplains in Hospice and Palliative Care represents a reality which is not necessarily practiced by other fellow chaplains. Perhaps this is one of the reasons why Hospice and PC Chaplaincy Certification³⁸ is the only official recognition beyond BCC. To this, I must add that a core difference between other chaplaincy practices and PC chaplaincy is the intensely interdependent team work. PC chaplains are not afforded the luxury of working independently. PC chaplains' work depends on and responds to the PC team's³⁹ work, tasks, needs and goals which could be summarized as follows: a) to bring relief from pain, shortness of breath, anxiety, stress and any other symptoms caused by illness, treatments and hospitalization; b) to improve quality of life; c) to bring relief from suffering; d) to assist patients and families in establishing/defining their goals of care; e) to offer support; f) to offer psycho-education; g) to facilitate informed decision-making; h) to engage patients and families in EOL discussions; and i) to facilitate EOL transitions.

In my opinion, it is around the above goals/tasks that PC chaplaincy differentiates from other types of chaplaincy practices. In my experience, this difference becomes evident in the way that spiritual assessments and plans of care are developed, effectively contributing to the overall work/goals/tasks of the Palliative Care team.

³⁷ See Appendix A.

³⁸ BCC-HPCC.

³⁹ It should be noted that the Roper St. Francis PC philosophy establishes that patients and families are members of the hospital PC team. Their input, goals and preferences constitute a central/definitional ingredient in developing the PC task.

iii. SPIRITUAL ASSESSMENT

When thinking about professional chaplaincy and PC chaplaincy, one of the first topics which comes to mind is that of spiritual assessment. The reason is simple: spiritual assessments are one of the means by which chaplains justify what they do. At the same time, documented spiritual assessment shows how chaplains contribute to patient care and the healthcare team. I believe that spiritual assessments hold chaplains accountable for their performance and level of expertise. Therefore, it is a core component of chaplaincy practice.

In my years of experience as a hospital chaplain, I noticed that everything charted by clinical and ancillary team members was interdependent and contributed to the holistic plan of care of any given patient. This activity was usually done in such a way that the vital signs measured by a tech, as well as assessments from dietary specialists, case managers, and physical/occupational therapists informed what the rest of the team was doing and would do for a patient. However, this was not necessarily true for spiritual assessments, which were often poorly elaborated and/or unhelpful to the interdisciplinary team.⁴⁰ Therefore, they were often disregarded.

According to JC, “Poor timing, lack of training, and discomfort with the subject matter are just a few of the barriers that can stand in the way of a staff member’s conducting spiritual assessments effectively.”⁴¹ With regards to this, Sue Wintz, chair of the Commission on Quality in Pastoral Services said:

It is essential to listen to the patient’s needs with an open mind in order to gain understanding of the patient’s beliefs. The patient’s needs and beliefs can guide

⁴⁰ Or, IDT.

⁴¹ Joint Commission, 6.

the assessor in terms of how the patient wants to utilize spiritual or religious beliefs in their care or treatment...A staff member's comfort in assessing spirituality may be linked to his or her own experiences with spirituality. For this reason, if your organization or community has pastoral care resources, it may also be helpful to access information from pastoral care professionals. Clinically trained, professional pastoral care providers can offer insight and assistance in developing spiritual assessments for your organization.⁴²

Also on the topic of spiritual assessment, an article published in 2005 by JC said:

Per standards and elements of performance (EPs)... the Joint Commission requires organizations to include a spiritual assessment as part of the overall assessment of a patient to determine how the patient's spiritual outlook can affect his or her care, treatment, and services. This assessment should also determine whether more in-depth assessments are necessary. While the Joint Commission leaves the specifics to each organization, spiritual assessment should, at a minimum, determine the patient's religious affiliation (if any), as well as any beliefs or spiritual practices that are important to the patient. While the content and format of the spiritual assessment will vary depending on the organization and type of patients served, organizations should develop a basic policy regarding the content and scope of spiritual assessments and outline who is qualified and competent to perform such assessments within the organization...Assessing a patient's spirituality and the need for support can be a delicate subject with some patients, and staff members need to extract helpful information without causing offense. The main goal of the spiritual assessment should be to identify the patient's needs, hopes, resources, and possible outcomes regarding spirituality and determine appropriate actions necessary to address those issues. Individuals assessing a patient's spirituality must be careful not to impose their belief system or definition of spirituality on the patient.⁴³

In reviewing literature on the topic, the most serious work that I have found on spiritual assessment is by Chaplain George Fitchett, who published his spiritual assessment book in 1993.⁴⁴ Interestingly, after Fitchett's work a lot has been published on the topic, typically in the form of articles. More curious is the fact that most of the work

⁴² Joint Commission, 6.

⁴³ Ibid.

⁴⁴ George Fitchett, *Assessing Spiritual Needs. A Guide for Caregivers* (Minneapolis: College of Chaplains, 1993), 7.

and reflection done in the field of spiritual assessment has been published by doctors, nurses⁴⁵ and social workers, while clinical chaplains have been nearly silent.

Empirical evidence also demonstrates that the chaplains who work with the PC team at Roper St. Francis Healthcare do not use any standardized tool to do spiritual assessments. Similarly, reviewed literature shows that the preferred assessment tool utilized to measure spiritual issues might be FICA,⁴⁶ which is not a spiritual assessment tool but an intake tool for spiritual history.⁴⁷

The most recent information which corroborates my empirical findings comes from the JC surveyor who visited Roper St. Francis Healthcare in 2014 to recertify the PC program. Essentially, this surveyor pointed out the fact that the practice and quality of documented spiritual assessments performed by chaplains involved with the PC services was not standardized. To conclude, the surveyor highlighted the need for integrating more of the chaplains' work with that one of the PC team using the clinical chart as the common communication tool.

Puchalski's theoretical frame of reference is helpful in clarifying the scope and limits of spiritual screening tools, spiritual history tools, and spiritual assessment tools. However, my overall impression is that spiritual assessments do not follow common guidelines. It is for this reason that the topic is confusing; therefore, chaplains and

⁴⁵ Leonard Hummel, et al. "Defining Spiritual Care: An exploratory Study." *Routledge, Taylor & Francis Group. Journal of Health Care Chaplaincy*, 15:40-51 (2008). 40, <http://healthcarechaplaincy.org/userimages/defining-spiritual-care.pdf> (Accessed June 27, 2015).

⁴⁶ Christina Puchalski, M. MD and Betty Ferrell, RN, PHD, *Making Health Care Whole. Integrating Spirituality into Patient Care* (West Conshohocken, PA: Templeton Press, 2010), 198.

⁴⁷ *Ibid*, 94-95.

clinicians use the terms interchangeably. This is also why there are spiritual assessment tools which focus on a varied number of topics, such as: spiritual pain; spiritual coping; spiritual distress; existential issues; religious issues; culture, values and beliefs; meaning-making and purpose; and spiritual well-being; among many others.

As far as I was able to discern, the most commonly used tools used in PC are: FICA,⁴⁸ HOPE,⁴⁹ SPIRIT,⁵⁰ the 7 x 7 Spiritual Assessment model,⁵¹ and the Dignity-Conserving Therapy⁵² model. However, they are not very helpful to my PC chaplaincy practice at Roper St. Francis, nor are they used by any of my chaplain colleagues. For some reason, chaplains involved with the PC services and the PC team know about these tools but rarely use them. Personally, I opted for developing my own spiritual assessment model inspired on Clinebell and Dohering's holistic pastoral care paradigms and Fitchett/Chochinov's models, respectively. Despite my own efforts, I still need to know more about what it is that our PC chaplains are assessing that is perceived as useful for the local PC team.

⁴⁸ Christina Puchalski, M. MD and Betty Ferrell, RN, PHD, 198.

⁴⁹ Ibid, 200.

⁵⁰ Ibid, 199.

⁵¹ Fitchett, *Assessing Spiritual Needs. A Guide for Caregivers*, 39-51.

⁵² Harvey Max Chochinov, MD, PhD, FRCPC, "Dignity-Conserving Care. A New Model for Palliative Care. Helping the Patient to Feel Valued," *Journal of the American Medical Association* 287, no. 17 (May 1, 2002), 2255. http://www.pccf.org/clinicaltools/JAMA_Dignity_Chochinov_HM.pdf (Accessed June 27, 2015).

CHAPTER THREE

BIBLICAL/THEOLOGICAL REFLECTION

a. INTRODUCTION

My research inquiry addresses the topic of spiritual assessment in the context of a team in the field of Palliative Care chaplaincy. The heart of my research investigation focuses on the perceived value of spiritual assessments made by PC chaplains as part of the Palliative Care team. Hence, I feel compelled to consider the theology of the Triune God as a relevant theological rationale for this paper. In my opinion, this theology is pertinent to be considered because it talks about relationships. It also allows me to reflect on spiritual assessments made by each Trinitarian person. Below, I will reflect on the topics of Trinity as a “community/team paradigm,” and “Trinity and assessment.” I will also include a brief introduction to the topic of “Trinity, church and assessment.” My intention is to historically demonstrate how the Christian church used spiritual assessments to organize its praxis.

b. TRINITY AS COMMUNITY/TEAM PARADIGM

I, as a Christian and Baptist, believe in the Trinity: God-Father, Jesus Christ-Son and the Holy Ghost. According to Justo Gonzalez, it is a biblical doctrine present in 2 Corinthians 13:14, 1 Peter 1:2, John 10:30, 5:17, 30, 36, 14:6.⁵³ Gonzalez establishes that the classic doctrine of the Trinity is about one substance and three persons. This author declares that this is not a biblical statement, but it seems to better reconcile what different biblical texts say about the relationship and nature of God-Father, Jesus Christ-

⁵³ Justo L. Gonzalez and Zaida Maldonado Perez, *Introducción a la Teología Cristiana* (Nashville: Abingdon Press, 2003), 46.

Son and the Holy Ghost. Paraphrasing Justo Gonzalez's words, this doctrine affirms that there is an equal status among the three persons, who at the same time are the same God.⁵⁴ Gonzalez's Trinitarian considerations lead him to say that the best way to approach the doctrine of the Trinity is not through our effort to understand it. Rather, we should imitate it. The way to do this would be to acknowledge that God-Father, Jesus Christ-Son and the Holy Ghost share their divine status, therefore, none of the persons are diminished by the other or left out. In translating the previous statement to the practice of Palliative Care, I believe that Gonzalez is inviting us to live in community as equal participants. Gonzalez implies that this should be a rich experience.⁵⁵

In expanding this reflection on the Trinity as a paradigm for PC chaplaincy, I will reflect on Norman Metzler's⁵⁶ work. Metzler addressed the topic of the Trinity with regards to its social dimension. He did so from a more critical and systematic point of view than Justo Gonzalez. This author started his reflection by saying that the concept of Social Trinity is "certainly the most prominent and profound development of Trinitarian thinking today."⁵⁷

Metzler declared that contemporary thinkers perceive each Trinitarian person in relationship and community with each other, instead of considering them isolated from each other. In the author's own words, "God needs to be reconceived as relational; the

⁵⁴ Justo L. Gonzalez and Zaida Maldonado Perez, 48-49.

⁵⁵ Ibid, 50.

⁵⁶ Norman Metzler, "Questioning the Social Trinity," *Concordia Theological Quarterly* 67: no. 3 (July/October 2003): 270-287.

⁵⁷ Ibid, 270.

idea of person-in-relationship is almost universally assumed.”⁵⁸ Metzler said that this conception brought together pluralistic Christian thinkers from diverse traditions.

However, this author opposed the idea of the social Trinity. In my interpretation of his work, he did so because he was unable to get over his concerns about three-theism.

On his part, Jürgen Moltmann did not hesitate to say:

The Trinity is our Social Programme... the triune God shows just such a unity of person and community, in which the Persons have everything in common apart from the attributes and differences of their personhood. This means that a human society which corresponds to God's Tri-unity, and lives in it, must be a community without privileges, and one where liberty is not infringed. Persons can only be persons in community; the community can only be free in its personal members....⁵⁹

At the core of Moltmann's triune thinking lays the idea that Trinity is about social relationships. Chaplaincy in general, and PC chaplaincy in particular, are relational disciplines, especially the latter, which is mostly conceived within the context and practice of the PC team. In this case, the existence of a PC team is a precondition for the existence and practice of PC chaplaincy, just as the Trinity is the matrix of existence for each Trinitarian person.

In addition, Moltmann's theology establishes the presence of communalities and differences among the members of the trinity or Persons. In this declaration, I find a context to say that the PC team is integrated by different people and disciplines which have in common their belonging to a team which has specific/common goals and tasks. Yet, each PC team member has a unique role, function, and expertise as a member of this

⁵⁸ Norman Metzler, 272.

⁵⁹ Jürgen Moltmann, *The Trinity and the Kingdom* (Minneapolis, MN: First Fortress Press, 1993), 332.

team. At times, PC chaplains assess a patient's pain and other symptoms, while at other times, other PC team members screen for spiritual issues or obtain patient's spiritual history. Despite these changes in role or function, a doctor does not stop being a doctor and a PC chaplain does not stop being the team's chaplain. Similarly, God manifests as Father, Son and Holy Spirit, but never ceases being God.

To end, as each Trinitarian person is differentiated from the other through the others, PC chaplains differentiate themselves by discovering how they are different from other PC practitioners. I share the conviction that personal and professional self-differentiation is important to functioning as part of a PC team. PC chaplaincy self-differentiation can be achieved by understanding "who I am" and "what it is that I do which makes me unique as a professional member of the PC team". I believe that it is a healthy, albeit complex exercise to do, and it is aligned with the purpose of my research project. Essentially, I am trying to understand through others what they find useful about what I do and offer as a Palliative Care chaplain.

c. TRINITY AND ASSESSMENT

In talking about spiritual assessment,⁶⁰ PC chaplaincy and the Trinity as a paradigm, I must address the following questions: Is there any evidence which demonstrates that the Holy Trinity assessed? If so, what was it that was being assessed? Let us start with God-Father, then Jesus Christ-Son, and conclude with the Holy Spirit.

⁶⁰ For the purposes of this section I would like to present my considerations in the use of three terms when referring to spiritual assessment. These terms are: diagnosis, discernment and assessment. On one hand, according to an online etymology dictionary (www.etymonline.com), the term "diagnosis" derives from the Greek and is interpreted as discernment. On the other hand, the online Thesaurus dictionary (www.Thesaurus.com) establishes that a common synonym of the terms "assessment" and "discernment" is "judgment." It is based on these findings, and my experience in assessing patients' spiritual needs, that I consider any of these terms to be synonyms when referring to spiritual assessment.

Genesis 3 evidences how God assessed that humankind disobeyed and broke the initial alliance with Elohim. These actions were deemed as sin. It led to the humans' disconnection from God, punishment and death. This assessment was focused on measuring the relationship between the human and the divine. In Seward Hiltner's theology, it referred to the human misuse of freedom.⁶¹ In Gen. 6:1-8, God assessed the existential depth of humankind's sins, which led God to destroy His creation. However, in Gen. 7, God assessed that Noah was righteous, so He decided to save him with part of His creation. This assessment focused on getting to know the core of people's intentionality and what was in their hearts and souls: the inner intentions, motivations and triggers.

Exodus 3:7 exemplifies how God assessed the emotional and spiritual condition of the Hebrew captives in Egypt. Also, it describes how God called His prophet Moses to validate and work with this assessment within the institutional context of those times, the Pharaoh and its oppressive social structure. In this case, God assessed that the Hebrews were afflicted and were crying and in pain because they were oppressed by the Egyptians. Similarly, in John 3:16 we read: "For God so loved the world that he gave his only Son, so that everyone who believes in him may not perish but may have eternal life." In this statement, there is evidence that another assessment has been made: humanity was perishing, which was why God had to send His son, Jesus Christ, so that humankind could be saved.

As God assessed, so did Jesus. Perhaps Jesus' very first assessment can be found in Matthew 4:1-11. In this case, Jesus discerned the devil's temptations. In Matt. 8:1-4,

⁶¹ Seward Hiltner, *Theological Dynamics* (Nashville: Abingdon Press, 1972), 81-82.

Jesus healed a leper and assessed that it was important for him to go and see the priest to follow the Jewish religious tradition established on Lev. 13 and 14. This assessment pointed to the leper's need to reestablish his relationship with God and the faith community. Also, in Matt. 8:5-13, Jesus assessed and witnessed the Roman centurion's depth of faith. Likewise, in Matt. 9:1-8, Jesus assessed that what was causing the paralysis of the "paralytic" were his sins.

To continue, in Matt. 15:1-20, one can find Jesus assessing the content of what really contaminated the Pharisees and humankind. He said that it was not necessarily the disruption of a hygienic/ritualistic practice, but the inner motivations which come from the heart, leading people to commit sins.

Similarly, but not in the same way, it is possible to argue that the Holy Spirit got involved with humankind based on assessments that were made as well. It was different than in the case of God and Jesus, because the Spirit only talked through God, Jesus, the Apostles, and the church. Upon this premise, I could argue that John 14:15-26 revealed to us the Holy Spirit's assessment through the words of Jesus. In this case, it was an implied assessment. I say "implied assessment" because the Bible mostly revealed the plan of action to address the identified need: the void created by Jesus Christ's departure to the Father. This assessment established that Christ would no longer be physically present with his disciples and the church. It revealed that a new "Advocate" was needed after Jesus was gone. This "Advocate" will reside in the church forever. It will be "the Spirit of Truth," and the one that will live within the church, filling the inner void so that Christians will not feel abandoned. This assessment also implied that the Christian church will need a teacher to reveal the path which leads to salvation. Thus, Acts 1:2 informs us

that the Holy Spirit instructed the apostles. The Holy Spirit instructed the apostles because they needed guidance, which was why, from a deductive perspective, I can say that an assessment was made which addressed the need for guidance.

Likewise, in Acts 2, the Holy Spirit empowered the apostles to preach the Good News of Salvation to the people of Jerusalem and “the world” in their native language. I believe that the Holy Spirit intervened after assessing that Christians needed encouragement and knowledge to communicate the Christian message to other people. This was how the Christian church was born.

Also, Acts 5 exemplifies how the Holy Spirit revealed to Peter Ananias’ and Sapphira’s need to lie. In this case, the assessment was possible thanks to the revelation of the Holy Spirit which ended up in a call to honesty. According to this narrative, without honesty, life and community are not acceptable to God.

d. TRINITY, CHURCH AND ASSESSMENT

Someone once said: “Trinity is the Christian relational theology.” In my experience as a Christian, I experience relationships in the context of the church. I believe in Jesus Christ, pray to God the Father and serve my faith community inspired by the Holy Spirit. This is the practice and faith of most of the Christians I know, but it was not always this clear.

When we go back to the origins of the church, the first Christians’ communities became aware of the spiritual gifts they received from the Spirit. It was an issue addressed by the Apostle Paul in his first letter to the Corinthians (1 Cor. 12:1-11). In this letter, it is evident that the Corinthian community was facing problems with embracing and integrating the diverse gifts, roles and ministries present in their church. They were in

conflict. They did not know how to work together. In some ways, the Corinthians resembled a team which was transitioning through the phase of “storming,” while Paul was inviting them to move to the phase of “norming.”⁶² I believe that Paul’s words to the Corinthians were grounded in his assessment of their organizational needs. Paul realized that the Corinthians could better use their spiritual gifts by serving in an organized fashion, increasing their efficacy.

The above realization led Paul to reflect on the topic of the church as “one body with many members” in 1 Cor. 12:12-31. I find this topic to be relevant in the context of this research. The Palliative Care team is not a church like the Corinthians were, but it is a place where God can be found. Part of the chaplain’s role is to remind other team members about the importance of using their different gifts, roles and skills to be effective. Also, chaplains remind the Palliative Care team of the existence, presence and action of God and the church. It is in the context of this team that the chaplain prays to God in the name of Jesus while he or she is moved by the Holy Spirit to serve patients, families and team members.

To continue with the topic of church and assessment, Galatians 5:16-26 presents an inventory made by Paul for the Galatian community. This inventory has taught generations of Christians how to discern the fruit of the Spirit, contrasting it with the work of the flesh. Essentially, this inventory became one of the church’s spiritual assessment tools, still used by many Christian communities.

As Christianity moved forward, the debate created around the topic of the Trinity became an issue of dispute within the church. The Church Fathers debated extensively to

⁶² See Wikipedia: Tuckman's Stages of Group Development.

determine and define what the true Trinitarian doctrine of the church was and what heresy was. In this way, those who represented the orthodoxy of the church determined which church faith and practices were embraced and which ones were rejected. This process of discrimination was essentially made through a doctrinal assessment.

In addition, I would like to mention a couple of examples of contemporary churches and theologians who have contributed to the field of assessment. James Fowler and Richard Niebuhr's works have both been important. Fowler⁶³ had an interest in assessing and differentiating the stages of faith according to human development and the search for meaning. Similarly, as a Christian theologian, Richard Niebuhr⁶⁴ reflected on the topic of "Christ and Culture," contributing to the theological and missiological praxis of the church with his work. In my opinion, Niebuhr's work was very relevant in assessing how churches and theologians engaged—theologically and pastorally—the mission of the church within the culture they served. As a parish pastor, I used and promoted Fowler's work to assess my own and my parish's theological position with regards to the Cuban culture.

Changing direction, I would like to present a couple of biblical considerations regarding the topic of spiritual assessment within the context of "multiple disciplines." In so doing, I intend to present a biblical reflection based on Lev. 13:1-8 and Mark 5:24-34 as the research project's biblical rationale.

⁶³ James W Fowler, *Stages of Faith. The Psychology of Human Development and the Quest for Meaning* (New York: HarperCollins, 1995).

⁶⁴ H. Richard Niebuhr, *Christ and Culture* (New York: HarperCollins, 2001).

e. BIBLICAL RATIONALE

The exercise of building a biblical reflection around the topic of this paper has been challenging for me. This is because there has not been much research done on the specific subject of my inquiry. Also, the overwhelming majority of the literature I have reviewed does not present a biblical reflection about PC chaplaincy. This was consistent with some D. Min and Ph.D dissertations that I consulted. Some of these bibliographical sources addressed the topic of chaplaincy and spiritual assessment, but only a few of them reflected on biblical or theological issues. I must confess that this finding surprised me because pastoral-biblical-theological reflections are a core component of Clinical Pastoral Education in the United States.

To be honest, I have not found any explicit reason which justifies or at least attempts to explain the above phenomenon. In my own experience, this may have happened for two reasons. First, modern chaplaincy was born as a pastoral ministerial practice which seems to be adapting to a new and changing healthcare system, at least in the United States. As a survival strategy, this pastoral practice seems to be moving away from its Christian religious roots to fit into the modern healthcare paradigm, thus becoming more holistic, ecumenical and clinical. Hence, modern chaplaincy is finding new arenas which might be challenging the idea of using biblical and traditional Christian theologies to support its praxis. Healthcare chaplaincy is no longer just a Judeo-Christian discipline.

Second, based on the characteristics of the modern conception of medicine, patient care philosophies, and bio-ethics dilemmas, it could feel forceful to use a classical reading/interpretation of the Bible. Biblical writers did not necessarily face the

same healthcare challenges that we are facing nowadays. However, it is my conviction that the Bible has something to say; therefore, it should be said.

To talk about how I interpret my PC chaplaincy ministry from a biblical standpoint, I find peace of mind in something I learned in CPE: to claim my pastoral identity/tradition by reflecting on what I do as a PC chaplain. It is here that I discover how to be honest and honor my Baptist and Judeo-Christian roots. I do this with the awareness and responsibility of not forcing the Bible to say what it did not mean to say. It is from this state of mind that I will approach my biblical reflection.

As I mentioned earlier, PC is a new medical discipline among healthcare professionals. Therefore, PC chaplaincy is a new pastoral ministerial practice as well. Thus, in biblical times, none of these disciplines existed in the ways we practice and understand them today. Yet, as a PC chaplain I believe that the roots of what I do as a pastor are grounded in priestly and prophetic ministerial practices of the Old and New Testaments.

As a Baptist Judeo-Christian pastor, I acknowledge that my pastoral ministry was originally inspired by God and the priests of Israel, who were ancestors of Jesus Christ, and, therefore, are my ancestors as well. It is based on this biblical-historical ground that I decided to approach the book of Leviticus in the Old Testament and the gospel of Mark in the New Testament, through the pericopes of Lev. 13:1-8 and Mark 5:24-34.

I chose these pericopes based on a simple fact: in my opinion, these texts represent two of the biblical narratives which clearly illustrate the healthcare practice of my vocational ancestors. These narratives are explicit in telling us how God commanded Israelite priests to take part in the ancient Israelite healthcare system, and how Jesus did

so as well. It is with this conviction that I align/locate my ministry and practice of PC chaplaincy. Just like the Israelite priests and Jesus, PC chaplains today also belong to the healthcare system. In their ministry, PC chaplains fulfill God's commandment given to the Israelite priests and their descendants in Lev. 10:10.⁶⁵

As I move forward with my biblical reflection, I will utilize ideas in Lev. 13:1-8 and Mark 5:24-34 which support the interdisciplinary/interdependent role and the usefulness of our chaplain ancestors' assessments. It is my conviction that these findings will bring to light the biblical validation of this project. In pursuing this task, I developed a brief introduction to each book and a brief exegesis of the selected pericopes,⁶⁶ to later on, elaborate my own reflection on the subject of PC chaplaincy. I begin with Leviticus and then continue with the Gospel of Mark, following a chronological order.

i. Leviticus 13:1-8

Early in this work, I established my research project's goal: to better understand what is useful for the Roper St. Francis PC team in terms of PC chaplains' assessments. This question points to two important matters: a) the problem of the content of chaplain assessments; b) and the problem of usefulness of the chaplains' assessments for representatives of other clinical disciplines. In the light of these two issues, it is my opinion that Lev. 13:1-8 is helpful to biblically validate the nature of my inquiry.

⁶⁵ "You are to differentiate between what's sacred and common and between what's unclean and clean..." (International Standard Version)

⁶⁶ In order to reduce the length of this paper, the introduction to each book as well as the exegesis developed for each pericope was placed in the Appendices. Please see Appendices E and G (for Lev. 13:1-8) and Appendices F and H (for Mark 5:24-34).

The literature that I reviewed established that Leviticus is not a book of metaphors or stories with a hidden meaning. Leviticus is a book that instructs Israelite priests in their duties. The Israel of Leviticus was a theocratic society where government and powers were split between monarchs and priests. It was not a well-developed society. It was complex, but not as complex as our modern society. The Israel of Leviticus shows us that priests were political, economic, religious, social and medical figures directly involved in social affairs. Israelite priests held all of these powers. However, our modern society, and specifically the US healthcare system, does not have only one figure that embodies all the powers held by Israelite priests. Rather, these powers are divided among multiple members of society and, in our case, the PC team.

In Israel, it was common to believe that illness was the result of sin and God's punishment; therefore, health and faith were perceived as directly correlated. However, the theology of Lev. 13:1-8 does not imply this type of rationale. This pericope is somewhat concerned about presenting Israelite priests as key figures in the process of diagnosing *tzara'at* while establishing a socio-religious plan of care for those who suffered from *tzara'at* symptoms. The priests were commanded to assess who was clean or unclean in order to restore people's relationship with God. These duties were given by God. They were commanded by God. I believe this validation extends to PC chaplains in their responsibilities as well. God wants chaplains and PC chaplains to be involved in faith and health affairs. Just like Israel's priests, PC chaplains work with the PC team to manage patient symptoms without intending to cure the illness.

Tzara'at was diagnosed through its symptoms. It has been translated as "leprosy," but the biblical exegesis does not favor this interpretation (however it does not disregard

it completely, either). Despite the reasons of why *tzara'at* was translated as and/or meant “leprosy,” I could argue that patients who suffered from *tzara'at* were treated as if they had leprosy. Based on this argument, I cannot prove or deny if *tzara'at* represented a chronic illness. So, in approaching the text, I gave myself the benefit of the doubt and entertained the possibility that we could be dealing with a potentially chronic disease—therefore, a PC scenario.

To continue, Lev. 13:1-8 is clever about something: the priests diagnosed illnesses based on patients' symptoms. They assessed and reassessed the severity of these symptoms and developed a group of socio-religious interventions to deal with them. According to the pericope in question, the priests' goal was not to treat or cure *tzara'at*, but to socio-religiously manage it with the goal of helping people be clean⁶⁷ again. My sense is that PC chaplains play a relevant role in assessing, reassessing and managing the symptoms of their patients. In my experience, whenever I find a patient in pain, I make a referral to a fellow PC team member for pain and symptom management. If patients are concerned, distressed, and/or struggling in any way, I address these issues, attempting to reestablish wholeness in my patients' lives. In so doing, I am certain that my goal as a PC chaplain is not to clinically cure the cause of these symptoms. Rather, my purposes are to facilitate a patient's sense of connection, communion and equilibrium with God, self and others.

In the modern healthcare system, where chaplaincy as a clinical discipline is questioned by secular authorities, I find the above reflections empowering to the practice of PC chaplaincy. This is because Lev. 13:1-8 makes a stand in saying that PC chaplains

⁶⁷ Please note that I am referring to being “clean/holy” as a means to being in communion with God/the sacred.

belong in the healthcare system. Like the Israelite priests long ago, PC chaplains also possess multiple roles: those of a clinician and a religious representative. Also, as in Lev. 13:1-8, PC chaplains do not try to medically treat or cure their patients but instead to manage their bio-psycho-socio-religious situations.

Of course, there are important differences between the practices of Israelite priests and PC chaplains. Because of the developmental stage of their society, the priests had legal, political, financial, social, medical and religious powers and responsibilities. However, the society a PC chaplain lives in is different. There are many experts who represent and are responsible for each area of expertise: legal, political, financial, social, medical and religious, among others. Today, the roles and powers are distributed among various professionals, which include: doctors, social workers, lawyers, financial experts, pastors and chaplains. We no longer have a theocratic society, but instead a representative one. Nowadays, all of us are, hopefully, interdependent team players.

According to Lev. 13:1-8, Israelite priests, individually assessed and reassessed patients in order to, later on, offer religious rituals to reconcile individuals with God (as seen in Lev. 14). In modern PC chaplaincy, patients are already isolated⁶⁸ by doctors' orders. The doctors are in charge of examining people's bodies. However, PC chaplains are expected to perform bio-psycho-social and spiritual assessments. I believe that this function shares commonalities with the functions of Israel's priests.

To return to the issue of assessments and reassessments performed by Israelite priests, I feel that Lev. 13:1-8 is explicit in saying that the priests' assessments had social and religious consequences for the ill person. Based on this, I could argue that priests'

⁶⁸ I am referring here to social and contact isolation precautions.

“clinical” assessments determined what would occur with any given *tzara’at* patient. In other words, the priests’ assessments were helpful in determining what to do socio-religiously with *tzara’at* patients. I find this fact to be essential to the purpose of my research project. It demonstrates and validates how priests’ assessments were helpful in making decisions and interventions concerning the physical, social and religious affairs of people. I must argue that a modern interpretation of this fact is that PC chaplains’ assessments should somehow contribute to the work of other clinicians, chaplains and social workers as those who represent people’s scope of existence.

ii. Mark 5:24-34

To continue with the biblical reflection, I decided to incorporate a pericope which belongs to the gospel of Mark. In so doing, I am adding the Christian/New Testament view to enlighten my research project proposal with this perspective as well. I am considering this pericope as a thematic continuum prevalent from Israel’s Code of Purity (Lev. 11-15). In this particular case, the Code of Purity in question is related to blood and uncleanness.

In addition, I chose the gospel of Mark because it tells the story of the woman who suffered from a hemorrhage with more details than its parallel texts in Matthew 9:19-22 and Luke 8:43-48. My sense is that this particular story presents the right circumstances to hermeneutically support the practice of my research project.

As in the case of Lev. 13:1-8, I developed a brief introduction to the gospel and exegetically engaged the selected pericope. In addition, I compared the synoptic stories described in the gospels. I also consulted various New Testament commentaries on Mark 5:24-34, establishing some connections with my experience and the practice of PC

chaplaincy. This exegetical work can be found in Appendix H. Below, I present some of my own hermeneutical considerations applied to the purpose of my research.

Mark 5:24-34 presents a story which makes sense within its context. Years ago, as I was receiving education in Bible and theology, I met a feminist professor who argued that the story in question was the hermeneutical key in understanding the story of Jairus' daughter. For this seminary professor, the central theme of this narrative was the issue of blood and bleeding.

In thinking about blood and bleeding, I cannot help but go back to Leviticus' Code of Purity. Right after God addressed the issues of *tzara'at*, He instructed Moses and Aaron, in Lev. 15:25-30, about how to deal with females who were bleeding. The point of Leviticus was that blood and bleeding made the suffering person, and whatever she touched, unclean.

Mark's story tells us about an unnamed woman who suffered from a bleeding disorder for twelve years—in other words, a very long time. Mark 5:26 says that after being treated by many doctors, she was doing even worse. Mark's narrative did not specify what type of illness this woman was dealing with. The story in question only points to the symptoms caused by her condition and her attitude as she sought healing. Although we lack information about what type of specific illness this woman was dealing with, we can agree that this woman was facing a chronic condition. The definition of chronic disease is: "a disease that persists for a long time... 3 months or more... (which) generally cannot be prevented by vaccines or cured by neither medication, nor do they

just disappear...’⁶⁹ Therefore, this woman was in a potential PC situation, which grounds us in the topic of my project. However, a challenge remains: how to demonstrate the interdisciplinary-interdependent work among the different “experts/characters” of this story.

To answer the above question, I must refer to the definition of a system and the way that the Merriam Webster Dictionary defines this term: a system is “a form of social, economic, or political organization or practice” or “an organized society or social situation regarded as stultifying or oppressive.”⁷⁰ In Bowen’s theory, we are in the presence of a system when dynamics such as stress, self-differentiation, homeostasis, and triangles are present.⁷¹ In my opinion, these dynamics are always present within the PC teams with which I have worked, and they were present in the situation described in Mark 5:24-34.

To continue, Mark’s pericope presents us with a woman who was stressed and distressed by her chronic condition. Her health problems made her suffer and endure the socio-religious dynamics of her oppressive social system. After struggling for twelve years, this woman decided that she wanted to pursue change. She did not want to surrender to the conformity, condemnation and marginalization of her society. She dared to triangulate with Jesus in order to cope with the failure and frustrations caused by her

⁶⁹ MedicineNet.com, <http://www.medicinenet.com/script/main/art.asp?articlekey=33490> (Accessed September 24, 2015).

⁷⁰ “System,” Merriam-Webster Dictionary, accessed September 12, 2015, <http://www.merriam-webster.com/dictionary/system>.

⁷¹ See also Michael E. Kerr and Murray Bowen, *The Role of the Family as an Emotional Unit that Governs Individual Behavior and Development. Family Evaluation* (New York: W. W. Norton & Company, 1988). And Edwin H. Friedman, *Generation to Generation. Family Process in Church and Synagogue* (New York: The Guilford Press, 2011).

relationship with the physicians who treated her. In this way, she was restored to homeostasis and wholeness, which she had pursued for the last twelve years of her life. This was how she found freedom from the oppression to which she was condemned.

As a system, the society of Mark was significantly different from that of Leviticus. One of these important differences was the fact that in Leviticus, the priests were religious and healthcare practitioners. In Mark, it was possible to distinguish between professional healthcare providers and popular religious healers like Jesus. The system of my contemporary society and my PC team is more similar to Mark's society than Leviticus'. One person does not play all the functions or roles. Rather, there is a team of experts that is expected to function interdependently, as a system; therefore, it deals with all the different dynamics inherent in systems.⁷²

In my PC chaplaincy experience with Roper St. Francis Healthcare, patients and family members function as members of the PC team and system. For this reason, one of the most important PC practices is that of "PC family meetings." Meetings are arranged with the PC team and the patient, including his/her close relatives and whoever is his/her Health Care Power of Attorney.⁷³ The goal of this meeting is to mutually exchange information and ask clarifying questions so that everyone has access to the same amount of information. This way, patients and family members are able to make informed decisions, weighing treatment burdens and benefits. In so doing, patients' decision-makers have the final say about what to do and how to proceed. This includes the

⁷² Anxiety, self-differentiation, and triangulation, among others.

⁷³ HCPOA.

decisions of continuing to receive PC services or not, and naming which team members will be playing a role (or not) in caring for them.

In my opinion, the above statement shows how patients and their HCPOA and/or decision-makers have power in shaping the PC team which cares for them. It is from this perspective that I can entertain the idea that the woman who suffered from the hemorrhage, as a patient, was the one who shaped the clinical team that cared for her.⁷⁴ This woman put herself at the center of the system, becoming the common denominator and validating all the roles involved in her care, medical and spiritual. Similarly, Palliative Care patients surround themselves with various PC team members. The PC team offers them all of the clinical experts available to them, but ultimately patients and family members are the ones that decide who gets involved or not. At times, PC chaplains get dismissed by patients or family members, but most likely chaplains will get more involved when patients embrace dialogue about ultimate meaning. This conversation often takes place after physicians and/or patients/family members acknowledge that there is nothing left to pursue other than comfort care. It is then that chaplain assessments contribute most to the PC team.

My sense is that my above statement is similar to what occurred in the narrative of Mark 5:24-34. After each and every one of the woman's physicians failed to "fix" her, she reaches out to Jesus, whose assessment addressed her existential needs. Jesus saw what no one else was able to see. Jesus realized that this woman needed to be made whole again. Jesus assessed that her faith needed to be acknowledged so that she could go and find peace. Mark 5:24-34 does not say if this woman's physicians heard about what

⁷⁴ Physicians and Jesus.

Jesus did. The text does not say if they acknowledged what happened, but despite these unknowns, it is undoubtable that Jesus' assessment contributed to the management and final outcome of this woman's suffering. Ultimately, Jesus' final outcome represents the golden goal of any PC practice: to bring relief from symptoms and suffering.

It is based on all the above convictions that I believe and recommend the ministry and practice of Jesus Christ, as narrated in Mark 5:24-34, as a paradigm for PC chaplaincy. I believe that, as part of a social system, Jesus' assessment contributed to the PC team of his era, assessing this woman's needs while facilitating her relief of physical, emotional, religious, spiritual and social suffering.

CHAPTER FOUR
CRITICAL EVALUATION
a. INTERVIEW RESULTS

For the implementation of this research, fourteen members of the Roper St. Francis Palliative Care (PC) team were invited to participate in the investigation. Four of them were doctors (MDs), three were nurse practitioners (NPs), two were social workers (SWs), two were staff chaplains (SCs), two were resident chaplains (RCs), and one was a chaplain manager (CM). Twelve of them were interviewed and surveyed satisfactorily. Two of them were unable to participate. One of them was an MD who presented schedule and health related conflicts; and one was an NP who consented to participate too late in the process. Despite the unavailability of these two PC team members, I can say that the sample met the success' criteria defined in the research methodology.

Overall, the target community seemed committed to the research and expressed interest in the research findings. Participants produced meaningful data which is documented in this chapter. I feel that the knowledge obtained from the implementation of this research successfully addressed the research question. Also, it initiated a process to validate the research's tools that were used.

The twelve research participants admitted to the study had a role as a member of the PC team for three or more months. Some of them served within the PC team for years. All the MDs, NPs and SWs have previously worked with chaplains in the context of Palliative Care. This group of clinicians acknowledged having some exposure to spiritual assessments. One NP expressed that, occasionally, she did conjoined PC

patients' visits accompanied by a chaplain who focused in doing the spiritual assessment of patients and families while she did the physical assessment.

Despite the above findings, one MD expressed confusion about understanding what a spiritual assessment was about, the language, and where to find it in patient's electronic records. This MD showed interest on having a "common language" to document spiritual assessments that could be understood by the interdisciplinary team. When I inquired about her idea of a "common language," she said that she did not refer to a universal language but to an agreement on core concepts and their definitions. She expressed the need for education around spiritual assessment terminologies, because medical practitioners were not properly familiarized with spiritual assessments.

Additionally, the above MD highlighted the importance of having someone to interpret the meaning of different religious practices, beliefs and faith preferences for the PC team. She felt insecure doing this by herself, although she recognized the importance of faith and its ethical values for the practice of PC medicine. This MD thought of spiritual assessments as a product which required expertise.

In Table 1. "Palliative Care Team Job Description,"⁷⁵ it is observable that MDs were specific and holistic⁷⁶ describing their jobs. They felt entitled to care for their patient's physical, emotional, social and spiritual wellbeing. NPs' answers seemed less inclusive, more focused on visitation, the physical, family discussions and goals of care. SWs' concentrated their answers on helping with resources and offering emotional

⁷⁵ See Table I.

⁷⁶ By holistic care I am referring to the provision of physical, emotional and spiritual care.

support to their patients. In general, SCs, RCs and the CM were more wide-ranging in their answers. In so doing, SCs and RCs focused on the spiritual assessment/plan of care part, the emotional/end-of-life support offered to patients/families, the sharing of their assessment to PC team members, and the role of presence, prayer, listening and observing the dynamics of conversations. It must be noticed that SWs and SCs, RCs and the CM overlapped in the provision of emotional support while MDs and chaplains⁷⁷ claimed to work with the spiritual piece. Yet, the only professionals who clearly talked about caring for the whole person were the MDs. Whether this is a factual or a narrative issue, in their answers MDs seemed to have the holistic approach to patients' care more integrated than chaplains, NPs and SWs.

In light of the above findings, I would argue that chaplains practice holistic care. It is evident that the chaplains who participate in this research were able to talk about the emotional and spiritual care component of what they do, yet they neglected claiming how they work with the physical aspects of their patients' care.

It is my experience that PC chaplains care for the physical being of their patients. There are times during a chaplaincy visit that spiritual caregivers identify that patients are struggling with physical pain. In this case, chaplains advocate making an appropriate referral to the patient's RN or the PC team for pain management. Another example is when, as a PC chaplain, I visited patients prior to other PC practitioners and identified that they were dying. They were dealing with agonal breathing. This assessment allowed

⁷⁷ "Chaplains" in general refer to staff chaplains (SCs), resident chaplains (RCs) and the chaplain manager (CM). They have in common similar Clinical Pastoral Education (CPE) training, have a Masters of Divinity or an equivalent, and serve as chaplains within Roper St. Francis Healthcare.

me to do a referral to the patient's RN and the PC team to ensure that this patient receives immediate attention for comfort care.

A last scenario I would like to share is connected to those times in which I have prayed and offered emotional support to patients/families. In so doing, I practiced touching of hands, shoulder and, at times, I offered comforting hugs. I consider this as a unique way of providing physical care to patients, as it does not intend to take blood or assess what is going on in patients' bodies, but instead, the intention is to give comfort, express love, compassion and care for the soul in a more physical way. In this regard, chaplain's physical care is about giving, not taking.

In Table 2. "Information of Interest by Specialty and Sources of Information,"⁷⁸ it is observable that Palliative Care MDs offered again the most detailed answers. MDs and NPs expressed that they desired to assess the whole person. SWs showed interest on patients' clinical status and their understanding of it to determine if there were disconnections. Naturally, these professionals gave extra attention to patient's financial situation and social needs. Additionally, SWs tried to gain insights about patients' emotional state in terms of grief and coping processes.

SCs expressed that, to do what they do, they sought for the information gathered by the interdisciplinary team regarding the physical-socio-psycho-spiritual assessment. For some reason, SCs seemed to rely more on obtaining information through the team rather than gathering the information they need by themselves. However, this tendency might only be reflecting the way SCs interpreted the question asked.

⁷⁸ See Table II.

In addition, SCs put emphasis on learning about patients' religious data which does not seem too different from what is assessed by MDs and NPs, but it seems more detailed (for example who are patients' religious leaders). SCs expressed that they sought to understand patients' spiritual distress and how their beliefs/spiritualities impacted end-of-life decisions and the decision-making process itself. This is something that other PC practitioners claim they do, however they do this at a screening level. In this regard, RCs were not very different from SCs. What seems different is the level of engagement with the interdisciplinary team. SCs seemed to work closer to other PC practitioners than RCs who depended more on patients' and family members' interactions as their source of epistemology. The CM pointed out that the most relevant information that she tried to obtain from her patients was related to family dynamics and patients/families' life-stories through her direct interaction with them.

Based on the data gathered on Table No. 2, I would argue that information concerning the family system, faith/spirituality and emotions are the constants themes across disciplines. These themes seem to vary in depth and dynamics and the amount of details gathered per PC specialties. All the research participants were in agreement about the relevance of obtaining these types of information as it directly impacted patient's care, decision-making and how patients/families approached the end-of-life.

The thematic differences across disciplines were around the fact that MDs/NPs sought a more thorough understanding of patients' physical/illness. SWs focused more on the financial/social aspects of patients' care; and chaplains on religion, spirituality and patients' stories.

Regarding how PC practitioners gathered the information they needed to care for patients, all the practitioners mentioned they used patients' electronic records and conversations with the interdisciplinary team and with patients/families. However, MDs, NPs and SWs seemed to use the electronic record and the interdisciplinary team more than chaplains. For their part, chaplains seemed to obtain more of their information directly from patients, family members and significant others. Perhaps, in this group, SCs started to assimilate the gathering data preferences used by MDs, NPs, and SWs. In this way, SCs split away from RCs and the CM data gathering preferences. The reasons of this SCs' tendency was not investigated in this research. My assumption would be that this phenomenon occurs because of the proximity and intensity of the relationships between SCs and PC practitioners. By the nature of their responsibilities, RCs and the CM spend less time working with the interdisciplinary PC team.

Table 3. "Interdisciplinary Understanding of Spiritual Assessment,"⁷⁹ inquired about research participants' assumptions regarding the purpose of spiritual assessments. The answers offered by physicians demonstrated that these professionals had different opinions about what was a spiritual assessment. Only one seemed more confident talking about the theme, while for the other two it was more confusing. One implied that all the PC practitioners could do spiritual assessments. Another one was not sure how it was done. Another one put chaplains and social workers as the experts capable of doing it. Despite the different levels of comfort with the theme, all the interviewed MDs seemed to agree that spiritual assessments were important in the context of the patients/family care.

⁷⁹ See Table III.

The physician who seemed more comfortable with the theme pointed out that spiritual assessments were done by physicians, chaplains or other members of the interdisciplinary team. This MD equated spiritual assessments to FICA, the work of Christina Puchalski. This MD considered that spiritual assessments were about asking questions to find out what was important to patients about spirituality, faith, community or spiritual support system. For him, spirituality overlapped with religion, but it was more about the existential from his perspective. Religion was something experienced during childhood which had the potential to be harmful and offensive as it was his experience.

Another of the MDs felt that spiritual assessment meant many things. This MD was unsure whether chaplains or a department had a specific method to obtain the spiritual assessment. For this MD, spiritual assessment was about assessing patients' social function as it is related to how patients find meaning in the world, and how they relate to God/Higher Being, community and spiritual community. It was about understanding how spirituality influenced patients' relationships with physicians, caregivers and disease. This MD believed that spirituality was about what was universal to all people transcending the individual. It was about what was common to humankind and the community, beyond who people were individually.

The last physician perceived spiritual assessment as an enigma. This MD was aware of some questions asked of patients which seemed as gathering demographic data regarding patients' spiritualities. For this MD, this theme represented a gray area which caused uncertainty about the spiritual assessment being some sort of psychological assessment or not. In this MD's opinion, the psychological and spiritual overlapped. This MD referred to religious denominations or set of doctrines as the spiritual, and the

individual interpretations and application of those religious doctrines as the psychological. In this context, this MD felt that chaplains and social workers were very helpful clarifying/untangling or discerning if individuals were referring to a religious set of doctrines or a particular person's interpretation of those doctrines. This type of clarification required a specific set of skills perceived by this MD as useful for the Palliative Care work.

NPs felt they did spiritual assessments while chaplains did more in-depth assessments. For NPs, spiritual assessments were about determining a patient's religious affiliation, rituals, importance, what was meaningful, and assess spiritual distress in a more formal or informal matter.

Social workers suggested that spiritual assessments were about identifying where patients were in their spiritual journey as they related or not to their health care. It was about identifying a support system, what provided patients with comfort, coping mechanisms, types of resources, beliefs, denomination and spirituality. It was about identifying a patient's sources of strength, worries about future or dying or being sick or changes. For one of these SWs, spirituality was a big umbrella. It was about religion, relationship to God/the Church, meaning of life, hopelessness, comfort, belief system, not necessarily a conventional religion or a mainstream religion. In one or another way, SWs demonstrated familiarity with spiritual assessments. It seemed like they were used to doing it, at least at a screening level. Depending on the result of their screening, one of them said, they would do a referral to chaplains, if it was important to their patients.

Similarly, in Table 4. “What Chaplains Assess,”⁸⁰ chaplains were asked to comment on what was it that they assessed while caring for PC patients. In their answers, RCs were straight forward. They said that they assessed patients’ emotional, physical, spiritual and social conditions. They mentioned the use of FICA⁸¹ which is not a spiritual assessment tool. SCs showed preferences for seeking their own assessment models. One of these chaplains created his own model which he added to his team’s charting system. The other chaplain mentioned the use of CASH⁸² which is an existential assessment tool used by a PC team from a different hospital setting. What seemed to be new with CASH was that all the PC team members used it to assess their patients’ existential condition. It must be noticed that this model is not a spiritual assessment tool either. It is an existential tool developed by physicians. The way they used it seeks to triangulate the information obtained by different PC specialties in one place to obtain a more integrated and accurate assessment.

Overall, staff chaplains tried to assess emotional-spiritual distress,⁸³ spiritual/personal history, spiritual vocabulary, engagement with faith tradition, strengths, primary concerns, patient’s conflicts between embedded and deliberative theologies,

⁸⁰ See Table IV.

⁸¹ FICA refers to: Ffaith, Importance of spirituality, Community, and interventions to Address spiritual needs.

⁸² Erin R. Alesi, “Development of the CASH Assessment Tool to Address Existential Concerns in Patients with Serious Illness,” *Journal of Palliative Medicine*, Volume 18, Number 1 (2015): 71-75. CASH stands for: Care, Assistance/help, Stress, Hopes/fears

⁸³ One of the staff chaplains referred to distress as: “emotional or spiritual struggles that are actively interfering with their (patients’) daily functioning... spiritual dissonance or discord causing direct anxiety that is keeping this person from engaging in the activities of their daily lives, relational dynamics, preventing them.”

social/spiritual isolation, fears or questions about God, grief, guilt and shame. Also, they evaluated relational dynamics related to illness, religious coping and its helpfulness or not, family dynamics, religious beliefs/heritage identifying how it fits or not the sickness or what patients are going through, resources available to them, inner strength, interventions made, outcomes and plan of care.

As it could be seen, SCs were more thorough in their answers than RCs which was not a surprise given the experiential factor. They focused their assessments around the emotional, religious, spiritual and family dynamics. Interestingly, they did not talk about the physical dimension. Rather, they focused on the meaning-making part of patients in light of their spirituality and medical condition.

The CM expressed that she distanced herself from the medical and social assessments because they were not part of her scope of practice. She stated that her assessment was not different from the assessments made by other practitioners. She said that she practiced “listening with her heart” to what was going on with the humanity of patients and families during PC family meetings. The CM defined spirituality as: “...journey, relationships with God, a being, creature, whatever you want to name it. We all have that life journey, that spirit within us.” Then, she got more specific about assessing spiritual background, where hope is found, and ended up saying that she listened to patients’ and families’ stories because their spiritualities were contained within these stories. For her to be informal, listen with the heart and listen to the stories was what was important.

It is interesting to me that all of the chaplains were fairly involved with PC. However, their spiritual assessment practices or the way they talked about it did not seem

congruent or in agreement with each other. RCs seemed to look at their immediate CPE formation. SCs looked at creating their own models or outside models. And The CM was looking at her experience⁸⁴ which might be seen as her own model. Rather, all the chaplains seemed inconsistent⁸⁵ with each other. I am stating this in contrast to how MDs, NPs, and SWs articulated what they do which seemed more consistent and easier to follow than in the chaplains' case. I wonder if this causes confusion on what non-chaplain PC practitioners hear from various chaplains about what is it that chaplains assess or what is a spiritual assessment or what is it that chaplains do. I wonder how this phenomenon is impacting (or not) the efficacy of the PC team in light of patients' care.

Table 5. "Spiritual Assessment Models. Preferences and Reasons,"⁸⁶ inquired about the PC team's familiarity with spiritual assessment models and if there was a reason for this familiarity or preference. MDs demonstrated they were unfamiliar with any particular spiritual assessment model. They mentioned FICA as the model they were most familiar with, the model which they used (if infrequently) as part of their overall assessment of patients. They acknowledged Christina Puchalski as the MD creator of this model. Yet, they struggled to remember what questions this model used and struggled to talk about it.

⁸⁴ In this statement, I am not denying that resident and staff chaplains were not using their experiences. I am referring here to my impression about where their points of view seemed to be grounded.

⁸⁵ I am using the term "inconsistent" because chaplaincy practitioners did not provide similar answers. It was difficult to assess or perceive an answering pattern through their narrative pointing to what could represent a standard of practice or their points of agreement. To me "inconsistent" does not mean that chaplains' answers were not irreconcilable. I am merely acknowledging the phenomenological fact that they focused on different elements of what they assessed.

⁸⁶ See Table V.

NPs mentioned familiarity with FICA but they were unfamiliar with spiritual assessment models used by chaplains. One NP mentioned that a chaplain she worked with put together a group of themes to document spiritual assessments. This NP stated that these themes could be found in existing/validated spiritual assessment tools. The same NP expressed that it was her preference to receive the chaplain's spiritual assessment of a patient orally. She argued that this way she could get more up-to-date information directly from the chaplain. She felt that through orality, she could ask clarifying questions and get as many details as possible. If oral communication was not possible, her preference was to get the spiritual assessment via email or text because it was more direct and she would have instant access to it on her phone. To obtain chaplains' spiritual assessment from the medical records would be her last preference. She thought that it was impossible to document in a charting box what happened between a chaplain and a patient during a one hour visit.

SWs expressed that they were unfamiliar with spiritual assessment models. They observed some questions more/less specific in the electronic record but they did not know about models' names.

Along these lines, when PC team members were asked, "do chaplains who work with you use any specific spiritual assessment model that you are aware of?" Their responses were:

MD: "I trust they do but I am not aware about which one they use." "Not that I am aware of..." "I am going to say no because it is not discussed in that way... when we are meeting together in the interdisciplinary group, I am not citing my pain assessment. I am giving my impression of what I think is going on. And I think that when we meet together, if the chaplains are using a tool, a prescriptive tool, when we are talking about the patient, they are really giving me their assessment. So, I do not think that comes up a lot when we are together."

Researcher: Will it be helpful for you if the chaplain reveals what tool is he/she

using? Will this be helpful or the information that he/she shares is more important? **MD:** “I think it will be helpful. There might be varying opinions about that but I do think that, just when you go into a room and the patient is obviously in pain, you ask about their physical pain. You know... if they are grabbing their leg or whatever... So, for me, understanding kind of the basics of a spiritual assessment or tool that is been used for a patient who appears to be in spiritual pain, I would, at least have some idea of where to take that. For me, I think the tool is nice. I think... if we are going to collect data overtime about our interventions and outcomes, we need some sort of standardized elements.”

NP: “I recall seeing a template of what the documentation tool was going to be but I am not sure it is a recognized tool like FICA, so I am uncertain.” And “I am not sure about spiritual assessment models but our home PC chaplain does this kind of assessment... one created by him...”

SW: “I do not know. I know that you used something but I am not sure what it is called.” “I think they do but I do not know what they are.”

When asked similar questions, RCs referred to the Amy Van Deurzen’s existential model⁸⁷. RCs acknowledged that it was not a spiritual assessment tool but they used it because it was the model presented to them by their CPE supervisor. It was easy to understand/follow. They felt that spiritual assessment models could be built upon this one as it might be the case of FICA, and it allowed to ask deeper questions about what gives people meaning and strength.

SCs were divided about the spiritual assessment model they used. One of them expressed that he created his own spiritual assessment model after “playing” with various models. For this SC, being informal, more relaxed and relational were important at the time of performing a spiritual assessment, therefore the use of tools felt artificial. Tools were not helpful to create a desired atmosphere, safe and natural, to care for patients. He added that this was a conviction he arrived at while caring for patients. It led him to his decision of picking and choosing themes to informally assess PC patients’ spiritual needs instead of using a validated tool. On her part, the second SC expressed preferences for the

⁸⁷ This model refers to the Emmy Van Deurzen: “Everyday Mysteries: Existential Dimensions.” This model observes human existence considering the physical, social, emotional and spiritual.

use of CASH to assess spiritual needs of patients. Her preference for this tool was motivated by the possibility that the entire PC team could use it. The tool itself was a sort of “lingua-franca.” Every PC team member would assess the same issues/themes/questions from different perspectives, MDS and NPs from a medical perspective, SWs from a social perspective, and chaplains from a more spiritual perspective.

The CM was asked the same questions as the RCs and SCs. Her answers pointed to the use of the McKesson⁸⁸ model which is built-in the Roper St. Francis hospital charting system. The CM pointed to the use of keywords for documenting spiritual assessments such as: denial, fear of death, isolation and spiritual/family abandonment and other issues or triggers in families. The CM was unable to remember any spiritual assessment tool but highlighted that the documentation of spiritual assessment had to be done in a very responsible way because it was about people’s lives.

The analysis of the above data allows me to say that at our medical center there is not a clear view of what is a spiritual assessment tool. MDs, NPs and SWs acknowledge that it was important, and it was something done either by them or chaplains. Yet, they seemed to be very unfamiliar with models and contents.

The chaplains as a group were inconsistent for the reasons already explained. RCs opted for using an existential tool they were introduced to in their CPE training. SCs were divided, one pursued the creation of his own tool while the second one preferred to use a PC team “lingua-franca’s” existential tool to do spiritual assessments. The CM stayed with what was built-in the system, expressing concerns about how much and what to

⁸⁸ McKesson was the name of the name of the Roper St. Francis’ clinical documentation system.

disclose in the chaplaincy chart. Overall, chaplains seemed to be inconsistent in their practice as a discipline. Individually, chaplains seemed clear about what they do but not as a group. The remaining Palliative Care team members seemed confused about what was a spiritual assessment and the existence/use of any particular tool used by chaplains for this purpose. I feel this phenomenon might be reflective of the inconsistencies within the chaplaincy practice. I wonder if the diversity of preferences among chaplaincy practitioners is hindering the quality of the chaplaincy practice, the effectiveness of the PC team and the patient's care outcomes. This might be a theme worthy of research or further exploration.

Table 6. "Spiritual Assessment. What is Helpful? What was found Helpful? The Ideal"⁸⁹ represents the core information sought by this research. It tries to answer the question: What it is that Palliative Care chaplains assess which is perceived as useful for the Roper St. Francis Palliative Care team? This table organized the gathered data based on what is theoretically and empirically helpful and what is perceived as ideally helpful across disciplines. The symphony of the acquired data was phenomenologically reduced by PC specialty considering and combining the answers given by the interviewees. This process led to the development of three analysis categories: A) assessment and cause-effect, B) assessment deducted from chaplaincy interventions, and C) assessment and team functionality.

Assessment and Cause-Effect: establishes that a chaplain's useful assessment information might identify those elements which have a direct or indirect impact in how

⁸⁹ See Table VI.

patients perceive their disease, life, treatments, end-of-life options and make decisions regarding aggressive treatments. Among the identified issues within this category were:

Medical Doctors:

- Patient's culture (Patient's faith tradition or type of spirituality, religious coping style, values, community, spiritual practices/rituals and family system).
- Spiritual concerns.
- Interpretation about what motivates patients to use particular elements of their faith or spirituality.
- Expectations and hopes.
- How far patients are willing to go bargaining the quality of their life.

Nurse Practitioners:

- Religious practices used to cope, avoid making end-of-life decisions, and/or explain their behavior. How religious practices impact patients' meaning-making, life, stories, narrative, wellbeing and preferred rituals.
- Impact of feelings and issues such as: fears, isolation, relational tensions, grief and existential anxiety.

Social Workers:

- Assess how emotions and disconnection inform patients' distress.

Chaplains:

- Assess impact of family meetings on patients'/families' psych-spiritual state as it influences, thought processing, spiritual wellbeing, coping, hopes, expectations, joy, sadness, tendencies and future expected/desired outcomes.
- Assess needs for trust building, reframe meanings, transcending and significance as it impacts decision making.
- Assess how unresolved grief and relational tensions, family dynamics, conflicts and existential anxiety impact decision making.
- Discern how spirituality and theologies are used "to hide" what happens in patients' bodies.
- Determine if, after a family meeting, patients and families need chaplaincy presence to address the existential anxiety produced by the meeting as well as talking about ultimate realities.

My interpretation of this section, "Assessment and Cause-Effect," allows me to observe: A) All the PC specialties identified that chaplain's emotional assessment of patients was helpful. It was the only theme everyone agreed on. B) The second most common theme among disciplines was present in the answers of MDs, NPs, and Chaplains. It communicated interest on identifying patients' motivations to access certain

faith or spiritual beliefs/practices. These professionals were interested in how these impacted patients' lives, and how these were used by patients to cope, avoid or hide while talking to the medical team or considering end-of-life options.

In my observation of this section, MDs and Chaplains were the two practitioners who offered unique thematic contributions. MDs seemed to have a unique interest on assessing patients' culture, spiritual concerns and how far patients were willing to bargain the quality of their life. Chaplains had unique interests on assessing the psycho-spiritual and existential impact of family meetings on patients and families. Also, chaplains expressed interest on assessing if trust building, reframing meaning or exploring patients'/families' views about transcendence was necessary or significant to face end-of-life options. Furthermore, chaplains were attentive to assess if they needed to be present to patients/families after a family meeting, because existential anxiety was raised from the PC discussion.

Assessments deduced from chaplaincy interventions refers to actions taken by chaplains, during family meetings or clinical rounds, which pointed to implicit or explicit assessments made a priori. The idea was to deduct, from chaplaincy actions, the content of these assessments.

Medical Doctors:

- Relational anxiety. Prayers were used by chaplains when relational anxiety was identified as an obstacle to the patient care and the PC team efficacy. What MDs shared about how chaplains used prayer implied that chaplains assessed that it was necessary to eliminate/smooth relational polarities (PC team vs patient). The need to build trust was identified by chaplains as relevant to boost the PC team performance while caring for patients' spiritual wellbeing. In this spirit, prayers were used by chaplains to bless the clinical practice as divine intervention while opening potential outcomes founded on "God's Will or divine determination."
- Anxiety. MDs identified that chaplain assessment of patients' anxiety was important, as it allowed chaplains to provide reassurance. Perhaps, the reason

behind this statement is based on the fact that one of the PC team goals is to assist and reduce anxiety on PC patients.

- Assessing the need for chaplaincy presence was identified by MDs as helpful. It seems to be based on the idea of accessing spiritual care services and holistic care provided by the PC team. In this case, chaplains might have assessed the significance of spirituality for any given patient.
- Assessment of productive trust prior to a family meeting. Chaplains assessment on productive trust would be helpful to determine how much trust work with patients/families might be needed to deliver meaningful PC outcomes.

Nurse Practitioners:

- Anxiety assessment was identified as relevant for chaplaincy interventions.
- Search for purpose assessment was identified as relevant for chaplaincy interventions.
- Prayer concerns assessment.
- Spiritual distress assessment seeking to reduce patients' spiritual suffering, produce positive end-of-life experiences, and better spiritual coping.
- Assessment of patient's religious coping limitations.

Social Workers:

- Assessment of need and significance of chaplaincy presence to create trust.

Chaplains:

- Identify if patients and families need time to process the information received during and after family meetings.
- Identify patients' Health Care Power of Attorney.
- Assess if prayers are needed at the beginning and end of a family meeting to create a sense of sacredness.
- Discern how to be present to patients' stories to identify their spirituality.
- Identify when Palliative Care education is needed to ease patients' and families' anxiety.
- Identify effective ways/approaches (religious, hope and/or inspirational focus, among others) to be in a helpful relationship with patients and families.
- Identify if there are questions that patients and families are not asking the Palliative Care team, especially to the doctors.

In this section, the theme of prayer was the most common. It was raised by MDs, NPs and Chaplains. MDs perceived prayers as helpful when relational anxiety between patients/families and the PC team was identified. NPs referred to prayers as an intervention made after assessing patients'/families' prayer concerns, and chaplains

referred to it after assessing the need of creating a sacred space, perhaps, trying to address MDs' relational anxiety.

The themes of anxiety and chaplaincy presence assessments were tied. Each counted with two PC specialties claiming their relevance. MDs and NPs expressed that chaplains' anxiety assessments were helpful, while MDs and SWs communicated that to assess if chaplaincy presence was needed was important.

Regarding unique contributions, MDs were the only ones to acknowledge that chaplains' assessment of the need to building a productive trust was important. Here they seemed to connect with one of the chaplain's unique contributions of the previous section. NPs' unique contributions remarked that chaplains' assessments were helpful when identifying patients' search for purpose, spiritual distress and patients' religious coping limitations.

Interestingly, in reading chaplains' unique contributions to this section, I realized that most assessment themes were unique to this PC specialty. Chaplains were the only ones who expressed interest in assessing if patients/families needed time to process the information received from the PC team during a family meeting. Chaplains expressed interest in identifying patients' Health Care Power of Attorneys. The group in question showed interest in assessing how to be present to patients' stories to identify care seekers' spirituality. They expressed interest in identifying if PC education was needed to reduce patients' anxiety. Also, they were curious about identifying what type of spiritual care or existential approach would be required to develop helpful relationships with patients and families. Finally, chaplains gave attention to the identification of questions that patients were not asking the PC team, especially doctors.

Collateral to the goal of this research, another unique contribution made by chaplains was identified. It was fascinating to hear chaplains saying that during various PC family meetings in which they participated as PC practitioners, family members asked the PC team to delay making end-of-life decisions for two or more days. The PC team honored family requests, stepped away and left chaplains with them. In these post-family meeting encounters, chaplains reported being very active through multiple interventions. The outcome of these was that family members made the end-of-life decision within the hour after the family meeting concluded. I have no evidence to say that this outcome was directly or uniquely influenced by chaplaincy assessments and interventions, but I found it was fascinating to hear this report coming from different chaplaincy practitioners.

Assessment and Team Functionality refers to the chaplain's role assessing issues which directly impact the PC team performance. It perceives the chaplain as an expert consultant for the PC team.

Medical Doctors:

- Chaplain could be more effective identifying what was helpful or not for patients regarding what the PC team said or did. Identifying what patients/families were able to hear from the PC team or not.
- Chaplains could be more effective identifying what was missed, unattended or neglected in the interaction with patients and families during a family meeting so the team can correct it.

Nurse Practitioners:

- The chaplain assessment of what NPs missed while talking to patients.
- Identification of faith community contact person.
- The assessment of patients' strength to cope.

Social Workers:

- Chaplains' identification and interpretation of belief system, rituals and culture for the PC team.
- The assessment of faith base (significance-strengths) and support system.
- The identification of what needs to be said/done to ease what patients might be experiencing as uncomfortable and/or sad.

Chaplains:

- Identify patients' spiritual preferences, practices, strengths, resources and spiritual needs.
- Identify when the Palliative Care team might benefit from learning about patients' stories, struggles, emotions, suffering and isolation.
- Assess clinicians' spiritual preferences and culture.
- Assess the need to translate theological dissonance from patients to PC practitioners so they can make sense of what patients are communicating.
- Identify when patients need to be referred to other PC team practitioners.
- Identify and address patients' spiritual/existential needs which are out of PC team members' comfort zone.
- Identify and provide religious education to PC practitioners regarding religious groups' end-of-life preferences or customs.
- Identify when PC practitioners need chaplains to translate religious language to existential language to make sense of what patients are communicating.

In this section, PC team members seemed scattered in their answers. In my interpretation, based on the phenomenological reduction, I observed four assessment themes which were consistently echoed by subgroups of PC disciplines:

- The first theme was suggested by NPs, SWs and Chaplains. These PC practitioners expressed that to identify what gave strength to their patients was important.
- The second theme was a concern of MDs and NPs. They said that chaplains would be helpful assessing what was missed, unattended or neglected in the conversation with patients in the context of family meetings.
- The third theme was noted by NPs and SWs. It focused on identifying patients' faith communities and contact person.
- The fourth theme was identified by SWs and Chaplains. It said that it would be helpful if chaplains assessed when they needed to interpret existential language, patients' belief systems, theology, ritual and/or culture for other PC practitioners.

As unique themes, MDs communicated interest in chaplains assessing what was helpful or not for patients (in the context of PC family meetings), and what patients and families were able to hear or not about what was said by the PC team. NPs had no unique themes. SWs identified as a unique chaplains' assessment/interventions made when patients felt uncomfortable or sad.

Curiously to me, most of the chaplains' comments were unique in nature. They could be observed in the above chaplains' vignettes. What captured my attention the most was that chaplains assessed fellow PC teammates' spiritual culture, preferences and needs. It appears that chaplains were actively concerned about filling the blanks of their fellow team members, so they could be more effective caring for patients.

b. ANALYSIS OF SURVEY RESULTS

As it was defined in the research's methodology, research participants were surveyed after the interview phase concluded. This activity had four goals:

- To determine which validated tool, already used in the field of Palliative Care chaplaincy, offered the team the most meaningful data.
- To determine if the information obtained from the interviews could be found in an existing assessment tool.
- To determine if there was team agreement about what tool was most helpful.
- To capture other assessment models used by PC team members who were not considered by the researcher.

In this survey, participants were asked to rate three different validated assessment tools historically utilized in the field of Chaplaincy and Palliative Care. In so doing, the target community was asked to rate the tools based on which one offered them the most meaningful information to practice Palliative Care. In so doing, the survey utilized values from the scale 1-5. In this scale, 1 represented the one less relevant tool and 5 the most relevant one. These assessment tools were FICA, the 7 x 7 model of Spiritual Assessment, the Dignity-Conserving Therapy Model, and there was a fourth slot for any other model by which a professional participant would like to mention and assign value. At the end of the survey, participants were invited to share some of the elements that influence why they scored the way they did. It must be noticed that from all these models, the 7 x 7 format was the only validated Spiritual Assessment tool. FICA was a spiritual

history tool, and the Dignity-Conserving Therapy model was an existential tool utilized to address patients' dignity needs at the end of their lives.

Table 7. "Survey Results"⁹⁰ offers a panoramic view of the surveyed answers. In a group base, MDs, SWs and RCs assigned the highest score to the Dignity-Conserving Therapy model. MDs felt it was the best and most transparent model to collect information. They felt it retrieves the most pertinent and important information in the most sensitive and effective way, however, the difficulty was that it was too lengthy. SWs explained their scoring saying that it covered patients' physical and afterlife distress. Yet, the model could be improved by adding patients' history background. RCs said that this model was comprehensive and focused on what gave patients' meaning.

NPs, SCs and the CM did not feel that the Dignity-Conserving Therapy model was the most helpful. NPs felt that the model was good and comprehensive. Somehow, they felt the themes were good but to do the inventory was not. They implied that the information could be obtained through other forms of communication. This group felt that the model was too specific about end-of-life, making it helpful for this purpose but not in doing an overall assessment. SCs felt the model was interesting but too long. It limits its focus to dignity issues, therefore, it was not comprehensive enough. They said that it might be better for SWs than chaplains. The CM said that the model could be used if there was a good relationship with patients. Overall, the CM felt the model was complicated.

Interestingly, NPs, SCs and the CM were scattered regarding which model offered the most helpful data to practice Palliative Care. The two NPs felt that the 7 x 7 Spiritual

⁹⁰ See Table VII.

assessment model was the most helpful. They said that this model was good, comprehensive and the most thorough. It would elicit helpful information. MDs felt that this model could distance patients because it was too detailed and long. SWs felt it was complicated, yet, it seemed the most thorough. They would be more interested in using it as SWs. SCs agreed with what was said by SWs and added that it was confusing to them. RCs agreed with what SCs said. The CM liked it, but it was too complicated.

The surveyed SCs scored the highest two different models that were not present in the survey. One of them scored the highest the model that he created which was based on picking and choosing from various models. This SC (1) explained that the model required much more work, but it was helpful because it adapted to individuals' needs. It allowed a more detailed spiritual assessment and used a relational language to communicate. The other SC (2) scored the highest the CASH existential model. The reasons behind the CASH scoring were: it could be used by the entire PC team, it was short and easy to remember, and it asked direct questions which could provide data that could be easily translated to the format used by the hospital chaplaincy charting (McKesson). Also, the CASH model included plan of care, asked about patients/family conflicts, and allowed the care provider to assess beyond what patients said.

The CM scored differently than everyone. She pointed out that FICA was the most useful format. She argued that this model was the most basic one used for more than ten years.

About FICA, MDs agreed with the CM that the model was basic and easy to remember. They added that it lacked of depth which chaplains could provide. NPs said that it was a good model but brief, not thorough enough for a chaplain assessment. SWs

perceived it as a short model, but it provided helpful, in-depth information. It was a good, quick assessment tool. It could be used to do the initial assessment, and in subsequent visits one might use other models presented in the survey. SCs said that FICA was easy to remember and integrate for clinicians in their practice, but it did not have room for psychological issues like fear. It lacked of depth. RCs made no comments on this model.

A data analysis summary of Table 7 would say that from the six Palliative Care subgroups (MDs, NPs, SWs, SCs, RCs and CM) representing four different specialties, the Dignity-Conserving Therapy model was the one which received the highest scores. It represented the preference of three out of the six subgroups and reflected the preference of three PC specialties out of four.

When considering chaplains' (SCs, RCs and the CM) responses to the survey, it is interesting to find that these three subgroups disagreed among each other about what assessment tool was the most helpful for Palliative Care practitioners. Actually, the three subgroups produced four different assessment tools as the most useful ones for the practice of PC.

Overall, this analysis shows evidence of the existence of intrinsic and extrinsic discrepancies in the quality and standards of practice of Palliative Care chaplaincy. This reality makes me wonder if this is one of the reasons that what chaplains assess/do is confusing for Palliative Care practitioners. I wonder how it is impacting PC team members' motivation to read chaplaincy charts. I wonder if this is making more difficult the integration of chaplaincy into the PC team function. I feel these could be themes worthy of future research in the field of Palliative Care chaplaincy.

c. FIELD NOTES SUMMARY

As it was established in the research methodology, during the interviewing and surveying part, I obtained some field notes to report. I feel these observations describe essential factors which directly impacted and made possible the successful completion of this research.

- During the interviewing process, all participants showed a significant interest in the research topic.
- Some of the interviewees expressed they were nervous or anxious during the interview.
- Some seemed to struggle finding the right words to communicate their experiences and convictions.
- Consistently, interviewees expressed interest on learning about the research findings.
- It was notable that interviewees answered questions to the best of their knowledge. They asked clarifying questions and often tried to make conversation about what I have learned from this research so far.
- Some participants expressed regrets about not being well prepared to offer better answers. I reassured them that the methodology used planned to access interviewees' most spontaneous answers, not elaborated answers.
- One participant asked if more spiritual assessment tools could be taught during chaplains' training.
- Approximately three interviewees brought copies of the spiritual assessments they used and utilized this material to answer the research questions.
- Overall, the target community expressed sensitivity regarding the value of chaplaincy practices and spiritual care for Palliative Care patients, families and team members.
- The target community showed knowledge regarding spirituality, its relevance in patient's care and the value of the chaplain role for Palliative Care.

d. RESEARCHER AND RESEARCHING TOOLS' EVALUATION

Continuing with the research's methodology and evaluations, a second survey was developed so the researcher and the researching tools could be evaluated by the target community. Palliative Care team members were asked to rate their answers to the questions utilizing the scale 1-5 in which 1 would represent "I strongly disagree" and 5 "I strongly agree." The five questions were:

1. Do you feel that the questions asked by the researcher were clear and easy to understand?
2. Do you feel that the questions asked were helpful to identify those aspects of PC chaplains' spiritual assessments that you consider useful for your clinical practice? Why?
3. Do you feel that the researcher allowed you to freely express your professional opinion regarding the subject of inquiry?
4. Do you feel that the methods used by the researcher allowed you to freely express your professional opinion regarding the subject of inquiry?
5. What else would you like to comment about the researcher and/or the topic of inquiry?

The results of this survey are detailed in Table 8. "Research's Assessment Questionnaire for the Palliative Care Team."⁹¹ A summary of the target community's answers would show that:

- Ten out of thirteen participants answered question one assigning it a value of 5. This ten strongly agreed that the research's questions were clear and easy to understand. Most of them did not provide any comments. One RC said that some questions seemed to overlap their answers while the CM said that the researcher was very professional and willing to offer clarification. From these thirteen participants, three scored the question with a 4. They agreed that the questions were clear and easy to understand. One of them was an MD who commented that the survey questions seemed vague, therefore required the researchers' assistance for clarification. The other two participants who scored 4 were SCs, but they did not make any comments.
- Eleven out of thirteen participants assigned a value of 5 to question number two, strongly agreeing that the questions asked in the research were helpful to identify those aspects of PC chaplains' spiritual assessments considered most useful for the individual PC practices. One MD commented that the questions really focused on what he or she really wanted to know from chaplain's assessment. The two RCs reflected on how much they learned from the questions asked. Only two individuals answered this question assigning a score of 4. These two seemed to agree that the questions asked met their purpose. One of these two was a SC who commented that she would like the researcher to ask her more questions or give examples to facilitate her answers. The second person was the CM who commented that chaplains have different practices; therefore, they will answer these questions differently.
- Twelve out of thirteen participants strongly agreed that the researcher allowed them to freely express their opinions about the subject of inquiry. Only one, a SC answered the third question with a score of 4. This SC did not provide any

⁹¹ See Table VIII.

comment. The only comment this question received came from the CM, who scored with 5, CM said, "Absolutely."

- The thirteen participants of this survey expressed that they strongly agree that the research methods used by the researcher allowed them to freely express their professional opinions regarding the subject of inquiry. The only comment made to this question came from a SC. This participant liked that there was oral sharing as well as reading and writing.
- The fifth question was an open-ended question. Its goal was to capture any feedback or comment made by research's participants about the researcher, the researching methods and procedures used. These were the comments:
MDs: "Very open. "Genuine interest in patient care." "Interesting experience for me." "Enjoyed focusing on the chaplain's role in Palliative Care." **NPs** said: "Helpful research to understand how spiritual care is practiced and documented." **SWs:** "I think it is interesting and appreciate being able to give feedback to, hopefully, improve Palliative Care services for team, patients, etc." "Thank you. Looking forward to results and how we can put them to work with Palliative Care." **SCs:** "Thank you for including me!" "Thanks. I eagerly look forward to hearing the results of your work! I feel it will have a great impact on our work as a Palliative Care team. Your demeanor was very respectful, collegial, inviting. Thank you!" **RCs:** "I will be interested in the conclusions and implications of the research with respect to improving Palliative Care to patients." "I would like to know what is most useful to the other members of the interdisciplinary team." **CM:** "Good research."

In reading the results of this survey, I can conclude that the target community had a strong interest in the findings of this investigation. It seems they had a positive research experience. The target community seemed to be expecting that the research results will positively impact the PC team functioning and the quality of patient care. In addition, participants seemed to have a positive experience with the researcher as well as with the methods and processes utilized. Those Surveyed expressed that researching tools were appropriate to learn about the topic of inquiry. Overall, the research participants expressed their appreciation for being selected to participate in the investigation. Some of them, the minority, made some positive comments which could be considered at the time of replicating this investigation in a different health care setting or at a later time within Roper St. Francis Healthcare.

e. **TEACHING GUIDELINES AND ACTIVITIES**

As the principal investigator of this research, I feel that the research question was answered when the research sample was validated and when the researching data was gathered, analyzed and phenomenologically reduced in the previous sections. However, as it was defined by the research's methodology, there is one expected outcome which has not yet been addressed. Based on the research findings, this outcome attempts to delineate a series of teaching guidelines to train chaplains who minister as Palliative Care practitioners. These guidelines will be presented and discussed with a certified ACPE supervisor to explore, from an educational perspective, its viabilities to equip PC chaplains with the findings of this research.

i. **Teaching Guidelines**

1. Palliative Care chaplaincy training should be developed upon the agreements obtained from the "Integrative Activities" section. The outcome of these activities is intended to be the result of a group process.
2. Palliative Care chaplains' training should continue to use the action-reflection-action model of CPE, intentionally addressing the themes suggested in the "Teaching Activity" section. This should be more intentionally integrated to verbatims, Interpersonal Relationships, Individual Supervision and Weekly Clinical Reflection Papers, among others.
3. Palliative Care chaplains should be taught to document and/or communicate spiritual assessments through a model of mentoring or apprenticeship. A more senior PC chaplain will coach a more junior PC chaplain to do so.
4. During the Palliative Care chaplaincy training, spiritual assessments will be sampled, presented and validated by the PC interdisciplinary team involving two or more PC specialties. Space for feedback and debate should be created.
5. This research should be replicated in other Palliative Care settings to pursue a longitudinal analysis and validate the quality of the acquired data.

ii. **Integrative Activities**

- Conduct a half day workshop with chaplains to define what we understand by spiritual assessment at Roper St. Francis.
- Build a tool or a 2.0 version of the Dignity-Conserving Therapy model improved with missing themes, adding sections to consider interventions,

outcomes and plans of care. Train chaplains to work with this format in an informal way.

- Conduct a second workshop with the PC team presenting/negotiating the themes identified in the 2.0 version of the Dignity-Conserving Therapy model with the intention of making of it a common tool used by the Roper St. Francis Palliative Care team. Yet, it might need to be simplified.
- Provide a training workshop to explore a unified way for chaplains to define and communicate what they do/assess based on this research's findings.
- Develop a program to educate PC practitioners on spiritual assessment.
- Provide a workshop to train chaplains on exploring case-effect and co-relations between culture, spirituality and bio-psychosocial and spiritual issues as they influence meaning-making, decision-making and end-of-life preferences.

iii. Teaching Activities. Didactics

In this section, I am proposing a series of didactics to conceptually train Palliative Care chaplains capable of performing spiritual assessments useful for the Roper St. Francis PC team. The themes of these didactics were conceived out of the research participants' answers and my own experience as a Palliative Care practitioner. At a first glance, it might look like there are too many didactics to accomplish. Yet, what I am suggesting is conceived from a developmental perspective. It is intended to be conceived as a continuing education program which, anyway, is a requirement to be Board Certified as a Professional Chaplain. I feel that the Clinical Pastoral Education method of learning, action-reflection-action, would be the most effective method to train chaplains in the use of these conceptual skills.

- Didactics and practical exercises on the following assessment tools: FICA, Amy Van Deurzen, and CASH.
- Didactic on Spiritual Care taxonomies, including spiritual isolation, spiritual concerns, spiritual distress and spiritual despair.
- Didactics on religious meaning-making and religious coping, especially at the end of life. There are expectations that chaplains will be experts at describing and clarifying these phenomena.
- Didactics to develop cultural assessment and competences. Themes should address cultural EOL views, idiosyncrasies, preferences, meaning-making, decision-making and family dynamics.
- Didactics in family systems and family dynamics.

- Didactics on emotions and emotional dynamics.
- Didactic on Body and Spiritual Assessment.
- Didactic on how religious practices, beliefs, and spiritual preferences impact patients' relations with caregivers, disease, decision-making and end-of-life preferences.
- Didactics on communication, theory and practice.
- Didactic on how family systems impact decision-making and end-of life preferences.
- Didactic on how emotions impact decision-making and end-of-life.
- Didactic on narrative theory and story-telling, end-of-life archetypes or narratives.
- Didactic on how to be present to patients' stories and how to hear in these stories patients'/families' end-of-life preferences.
- Didactic on how to use multiple sources to do spiritual assessments.
- Didactic on helpful and unhelpful psycho-spiritual coping mechanisms.
- Didactic on quality of life at the end-of-life.
- Didactic on theories of meaning-making, grief, relations and trust.
- Didactic on conflict mediation.
- Didactic on how to assess PC teammates' spiritual culture and preferences.
- Didactic on theories of anxiety and relational anxiety.
- Didactic on chaplaincy presence.
- Didactic on the use of prayer in Palliative Care chaplaincy.
- Didactic on the human search for purpose at the end-of-life.
- Didactic on hermeneutic of suspicion applied to Palliative Care family meetings.
- Didactic to assess theological dissonance.
- Didactic on chaplaincy interventions to co-create patient's and family's sense of peace.

iv. ACPE Supervisor Interview Results

As it was defined by the research methodology, a Certified Clinical Pastoral Education Supervisor was interviewed about the proposed "Teaching Guidelines." This activity had two phases. The first one consisted of presenting the research results to the CPE supervisor. This included the teaching guidelines. The second one was the interview itself. It consisted on an unstructured interview around the teaching guidelines' viability and appropriateness to train chaplains in PC spiritual assessment. These were the ACPE educator's recommendations:

3. The proposed teaching guidelines could help Palliative Care chaplains at Roper St. Francis to develop a more consistent practice.
4. It would be helpful to create a program to prepare staff chaplains as trainers of CPE students who express interest on receiving PC formation. This would be possible after students completed two or more CPE units.
5. The teaching guidelines should avoid using CPE vocabulary “outside” the standardized CPE practices. Terms such as the “CPE method of learning (action-reflection-action)” and “mentoring” should be changed for others to avoid confusion.
6. The recommended didactics could be presented by chaplains, Professional Advisory Committee⁹² members and/or other professionals skilled in the didactic theme.
7. The teaching guidelines could be helpful to prepare staff chaplains interested in pursuing Board certification as Palliative Care Chaplains through the Association of Professional Chaplains.
8. Staff chaplains might be the ones who benefit the most from this program. It seems too long to train CPE residents. They need to be exposed to a wider variety of chaplaincy scenarios beyond PC.
9. When documenting spiritual assessments, the incorporation of spiritual care and spirituality language will be important.
10. A didactic on Charleston demographic religious traditions and their end-of-life perspectives could be beneficial to be added to the “Teaching Activities.”
11. Training about ethic consults, bio-ethics, Catholic Directives and end-of-life issues would enrich the didactic section.
12. A didactic on humanist/creative PC chaplaincy interventions during patient’s end-of-life would be helpful.
13. Staff chaplains could present didactics to the Roper St. Francis Palliative Care team.
14. Roper St. Francis could create a PC chaplaincy program to train chaplains from the community of Charleston based on the proposed teaching guidelines. It would be a continuing education program open to chaplains serving in various health care organizations beyond Roper St. Francis. It could start as a satellite program to train these chaplains in Palliative Care and spiritual assessment.

As I interviewed the ACPE supervisor, I had the perception that some of the research findings called her attention. One of these findings was what I perceived as an

⁹² PAG. This committee is an ACPE Accreditation standard set for CPE programs. The members of this committee could be community clergy representatives from various faith and religious traditions. Also, professionals from various specialties, health care related, could be part of it.

inconsistent chaplaincy practice, and the potential impact it might be having on PC team members, and their interest to read chaplains' clinical documentation.

Overall, the ACPE supervisor seemed motivated by the research, its findings and the proposed "Teaching Guidelines." She identified that resident chaplains could benefit from this type of formation, but staff chaplains could be the ones who might benefit the most. This ACPE supervisor expressed optimism around the possibility of utilizing the proposed guidelines and activities to train chaplains of the Charleston, SC community in the themes of Palliative Care and spiritual assessment.

CHAPTER FIVE

CONCLUSIONS AND FINDINGS

a. METHODOLOGICAL FINDINGS

The target community met the quality indicator's criteria described in the activity number two of this research's methodology:⁹³ 1) more than five PC team members participated in the interviews; 2) the sample comprised a diverse interdisciplinary representation; and 3) the percentage of questions answered exceeded the following indicators:

- More than two chaplains involved with PC services participated in the interview, answering 80% or more of the questions.
- More than one resident and staff chaplain participated in the research.
- More than three PC team members representing two or more disciplines participated in the interviews, answering 80% or more of the questions.

The chosen phenomenologic research methodology demonstrated to be effective to produce insightful literature in the field of Palliative Care chaplaincy spiritual assessment. The completion of this paper and the acquisition of meaningful data proved the worth of this methodological approach. The majority of the research participants found the research and its tools as appropriate to gather meaningful data pertinent to the topic of inquiry.

b. THEOLOGICAL FINDINGS

The second finding of this research is theological. It is related to my theology of Palliative Care chaplaincy and spiritual assessment in the context of a team. As I was challenged by the academic exercise of thinking theologically about what I was investigating, I discovered the concept of the "Social Trinity." In so doing, I became

⁹³ See page 13-14.

aware of the Trinity as the Christian relational paradigm for the first time in my life. Thanks to this finding, I started to reflect on the Palliative Care chaplaincy role relationally. I based my reflection on the principles of justice, differentiated professional practice and team work equality. Also, the trinitarian reflection allowed me to discover a theology which says that God is consistently revealed in history as Father, Son and Holy Ghost, after what could be perceived as a sort of spiritual assessment. This divine assessment seemed to guide God to intervene in the History of Salvation and, of course, in the church. Essentially, these theological reflections became a new source of pastoral authority for me as it empowered me as a chaplain member of the Palliative Care team.

c. BIBLICAL FINDINGS

The third finding of my research was biblical. I rediscovered the Israelite priest in Lev. 13:1-8 as the ancient PC chaplaincy practitioner. In this research, I rediscovered the “kohen” as spiritual assessment practitioners who observed the body to evaluate ill individuals’ spiritual conditions. Also in Mark 5:24-34, I rediscovered Jesus Christ as a paradigm to my modern practice of PC chaplaincy. For the first time since I became a chaplain, I was able to read Mark 5:24-34 and realize Jesus’ spiritual assessment practice in the midst of his society or what I entertained as “His Palliative Care interdisciplinary team.”

d. FINDINGS FROM THE INTERVENTIONS MADE

As I asked the research target community and myself the question, “what is it that chaplains assess which was perceived as useful for the Roper St. Francis Palliative Care team?”, I learned that:

- The entire Roper St. Francis Palliative Care team acknowledged the relevance of faith and spirituality for their patients and had a significant interest in the research findings.
- In caring for patients, Palliative Care practitioners at least screened their patients for spiritual issues.
- The Palliative Care team recognized chaplains as the spiritual care experts capable of doing more in-depth spiritual assessments and interpreting patients' faiths, cultures, spiritualities and relational-emotional dynamics when considering end-of-life. Emotional assessment was the only chaplaincy spiritual assessment theme that all the PC practitioners agreed about its relevance for PC chaplaincy.
- Chaplains involved with the Palliative Care services were not on the same page regarding what and how to assess. At times, their assessment interest resonated with other PC practitioners, but most of the time they pursued more individualized preferences.
- In the entire PC team, chaplains were the only ones who expressed concerns about assessing patients and families as much as assessing the spiritual preferences and competences of PC teammates.
- Other than chaplains, the PC specialty that contributed with more meaningful data were the medical doctors. Chaplains offered a good variety of spiritual theme assessments helpful for the PC team, but only a handful of themes were echoed by other PC practitioners.
- Other themes were suggested by a subgroup of participants as relevant for PC chaplaincy spiritual assessments. These themes were: A) assess what motivates patients to access certain beliefs or practices to avoid or cope. B) assess if productive trust is needed, C) assess when prayer and chaplaincy presence are necessary to deescalate existential anxiety and/or relational anxiety, D) assessment of patient's search for purpose, spiritual distress and patient's religious coping limitations, and E) assess patients' spiritual resources.
- From the three validated assessment tools presented to the research participants, the one which received recognition the most regarding its helpfulness was the "Dignity-Conserving Therapy" model.
- A research "accidental" finding registered multiple chaplaincy reports indicating that chaplaincy presence, after a PC family meeting concluded, contribute to families making end-of-life decisions in a matter of hours instead of days. It seems to improve PC outcomes reducing patients and family members' length of hospital stay, unnecessary treatments and prolonged suffering.

e. VIABILITY OF TEACHING GUIDELINES

I feel that all the bullet points suggested by the Certified ACPE supervisor were valid and would enrich the "Teaching Guidelines" and "Teaching Activity" sections

respectively. I found particularly interesting the suggestion of utilizing the research “Teaching Guidelines” and “Activities” as a viable means to impact the Roper St. Francis immediate community enriching the presence, expertise and practice of professional chaplaincy practitioners. It is for all of these reasons that I recommend integrating the ACPE supervisor recommendations to what I initially offered.

f. RESEARCH CONTRIBUTIONS TO THE RESEARCHER

I started this investigation feeling that my needs and motivations to answer the research question were only mine. It was a nice surprise to find out that I was not alone. I discovered that chaplains, medical doctors, nurse practitioners and social workers at Roper St. Francis shared my concerns. They exhibited genuine interest in the research topic and its discoveries. It became evident to me when twelve, out of fourteen, PC professionals consented to voluntarily participate in the research, sharing their expertise.

I was surprised by the overwhelming response the Palliative Care team, Pastoral Care department and my hospital gave me. I did not know I had so many people interested on what I was learning nor willing to support me during this journey. This blessing showed me something which humbled me, even more. I learned that my capacity to advance in life acquiring a higher academic degree was directly proportional to the quality of my family and the community that surrounds me, whether it is the D. Min cohort group, Pullen Memorial Baptist church or my professional colleagues. Someone said: “It take a village to raise a child.” Today, I feel like that child who received the necessary guidance and support to grow up. I am thankful to my “village” for giving me all of that.

Existentially and historically, this research has been rewarding to me. Five years ago I was not sure about my ability to complete such a work in a second language. The exercise of writing it and obtaining the Institutional Review Board approval to inquire about my research topic brought me a lot of satisfaction. It made me feel proud, humble and grateful. There is a chance this is the first research conceived and developed by a chaplain at my ministerial setting performed according scientific's and IRB's rigorousness.

This research experience affirmed me as a Cuban-American. As such, resilience and creativity were two cultural skills/values which proven helpful in more than one occasion. They helped me navigating the phase of defining what I wanted to research, deal with the institutional requirements of both, my divinity school and hospital, and discover a biblical and theological rational which enlightened my research and praxis.

I feel encouraged by the findings of this investigation. It feels good to know that, as a Palliative Care chaplain, I have a lot to do and offer at my ministerial place. As a Spiritual Care department we can continue to grow in organization, standards of practice and quality. We have plenty to give back to our community training the present and future generation of professional Palliative Care chaplains. My research proved that a standardized spiritual assessment practice for Palliative Care chaplaincy was needed and, I believe, possible. I feel this is my new professional goal. This is one of the directions I would like to pursue in my chaplaincy ministry. I am looking forward to it.

I finished this investigation feeling that I contributed to the literature researching in the field of Palliative Care chaplaincy and spiritual assessment. The research's findings are already impacting my Clinical Pastoral Education supervisory process. This research

is shaping the type of student chaplains I am training and will train for generations. The biblical/theological rationale I utilized in this paper is informing my theory position papers as a CPE supervisor. The research results and the teaching guidelines are defining my supervisory style and the curriculum I am teaching.

In summary, I learned how to professionally utilize the phenomenological method of research which is easier to read about than to systematically practice. I learned more about the significance of boundaries, role identity, role diffusion, and role authority as the project moved from prospective to implementation to reflection to praxis. Not merely with this project did these concepts need differentiation, but also in my professional life as supervisory student and in my personal life as husband and father.

Finally, there was a "parallel process" which Dr. Dickens, D. Min advisor, helped me explore between the project and my own life. This "parallel process" is reflected in the similarities between my resistance to growth and change perspectives which is something my target community might be experiencing as well. A simple way of acknowledging this "parallel process" is that some of the research participants were surprised with the research findings but have done little to make changes. Perhaps, this represents an opportunity for me to continue advocating for the competency of Palliative Care chaplains while offering what I learned about dealing with the resistance to change.

g. RESEARCH CONTRIBUTIONS TO THE MINISTRY SETTING

I am under the impression that this research brought my department and me closer to the Palliative Care department and its team. As I informally shared some of my research findings with other colleagues, I have seen how they got curious and surprised by what I have learned.

This research has motivated reflections at my ministerial place. It presented new opportunities to improve the Palliative Care interdisciplinary collaboration with the potential of improving patient care outcomes. In addition to all of this, the “Teaching Guidelines” and “Activities” are offering opportunities for staff chaplains to pursue continuing education as professional chaplains. Also, they are creating opportunities for staff chaplains to pursue the only advanced certifications offered beyond the Board Certification as a Professional Chaplain⁹⁴. It might contribute to my department’s participation in community outreach programs which is one of the Roper St. Francis Healthcare goals.

In conclusion, I want to share that at least another health care organization showed interest on replicating this research. Also, comments have been made at my ministerial place regarding the possibility of publishing part of the research findings.

At a personal level, I am excited about what I have learned as it is directly impacting my formation as a CPE supervisor. So far, this research changed the way I think about chaplaincy and what I teach to my students.

⁹⁴ This certification is offered by the Association of Professional Chaplains Inc.

APPENDIX A

Board-Certified Chaplain

a. Credentials of the Board-Certified Chaplain.

- Obtained a bachelor's degree from a college or university that is appropriately accredited.
- Obtained an appropriately accredited master's degree in theological studies or its equivalent.
- Be ordained, commissioned, or similarly recognized by an appropriate religious authority according to the standard practice and policy of that authority.
- Completed four units (1600 hours) of Clinical Pastoral Education as accredited by the Association for Clinical Pastoral Education (ACPE), the United States Conference of Catholic Bishops Commission on Certification and Accreditation, or the Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP); one of these units may be an equivalency.
- Current endorsement by a recognized religious faith group for ministry as a chaplain.
- Met competencies for chaplaincy as established by the Spiritual Care Collaborative.
- Remain accountable to the endorsing faith group, employer, and certifying body.
- Affirm and practice chaplaincy according to the Common Code of Ethics.
- Maintain membership in a certifying body by participating in a peer review every five years, documenting at least 50 hours of continuing education each year, and providing documentation of endorsement with her or his faith tradition every five years.⁹⁵

c. Chaplaincy Care with Patients and Families

Standard 1, Assessment: The chaplain gathers and evaluates relevant data pertinent to the patient's situation and/or bio-psycho-social-spiritual/religious health.

Standard 2, Delivery of Care: The chaplain develops and implements a plan of care to promote patient well-being and continuity of care.

Standard 3, Documentation of Care: The chaplain enters information into the patient's medical record that is relevant to the patient's medical, psycho-social, and spiritual/religious goals of care.

Standard 4, Teamwork and Collaboration: The chaplain collaborates with the organization's interdisciplinary care team.

⁹⁵ Association of Professional Chaplains. "Standards of Practice for Professional Chaplains in Acute Care Settings." *Association of Professional Chaplains* (June 2015). 3, http://www.professionalchaplains.org/files/professional_standards/standards_of_practice/standards_practice_professional_chaplains_acute_care.pdf (Accessed August 2, 2015).

- Standard 5, Ethical Practice: The chaplain adheres to the Common Code of Ethics, which guides decision making and professional behavior.
- Standard 6, Confidentiality: The chaplain respects the confidentiality of information from all sources, including the patient, medical record, other team members, and family members in accordance with federal and state laws, regulations, and rules.
- Standard 7, Respect for Diversity: The chaplain models and collaborates with the organization and its interdisciplinary team in respecting and providing culturally competent patient-centered care.

d. Chaplaincy Care for Staff and Organization

- Standard 8, Care for Staff: The chaplain provides timely and sensitive chaplaincy care to the organization's staff via individual and group interactions.
- Standard 9, Care for the Organization: The chaplain provides chaplaincy care to the organization in ways consonant with the organization's values and mission statement.
- Standard 10, Chaplain as Leader: The chaplain provides leadership in the professional practice setting and the profession.

e. Maintaining Competent Chaplaincy Care

- Standard 11, Continuous Quality Improvement: The chaplain seeks and creates opportunities to enhance the quality of chaplaincy care practice.
- Standard 12, Research: The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research.
- Standard 13, Knowledge and Continuing Education: The chaplain assumes responsibility for continued professional development, demonstrates a working and current knowledge of current theory and practice, and integrates such information into practice.⁹⁶

f. Scope of Services

Chaplains provide a broad and diverse range of services including:

- An assessment and determination of a plan of care that contributes to the overall care of the patient that is measurable and documented.
- Participating in interdisciplinary teamwork and collaboration.
- Providing spiritual/religious resources, (e.g., sacred texts, Shabbat candles, music, prayer rugs, rosaries, etc.).
- Offering rituals, prayer, and sacraments.
- Contributing in ethics, e.g., through a primary chaplaincy relationship, participation on an ethics committee or consultation team, and/or participation on an institutional review board.

⁹⁶ Association of Professional Chaplains, 1.

- Helping interpret and broker cultures and faith traditions that impact health care practice and decisions.
- Educating and consulting with the health care staff and the broader community
- Building relationships with local faith communities and their leaders on behalf of the health care organization.
- Offering care and counsel to patients and staff regarding dynamic issues, e.g., loss/grief, spiritual/religious struggle as well as strengths, opportunities for change and transformation, ethical decision making, difficult communication or interpersonal dynamic situations.
- Providing leadership within the health care organization and within the broader field of chaplaincy.⁹⁷

g. Detailed Expectations for Professional Palliative Care Chaplains

- It is expected that PC chaplains perform spiritual assessments with more accuracy, identifying obstacles which could potentially hinder the patient's care.
- It is expected that PC chaplains utilize validated assessments instruments.
- Spiritual assessments and plans of care should be updated with more frequency.
- It is expected that the PC chaplain be more culturally competent and capable of developing a more thorough cultural assessment.
- It is expected that the PC chaplain have access to medical records, so he/she can document spiritual assessments, making them accessible for the IDT.
- It is expected that PC chaplains participate in IDT meetings, contributing with their assessments to the holistic plan of care for patients and families facing life threatening illnesses and/or are at the end of their lives.
- It is expected that PC chaplains participate actively in PC family meetings.
- It is expected that PC chaplains have knowledge of the other PC team disciplines, recognizing their values and expertise while remaining aware of how he/she can contribute. The PC chaplain must have good professional boundaries.
- The PC chaplain must be able to integrate other disciplines' assessments to patients and families plan of care. Simultaneously, the PC chaplain must remain as patients and families advocate honoring their goals of care and/or preferences.
- The PC chaplain must possess good skills in understanding group dynamics, processes and development.
- The PC chaplain must follow the same bio-ethics principles as the rest of the PC team. In addition, PC chaplains must assess ethics cases based on the principle of double-effect, and must advocate for patients according to their religious directives, and cultural/idiosyncratic preferences.
- It is expected that the PC chaplain be more knowledgeable of HIPPA and State regulations concerning communication of information and confidentiality, while

⁹⁷Association of Professional Chaplains, 3-4.

considering factors such as situation, patients' and families' characteristics, type of information which is being handled, and who must access to it.

- It is expected that the PC chaplain be more involved with their team self-care practices.
- It is expected that the PC chaplain contribute more to their organization, leadership relationships, increase the quality of services, promote the PC culture and develop research within the institutional guidelines.
- Finally, it is expected of PC chaplains that they continue educating themselves in what concerns PC-End of Life issues and at the same time contribute to the education of other team members.⁹⁸

h. Access and Notation of Documentation

- History and physical history of patient (to learn about diagnosis, prognosis, psycho-social/spiritual history from MD/DO assessment).
- Progress notes.
- Nurse's notes.
- Social worker's notes.
- Case management's notes.
- Interdisciplinary plan of care.
- Advance directives.

i. Notation

- Reason for encounter (i.e., request for total pain management, goals of care, compassionate extubation, centers for Medicare and Medicaid services, and Joint Commission requirements).
- Spiritual/religious preferences and desire for, or refusal of, ongoing chaplaincy care.
- Critical elements of spiritual/religious assessment.
- Patient/family-desired outcome with regard to care plan.
- Chaplain's plan of care relevant to patient/family goals.
- Indication of referrals made by chaplain on behalf of patient/family.
- Relevant outcomes resulting from chaplain's intervention.⁹⁹

⁹⁸ Association of Professional Chaplains. "Standards of Practice for Professional Chaplains in Hospice and Palliative Care." *Association of Professional Chaplains* (June 2015): 7-16, http://www.professionalchaplains.org/files/professional_standards/standards_of_practice/standards_of_practice_hospice_palliative_care.pdf (Accessed August 2, 2015).

⁹⁹ Ibid, 8-9.

APPENDIX B

Chaplain's semi-structured interviewing questions

1. Are you a resident chaplain, a staff chaplain, or a pastoral care clinical manager?
2. Have you been exposed to the PC team work at Roper St. Francis, continuously or not, for at least three months?
3. In a few words, what is it that you do as a member of the PC team?
4. As a Palliative Care team member, what type of information do you try to obtain in order to do what you do?
5. How do you obtain that information?
6. Have you performed spiritual assessments on PC patients? What do you assess?
7. Do you follow a specific spiritual assessment model? Which one do you use? Why do you use that particular spiritual assessment model instead of using others?
8. From your assessment, what do you consider is helpful for the PC interdisciplinary team work and functioning? Why?
9. Can you recall anything you said or did with a PC patient and/or family which you consider was helpful for the PC team?
10. Based on your personal/professional experience, what is it that a PC chaplain should assess? How will this assessment be helpful to you/your discipline and the Palliative Care team?

APPENDIX C

PC team semi-structured interviewing questions

1. Are you a team member for the Roper St. Francis PC program?
2. Have you been exposed to the PC team work at Roper St. Francis, continuously or not, for at least three months?
3. In a few words, what is it that you do as a member of the PC team?
4. What type of information do you try to obtain in order to do what you do?
5. How do you obtain that information?
6. Have you ever worked with one of the hospital chaplains?
7. What do you understand by spiritual assessment? Are you familiar with any specific model? Do chaplains who work with you use any specific model that you are aware of?
8. Have you ever been exposed to a spiritual assessment?
9. What have you found helpful from this/these spiritual assessments?
10. Can you recall anything a chaplain said or did with a PC patient and/or family which you considered to be helpful to what you do as a PC team member?
11. Based on your personal/professional experience, what is it that a PC chaplain should assess? How will this assessment be helpful to you, your discipline and your work?

APPENDIX D

Survey Tools

a. FICA Spiritual History Tool

F - Faith and Belief

"Do you consider yourself spiritual or religious?" or "Is spirituality something important to you" or "Do you have spiritual beliefs that help you cope with stress/ difficult times?" (Contextualize to reason for visit if it is not the routine history).

If the patient responds "No," the health care provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature. (The question of meaning should also be asked even if people answer yes to spirituality)

I - Importance

"What importance does your spirituality have in our life? Has your spirituality influenced how you take care of yourself, your health? Does your spirituality influence you in your healthcare decision making? (e.g. advance directives, treatment etc.)

C - Community

"Are you part of a spiritual community? Communities such as churches, temples, and mosques, or a group of like-minded friends, family, or yoga, can serve as strong support systems for some patients. Can explore further: Is this of support to you and how? Is there a group of people you really love or who are important to you?"

A - Address in Care

"How would you like me, your healthcare provider, to address these issues in your healthcare?" (With the newer models including diagnosis of spiritual distress A also refers to the Assessment and Plan of patient spiritual distress or issues within a treatment or care plan.¹⁰⁰

¹⁰⁰ Christina M. Puchalski., MD, "FICA Spiritual History Tool," *GW School of Medicine & Health Sciences* (1996), <https://smhs.gwu.edu/gwish/clinical/fica/spiritual-history-tool>(Accessed October 11, 2015).

b. Description of the 7 x 7 Model

The 7 x 7 model for spiritual assessment has two broad divisions: a holistic assessment and the multi-dimensional spiritual assessment.

These are illustrated in Figure 1.

Holistic Assessment	Spiritual Assessment
Medical (Biological) Dimension	Beliefs and Meaning
Psychological Dimension	Vocation and Obligations
Family Systems Dimension	Experience and Emotions
Psycho-Social Dimension	Courage and Growth
Ethnic, Racial, Cultural Dimension	Rituals and Practice
Social Issues Dimension	Community
Spiritual Dimension	Authority and Guidance

Figure1. The 7 x 7 Model for Spiritual Assessment

The 7 x 7 model. Holistic Assessment

The holistic assessment looks at six dimensions of a person's life.

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?

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

Family Systems Dimension: Are there at present, or have there been in the past, patterns within the person's relationships with other family members which have contributed to or perpetuated present problems?

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?

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?

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

The 7 x 7 model. Spiritual Assessment

The spiritual assessment looks at seven dimensions of a person's spiritual life.

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)?

Vocation and Obligations: Do the persons' 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 atonement or otherwise essential to this person's sense of duty?

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

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?

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?

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?

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?¹⁰¹

¹⁰¹ George Fitchett. D. Min. "The 7 x 7 Model for Spiritual Assessment: A Brief Introduction and Bibliography." *Department of Religion, Health, and Human Values*. Rush University Medical Center. Chicago, Illinois, <https://www.rushu.rush.edu/servlet/Satellite?blobcol=urfile&blobheader=application%2Fpdf&blobkey=id&blobnocache=true&blobtable=document&blobwhere=1144357138306&sbinary=true> (Accessed October 11, 2015).

c. Model of Dignity and Dignity-Converting Interventions for Patients Nearing Death

Factors/Subthemes	Dignity-Related Questions	Therapeutic Interventions
Symptom distress Physical distress	“How comfortable are you?” “Is there anything we can do to make you more comfortable?”	Vigilance to symptom management Frequent assessment Application of comfort care
Psychological distress	“How are you coping with what is happening to you?”	Assume a supportive stance Empathetic listening Referral to counseling
Medical uncertainty	“Is there anything further about your illness that you would like to know?” “Are you getting all the information you feel you need?”	Upon request, provide accurate, understandable information and strategies to deal with possible future crises
Death anxiety	“Are there things about the later stages of your illness that you would like to discuss?”	Upon request, provide accurate, understandable information and strategies to deal with possible future crises
Level of independence	“Has your illness made you more dependent on others?”	Have patients participate in decision making, regarding both medical and personal issues
Cognitive acuity	“Are you having any difficulty with your thinking?”	Treat delirium When possible, avoid sedating medication(s)
Functional capacity	“How much are you able to do for yourself?”	Use orthotics, physiotherapy, and occupational therapy
Dignity-Conserving Repertoire		

Dignity-conserving perspectives Continuity of self	“Are there things about you that this disease does not affect?”	Acknowledge and take interest in those aspects of the patient’s life that he/she most values See the patient as worthy of honor, respect, and esteem
Role preservation	“What things did you do before you were sick that were most important to you?”	Acknowledge and take interest in those aspects of the patient’s life that he/she most values See the patient as worthy of honor, respect, and esteem
Maintenance of pride	“What about yourself or your life are you most proud of?”	Acknowledge and take interest in those aspects of the patient’s life that he/she most values See the patient as worthy of honor, respect, and esteem
Hopefulness	“What is still possible?”	Encourage and enable the patient to participate in meaningful or purposeful activities
Autonomy/control	“How in control do you feel?”	Involve patient in treatment and care decisions
Generativity/legacy	“How do you want to be remembered?”	Life project (e.g., making audio/video tapes, writing letters, journaling) Dignity psychotherapy
Acceptance	“How at peace are you with what is happening to you?”	Support the patient in his/her outlook Encourage doing things that enhance his/her sense of well-being (eg, meditation, light exercise, listening to music, prayer)

Resilience/fighting spirit	“What part of you is strongest right now?”	Support the patient in his/her outlook Encourage doing things that enhance his/her sense of well-being (e.g., meditation, light exercise, listening to music, prayer)
Dignity-conserving practices Living in the moment	“Are there things that take your mind away from illness, and offer you comfort?”	Allow the patient to participate in normal routines, or take comfort in momentary distractions (e.g., daily outings, light exercise, listening to music)
Maintaining normalcy	“Are there things you still enjoy doing on a regular basis?”	Allow the patient to participate in normal routines, or take comfort in momentary distractions (eg, daily outings, light exercise, listening to music)
Finding spiritual comfort	“Is there a religious or spiritual community that you are, or would like to be, connected with?”	Make referrals to chaplain or spiritual leader Enable the patient to participate in particular spiritual and/or culturally based practices
Social Dignity Inventory		
Privacy boundaries	“What about your privacy or your body is important to you?”	Ask permission to examine patient Proper draping to safeguard and respect privacy

Social support	“Who are the people that are most important to you?” “Who is your closest confidante?”	Liberal policies about visitation, rooming in Enlist involvement of a wide support network
Care tenor	“Is there anything in the way you are treated that is undermining your sense of dignity?”	Treat the patient as worthy of honor, esteem, and respect; adopt a stance conveying this
Burden to others	“Do you worry about being a burden to others?” “If so, to whom and in what ways?”	Encourage explicit discussion about these concerns with those they fear they are burdening
Aftermath concerns	“What are your biggest concerns for the people you will leave behind?”	Encourage the settling of affairs, preparation of an advanced directive, making a will, funeral planning

d. Survey Questionnaire for the Palliative Care Team

Please, rate the below questions using the scale that goes from 1 to 5. Circle one of the five numbers considering that 1 is disagree and 5 strongly agree. When appropriate, elaborate the reasons of your score.

Do you feel that the questions asked by the researcher were clear and easy to understand?

1 2 3 4 5

Comment:

Do you feel that the questions asked were helpful to identify those aspects of PC chaplains' spiritual assessments that you consider useful for your clinical practice? Why?

1 2 3 4 5

Comment:

Do you feel that the researcher allowed you to freely express your professional opinion regarding the subject of inquiry?

1 2 3 4 5

Comment:

Do you feel that the methods used by the researcher allowed you to freely express your professional opinion regarding the subject of inquiry?

1 2 3 4 5

Comment:

What else would you like to comment about the researcher and/or the topic of inquiry?

APPENDIX E

Leviticus ויקרא 13:1-8

א 1 And the LORD spoke unto Moses and unto Aaron, saying:

ב 2 When a man shall have in the skin of his flesh a rising, or a scab, or a bright spot, and it become in the skin of his flesh the plague of leprosy, then he shall be brought unto Aaron the priest, or unto one of his sons the priests.

ג 3 And the priest shall look upon the plague in the skin of the flesh; and if the hair in the plague be turned white, and the appearance of the plague be deeper than the skin of his flesh, it is the plague of leprosy; and the priest shall look on him, and pronounce him unclean.

ד 4 And if the bright spot be white in the skin of his flesh, and the appearance thereof be not deeper than the skin, and the hair thereof be not turned white, then the priest shall shut up him that hath the plague seven days.

ה 5 And the priest shall look on him the seventh day; and, behold, if the plague stay in its appearance, and the plague be not spread in the skin, then the priest shall shut him up seven days more.

ו 6 And the priest shall look on him again the seventh day; and, behold, if the plague be dim, and the plague be not spread in the skin, then the priest shall pronounce him clean: it is a scab; and he shall wash his clothes, and be clean.

ז וְאִם-פִּשְׁעָה תִפְשָׁה הַמִּקְפַּחַת בְּעוֹר, אַחֲרֵי הִרְאָתוֹ אֶל-
הַכֹּהֵן לְטַהַרְתּוֹ; וְנִרְאָה שְׁנִיתָ, אֶל-הַכֹּהֵן.
7 But if the scab spread abroad in the skin,
after that he hath shown himself to the priest
for his cleansing, he shall show himself to
the priest again.

ח וְנִרְאָה, הַכֹּהֵן, וְהִנֵּה פִשְׁעָה הַמִּקְפַּחַת, בְּעוֹר--וְנִטְמָאוּ
הַכֹּהֵן, צָרַעַת הוּא. {פ}
8 And the priest shall look, and, behold, if
the scab be spread in the skin, then the
priest shall pronounce him unclean: it is
leprosy. {P}¹⁰²

¹⁰² Mechon-Mamre. <http://www.mechon-mamre.org/p/pt/pt0313.htm> (Accessed September 12, 2015).

APPENDIX F

Kata Markon 5:24-34

²⁴ και απηλθεν μετ αυτου και ηκολουθει αυτω οχλος πολυς και συνεθλιβον αυτον
²⁵ και γυνη ουσα εν ρυσει αιματος δωδεκα ετη
²⁶ και πολλα παθουσα υπο πολλων ιατρων και δαπανησασα τα παρ αυτης παντα
και μηδεν ωφεληθεισα αλλα μαλλον εις το χειρον ελθουσα
²⁷ ακουσασα τα περι του ιησου ελθουσα εν τω οχλω οπισθεν ηψατο του ιματιου
αυτου
²⁸ ελεγεν γαρ οτι εαν αφωμαι καν των ιματιων αυτου σωθησομαι
²⁹ και ευθυς εξηρανθη η πηγη του αιματος αυτης και εγνω τω σωματι οτι ιαται
απο της μαστιγος
³⁰ και ευθυς ο ιησους επιγνους εν εαυτω την εξ αυτου δυναμιν εξελθουσαν
επιστραφεις εν τω οχλω ελεγεν τις μου ηψατο των ιματιων
³¹ και ελεγον αυτω οι μαθηται αυτου βλεπεις τον οχλον συνθλιβοντα σε και λεγεις
τις μου ηψατο
³² και περιεβλεπετο ιδειν την τουτο ποιησασαν
³³ η δε γυνη φοβηθεισα και τρεμουσα ειδυια ο γεγονεν αυτη ηλθεν και
προσεπεσεν αυτω και ειπεν αυτω πασαν την αληθειαν
³⁴ ο δε ειπεν αυτη θυγατηρ η πιστις σου σεσωκεν σε υπαγε εις ειρηνην και ισθι
υγιης απο της μαστιγος σου¹⁰³

Mark 5:24-34

24 So he went with him. And a large crowd followed him and pressed in on him.
25 Now there was a woman who had been suffering from hemorrhages for twelve
years. 26 She had endured much under many physicians, and had spent all that
she had; and she was no better, but rather grew worse. 27 She had heard about
Jesus, and came up behind him in the crowd and touched his cloak, 28 for she
said, "If I but touch his clothes, I will be made well." 29 Immediately her
hemorrhage stopped; and she felt in her body that she was healed of her disease.
30 Immediately aware that power had gone forth from him, Jesus turned about in
the crowd and said, "Who touched my clothes?" 31 And his disciples said to him,
"You see the crowd pressing in on you; how can you say, 'Who touched me?'"
32 He looked all around to see who had done it. 33 But the woman, knowing what
had happened to her, came in fear and trembling, fell down before him, and told
him the whole truth. 34 He said to her, "Daughter, your faith has made you well;
go in peace, and be healed of your disease."¹⁰⁴

¹⁰³ 1881 Westcott-Hort New Testament (WHNU)
<https://www.biblegateway.com/passage/?search=Mark+5%3A24-34&version=WHNU> (Accessed
September 26, 2015).

¹⁰⁴ Bible, New Revised Standard Version (NRSV).

APPENDIX G

Part II: Old Testament

I believe that in the Old Testament are found the roots of my Christian faith and ministerial practice. It is for this reason that, when considering the biblical foundations of this research, I had to return to the Old Testament. This premise was the one which, after much consideration, made me settle with the portion of the Scripture that we can find in Leviticus 13:1-8.

The reasons which led me to choose the pericope in question were two: A) it belongs to the Pentateuch or Torah; therefore, this pericope is present at the core of the Jewish tradition, and B) it teaches us about the ministerial role of my ministerial ancestors as it was commanded by God.

As I stated earlier, my plan to work with this pericope consists on presenting a brief introduction to the book of Leviticus, followed by some considerations regarding Israel's priesthood and *tzara'at*. Later on, I will develop an exegetic exercise based on role and narrative analysis, to end with hermeneutic considerations concerning the overall goal of my research project.

a. Introduction to Leviticus

Leviticus (ויקרא) is the third book of the Torah. Its Hebrew name is *Vayyikra*¹⁰⁵ ("And He called").¹⁰⁶ "According to the Masoretic tradition, Leviticus has 27 chapters

¹⁰⁵ Philip Birnbaum, *A Book of Jewish Concepts*. (New York: Hebrew Publishing Co. 1964), 182.

¹⁰⁶ Geoffrey Wigoder, *The New Encyclopedia of Judaism*. (Washington Square, New York: New York University Press, 2002), 476.

and 859 verses ... Jewish traditions maintain that Leviticus, in common with the other books of the Pentateuch, was directed by God to Moses.”¹⁰⁷

Regarding Leviticus’ authorship, Bryan D. Bibb states that there is not an agreement about who wrote the book.¹⁰⁸ Jewish scholars argued and disagreed about the origin and formation of this book. An accepted conjecture established that there is no evidence to indicate that this book is older than the epoch of Moses. Some academics believe that the book in question comes from a priestly source “P” and another source called “H.” Others argue that the book is a continuation of Exodus.¹⁰⁹ It seems that a consensus could be found around the idea that this book is a collection of writings, laws and traditions¹¹⁰ glued by its rituals.¹¹¹

Bryan D. Bibb argues that the book of Leviticus has been neglected as a “ ... subject of literary-critical study...” Simultaneously, this author says that Leviticus represents “ ... an incredibly rich resource for the history of Israelite religion and of Jewish ritual theology ...”¹¹²

¹⁰⁷ Geoffrey Wigoder, 476.

¹⁰⁸ Bryan D Bibb, “Ritual Words and Narrative Worlds in the Book of Leviticus,” *T & T Clark. Library of Biblical Studies*. New York – London (2009): 5-12, <http://web.b.ebscohost.com.ezproxy.gardner-webb.edu/ehost/ebookviewer/ebook/bmxlYmtfXzM3ODUwOV9fQU41?sid=fe0553c3-d5db-4ca6-bc50-ca48b8a92246@sessionmgr111&vid=1&format=EB&rid=1> (Accessed May 13, 2015).

¹⁰⁹ Ibid, 12.

¹¹⁰ Geoffrey Wigoder, 2000, 476-477.

¹¹¹ Bryan Bibb, 10.

¹¹² Ibid, 5.

Leviticus is a book of laws focused on the roles of the Israel's priests and Levites. Israelites were taught using these law codes. This book describes sacrifices and rituals necessary to be considered clean and devoted to God. Among the many teachings of this book, it is possible to find the one which establishes that "... The holiness of God requires human holiness, which includes such details as cleanliness and self-discipline. The relation between hygiene and religion is stressed in the regulations about leprosy ...",¹¹³

It is around the topic of leprosy that I found a very unique text in Leviticus which, in my opinion, points to a modern neglected pastoral practice directly related to my research inquiry: the role of the priest and its implications with the health care. I believe that many other texts in the Bible, especially those which tell prophets' stories, talk about health miracles, but not too many talk about the specific religious-socio-political role of priests. It is my conviction that what is known as the modern chaplaincy practice, instinctively, to some extent, has attempted to rescue this ancient priestly role. It is based on this conviction that I decided to reflect on Leviticus 13:1-8, focusing on the health care role of our ministerial ancestors, the Israel's priests.

b. Leviticus and the Israel's Priests

Leviticus 13 falls within the collection of chapters (Lev 11-15) which deal with the "code of ceremonial purity."¹¹⁴ Despite the epoch in which the book of Leviticus was

¹¹³ Philip Birnbaum, 183.

¹¹⁴ George Arthur Buttrick, et al., ed., *The New Interpreter's Bible in Twelve Volumes*. (New York – Nashville: Abingdon Press, Volume II, 1953), 3.

written, the texts of Leviticus 13:1-8 are politically representative of a Theocratic¹¹⁵ form of government. In Lev 13:1-2, we find evidence that God dictates to His prophet Moses, Aaron and Aaron's descendants, what must be done to be Holy, which means "... set apart by God..."¹¹⁶ According to North, "... The theocratic status of a civil government is also manifested by the presence of a priesthood." Israel, as a "... congregation is a nation of priests (Ex. 19:6)."¹¹⁷

In Birnbaum's opinion, Israel's priests (כֹּהֲנִים) had to be direct descendants from Aaron¹¹⁸, Moses' oldest brother and Miriam's younger sibling.¹¹⁹ Aaron was Moses' spokesperson in front of Egypt's Pharaoh and became the first high priest of Israel after the Tabernacle's construction was finished. After him, Israel's hereditary priesthood was established¹²⁰ (kohanim or Aaron direct descendant priests¹²¹). Aaron was considered:

... an idealized spiritual figure, not remote and austere like Moses, but one close to the people who reconciled their differences and restored domestic peace. They portrayed Aaron as the biblical ideal of priesthood, a view that inspired Hillel's injunction: "Be a disciple of Aaron, loving peace and pursuing peace, loving your fellow creatures and attracting them to the Torah..."¹²²

¹¹⁵ North defines theocracy as "rule by God." In: Gary North, "Leviticus. An Economic Commentary." *Institute for Christian Economics*. Tyler, Texas (1994): 102, <http://www.garynorth.com/freebooks/docs/pdf/leviticus.pdf> (Accessed August 28, 2015).

¹¹⁶ North, 1.

¹¹⁷ North, 102.

¹¹⁸ Philip Birnbaum, 283.

¹¹⁹ Geoffrey Wigoder, 2002, 17.

¹²⁰ Ibid.

¹²¹ Ibid, 476.

¹²² Ibid, 17.

Birnbaum argues that the principal duties of Israel's priests were to perform religious sacrifices at the Jerusalem temple and to teach the Torah.¹²³ As time passed, the number of Israel's priests increased so much that they needed to be divided into twenty-four divisions (families) to serve daily in the temple. These services allowed them to enjoy certain privileges and support themselves financially, since they were not allowed to own and cultivate lands.

Among the priests, one of them was appointed as Israel's high priest. This figure was considered the principal spiritual leader. Occasionally, this person was also regarded "... as the secular head of the community as well..." During the Hellenistic period, his contact with foreign rulers, for whom he collected the taxes of the people, introduced a process of assimilation among the priests.¹²⁴

During the times of the First Temple, high priests were anointed with oil and had nearly as much power as a king. At the time of the Second Temple, high priests were not anointed; only the one occupying the high priest role was anointed, and those who went to war with the military. This last group will conserve similar status as the high priest.¹²⁵

In more recent times, the Israelite priest's role suffered significant changes. Their roles were limited "... to pronouncing the priestly benediction on festival days, the avoidance of contact with a corpse, the redemption of the firstborn males on the thirty-first day after birth ... and the precedence of a *kohen* at functions such as the public

¹²³ Philip Birnbaum, 283.

¹²⁴ Ibid.

¹²⁵ Geoffrey Wigoder, 2002, 620.

Torah reading”.¹²⁶ In summary, “... the duties of the priests, as described in 10:10 are to distinguish between the holy and the common, and between the holy and the profane...”¹²⁷

Similarly, and as part of the Israelite priesthood, there were the Levites (לְוִי). In referring to this group, Birnbaum explains that they belonged to the tribe of Levi “... third son of the patriarch Jacob...”¹²⁸ They were granted the ministry of priesthood, but they were not necessarily direct descendants from Aaron. Early on in history, Levites were set to be priests’ helpers. By the age of thirty, Levites were allowed to serve at the sanctuary as “... custodians of the sanctuary and its furniture, and musicians, judges, scribes, teachers.”¹²⁹ Levites were responsible for moving the different parts of the sanctuary through the wilderness as Israel migrated from one place to the next. They usually camped in the inner circle among the tribes.

c. Leviticus Chapters 13:1-8. *Tzara’at*

In general, among the many roles of Israel’s priests, they were responsible for “...examining certain types of growths for *tzara’at* — loosely and probably inaccurately translated as leprosy – which had appeared on a person’s body, in a building, or on a fabric...”¹³⁰ This is the central topic which motivated the biblical authors to write two

¹²⁶ Philip Birnbaum, 284.

¹²⁷ Bryan Bibb, 29.

¹²⁸ Geoffrey Wigoder, 2002, 476.

¹²⁹ Philip Birnbaum, 310.

¹³⁰ Geoffrey Wigoder, 2002, 620.

chapters detailing everything that could be of concern, "... the diagnosis, separation, and ritual treatment (for re-admittance into the camp) of a victim of *tzara'at*, a condition that can affect the body, garments and even houses."¹³¹

In regard to the topic of *tzara'at*, Olanisebe¹³² and most of the authors I read, established that *tzara'at* is not about:

Hansen's disease (HD), the medical term for what was popularly called leprosy, is a dreaded malady. It mutilates and horribly disfigures. It is contagious and spreads slowly. Certain images readily come to mind when a leper is mentioned – lumpy skin, glazed eyeballs, hands without fingers, etc. However, biblical *tzara'at* does not display any of these symptoms.¹³³

According to Olanisebe, what we find in Leviticus is the socio-political and religious stigma set upon people with some type of temporary physical deformity or disease which was equated to leprosy. It was so because, as in the case of lepers, those who suffer of *tzara'at* had to endure the physical illness, as well as the social exclusion "... as a way of preventing the spread of the disease ..."¹³⁴ In Olanisebe's words: "...*tzara'at* of the body is a skin condition which requires critical examination by the priest, who seems here to combine both religious and medical roles ..."¹³⁵ As far as the

¹³¹ Samson O. Olanisebe, "Laws of *Tzara'at* in Leviticus 13-14 and Medical Leprosy Compared." *The Jewish Bible Quarterly*. 121, http://jbq.jewishbible.org/assets/Uploads/422/jbq_422_7_olanisebetzaraat.pdf (Accessed June 21, 2015).

¹³² Professor of the Department of Religious Studies at Obafemi Awolowo University in Nigeria.

¹³³ Samson O. Olanisebe, 121.

¹³⁴ *Ibid*, 121.

¹³⁵ *Ibid*.

literature goes, the causes of this skin conditions were unknown but directly modifying the socio-religious life and behavior of the ill person.¹³⁶

Olanisebe believed that the association of *tzara'at* with HD took place "... when the Hebrew Bible was translated into Greek, the Septuagint rendering צרעת as λέπρα (lepra), a generic term for skin disease."¹³⁷ This author finds that the only commonality between *tzara'at* and HD is the fact that both affect the skin. However, Olanisebe finds differences in the way these skin conditions are diagnosed. To give an example, the author says that: "... in the Bible there is an absence of all allusion to the hideous facial deformity, the loss of feeling, and the rotting of some parts of the body with which HD is associated".¹³⁸ To this, Olanisebe adds: "There are many significant distinctions between *tzara'at* and HD. For instance, *tzara'at* can undergo complete healing without the administration of drugs, whereas, apart from isolated exceptions, HD is incurable and can only be controlled by application of the required medicine ..."¹³⁹

In Olanisebe's opinion, and despite the existence of different kinds of skin problems, the biblical *tzara'at* was "... a ritual concern rather than a medical one."¹⁴⁰ The

¹³⁶ Samson O. Olanisebe , 121-122.

¹³⁷ Ibid, 123.

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ Ibid, 125.

Israelite priest's concern was related to maintain the equilibrium between God and the people.¹⁴¹

Somehow, contrary to Olanisebe's conclusion, Feder's analysis of Leviticus 13 led him to believe that leprosy was one of the skin problems which were considered *tzara'at*. Perhaps, leprosy was the main and scariest type of *tzara'at*; the one which raised more fear and repulsion in the community.¹⁴² However, Feder and Olanisebe agree that the rites presented in Lev 14 do not intend to heal the leper but purify him/her.¹⁴³ To this, Feder adds that these rituals did not have the purpose of expelling a demonic force because there was not magic thinking involved.¹⁴⁴ In addition, and after analyzing a group of healing ritualistic texts from the epoch of Leviticus 13 and 14, Feder concludes that the Israelite priests were familiar with the healing rituals used to treat leprosy. These rituals were known by the Israelite priests and unknown to the ordinary people. However, for some purposeful reasons, the information present in the biblical texts was carefully selected, omitting those parts which addressed the healing rituals details¹⁴⁵ which were taken "... from Emar and Assyro-Babylonian namburbi rites ..."¹⁴⁶

¹⁴¹ Samson O. Olanisebe, 124.

¹⁴² Ibid, 2.

¹⁴³ Yitzhaq Feder. "Behind the Scenes of a Priestly Polemic: Leviticus 14 and its Extra-Biblical Parallels." *Journal of Hebrew Scriptures*. Volume 15, Article 4. University of Haifa, Canada. 4, http://www.jhsonline.org/Articles/article_207.pdf (Accessed August 28, 2015).

¹⁴⁴ Ibid.

¹⁴⁵ Ibid, 5-9.

¹⁴⁶ Ibid, 12.

d. Characters Present on Leviticus 13:1-8

Changing gears and focusing more on Leviticus 13:1-8, I decided to pursue a socio-political-narrative understanding of the text through a detailed identification of the characters present in the story and their actions. It is my assumption that this exegetic approach would reveal and clarify the social dynamics and relationships that are part of the story. In my opinion, this approach would be essential to establish the Old Testament ground upon which my research stands.

The narrative of Leviticus 13:1-8 describes the relationship among “four” different positive characters (the Lord, Moses, Aaron, the priestly sons of Aaron, the man/he/him) and one negative (the plague of leprosy/ the plague/ leprosy). In this narrative, “the Lord” is mentioned only once, as well as “Moses” and “Aaron.” “The priests” is mentioned once while “the priest” is mentioned nine times. The “man/he/him” is mentioned thirteen times. “The plague of leprosy” is mentioned two times, “leprosy” once, and “the plague” is mentioned eight times.

In these verses “the Lord” represents the divinity, “Moses” the prophet, and “Aaron” the high priest. In the case of “the priest(s)”, it seems unclear. Lev 8:1 is the only verse which uses a plural reference to all the priests (pl. כֹּהֲנִים *kohanim*¹⁴⁷), sons of Aaron but after this unique occasion, the author uses “the priest” (כֹּהֵן *kohain*¹⁴⁸) which is singular and could be pointing to Israel’s High Priest. The case of “man/he/him” is particular as well. The term “man” (אִישׁ) is used and translated in this way in the second verse while; later on, it is translated using the third person pronoun and possessive in its

¹⁴⁷ Wikipedia.

¹⁴⁸ Ibid.

male singular form. Yet, and in my interpretation, it is probably referring to anyone of the Israelite people.

Similarly, I believe that the terms “the plague of leprosy,” “leprosy,” and “the plague” are used interchangeably and is not necessarily referring to the modern understanding of the disease called leprosy. However, this “character” represents “devil,” therefore, it represents the adversary, that “thing” that is being fought against. It represents the condition to be unclean and socially segregated. It represents the reason which justifies the need for an expert to assess and diagnose it, “the priest(s).”

e. Role-Action Analysis on Leviticus 13:1-8

In analyzing the characters of this pericope, in the context of their actions, it is possible to observe that “the Lord” is the one who speaks and say things only to two other characters, “Moses” and “Aaron.” “The Lord” performs these actions only once. God speaks about others (man/he/him) as distant figures. “The Lord” is the one who commands, establishing what is to be done. I arrived at this conclusion because of the use of the verb “shall.” According to the Merriam-Webster dictionary, this verb is used to command, communicate expectations and/or communicate inevitable future events. It is used to establish laws.¹⁴⁹

“Moses” and “Aaron” are those whose implied responsibilities were to listen to “the Lord” and make sure to execute God’s directives upon the “man/he/him.” Consequently, the “man/he/him” had the role of carrying the symptoms of the so called leprosy. This “character” had to be brought to the priest, be initially assessed by him, be segregated because of the symptom of the illness, be reassessed after seven days, and be

¹⁴⁹ Merriam-Webster Dictionary.

brought back to “the priest” to be declared unclean and later on clean. After the priest assesses if the “man/he/him” got healed from the disease, the “man/he/him” needs to go back to the priest and perform the cleansing ceremony ritual (Leviticus 14). However, if the symptoms recur, the “man/he/him” is responsible for going back to “the priest(s)” again to be assessed and start the process over.

On their part, “the priest(s)” were those who executed what was established by “the Lord” and communicated to “Moses” and “Aaron.” Their role was to receive those who were brought to them. They “shall look” for signs and symptoms characteristic of the disease they were diagnosing. If “the priest(s)” observed some of these signs and symptoms, then he/they were responsible for pronouncing unclean whoever had the symptoms. Whenever “the priest(s)” found these symptoms on someone, they “shall shut up” this person for seven days because of the plague. After seven days, “...the priest shall look on him the seventh day; and, behold, if the plague stay...” If the “plague” did not spread more, it was “the priest(s)’s” responsibility to “shut up” the patient again for seven more days. After the established period of time, the priest had to repeat the same assessment procedure to determine if the “plague dim.” If it did so, then “the priest(s)” “shall pronounce” the person clean and the “man/he/him” “shall wash” his cloths to be clean. But if the symptoms recur, then “the priest(s)” will reassess the “man/he/him” again. In this case, “the priest(s)” would repeat the same procedures: “shall look”, “behold,” “shut up” and “shall pronounce” the person unclean or clean. It should be noticed that overall “the priest(s)” actions were four: “shall look” which was used five times; “behold” which was utilized on three occasions; “shall pronounce” which was

used three times to declare patients' condition of clean or unclean; and "shall shut up/shall shut" which was used only in two opportunities.

For its part, "the plague" as a character had roles and actions as well. "The plague" was meant to be manifest through signs and symptoms, to "... become in the skin of his flesh ..."; to "... be turned white ..."; to "... be deeper than the skin of his flesh ..."; to appear to "... be not deeper than the skin ..."; "... be not turned white ..."; "... stay in its appearance ..."; "... be not spread in the skin ..."; "... be dim ..."; "... be not spread in the skin ..."; and "... spread abroad in the skin ..."

APPENDIX H

Part III: New Testament

a. Introduction to the Gospel of Mark

The book of Mark is the oldest of the three synoptic gospels. This book seems to be product of the work of John Mark, an assumption which was questioned by many scholars. For this reason, when referring to authorship, The Interpreter's Bible invites us to observe this book as an anonymous work.

As literature, the book in question does not intend to be historical or biographical in nature. It was created with the intention of presenting, teaching and defending the good news of the Christian salvation proclaimed by Jesus Christ and his Apostles.

The gospel of Mark points to the recipients of its message as being those Christians who were facing the martyr's fate under Rome's prosecution. The message of Mark had the intention of strengthening the Christians' faith and convictions while facing the possibility of death.

According to The Interpreter's Bible, the book in question was written in Rome.¹⁵⁰ Papias of Hierapolis seemed to be the oldest source which commented about the origin of this gospel.

Papias said that Mark, "the author," did not follow a historical logic in writing his book because he met Jesus toward the end of his ministry. Rather, Mark was Peter's follower and interpreter. What Mark intended to do was to write, as accurately as it was

¹⁵⁰ Mid-late 60s. In: Raymond E. Brown, *An Introduction to the New Testament. The Anchor Bible Reference Library*. (New York: Published by Doubleday, 1997), 163.

possible for him, what he heard from Peter, Jesus¹⁵¹ and that which was conserved, orally and in written form, by the Rome-gentile Christian community.¹⁵²

Brown's introduction to the New Testament points to the Gospel of Mark's sources "The Secret Gospel of Mark ... and a short form of the Gospel of Peter ..." in addition to Mark's use of the source "Q" which has been questioned by various exegetes.¹⁵³

In addition, and in referring to Mark's theology, Brown argues that this gospel presents a basic Christology. Mark emphasizes the secrecy of Jesus as the Messiah and highlights that after "... disobedience, failure, misunderstanding, and darkness ..." the death of Jesus on the Cross was not the end but something necessary for Christ to defeat death through his resurrection,¹⁵⁴ enabling in this way, the Christian hope.

b. Comparison of Mark 5:24-34 vs Matthew 9:19-22 and Luke 8:43-48

In comparing the three parallel texts, I noticed that the encounter of Jesus and the woman with hemorrhage took place at some point when Jesus was heading to Jairus' home to see his daughter. Curiously, Matthew was the only gospel which referred to Jairus not by name but as a synagogue leader.

The three gospels agreed on the fact that there was a woman who suffered of hemorrhage for the length of time of twelve years. For some reason, Matthew does not

¹⁵¹ Please note that reviewed literature questions if Mark really met Jesus in person.

¹⁵² George Arthur Buttrick, et al., ed., *The New Interpreter's Bible in Twelve Volumes* (New York – Nashville: Abingdon Press, Volume VII, 1951), 629-645.

¹⁵³ Raymond E. Brown, 149-152.

¹⁵⁴ Ibid, 152-154.

mention that she received unsuccessful care delivered by physicians, a detail which was mentioned by Mark and Luke. However, Mark and Luke differed from each other regarding the physicians' role. Mark let us know that this woman had to endure physicians' treatments spending "... all that she had ...", while Luke agreed on the financial burden experienced by this woman but omitted her suffering due to the medical care she received. Another important difference between these two gospels could be found in the way they emphasized the situation of this woman. Mark said: "... and she was no better, but rather grew worse ..." while Luke only said: "... no one could cure her ..."

To continue, the narrative of Matthew and Luke moved faster to describe what this woman did to Jesus. Mark is the only one who let us know that she "... had heard about Jesus ..." prior to their encounter. The three gospels agreed that she came from behind Jesus and touched his cloak. Mark is the only one who mentions the "crowd" that was behind Jesus, while Matthew and Luke were very specific about this person touching "... the fringe of his cloak ...", a detail omitted by Mark.

Another curious aspect in comparing the referred parallel stories is the fact that Mark and Matthew reveal what the woman was thinking and her motivations to touch Jesus' cloak. The gospel of Luke does not give detail about this woman's intention but moves quickly to say that she touched Jesus and was suddenly healed. At this juncture, the gospels' narratives change significantly. In Matthew, there is not healing until Jesus turned around "knowing who this woman was" and talked to her. In Mark, after touching Jesus' cloak, the woman's hemorrhage stopped but Jesus did not know who touched him, a detail which was echoed by Luke's narrative. However, Mark added that the woman

was healed from her disease, a detail which was absent in Matthew and Luke's narratives respectively.

To all of the above, I would add that Matthew does not comment regarding the presence of Jesus' disciples, while Luke and Mark mentioned them talking to Jesus. Nevertheless, Mark and Luke differed from each other in the fact that Luke mentioned the name of Peter as the one who dialogued with Jesus. According to these gospels, Peter was the only person to whom Jesus explained the reason of why He was looking for whoever had touched Him. Matthew does not talk about it and in Mark, Jesus did not respond to his disciples' ironic comment.

To conclude, regarding the healed woman, I observed that in Mark she comes to Jesus because she knew what had happened to her. In Luke, she comes to Jesus because she was unable to remain hidden anymore. Both gospels agree that she was afraid. Luke said that she fell in front of Jesus and confessed to Jesus, and to the crowd, the reasons of why she touched Him and what happened to her. In Mark, the woman fell in front of Jesus, but only confesses to Him. In witnessing such behavior, the three gospels present Jesus referring to her as a daughter who had enough faith to make her well. Matthew ends saying that she was made well. Luke finished by sending her in peace; and Mark ended up making her well, sending her in peace and commanding her to be healed from her disease.

c. Characters Present in Mark 5:24-34

To continue with the pericope analysis, in Mark 5:24-34 it is possible to find the following characters: "he/Jesus/him and his/my/you/me," all of them referring to one person, Jesus, for a total of nineteen times. The "crowd" was another character. It was

mentioned four times, while “hemorrhage” was referred to on two occasions. The next chronological character was “a woman/she/I/her/daughter/you/your.” All of these expressions were referring to the woman who had the bleeding disorder. She was referred to nineteen times as in the case of Jesus. The next figure was the “many physicians.” They were mentioned only once as well as the “disciples.”

From this exercise, it is possible to conclude that the main characters of this story were Jesus and the woman who suffered with hemorrhage. The remaining characters played secondary roles which, in my opinion, were essential to put in context the events described in this pericope’s story.

d. Role-Action Analysis in Mark 5:24-34

When analyzing the characters present in this narrative in the context of their actions, it should be noticed that Jesus’ role was: “went with him (Jairus),” (Jesus was) “aware that power had gone forth from him;” “Jesus turned about in the crowd”; “He said”; “He looked all around”; “He said to her: your faith has made you well; go in peace, and be healed of your disease.” On its part, the “crowd” “followed him;” “pressed in on him.” The “crowd” helped the woman to hide. The “crowd” is the one Jesus speaks to in the first place. The “hemorrhage’s” function is to make the woman suffer for twelve years and to suddenly stop causing suffering. The next character is “she,” the “woman.” Her role was to be “suffering from hemorrhages for twelve years,” “endured much under many physicians,” “spent all that she had,” “she was no better” rather she got worst. Also, she “heard about Jesus,” “came up behind him,” and “touched his cloak” saying/hoping to “be made well.” In addition, the “woman” “felt in her body that she was

healed of her disease.” She knew “what had happened to her;” she “came in fear ... trembling, fell down before him, and told him the whole truth.”

To continue, the “many physicians” role was to make the woman “endure”, make her spend “all that she had,” and fail treating her so she got worst. For their part, the “disciples” role was to challenge Jesus’ perception.

The sequence of actions in this story starts with Jesus following Jairus to care for his dying daughter. As Jesus moved from the initial point to the place where Jairus’ daughter was located, the “crowd” made His path a little difficult. The “crowd” seemed to be an obstacle to Jesus’ initial plan. To this initial story, the gospel of Mark adds a whole new story. As Jesus moved within the “crowd,” He finds himself surprised by a woman who, desperate and tired of being sick, unclean, segregated in many ways, and poor, decided to take control of her life and “steal” her healing. Her initiative interrupts Jesus’ original plan. What called Jesus attention was a sensation of power leaving Him. Jesus got curious about who had done such a thing. The needs, determination, despair and courage of a woman was significant enough to change Jesus’ original purpose. When she found herself unable to hide anymore, she decided to confess, admitting her behavior, owning her decisions and actions, while experiencing fear and trembling. Such a daring attitude caused Jesus to experience compassion. In so doing, Jesus talked to her as a Father calling her “daughter.” In my opinion, here is where Jesus assessed what everyone else missed. This woman needed the compassion and love of a father; that was why He “adopted” her right there, on the spot, as His daughter. In Mark 5:34, Jesus acknowledges, as the source of her healing, not His power but her faith. This woman’s faith was what gave her back the fighting attitude. Her faith made her resilient and daring

in her relationship with God. She did not give up. It was her faith that healed her and not any doctors. Perhaps, they were looking for answers in her body, while the real answers were in her soul. Jesus said, “Your faith has made you well.” It could mean as well, your faith has made you whole again. To all of this, Jesus added two more important things, “go in peace, and be healed of your disease.” Interestingly, the event of being healed of her disease comes after she was made whole and was told to be at peace. It seems like these two preconditions set the basis to obtain healing (υγιης), which curiously was not translated as cure.

e. Mark 5:24-34. Bible’s Commentaries Review and Palliative Care

Hermeneutics

This pericope is not too long or complex in nature, which is perhaps why most of the biblical commentaries do not say much about it. Rather, biblical scholars invest their time and energy interpreting and understanding Jairus’ daughter’s story. However, I feel it is important to summarize here some of the thoughts developed around the pericope in question.

In Raymond E. Brown’s commentary to the gospel of Mark is found the idea that Jesus had a power which He did not fully control. This power was able to come out from Him freely and unintentionally and could reach someone without Jesus knowing it. This peculiarity of Mark 5:24-34 allowed Brown to argue that in the gospel of Mark, first of all that Jesus did not know everything, and secondly that the evangelist did not have a “...mechanical understanding of the miraculous power of Jesus...”¹⁵⁵

¹⁵⁵ Raymond E. Brown, 134.

Somehow, The Interpreter's Bible resonates with some of Brown's commentaries around what happened in Mark 5:24. Jesus had to change plans due to circumstantial events. Jesus was teaching when Jairus showed up and interrupted Him, asking for help.¹⁵⁶ In addressing this, the commentary in question invites us to consider how important is to be flexible and willing to change plans, prioritizing our help for those who need it the most. My hunch is that for Mark's community this text meant that Jesus will change plans in order to come to their rescue in the midst of their despair due to the persecution they were enduring. In my opinion, for PC chaplaincy, this verse represents an invitation to be flexible in our plans and schedules, so that we can make a priority of those who are wrestling with life-death situations.

The Interpreter's Bible continues its commentary on Mark 5:24-34 by focusing on how the woman with hemorrhage reached out to Jesus as her last resort. She first tried every other way to obtain health, but nothing worked. Perhaps, this was not uncommon during Jesus' time and in Rome some decades after Jesus died. I feel that today, this type of behavior is not hard to find in our society. Maybe, more often than what we would admit, we look to God as the last resort, when we are confronted by the ultimate concern, death. Often, this is my experience in working with PC patients and families. More or less, in PC family meetings, there is an orderly fashion for each clinical discipline to participate. In my experience, the most consistent practice starts with doctors' or nurse practitioners' interventions followed by social workers or chaplains. Similarly, patients' and family members' concerns start with medical questions, transitioning to existential and religious and spiritual concerns.

¹⁵⁶ George Arthur Buttrick, et al., ed., 1951, volume VII, 917-720.

In following the commentaries of The Interpreter's Bible, one of the author's comments, based on verse 27, was called to my attention. There is an anonymous informant who told the woman with hemorrhage about Jesus. Apparently, it was just an act of passing along information, but I wonder if it could have been a referral as well. In the modern PC practice, a patient referral always comes through a physician. However, a PC request could come from the patient, family member, and/or a team member, but what is essential in all of this process is that someone must educate patients and families about what PC is about and who are the team members of the interdisciplinary team. In my opinion, the informational/referral act connects the pericope in question with my experiential PC practice.

To continue, the commentary I referred to in the above paragraph led me to consider the presence of "magic thinking" on the woman of Mark's story. This phenomenon could be observed in verse 28. Potentially magical and/or wishful thinking represents one of the most important challenges faced by PC teams and chaplains today. In my opinion, it is a type of thinking which comes out from the dialogue between despair and hope. Often, this attitude is not based in direct denial but in the faith in the Almighty God who does miracles and brings back people from death, and who cures incurable diseases and impossible situations. As a PC chaplain, it has been my experience that some people oftentimes benefit from this type of thinking while others do not. At times I have witnessed patients who used their wishful thinking to recover and live longer than those who "accepted their reality." Perhaps this outcome is the result of a misdiagnosis, but maybe it is not. Maybe, and just maybe, wishful thinking gives people some type of resilience. At times, as well, I have witnessed people using their wishful

thinking to unintentionally prolong their own, and their caregivers' distress and suffering. However, and whatever be the case, in my PC experience, what ultimately helps any given patient and family member is their ability to live, fight, treat, accept and die according to what they really believe. Perhaps, the best PC chaplaincy intervention consists in assisting patients and families to make end-of-life decisions through a process of congruency and peace seeking.

Again, The Interpreter's Bible commentary on Mark 5:30-31 caught my attention. This commentary talks about Jesus' question regarding who touched Him. In so doing, the commentator argued that for Jesus it was important to provide an individualized care. This was the reason why Jesus noted the touch of the woman. In this regard, I found the idea of individualized care to be another connecting point with my PC chaplaincy practice. As a PC interdisciplinary team, we have the experiential and conceptual conviction that each PC patient and case is unique and deserving of our individualized and unbiased attention.

TABLE I

Table 1. Palliative Care Team Job Description.

Number of Participants	PC Specialty	Job Description Given by Practitioners
3	MD	<ul style="list-style-type: none"> -Based on the attending physician request: Consult seriously ill patients in the hospital. -Review charts, x-ray, scans, blood tests and the hospital courses. -Meet with patients and families to discuss their life's goals, and care goals. -Treat pain and suffering. -Evaluate patient's needs, physical and the whole person, including spiritual and social functioning.
2	NP	<ul style="list-style-type: none"> -Assessing and treating patients for pain and symptom management. -Assess status and condition of illness. -Assist with treatment plan around goals of care. -Discussion with patients and families. -PC visits.
2	SW	<ul style="list-style-type: none"> -Help with resources and emotional support
2	SC	<ul style="list-style-type: none"> -Outpatients and home PC services. -Supporting overall patient's health through making spiritual assessments that contributes to the plan of care. -Help with end-of-life decisions
2	RC	<ul style="list-style-type: none"> -Spiritual assessment of patients. -Communicate spiritual assessment information to PC team members to add to patients' plan of care. -Use part of the spiritual assessment of patients to provide pastoral care. -Participate from a spiritual care perspective. -Add the spiritual care dimension to the family visit. -Help in any way I can. -Help patients accessing their strengths and needs as a result of a PC family meeting.
1	CM	<ul style="list-style-type: none"> -Works with two or three PC patients so resident chaplains can gain experience working with this type of patients. -The most important is to be present, observing. -Meet with patients and families and educate them about what is palliative Care about. -After the Palliative Care Family meeting is over, stays with patients and families to offer support, clarification and prayers. -PC chaplaincy is about being present, listen, let people react, synthesize, cry or do whatever they need.

TABLE II

Table 2. Information of Interest by Specialty and Sources of Information

PC Specialty	Information of Interest	Sources of Information
MD	<ul style="list-style-type: none"> - History and physical, in the progress notes, previous discharge notes for the pt. to understand their disease process and how it is being treated. - I will notice who the family member is listed on the chart. - I meet with the pt. and families (family meetings) to discuss about what matters the most to them. - What are their (family) goals of care for the pt.? If I see anything that is not realistic or is not going to work well for them, I try to discuss that with them. - About how the pt. got the diagnosis of their disease. - How they (pts) understand the medical information about their disease. - Any type of suffering that they have through looking at things like: pain, nausea, depression, anxiety, and overall wellbeing, shortness of breath and some of those types of things that I might be able to direct medical therapy towards. - I also like to know about the person, the whole person. - Historical information about the pt., both, medical and personal. - Physical symptoms but also emotional, spiritual and social aspects of care. 	<ul style="list-style-type: none"> - The progress notes. - Previous discharge notes. - The chart or electrical records. - From the meeting with patients and families in the family meeting. - From examining the pt., talking to family members and talking to the doctors involved in that pt.'s care. - "...through the interdisciplinary team because everybody has different roles and expertise at obtaining that type of information from the pt. and family..." - Through pts' and families' interviews around the consultations. - From the bedside nurse. - From the home nurse if they are seen by home health or one of the other outpatients' disciplines. - From the primary treating physician and sometimes from the primary care doctor. - From the nurse and people from the hospital world including the nurse's aides and sometimes even housekeeping as they are observing as they come and go from the room. - From the formal PC setting when we have the team that has evaluated the pt to discuss with them what they have seen and observed, and the questions that they have answered, both around the consult and the daily interdisciplinary rounds, when we review the cases.
NP	<ul style="list-style-type: none"> -Medical background and information to understand patients' condition and the state of those conditions. -Medicine/medication history review. -Past medical history. -Social history/social aspects of their care: who they are, where they live or who is their family? Where are they from? What they do? Do they work? Do they engage in certain behaviors or hobbies, sports or maybe they are involved with the use of substances like alcohol or drugs. - Spiritual history information: Any relationship with our chaplain services? Are they affiliated with a church? What church or community? 	<ul style="list-style-type: none"> -Electronic medical record. - Through the case manager, a physician or a nurse or a chaplain. - Patient's interactions during initial or subsequent visits. - We do life review, advanced directives, HCPA-Living-Will, POLST forms, EMS DNR.

	<p>Have they been seen by a chaplain?</p> <ul style="list-style-type: none"> - Physical assessment/ complaints. -Life review to understand what is meaningful or important to the patient to address his goals of care. -Family dynamics. -Financial issues to refer to SW services. - How patients are feelings, the psychology part and psychiatry like depression mood and those types of things to treat anxiety and depression. -Brief spiritual assessment to identify spiritual distress, more like a screening to get PC chaplain involved. 	
SW	<ul style="list-style-type: none"> -The pts' clinical status. Where they are with their disease process. -Work with pts on their understanding of their clinical status. Look at ways that there might be disconnect between their understanding. -Identify what that person's goals and values are for their continue health care. -What are the resources available to support this patient on meeting goals of care. -Help patients prioritizing support services, resources and trying to get people where they need to be with their health care. - Where they are emotionally? What grief stage they are in? -How they are coping? 	<ul style="list-style-type: none"> - Through chart review of the medical records. - Interviewing patients and families, and the supportive people who are involved with the pt. - Family meetings, chart review, from staff, our IDT.
SC	<ul style="list-style-type: none"> - Primarily, I work based on referrals. Every pt. I work with, I receive a summary from the referring clinician about pts' basic demographics, name, age, DOB, primary diagnosis. They usually include a discussion around their assessment about what the most pressing physical needs are... the primary social concerns, and then, what they thought were emotional and spiritual concerns that caused the referral to be triggered to me. This summary is the main information I look for, usually, before I meet with the pt. - I try to make a thorough spiritual assessment of what the pt. is going through, hoping that it will also contribute to the plan of care for the whole PC team. - Religious background. - Who is their support system. - Do they have a community of faith that is supporting them during this time. -Do they have religious or spiritual or values beliefs that are contributing to either, how are they processing their sickness, how they want to be treated, how they want their life to end. - I try to find out what their spiritual needs or issues are. - Anxiety. 	<ul style="list-style-type: none"> - From referrals. - For every pt. I work with, I receive a summary from the referring clinician. -From weekly interdisciplinary team meetings. - Trough clinician's notes (their charting system). - If the pt. is alert and oriented, from them directly. - Talking to the family and friends who are at the bedside or if the pastor is able to come in. - Sometimes I go into the physical chart and review the notes form the other PC staffs. - Sometimes, I get the information from written documents or from McKesson (charting system).

	<ul style="list-style-type: none"> - Fear - I try to screen them for spiritual distress. - I try to find out what church do they belong to, or what synagogue, or what their community of faith is, the name of it, the name of their faith leader or pastor. - I try to see if their spirituality is affecting their health in a very direct way. - What beliefs are going to impact the decision of being a DNR or not. - I kind to try to figure out, spiritually, what might be impacting that decision for them or their family. 	
RC	<ul style="list-style-type: none"> -Where they are socially? -How are they connected or find their community, faith system or beliefs. -How they are doing emotionally, psychologically. -How they are doing spiritually. -How are they doing physically, if they are enduring any kind of pain. - The pt.'s situation. -The family-pt.'s dynamics. -The family spiritual strengths and needs both inner strengths and outer strengths, and resources that they can tap in to help them in their crisis. - How many people are in their room for a family meeting and who are they. - The real answer is that I really do not need to know much about anything because when I come onto a room with a PC setting, I listen with my heart and with my head and I discern. - I am usually quiet, letting the MD and SW lead the conversation and I assess as the meeting is going on how I can be of use. So, I cannot assess that until things are rolling. - The resources that this family has that might help them with whatever they are dealing. -What strengths do they have? -What are the dynamics that the spiritual care dimension can impact? 	<ul style="list-style-type: none"> - Through active listening, empathetic listening. -I listen to what they communicate verbal and non-verbally. -I use guided questions to get the information I need. - I use other chaplains who have seen the patients, family members, ministers or friends, people who have come in contact with them. - Through observation and active listening in family meetings. - I use the Amy Van Deurzen four dimensions of self, physical, emotional, spiritual and social. - I use the FICA model. -Questions about faith and perspectives of all of those dimensions (physical, emotional, spiritual and social).
CM	<ul style="list-style-type: none"> - I am much more concerned with the family dynamics: Who are the caregivers, who are the family members, who are the spouses, friends. It's that whole family dynamics. That is my focal point to get to know the family. - I might need to know, maybe, a little bit of the prognosis. -Patients' personal stories and the stories of their families. - I could get all the medical, but you have to find where to put all these things, in hearts and souls. 	<ul style="list-style-type: none"> - Initiating conversations. -“Walk” with the families. -From consistent, steady and informal interactions with family members. “...visiting with them or meeting them in the hallways, or over a cup of coffee, casually.” - “...I do not need to walk away with all the checkmarks or all the spiritual assessment tools... I want to walk away with a sense of who these people are. What are their dreams, hopes, what

	<p>- Family dynamics, family system, are family members strange? Have they been here (with the pt.)?</p> <p>-If people are here for a week or two, we have to hear about their families, the pt., their relationship, sorrows, sadness, dreams, jobs, what do they do, who were they before this.</p>	<p>frightens them, what makes them laugh, what makes them love...?"</p> <p>-"... If we get in doors like fear, denial, that all is going to transpire in communication, in conversation. You sense the fear, you hear the fear, you hear the love, and you hear desperation. Those are words but what is happening within the human being who express that? What is the posture? What is their deepest sadness all about? I want to kind of unlock all of that but with respect, that it is their story. It is their happening..."</p> <p>- I get a heads up before I go into a family meeting.</p>
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TABLE III

Table 3. Interdisciplinary Understanding of Spiritual Assessment

PC Specialty	Understanding of Spiritual Assessment
MDs	<p>-... Dr. Christina Puchalski, a world authority on spirituality and PC, gave the idea of the FICA questions to ask to pts and family members about their spirituality...</p> <p>- It is something done, either, by a physician or a chaplain or other members of the PC team involved in the pt.'s care to determine what it is important to the pt about spirituality. It is faith important to them? What is the community from which they get their care?</p> <p>- I think that the notes of the chaplains are far more trained in experiencing and assessing the pts and the family support system for spirituality but what I understand is that it is something that we all should do. But particularly from my point of view, a physician, should at least think about doing this. Some pts look at this issue like it will not be appropriate on any given visit or initial evaluation to ask about spirituality, but usually I do. I just saw a new pt. and ask him about that: if faith was important, how that was acting out, what community, what do we need to do to help with their spiritual support if they needed and when they needed in the hospital and after the hospital.</p> <p>Researcher: Do spirituality and religion mean the same for you or they are different? MD: For me the two are very different but they overlap, of course. Spirituality are existential questions for myself: why am I here? What should be my role in life? What will be satisfying in life to do and have done at the end of my life? Religion is, as a child, you are first exposed to acting out spiritual matters when your parents take you to church, which was true for me, but I think spirituality is not about the church I grew up in or their way of doing things (talked about spirituality as transcending religious doctrines as the right one or the only way which at time felt hurtful and offensive to him). Not having compassion or trust or acceptance of people's ways of dealing with their own spirituality, I think is that annoys me about organized religions (MD told a personal story in which someone used religion in a very hurtful and disrespectful manner to him and his family). Thanks God spirituality and religion overlap but they are very different. For me, spirituality is more global and diffused thing than just religion.</p> <p>- Spiritual Assessment can mean many different things, and I do not know if an individual chaplain or the department has a method or a process of obtaining the spiritual assessment. To me it means, assessing the pt.'s social function as they relate to meaning in the world and how they relate to God or a Higher Being. How they relate to the community at large. Do they have a spiritual community? and how do that influence how they relate to their physician, their caregivers and their disease.</p> <p>Researcher: How do you understand the spiritual? MD: It is very difficult to put in two words. I think it is the part of us that is universal between people, between humans. That we are not just individuals but we have a relation to humankind, to the community beyond just who we are.</p> <p>- It is a bit an enigma to me. When I do my assessment, for instance, something very tangible like pain, we have a series of questions that we use to identify the location, intensity, type, the quality, the exacerbating factors, the relieving factors. So, I have like a sort of mental checklist that I go through for a physical assessment. For the spiritual assessment oftentimes my experience ends it, you know, are you a spiritual person? And then, do you have a religion or faith? I think that we often use questions like: what gives you strength? What gives your life meaning? But I do not know if that falls as some sort of spiritual assessment or a psychological assessment, so I think it is a little gray for me.</p> <p>Researcher: How do you understand the spiritual and the psychological? MD: It is a very good question. I think there is a lot of overlap. I think, people often prescribe to at least</p>

	<p>previously described tenant or believe system, so that sort of more fixed. I guess if I heard about a JW or if they are Catholic, there is a sort of rules that people follows. Now, the individual interpretation of those rules and how they apply them to their own situation comes more like the psychological piece of it, I think. How those two marry is often confusing and I think that is oftentimes the chaplain and the SW become key in terms of helping me interpret what is happening.</p> <p>Researcher: And the spiritual? Is it part of the religious and psychological? MD: I would say yes till some extent. Although, there are things that the chaplain interprets and pics up that are very different from what I have seen in the surface. So I think there lies sort of the specialty. I think, the magic, right?</p>
NPs	<p>- I think I have an abbreviated version of spiritual assessment that I will do when I am with a pt. or their family. Then I will wait on the chaplain to do a more comprehensive assessment.</p> <p>- I think it is trying to elicit if the pts have any religious affiliation or rituals that are important to them. Trying to understand what is meaningful to them, what is important to them in life... I think that if they have a spiritual distress. Kind of eliciting if you heard key words like: "God is angry at me, which is why this is happening..." or other key words that might come out during an interview; things that might be obvious that the person is in spiritual distress... These elicited things sometimes are elements that move/come out through the conversation, no necessarily when you ask direct questions. They might come out when you learn about what are they concerned or when you find out what is important to them... Get to the button of these things could be important... How do they find meaning in life</p>
SWs	<p>- ... my understanding of what a spiritual assessment is: to identify where they (patients) are spiritually in their journey as it relates to their health care and, maybe, as it does not relate to their health care... just kind of where they are as far as that type of support if that is something they value. If it is something that provides them comfort is having that spirituality, and that assessment is valuable and it helps me to determine kind of what their coping is. So, when that assessment is complete and I kind of understand where they are or where they are not, and where their spirituality is, it helps me to understand more what types of resources I need to work toward, and even encourage more involvement with pastoral care or spiritual care or outside counseling.</p> <p>Researcher: How is it that you understand spirituality? SW: It is a huge umbrella that has many different facets. I guess the typical drive by and understanding is about religions and the relationship to God and the church. That is the top layer, and then I think that the deeper level is meaning of life, hopelessness, their comfort with life, a believe system that helps someone to kind of center themselves, even if there is not some type of conventional religion, is there some type of force or spirituality that helps calm or center someone and it does not necessarily has to be a mainstream religion or what we think typically as spirituality. It is about what their understanding is of where they are or what their places in the world are. So that is kind of my bigger way or umbrella.</p> <p>- The identification of people's religious belief, denomination, spirituality, where they get their strength, are they worried about their future, dying or being sick, changes that it might bring.</p>

TABLE IV

Table 4. What Chaplains Assess

Chaplain's Roles	Have you done Spiritual Assessments?	What Chaplains Assess in their spiritual assessment?
RC	Yes	<ul style="list-style-type: none"> - Assess the same things than with regular patients: the emotional, physical, spiritual, and social situation. RC mentioned the use of FICA.
SC	Yes	<ul style="list-style-type: none"> - One SC created his own charting template and found a way to add it to the interdisciplinary electronic chart. - Screen for Spiritual distress. Researcher: What does distress means to you? How do you define emotional/spiritual distress?) SC: The vast majority of my pts are in some sort of emotional or spiritual distress. For me distress will be: emotional or spiritual struggles that are actively interfering with their daily functioning. So, spiritual dissonance or discord is causing direct anxiety that is keeping this person from engaging in the activities of their daily lives, relational dynamics, preventing them. - Spiritual and personal history to get a sense of who this person is and a sense of their spirituality. - Spiritual vocabulary. - Engagement with any faith tradition, what that looks like over the years? What it looks like now? How their illness impacts that engagement? - Explore strengths. - The primary concerns they are walking with. - How they connect their spiritual story and vocabulary to what they are experiencing now with their illness. - Conflicts between patients' embedded theology with their theology of spirituality. - Signs of isolation/spiritual isolation. - Fears or questions they are having about God. - Assess grief, anticipatory grief, guilt and shame. - Relational dynamics. The impact of their illness on their relational dynamics, and vice versa based on family system theory. - Use of positive religious coping or more negative forms of religious coping. - Use CASH assessment model (she borrowed it from another institution and incorporated it in her practice). - I follow what is in McKesson, basic information about the pt. - Assess forenvironmental cues that could give information about what pts are feeling, their isolation and what are they going through. - The pt.'s involvement, active, minimal. Family involvement, is there family at the bedside, is there conflict there, are they subdued, if so, why? - Their religious beliefs as if they are active or inactive. - What does their religious heritage mean to them? - If their faith is helping them during these times or not. Some pts will say no, it is not helping me, so exploring why.

		<ul style="list-style-type: none"> - Assess if old practices or beliefs fit or not the sickness or whatever they are going through at the time. - Main spiritual issues they are going through, fear, faith issues, doubting God, relational issues, grief and loss, and anger. - What resources are available to them (supportive family, faith community support?) - Inner strengths (she talks about how she uses the narrative space in the charting to write. She puts an example). - Interventions made like getting a sacramental minister, arranging for a priest to do the Anointing of the Sick, reading scripture, prayer. - How is the issue that is presented met (Outcome). - The plan of care, assessing: does this pt. needs follow up? Do they have a supportive family who is going to support them? Do they have a faith group that is very active and is already taking care of them? Do they need more to explore their faith issues, do they need to explore grief and loss. Based on the assessment, I decide what I need to do and how to move forward.
CM	Yes	<p>... The medical is not my field. The social is not my field... Those are important. I do not dismiss them. They are there in the background but my assessment for pastoral care is not very different from somebody else in the hospital. I am not going in with a mind set about what it is that I am going to get.</p> <ul style="list-style-type: none"> - To listen with my heart what is going on, what is the humanity saying in all of this family meeting? - For me, spirituality is about journey, relationships with God, a being, creature, whatever you want to name it. We all have that life journey, that spirit within us. - What is the spiritual background? - Where is hope? - When you shut up and let people speak and give their story, you are beginning to unwrap their journey. You are beginning to unwrap their spirituality. They want to tell it.

TABLE V

Table 5. Spiritual Assessment Models. Preferences and Reasons

PC Specialty	Assessment Model. Reasons	Chaplain Group	Assessment Model. Reasons
MD	<p>-The one I personally have identified with and try at times to use if the FICA model of spiritual assessment of Pushalski...this is a basic type of spiritual assessment and she suggested...that physicians could use this as part of the overall evaluation of the patient, their illness, families, and their care plan.</p> <p>- Yes, but I cannot think of the name (later on he said FICA). Researcher: Do you know what is it that this model assesses? MD: It is used infrequently enough that I cannot recall. If they (the FICA questions) were on our paper that we use for our consult, our checklist for every day like pain, nausea, DNR, etc. that is very familiar to me... but since I do not see the spiritual assessment every day, I guess that this is part of the research, how do we have that? ...As I try to think of a question... how do the patient finds strength? A generic spiritual question which I think has been validated in some places. But in terms of the boards, the term questions, they are always going to say that you are not going to get an answer if you do not ask. And if they are not in front of you, you are not going to ask (referring to the spiritual assessment questions).</p> <p>- I know that they exist. As a group, we look at some of the computer entry but in terms of understanding content or the difference, it is something that I am really not familiar with.</p>	RC	<p>- Yes, I use the Amy Van Deurzen existential dimension of the person. I have look at other models but this one is the one that makes more sense to me. It is easier for me to think about, to apply, the steps are easier. I can use my personal reflecting process, I guess. It just makes sense. It flows easy. It is not complicated.</p> <p>- Amy Van Deurzen is an existentialist and what she offers is not necessarily a spiritual assessment but she added to the three dimension of self a fourth one about spiritual perspective so these additions have been tremendously helpful to me. Researcher: What caused you to use this model? RC:</p> <p>- It was one of the first one I learned about.</p> <p>- It made great sense to me because its simplicity.</p> <p>- It was like a foundation upon I could put other models and consider them.</p> <p>-I use other models to ask deeper questions and more formative questions like those used by the FICA model which help to facilitate conversations around what gives people' meaning. What makes people feel connected?</p> <p>- This helps me to get what give people's strengths and makes them feel connected and their needs.</p>
NP	<p>- FICA.</p> <p>- Not sure about spiritual assessment models.</p> <p>- Use assessment model created by the team chaplain. The difference between this and other models is the</p>	SC	<p>- Created his own spiritual assessment model for documentation. It does not have a name. Researcher: Why did you decided to use that spiritual assessment instead of other?) SC: I played around with</p>

	<p>selection of themes but these themes could be found in other models. Not sure if it is a model but it is easy to follow.</p> <ul style="list-style-type: none"> - Verbal communication is more important than written one to find out about what is happening with the pt. The chaplain debriefing in an IDT, or a phone call or an email. Regular communication more than IDT. I want to know about what happened in the PC chaplain visit, what he found out that was helpful to him that could be helpful to me. - I look at the written chart from time to time, but I feel I lean more toward the verbal communication. I feel I get more information that way. It is too hard to put what you learn in 1 hour visit in the charting box. With back and forth question, I can learn more about what happened and what I can do to help. 	<p>several and definitely incorporated pieces of several.</p> <p>Researcher: Which models you used? SC: 7 x 7, a lot of screening tools like FICA, HOPE... These tools seemed very formulate but my way of relating with pts they felt artificial to me, and I feel kind of the first step in actually providing spiritual care is in providing and environment that is safe, that is not scripted, at least for me, it needs to feel natural. I remember trying with a few pts and they did not like it. They did not like that I was running through a list of questions... The resistance from their side also led me to take a more personalized approach and find different ways during different visits to find all these pieces of the puzzle.</p> <ul style="list-style-type: none"> - CASH. I liked because it is simple, you assess four things and every PC practitioner uses it. It is a lingua-franca, like a common language that everyone can use. So, A social worker is seen a similar issue than the chaplain is seen and comparing their notes. <p>Researcher: So, everyone fills the same assessment? SC: Yes, everyone fills it out, the same assessment. It really feels like team work to me... of course everyone has a different perspective. If someone is answering to me (the chaplain) they might have a more spiritual perspective. They might tell a social worker: I really need help with finances or somethings. This model is easy to remember.</p>
SW	<ul style="list-style-type: none"> - I have seen some of the models that we have used in the past but I do not remember if there is actually a name. When I did the Cerner documentation, I glanced through some specific question and some less specific questions but I do not know their names. - No. 	<p>CM</p> <ul style="list-style-type: none"> -I got to be honest with you. I could not name it. Because of our charting system, to chart is important and definitely has to be done. I do it and encourage the residents to do it, but I am into some of the tools you and another chaplain have used, key words like denial, fear of death, isolation and spiritual/family abandonment, those kind of issues or triggers in families. We have to document that. That is a piece of it but I cannot name anyone right now. CM talked about the use of Mackeson and the need to be careful and professional in the documentation

			because it is about people's lives. (She mentioned pastoral intervention's outcomes here but it was brief).
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TABLE VI

Table 6. Spiritual Assessment. What is Helpful? What was found Helpful? The Ideal.

PC Specialty	What is Helpful (in theory)?	What was found Helpful (empirical)?	The Ideal
MD	<ul style="list-style-type: none"> - What the spiritual concerns or issues are for that pt. - Identified the matters that are going to affect how the pt. does with his disease or his life or his treatments. - The context of their spirituality. Usually when the chaplain brings this to me before I visit with the pt. is because they thought it was particularly important and helpful for me and for the pt. before I visit with them. - When life and death issues are going on for pts or their families the chaplain ask about if faith was important. How do they act their spirituality? Do they have a community of faith? What else should be done to assist and help the pts with any religious or spiritual actions necessary to deal with spiritual issues or spiritual questions? - Chaplains' interventions with patients. - The biggest one is whether there is spiritual suffering. Is there something that is going on, external to the disease process that the pt. needs forgiveness for... are they obsessed or worried about what might happen to them after they die? Maybe, influencing the big picture, maybe, influencing the pain, their resistance to agree to hospice, and maybe influencing their decision to continue or 	<ul style="list-style-type: none"> - When chaplains pray at the end of a difficult family meeting or at the pt.'s bedside. It is helpful and comforting. - Researcher: Can you recall things or key words that provided comfort to you, the pts and family members? MD: "To thank God for the care that the pt. has received. For the caring and feelings of the clinical team. It is not that I want or deserve that appreciation but still, it is very comforting. The second thing is that I felt comforted and supported by addressing God saying what is "Your Will" here. Whatever the Will is we are going to do the best we can. The third thing I noticed that I did not expect appreciating so much is that the chaplain, very calmly, at the end of every two to three sentences address God saying: "Oh God or dear God," and to very often repeat what we are speaking, offering our words and our thoughts and prayers to God not just to ourselves or to anybody else. As a more spiritual person than I am, this is very powerfully comforting and supportive to hear" (like a mantra). - "I think, the most helpful things I have seen from the interaction between the chaplain and pt. is prayer, if the family is accepting of that. I think it is a beautiful spiritual way to move into think about the pt.'s illness, outside of the medical piece. I think that the other times that I have seen beauty in the 	<ul style="list-style-type: none"> - The patient's faith tradition. - Religious affiliation. - To know if they are ministers or if someone in the family is a clergy or hold any ministerial leadership or status in the church. "...If that kind of information is in the chart, I would like to read that..." - If there are any specific beliefs that patients have about their treatments. - "...The spiritual-religious background it is helpful to know. It is like knowing the vital signs..." (MD pointed that any team member could screen this during the initial assessment). - "...I think a skill a chaplain can bring to a team is the piece about what is their overall suffering. Where are they in the scale of suffering and whether it is related to a family conflict that needs reconciliation? Is it a conflict with the church which needs reconciliation? - Are they (patients) spiritually ok? - Explore spiritual connections to ourselves and the world. - Who are really important people to them (patients)? - What are your expectations? - What are you hoping for? - What are you willing to accept or go through? - What quality of life? - "...when the chaplain

	<p>discontinue treatments. So, it is that key piece of if there is some suffering beyond what we are used to see from the medical assessment.</p> <ul style="list-style-type: none"> - The patient’s social function is as part of the family the community. How that affects their spiritual being, and how that influences any depression or anxiety and so forth... - Religious coping styles from their script religious background... that might influence these types of things, decisions that pts make, and how they feel they need to consult their spiritual advisors, the priest or the rabbi. - Chaplains are present and aware during PC family meetings to address questions about religious miracles or when talks about faith come up. - The other piece of it, the chaplain been as an observer of the pt. and family and providing feedback on how the team could actually function better for that particular pt. - To come back later and explore some nuances that maybe the physician and the nurse member of the team or the SW member of the team did not see, or really that the pt. kind of brought up and the rest of us sort of moved along. - It is been extremely helpful for me in trying to understand what motivates a particular pt. with a fairly strong faith or spiritual base. - The other piece is when, prior to the PC consult, the chaplain work to establish that relationship and that 	<p>chaplain-pt. interaction is when they discuss about forgiveness and love. That they are loved by somebody, their God or if their family loves them. They are going to be loved and be ok whatever happens.”</p> <ul style="list-style-type: none"> - When the chaplain is present in a family meeting. - When the chaplain engages patients and families when the “healing miracle” theme is brought up in a family meeting. - When chaplains have insight about how the PC team can better work/best approach to work with specific patients and families. - When chaplain identifies nuances that PC practitioners missed during the PC family meeting so they come back after and explore more these nuances. “...I think that that piece is invaluable...” - When chaplain debrief the PC team about what they learned from patients and families during follow up visits. And how to communicate that whole picture to the team caring for the pt. “...I think, we need a strong chaplain partner in that because it is such a big part of who people are, and a place where they go when they are critically ill or not doing well physically.” 	<p>brings that information to me (MD) that can be very helpful in how I start the conversation about serious illness or about circumstances...”</p> <ul style="list-style-type: none"> - Cultural awareness about patients and families. - Assess what were the disconnections about between the PC team and patients/families. What patients and families heard and what they did not hear.
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	<p>connection (with pts and families).</p> <ul style="list-style-type: none"> - Where people are religiously and spiritually grounded. If you do not understand where that person is in their spiritual faith and family, you are going to have a really hard time working with them in their health care. - One of the things that I would like to do more of is to have some kind of debriefing in groups' interactions with team members so we can talk about what is helpful and what is not helpful. 		
<p>NP</p>	<ul style="list-style-type: none"> - Religion: it might change the type of care they would want to receive, especially in EOL care. Types of practices or rituals they want to observe if they are in the hospital or when considering EOL. - How they use their faith or spirituality or religion to understand the meaning of what is happening (illness and EOL related) and how that impacts that (there is not preference about communicating this orally or by writing). I believe it does to a great deal of how they understand their disease, what is happening to them and their dying process. How they interpret that based on their faith. - I like to know not just how it (faith/spirituality) affects their meaning of their illness or they living but also how that affects their story. How their faith or spirituality might affect they story or narrative and how they live their life. - It is helpful for me to know if during the chaplain's visit there is any practice the pt. requests 	<ul style="list-style-type: none"> - When patient or families avoid making EOL decision saying that they put things in God's hands. "...I find that the chaplains will do a more thorough assessment of these people's faith and their believe in God, and identify things in these people's religions that they feel the need to continue to practice, like perhaps not turning off life support because it is not consistent with their faith... Then moving beyond that, once that is established and done, identifying what is behind the family responses in case it could be fears or something else that is underlying that we have not, obviously, assessed and talked about and all of that with the family... In many of these (family) meetings has been the chaplain who unraveled, assessed and got to the roots of what the issue, the fear and the problem of the concerns were." - "... building a therapeutic relationship with the pt., listening and praying for someone. Pts has said that it was meaningful for them when the chaplain prayed exactly for what they were 	<ul style="list-style-type: none"> - Faith-religious assessment. - Faith group. - Religious and practices. - How spirituality and religion impact them as persons. - Getting a sense of spiritual wellbeing. - To be able to assess their distress level if there is any distress. That is what I find helpful. - Chaplain working issues with pts and families, interventions and plans of care. - Chaplain will offer spiritual support transcending the offering of just religious support. "...I have found that people in the community are more open to receive that kind of spiritual support..." -Identify if patients have a community of faith and would like someone to contact them. - Identify patient's strengths to cope. "...This is important to me because if it helps my patients, it is helping me. If I know what my pts strengths are, when talking to them, I can

	<p>from the chaplain, as for example Scripture read or a prayer. Steps and interventions made during the chaplain’s visit.</p> <p>- What is helpful to me is when chaplains go deeper to explore the patient’s feelings about what is happening.</p> <p>-Sometimes, when I am with the chaplain in a consult, the chaplain might pick up on things that I am missing like if the pt. is expressing anxiety or depression or other concerns that later on, during a debriefing, the chaplain could share with me and I will further explore and address in my next visit with the pt.</p> <p>-Identifying key themes like: issues, fears, social isolation, disconnect from faith community, relational tension, grief, existential anxiety (NP mentions the importance of chaplains not just checking boxes but writing or making comments so she can better understand and address the pt.’s identified issues by the chaplain).</p> <p>- The chaplain’s interventions as for example how the chaplain prayer/rituals were utilized to target the pt.’s anxiety and search for purpose. NP pointed that it was helpful to initiate conversations with patients and understand what is the chaplain doing to promote healing on the pt.</p>	<p>worried about. Pts tell me that a lot, that the chaplain prayed for what they needed because he was listening. I think that is meaningful a lot to people. Sometimes that helps them with their connections or whatever they believe. I feel that for whatever reason it could be, this is meaningful to patients...”</p> <p>- Chaplains are helpful when assist patients finding a healthy spirituality. “...By healthy I mean, as opposed to spiritual distress which, I think, contribute to not healing. By healing, I am also referring, not just to the healing of the physical self which most of our patients are not going to be healed because they are going to stay sick and are going to die, but I am talking about healing in a way of finding meaning during that difficult time. Been able to have a healthy sense of coping which creates a more positive experience for the patient in that context, (pain, death and dying). I think that good spiritual care can relief suffering. Some of the suffering is not just pain that we treat with pain medication. I think that suffering is on the spiritual side too, chaplains’ visits can bring healing from that type of suffering.”</p>	<p>remind them of their strengths when important topics come up in discussions...”</p> <p>- Communicate, orally, chaplains’ assessments and interventions. When oral briefing is not possible, ITD meetings and electronic documentation is helpful.</p> <p>- Narrative documentation is more important than checking boxes. “...The biggest barrier to good communication is providers not looking at chaplains’ documentation...”</p> <p>Researcher: Why do you think PC practitioners do not look at chaplains notes?NP: “...the first reason, they might not know that they are there. So, some education could be helpful. Also, because, in part, some people do not realize of the value of spirituality... and because some people do not look at the whole person, just to the organ or system they focus on...”</p>
<p>SW</p>	<p>- The level of support or the level of distress that someone may have. Sometimes the distress is not necessarily the physical resources. It is looking at what types of resources we</p>	<p>-“ Being present in our family meetings, in our team meetings with families is supporting people in knowing that that is an important part of the dimension and depth of that</p>	<p>- Traditional supports within spirituality and religion. (SW identified that knowing patient’s church base is important but “unfortunately” not many people are affiliated</p>

	<p>have for emotional support and help if someone is very distressed about life meaning or frantic because EOL or long term care issues. I feel that we have to address those kinds of things first, rather than moving one to the physical needs.</p> <p>- Not that I can remember.</p>	<p>person, and the plan. I think that it helps people. It puts people at ease to know that we are concerned about that piece. I think it helps us gain trust because we kind of understand where are we coming from as far as their belief system. Sometimes, when people comes from different beliefs systems it is hard for them to explain cultures, and traditions and things like that, and sometimes pastoral care chaplains can pull that out and say, this is something that is important to me..."</p> <p>Here, the interviewed mentioned a couple of cases in which chaplains identified rituals that were important for patients and families at the EOL.</p> <p>- Family relationships, family dynamics coming from a non-medical stand point.</p> <p>- A family meeting is huge when chaplains come to those.</p> <p>-"... when chaplains share what he/she learned (during a visit) is very important. How the pt. is feeling. Sometimes, they are not going to tell the medical staff if they are upset because they might think if they are going to hurt their feelings or they do not want to disappointment them. I think that other team members like the chaplain can find out about it before other staffs."</p>	<p>and are not comfortable talking about it).</p> <ul style="list-style-type: none"> - Do they have a church home? - Do they have people who are going to support them during difficult times? - Do they have people who support them now? - What is their faith base? - What is their level of understanding of that? Do they find strength in that? Do they not find strength on that so it might be something we do not need to focus on? - Do they feel abandoned? - Do they feel hopeless? - Do they have life' meaning? - What are the things that bring them those things? - "...I think that to identify when people have a strong spiritual practice, it helps them to make difficult decisions and help them to embrace what the future might held for them. So it is helpful for me (as a SW) to get that from your assessment (chaplain). To know that this person is not necessarily in turmoil about their meaning of life but it helps me to understand that this person is in turmoil because of their diagnosis. So, this is helpful. It helps me to understand where I need to start, how high or low I need to go." - "...I always feel that chaplains know what to say when we get to that uncomfortable or really sad moment. I feel the chaplain always knows what to say in prayer when you all know when it is appropriate. Ending with a prayer is very helpful. I thinks that is very helpful and something almost
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			unique that chaplains can do.”
RC	<p>- The pts’ emotional state is very important. MDs assess the physical and chaplains the emotional. They go together. Emotional stability and wellbeing are essential to healing. They are chaplaincy goals in patients’ care.</p> <p>- The subjects of coping mechanisms, spiritual coping mechanisms, and other information I gather once the PC team leaves the pt. and family with me... how is the pt. and family coping with the news they just received, the potential outcomes, thoughts about their future, their own plan of actions that they have been able to develop... how are they going to cope with what they have learned (in the family meeting). Can they cope? Their strengths; they resources and what do they need spiritually.</p>	<p>- To share with the IDT patient’s stories of how life changed. They struggle, sadness, suffering, isolation and what gives them joy.</p> <p>- To debrief IDT members about patients’ emotional state and what did the chaplain do to work with these feelings. This has improved the IDT’s understanding and care of patients. “...I do not want to do anything in a vacuum, so, I do not operate by myself. Just the fact that I was communicating with the team what I did, help us to unify our care around the pt....”</p>	<p>- Assess their emotional state.</p> <p>- How they are coping with what they are going through.</p> <p>- If they were able to get any kind of support (Interviewee pointed that his assessment was based on a SW assessment model).</p> <p>- Assess if patients and families need companionship.</p> <p>- Assess if patients and families need to build trust.</p> <p>- Assess if patients and families need to reassign meaning to what they are going through.</p> <p>- Assess if patients and families need help processing their situation and redefining their life.</p> <p>- Religious and spiritual practices of preference.</p> <p>- Assess spiritual isolation.</p> <p>- Assess the “transcending’s” significance.</p> <p>- Assess need for chaplaincy presence after a family meeting.</p> <p>- Identify the “pieces” left to patients and family members after a PC family meeting to, later on, debrief the PC team.</p> <p>- Help patients and family processing the impact of the information they received in a family meeting from an emotional and spiritual perspective.</p> <p>- Identify patients and family wishes, plans, and goals of care after the PC team is gone so the chaplain can debrief the PC team. (Interviewee shared a case in which the patient’s family asked for two more days before they consider withdrawing care on their</p>

			<p>loved one. The chaplain stayed longer with them, helping them processing the information, so the family came to a resolution within the hour instead of waiting for two days. In this case, the chaplain interventions contributed to the time reduction of life sustaining treatments and reduced financial/emotional burdens).</p>
<p>SC</p>	<p>- I have found that the value of what I communicate varies by clinician. To some degree, I think it is kind of a subconscious process, I assess the clinicians I work with and their spiritual vocabulary, and the spiritual concepts they are very comfortable engaging with, engaging in their own life. - Anytime I assess significant unresolved grief, any time I assess a significant relational tension, or anytime that I assess some kind of theological dissonance as a result of their illness, I usually communicate those significant disturbances to the interdisciplinary team. I share these, and explain why I think that they matter. I share: this is why the pt. expresses these concerns. - A significant amount of the population I work with has the tendency to hide from the reality of what is going on in their bodies. Then they will use their spirituality or theology as a mean of hiding from reality instead of helping them to engage with it. Hopefully, when I assess</p>	<p>- “To some degree, I guess, I feel like any engagement with the pt. that helps them (patients) benefits the PC team; helps the PC team because if it helps the pt.” “...I feel it is a contribution to the team, that benefits the team: we assessed something, we screened something that is going on, and we believe that is impacting this person’s wellbeing. Could you go, do your job and help this person navigate this reality (Clinician referral). Any improvement in that condition helps the team and their work...” - “...A couple of things that I have found helpful is that sometimes, the pts will express spiritual concerns, share them with the clinician, and in many ways the clinicians are not comfortable to engage with those, either, those topics or those concerns for a variety of reasons. They might feel they are outside their professional scoop of practice or they are not part of their own spiritual vocabulary. So, I think that, and this is outcomes driven, the simple fact of doing that referral about something that they feel uncomfortable addressing or feel outside their scope of practice...”</p>	<p>- Broad screening for spiritual distress, active emotional and spiritual distress. - Explore patient’s personal stories as, sometimes at the end of their lives, they are dealing with painful stories of shame and regrets. Narrative approach is preferred. - Assess tensions, dissonance, and their spiritual relationships, the divine, transcendent, God, if that is a part of who they are. - Assess social relationships. - Assess grief, complicated grief, unresolved grief, guilt, shame, fear, denial. - Assess what the pt.’s spiritual needs are and how they should be address. Researcher: What do you mean by spiritual needs? SC: “...Specifically for PC I am referring to how the spirituality or religious practices or values impact their EOL care. How aggressively they want to be treated, and some of the emotional issues that arise moving toward comfort care and dying...”</p>

	<p>that, it is been a part of the process of communicating that to the team. Those are the major ones that I usually communicate.</p> <ul style="list-style-type: none"> - Based on clinicians' religious or spiritual language, the chaplain translates, decodes or not what patients express using religious language (The issues of having clinicians with diverse spiritualities, and not having a lingua-franca were pointed as interdisciplinary and communication barriers). Interviewed expressed that the use of terms such as isolation, dissonance, and tension were easier to understand by the interdisciplinary team. - Emotional issues. Ex. if the pt. is fearful of dying. Emotional issues that are connected to the spirit. - Spiritual issues. Ex, fear of going to hell. This is a spiritual issue that the PC team wants to know about because they are trying to discuss EOL care and DNR or hospice. - Family dynamics, who is the Health Care Power of Attorney? What are the more objective and subjective things a family is dealing with? What the family is like? Are there conflicts? All of these can help me, in family meetings, to interpret some of what is going on or speak it out loud or help the PC team understanding these family dynamics. 	<ul style="list-style-type: none"> - "... I feel that to share with the team what I learned about the pt.'s family relational dynamics, family system, is helpful and the team engage (patients) talking about these questions..." - "...with different patients, depending of what they religious background is, I clarify some basic questions as for example: what is this faith group and how do they approach the EOL decisions? How do they approach particular therapeutic modalities and things like that?" (It is like encyclopedic. The chaplain as a consultant). - It is helpful for the PC team when chaplains can explain, from an emotional, spiritual and family dynamics/behavioral stand point, patients and families attitude, feelings, expectations and biases toward the PC services and the EOL. - When the chaplain becomes a religious interpreter for the PC team. Meaning, when the chaplain translates patients' and families' religious statements/concepts use to a language that PC practitioners can understand/make sense. 	<ul style="list-style-type: none"> - Identify if prayer is a resource to be at peace and make an EOL decision. (At the end of the interview, one of the SC talked about how helpful it will be the enhancement of the IDT's communication and patient's care coordination/briefings among PC team members. SC felt it would improve patients' care quality. SC said that this problem existed because the IDT organization needed to improve).
<p>CM</p>	<ul style="list-style-type: none"> - That is different for every PC provider. There is one who prefers a lot more prayers from chaplaincy... Prayers at the beginning and end of the meeting... hope... your insights into what they have done and 	<ul style="list-style-type: none"> - When chaplains prepare patients, families and staff members through educating them and easing their anxiety about what is PC about. - When chaplains alert PC practitioners about terms/concepts used during a 	<ul style="list-style-type: none"> - (Started talking with hesitation because CM was biased with the word assessment. It felt too formal and institutional in caring for patients. CM referred to assessment as checking boxes. CM felt

	<p>they are doing, or how they spoke to that pt.</p> <ul style="list-style-type: none"> - To hear how people are communicating, identify what is the family hearing from the PC practitioners, and how that information is received or being processed and communicate that to the team. - Be present to the story, to the information, because that is spiritual being or connection might be sitting right next to them and the family. 	<p>family meeting that patients and families do not understand so clarification is offered.</p> <ul style="list-style-type: none"> - When chaplains build mutual trust between patients/families and PC practitioners. 	<p>that caring for a human being was much more than that. CM felt that without a relationship, assessments were worthless).</p> <ul style="list-style-type: none"> - CM said that chaplains should assess how to be in a relationship with patients and families. - People's fears and expectations. - The real questions that they cannot ask the doctor because they are afraid. - The spiritual question; the God question; the faith question. What is going to happen? Where am I going? - The joy, hopes, sadness, anxieties, expectations and fears tied up within the synopsis of patients' and families' stories in the here and now. - What patients and families heard or did not heard. - What is it that patients and families need: prayer, hopes, inspiration, clarification...
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TABLE VII

Table 7. Survey Results

PC Specialty	FICA	7x7 Spiritual Assessment (7x7)	Dignity-Conserving therapy (D-C)	Other Models	Scoring Reasons
3 MD	<ul style="list-style-type: none"> • 2 scored 3 • 1 scored 4 	<ul style="list-style-type: none"> • 1 scored 3 • 2 scored 4 	<ul style="list-style-type: none"> • 1 scored 4 • 2 scored 5 		<p>FICA: They were familiar with it. Basic and easy to use. Lacked of depth which the chaplain could provide.</p> <p>7x7: It might distant patients. Too detailed and long.</p> <p>D-C: The best, more transparent to collect information. Gets the most pertinent and important information in the most sensitive and effective way. Too long.</p> <p>Other: N/A</p>
2 NP	<ul style="list-style-type: none"> • 1 scored 3 • 1 scored 3 	<ul style="list-style-type: none"> • 1 scored 4 • 1 scored 5 	<ul style="list-style-type: none"> • 1 scored 2 • 1 scored 5 	<ul style="list-style-type: none"> • 1 scored 5 	<p>FICA: Good/brief to start. Not through enough for a chaplain assessment.</p> <p>7x7: Good and comprehensive. Most through. Would elicit good information.</p> <p>D-C: Good and comprehensive. Could be utilized to assist in communication techniques around the dimensions instead of doing the inventory.</p>

					<p>The model is too specific for end-of-life. It is good for this purpose but not for general assessments.</p> <p>Other: Developed by staff chaplain, combines models providing a through documentation. Offer interventions and plans of care.</p>
2 SW	<ul style="list-style-type: none"> • 1 scored 4 • 1 scored 4 	<ul style="list-style-type: none"> • 1 scored 3 • 1 scored 5 	<ul style="list-style-type: none"> • 1 scored 4 • 1 scored 5 		<p>FICA: Short but good in-depth info. A good quick assessment tool. Could use this one on initial assessment, and then expand to one of the other models.</p> <p>7x7: More complicated. Seems the most thorough. Will be more interested on reading as a SW.</p> <p>D-C: It covers physical and afterlife distress. Very good. Would like more of patient's history background which was why scored 7x7 with 5.</p> <p>Other:</p>
2 SC	<ul style="list-style-type: none"> • 1 scored 3 • 1 scored 4 	<ul style="list-style-type: none"> • 1 scored 2 • 1 scored 2 	<ul style="list-style-type: none"> • 1 scored 2 • 1 scored 3 	<ul style="list-style-type: none"> • 1 scored 4 • 1 scored 4 	<p>FICA: Easy to remember and integrate into clinicians' practices but not room for psychological</p>

				<p>issues like fear. Lack depth. 7x7: Interesting but too long. Confuses the chaplain D-C: Interesting but too long. Limits its focus to dignity issues. It is not comprehensive enough. Perhaps is better for SW to use instead of chaplains. Other: The model CASH could be used by all Palliative Care practitioners. It is short, easy to remember. Ask direct questions to patients and families to assess the fields on McKesson (Hospital electronic charting system at that time) which includes plan of care. CASH asks questions about the person and family conflicts. Allows doing an assessment beyond what the patient say explicitly.</p> <p>SC prefers using his own model of spiritual assessment. Acknowledges it needs a lot of work. It adapts to the individual need of patients and allow a more detailed</p>
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					spiritual assessment. Uses a relational language for communication.
2 RC	<ul style="list-style-type: none"> • 1 scored 3 • 1 scored 3 	<ul style="list-style-type: none"> • 1 scored 4 • 1 scored 4 	<ul style="list-style-type: none"> • 1 scored 5 • 1 scored 5 	<ul style="list-style-type: none"> • 1 scored 3 • 1 scored 4 	<p>FICA: No comments.</p> <p>7x7: Harder to understand.</p> <p>D-C: It is comprehensive. It considers a broader number of aspects of what gives patients' meaning.</p> <p>Other: Four dimensions of Self by Ammy Van Deurzen</p>
1 CM	<ul style="list-style-type: none"> • 1 scored 4 	<ul style="list-style-type: none"> • 1 scored 3 	<ul style="list-style-type: none"> • 1 scored 3 		<p>FICA: It has been the basic assessment for more than 10 years period.</p> <p>7x7: Like, but too complicated.</p> <p>D-C: If you have a relationship the components are rich. As an older chaplain, interviewed appreciates simplicity.</p> <p>Other: N/A</p>

TABLE VIII

Table 8. Researcher's Assessment Questionnaire for the Palliative Care Team

PC Specialty	Do you feel that the questions asked by the researcher were clear and easy to understand?	Do you feel that the questions asked were helpful to identify those aspects of PC chaplains' spiritual assessments that you consider useful for your clinical practice? Why?	Do you feel that the researcher allowed you to freely express your professional opinion regarding the subject of inquiry?	Do you feel that the methods used by the researcher allowed you to freely express your professional opinion regarding the subject of inquiry?	What else would you like to comment about the researcher and/or the topic of inquiry?
3 MD	<ul style="list-style-type: none"> • 2 scored 5 • 1 scored 4 Comments: -2 MD did not write comments. -1 MD said that the questions on the survey seemed vague to him/her and needed to be clarified by the researcher.	<ul style="list-style-type: none"> • 3 scored 5. Comments: -2 MD did not write comments. -1 MD said: Focused on what we would really want to know from chaplain assessments	<ul style="list-style-type: none"> • 3 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 3 scored 5. Comments: No comments.	2 Comments: -Very open. Genuine interest in patient care. -Interesting experience for me. Enjoyed focusing on the chaplain's role in Palliative Care.
2 NP	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. Comments: -Asked for professional/personal input on the matter.	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	1 Comment: -Helpful research to understand how spiritual care is practiced and documented.
2 SW	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	2 Comments: -I think it is interesting and appreciate being able to give feedback to, hopefully

					improve Palliative Care services for team, patients, etc... -Thank you. Looking forward to the results and how we can put them to work with Palliative Care.
2 SC	<ul style="list-style-type: none"> • 2 scored 4. Comments: No comments.	<ul style="list-style-type: none"> • 1 scored 5. • 1 scored 4. 1 Comment: -I would not have minded being prompted more to share about certain statements or to give examples because sometimes it is hard to think through the theoretical side of things on the spot.	<ul style="list-style-type: none"> • 1 scored 5. • 1 scored 4. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. 1 Comment: -I liked that there was oral sharing and reading/writing.	2 Comments: -Thanks for including me! -Thanks. I eagerly look forward to hearing the results of your work! I feel it will have a great impact on our work as a Palliative Care team. Your demeanor was very respectful, collegial, inviting. Thank you!
2 RC	<ul style="list-style-type: none"> • 2 scored 5. 1 Comment: -They were clear but I sensed the questions had overlap in the answers.	<ul style="list-style-type: none"> • 2 scored 5. 2 Comment: -They provided me with additional tools and perspectives for addressing the spiritual needs of Palliative Care patients. -It made me think of the importance of what I do and how my	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	<ul style="list-style-type: none"> • 2 scored 5. Comments: No comments.	2 Comments: -I will be interested in the conclusions and implications of the research with respect to improving Palliative Care to patients.

		assessment affects others on the team.			-I would like to know what is most useful to the other members of the interdisciplinary team.
1 CM	<ul style="list-style-type: none"> • 1 scored 5. 1 Comment: -Researcher was very professional, willing to repeat or give clarification to his questions.	<ul style="list-style-type: none"> • 1 scored 4. 1 Comment: -No two chaplains' ministry in identical ways so aspects could be varied, broad and fluid.	<ul style="list-style-type: none"> • 1 scored 5. 1 Comment: -Absolutely!!	<ul style="list-style-type: none"> • 1 scored 5. 1 Comment: -Yes.	1 Comment: -Good research.

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