

**THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA**

**Report by Rev Tom Rose – 2008 Churchill Fellow**

**Sir William Kilpatrick Churchill Fellowship an examination and comparison of pastoral care models with particular focus on children’s spirituality; family support and their search for meaning/purpose in intensive care situations; leading to the integration of the child’s spiritual needs into the overall care plan leading to a more holistic outcome.**

I understand that the Churchill Trust may publish this report, either in hard copy or on the internet or both, and consent to such publication.

I indemnify the Churchill Trust against any loss, costs or damages it may suffer arising out of any claim or proceedings against the Trust in respect of or arising out of the publication of any Report submitted to the Trust and which the Trust places on a website for access over the internet.

I also warrant that my Final Report is original and does not infringe the copyright of any person, or contain anything which is, or the incorporation of which into the Final Report is, actionable for defamation, a breach of any privacy law or obligation, breach of confidence, contempt of court, passing – off or contravention of any other private right or of any law.

Signed..... Dated.....

## INDEX

<b>Introduction</b>	Page 3
<b>Executive Summary</b>	Page 4
<b>Fellowship Study Program</b>	Page 5
<b>Main Body - Fellowship Report</b>	
a. Spiritual Care Collaborative Summit 09.	
1. The Conference Plenary Sessions.	Page 6
2. The Pre Conference and Conference Workshops.	Page 7-8
3. Brief Summary Comment.	Page 9
b. NHS Scotland - How chaplaincy is unfolding in changing cultural and faith mix circumstances.	Page 10-12
c. 'Theoretical models of healthcare chaplaincy service and practice,'-South Yorkshire NHS in May 2006.	Page 13-14
d. 'Professionalization' of Chaplaincy and Pastoral Care.	Page 15
i. Spirituality	Page 16-17
ii. The Art of Spiritual Assessment: Associate Professor George Fitchett (7X7 Model)	Page 17 Page 18-22
iii. Bereavement Care	Page 23-25
iv. A Note about Palliative Care 'Starshine' Hospice Programme CCHMC	Page 25-26 Page 26
v. Pastoral Care Departments – a brief overview of area served and some unique features	Page 27-30
vi. Some Multi-Faith Issues discussed.	Page 31-32
vii An Ethical Issue surrounding Modern Technology	Page 33
viii PICU Some observations	Page 34
ix. Models of Pastoral Care – Recording system at Children's Hospital Boston.	Page 35-36
e. Education in Pastoral Care Informed by Research	Page 37-43
<b>Conclusions and Recommendations</b>	
Concluding Comment and points for consideration in Australia.	
i. Cross Pollination – ideas and initiatives.	Page 44
ii. For further consideration in Australia.	Page 44-47

## **INTRODUCTION**

The Churchill Trust enabled attendance at a Spiritual Care Summit and a visitation program that covered a number of paediatric hospitals and research sites across Scotland, England, Canada and the USA. To all associated with the Trust, I extend my sincere thanks for this extraordinary, once in a lifetime, opportunity. Thank you also to my wife and family for their ongoing support and encouragement. Thank you to The Uniting Church in Australia and to members of the RCH staff. I would also express my deep gratitude to the many people who so generously shared their knowledge and experience, enriching the learning and the collegial bonds that stretch across the world.

This report provides some insight into pastoral care practices in differing contexts and how these models of care support the distinctive nature of spiritual care with respect to children, families and hospital staff.

Three major themes emerged in which this paper is framed.

### **Context.**

There is a national component to this, exemplified by, for example, the close involvement of the Scottish Government and introduction of guidelines for more uniform practice of pastoral care across the land. Other hospitals, such as those in England, have a variety of approaches drawn, in part, from a more independent or local authority. In the USA, 'ownership' determines how pastoral care is organized. For instance, University or Teaching hospitals adopt a different approach to the Public (County funded) hospitals. Then there are the faith based hospitals who are different again.

### **Professionalization of Chaplaincy and Pastoral Care.**

Across all hospitals visited is the trend to a more professional approach to the chaplaincy discipline and how this finds its place in the multidisciplinary health care system. Moreover, chaplaincy is no longer about 'mission' as such but, with the emerging multi-faith and multi-cultural reality we all live in, there is a need to cater for that change. A document prepared by "South Yorkshire NHS" explains, in general terms, this transition toward the contemporary understanding of spiritual care in England. How pastoral/spiritual care (and I use these terms synonymously in this report) is engaged varies; in some cases hospital paid chaplains from other than Christian faith perspectives (or with bi-lingual capabilities) is one answer of meeting professionally the change in circumstances. A variety of approaches to on-call responsibilities and the allocation of chaplains to specific units are other ways of adapting to the changing professional needs.

### **Education and Pastoral Care Informed by Research.**

With more complex procedures emerging in the medical field, so too does the ethical dilemma facing medical professionals increase. How do we train chaplains to be part of this growing challenge? How are chaplains to be 'ritualistic' leaders in this new 'hi-tech' age? And how, in this machine and computer driven medical profession, are we to manage a dignified death? What are the spiritual questions which emerge and how do we train chaplains to support staff and families in these difficult situations? The role of spiritual assessment, CPE and other training processes, and how these are influenced by differing contexts such as those I found in Toronto (Canada) and at St. Thomas' (England) add to the broader goal of preparing chaplains for the difficult and challenging role. Research at Rush University Medical Center and in Cincinnati Children's Hospital Medical Center are ground breaking in the area of pastoral care. Ongoing research will greatly inform why we do what we do emphasising the growing trend for evidence based spiritual care.

## **EXECUTIVE SUMMARY**

Rev Thomas A Rose  
14 Currajong Street Vermont South Vic 3133  
Phone (H) 0 9803 5340 (M) 0400071599

The generosity of the Churchill Trust enabled me to split the Fellowship with attendance at a conference from 30<sup>th</sup> Jan 2009 to 4<sup>th</sup> Feb 2009 and then a hospital visitation program during May and June 2009. I express my gratitude to the Churchill Trust for this opportunity. The aim of the Fellowship was "to meet international colleagues; an examination and comparison of pastoral care models; study of George Fitchett's 7 X 7 spiritual assessment model with a focus on children's spirituality; family support and the search for meaning/purpose in intensive care situations..."

### **Highlights included:**

- Attendance at the Spiritual Care Collaborative Summit '09 in Orlando Florida, USA.
- Discussion with Programme Director for Healthcare Chaplaincy and Spiritual Care NHS Education for Scotland and Government representative in Edinburgh, Scotland.
- Meeting colleagues in Birmingham, Great Ormond Street London, Toronto; four (4) hospitals in Chicago; Cincinnati, Boston and Philadelphia.
- Attendance at a training session on the 7X7 model of spiritual assessment led by Associate Professor George Fitchett.
- Reviewing educational models and pastoral care models based upon local need.
- Meeting with researcher Dr Daniel Grosseohme in Cincinnati.
- Presentation of study findings to healthcare chaplaincy teams, including CPE participants, at hospitals in Chicago and Cincinnati.

### **Recommendations**

To further develop pastoral care in Australia, it is necessary to:

1. Raise awareness of the move to evidence based pastoral care in paediatric environments. Research will further develop a growing professional outlook for chaplaincy within the broader healthcare system. This includes educational programs to connect more effectively with the changing demands upon the healthcare sector based on multi faith, cultural and resource imperatives.
2. Raise awareness of Associate Professor George Fitchett's 7X7 spiritual assessment model. The art of spiritual assessment defines 'who we are and what we do'; it identifies our distinctive role in the more collaborative nature of the healthcare system. Such spiritual assessment is clinically based and adds to the professional holistic care of the patient/child and, by association, families and staff.
3. Raise awareness of the possibility of pastoral care being more effectively integrated into healthcare teams such as trauma and transplant teams (recognizing that this is a part of some transplant teams in Australia). Evidence for this is contained within the role expected of chaplains in the USA where designated chaplains form part of the integrated trauma teams and transplant teams.
4. Explore the possibility of chaplaincy exchanges for a period of training and professional development. With greater mobility of people across the globe, many issues we face are similar and the sharing of ideas is a way to encourage 'best practice.'
5. Explore models of pastoral care that involve contract chaplains to complete on-call responsibilities or chaplains employed specifically to cover the nightshift.
6. Explore the possibility of appointment by hospitals of chaplains from other faiths or multi-lingual skills to meet specific and local needs.

### **Implementation and Dissemination**

- Provide a copy of reference material to the RCH's management team for consideration.
- Share information with paediatric hospitals/units across the country through electronic medium, written articles and seminar presentations.
- Equipping of chaplains for work in the hospital environment through CPE and other supervised pastoral care/field education programmes.
- Speaking engagements with community groups and public forums.

## **Fellowship Study Program**

### **Spiritual Care Collaborative Summit '09 1 to 4 February, 2009**

Orlando Florida – USA - Health and Hope: *“The Hard Reality of Living Intentionally in a Village of Care”* (including pre conference workshops 30/31 January 2009)

### **NHS Scotland – 28 April, 2009**

Rev Ewan Kelly	Programme Director for Healthcare Chaplaincy and Spiritual Care NHS Education for Scotland	Scotland
Ms Sandra Falconer	NHS Government Representative Patient Focus and International Issues	Scotland

### **Birmingham Children’s Hospital – 6 and 7 May, 2009**

Rev Paul Nash.	Senior Chaplain Birmingham Children’s Hospital	England
Angolia Depew	Bereavement Care Service Co-ordinator	England

### **Great Ormond Street Hospital – 11 to 15 May, 2009**

Rev James Linthicum.	Senior Chaplain Great Ormond Street London	England
Ms Rosie Midson	End of Life Care Manager, GOSH	England

### **The Hospital for Sick Children –**

#### **“Toronto SickKids” Canada – 18 to 22 May, 2009**

Rev Norman Headley.	Senior Chaplain Toronto SickKids.	Canada
Rev Michael Marshall	Anglican Chaplain Toronto SickKids	Canada
Lori A. Ives-Baine RN	Palliative Care and Bereavement Coordinator Neonatology Program	Canada
Gurjit Sangha RN	Palliative & Bereavement Care Service	Canada

### **Chicago - 26 to 29 May, 2009**

#### **Rush University Medical Centre**

A/Prof George Fitchett	Researcher Rush University Medical Center Chicago	USA
Rev Mark Tabbut	Director CPE. Rush University Medical Center Chicago	USA

#### **Comer Children’s Hospital**

Karen Hutt	Chaplain, Comer Children’s Hospital Chicago	USA
------------	---	-----

#### **Children’s Memorial Hospital**

Rev Gretchen Steffenson	Chaplain Children’s Memorial Hospital Chicago.	USA
-------------------------	--	-----

#### **Stroger (Formerly Cook County Hospital)**

Cheryl Holt	Lay Chaplain – (Bishop Anderson House).	USA
-------------	---	-----

### **Cincinnati Children’s Hospital Medical Centre – 2 to 8 June, 2009**

Rev Bill Scrivener	Senior Director Chaplaincy CCHMC.	USA
C Jan Borgman	Bereavement Coordinator CCHMC.	USA
Paul C Beckman	ED/Trauma Chaplain CCHMC.	USA
Daniel H Grossoehme	Researcher CCHMC.	USA
Judy Ragsdale	Director Clinical pastoral Education CCHMC.	USA

### **Children’s Hospital Boston – 12 June, 2009**

Rev Mary Robinson (via email)	Chaplain Coordinator Boston Children’s Hospital.	USA
Rev Anoma Abeyaratne	Chaplain Boston Children’s Hospital.	USA

### **The Children’s Hospital of Philadelphia – 18 June, 2009**

Fr David Morris	Coordinator Chaplaincy. Children’s Hospital of Philadelphia.	USA
Sr Alice Stroger	Chaplain Children’s Hospital of Philadelphia.	USA

## MAIN BODY - FELLOWSHIP REPORT

### a. SPIRITUAL CARE COLLABORATIVE - SUMMIT 09. HEALTH AND HOPE The Hard Reality of Living Intentionally in a Village of Care

My reflections on the Summit are made in three parts.

1. The Plenary Sessions.
2. The Pre-Conference and Conference workshops.
3. Brief Summary Comment.

#### 1. The Conference Plenary Sessions

The opening gathering of some 1800 chaplains from across the world (including visitors from Japan, Israel, Canada, USA and two from Australia) met together to celebrate and share the richness of our vocation in a “village of care.”

Many had gathered a day or two earlier for Association meetings or pre-conference workshops - The challenges facing each other, each in our own context, drawn together in a moment of goodwill and prayerful, mutual support.

The conference plenary sessions formed the ‘hub’ of our learning experiences and opened the door to new insight or perhaps confronted us with what we may have known already, perhaps only dimly.

Initially, in Plenary Session 1, we were challenged to think beyond the World Health Organization definition of healthcare with a specific challenge to the notion of, and role of, the individual. Free autonomous choices, coupled with a culturally and economically driven approach (capitalism) towards what constitutes health and wellbeing, are a critical issue. The early Christians offer a different view, one in which the interconnectedness is stressed and health and well-being are understood in a ‘community’ context.

Ms Isasi-Diaz, originally from Cuba and describing herself as a political refugee, was even more forthright in Plenary Session 2, when she stated “living intentionally - means living morally - take responsibility for what we do, who we are, and what we become.” Living intentionally is not the way of the world. Care implies being concerned about each other, allowing ourselves to be disturbed by others. To understand differences is to pave the way for elimination of prejudice - racially, politically and economically.

Boundaries, says Ms Isasi-Diaz, are dependent on relationships - and that means knowing each other. The challenge posed directly at the USA and the West is to embrace a new way of being, that has, at its core, a new paradigm of caring for one another in such a way as to eliminate injustice. “What we do is for now; without it there is no future“.

Dr Corn, in Plenary Session 3 spoke of a circle of care - the ‘interlinking’ circle of patient, professional carers (medical and spiritual), family and neighbours. The role of chaplain does impact people’s lives and in a “Therapeutic Alliance” we can make a significant difference. Dr Corn describes us as wardens, each discipline, in the Therapeutic Alliance possesses a key. For us, it is the key to unlock the door to the spiritual kingdom. His research points to ‘unmet’ needs in patients. By their actions, they point toward ‘missing something’ - we were reminded that even with modern medical hi-tech procedures, spirituality is at the core.

“No cure that fails to engage our spirit will make us well.” Victor Frankl.

Connected to our humanness and the narrative of our life is the spiritual quest of others. Relationships foster hope! What is the opposite of time (that thing we have so little of). The answer is love – Time is limited; love is boundless.

## 2. The Pre-Conference and Conference Workshops

There were many workshops at the Summit and, although I was only able to attend seven of these, they did provide some insight into the growing professionalization of our vocation. In each workshop questions of how to be present and how to share the hope that resides in each of us emerged in the interconnectedness of our religious faith/spiritual being.

The following is a brief summary of those seven workshops. *(full details can be obtained from the Spiritual Care Collaborative website).*

### **Pre-Conference Workshop P2: Negotiating Uncertainty - The Ethical Challenges of Hope, Truth Telling and Informed Choice in Professional Caring.**

The question of hope/false hope and how our own perspective determines our response was focused within this workshop. Hope is a pervasive, illusive concept – an emotional attitude related to particular outcomes, personal values and goals. How we deal with this in healthcare opens up the question of ethics “basically about the way we do and should treat each other.” Ethics involves systematic investigation of our values and actions. The convergence of these in the process of good decision-making challenges the notion of autonomy and our own perception. “I have spread my dreams under your feet. Tread softly because you tread on my dreams.” (W B Yeats).

### **Pre Conference Workshop P4: Ten Stories, Three Streams: Teaching Tales from Buddhism.**

“Two simple happenings that got entangled – we are born and we die; everything happens and nothing happens.” Thus begins the journey into the three (3) streams of Buddhism and the story-telling, so much a part of its history. Coloured by cultural perspectives which have influenced practice over the centuries, Buddhism is a dynamic system of belief which offers wisdom and hope for those seeking spiritual care.

### **Pre-Conference Workshop P11: An Interdisciplinary Dialogue on Integrating Core Competencies for Physicians Social Workers and Those in Professional Ministry in Effectively Addressing the Impact of Substance Misuse on Families and Children**

Interdisciplinary dialogue focused on substance misuse, reinforcing the need to know the resources around us. Recognized as a brain disease, the way we care is focused more accurately in the medical model. Spiritual care emerges as the tangle of human existence/relationships begins to unravel. Values, belief systems and consistent behavioural modelling for children are major areas of care.

### **Pre-Conference Workshop P12: From Misery to Freedom Psycho Theology Goes to the Movies.**

With the use of classic films, this workshop invited participants to discover/uncover the process of transformation in people. How to uncover the transformative moment when deliberately initiating the “head on collision.” For Rodriguez in “The Mission” this moment came (after he had murdered his brother) in the statement by Fr Gabriel “you did love your brother – you have a strange way of showing it.” For Scrooge, it is a head on collision with his past and unresolved grief. Aspects and issues in both of these also find expression in the film “Miss Pettigrew Lives for a Day.”

### **Workshop M1.12: Death and Dying: An Islamic Perspective.**

The possibility of a Muslim chaplain baptizing a child sets up the somewhat challenging dynamic for all chaplains. Aspects of Muslim beliefs emphasizing patience, acceptance of God’s will are paramount. To remind a Muslim of his or her duty brings with it a sense of order and peace and prepares him/her for time in paradise. Death is a gateway likened to birth. All steps to preserve life must be taken (ie. We must not hasten death) so thorny issues such as futility of treatment and “Not for Resuscitation” arise. Autopsy is another area that can bring dispute; however, the law of the land always prevails.

### **Workshop M2.20: Working Collaboratively to Provide for the Spiritual Care of Trauma Patients.**

This workshop covered provision of spiritual care for trauma patients and invited us into what a ‘team’ approach might provide. A trauma surgeon, supportive of a chaplain on the team, a chaplain whose role seemed to encompass many aspects of what we would normally see undertaken by social work (at least in our context) and a researcher collecting data in order that analysis may guide the provision of future spiritual care actions more effectively. The chaplain is an integral and respected part of the team.

### **Workshop T1.2: Supporting Adult Caregivers of Grieving Children: In Hospital and Beyond**

How do I tell my children? This challenging question haunts every adult. How a spiritual carer can support families through those difficult times was one of the focuses of this workshop. The dialogue between adult good intentions and children’s need for truth formed the back drop for exploring children’s spirituality. Developmental stages of grief for children and appropriate responses were also offered. As spiritual caregivers, the responsibility is to start the conversation, perhaps with the question “are there children who will be impacted by this loss?” “We must always place the child at the centre; always remember this is important privileged work...to participate in each person’s journey...”

### 3. Brief Summary Comment:

From the Plenary sessions we are invited into the incontrovertible truth that our decisions have an impact on others! Being connected is part of our human story in all its richness and in all its poverty. For me, this theme is one that underscores all that we do in pastoral care and a lens through which the remainder of this report is written.

Much of the research I have read and much of my personal experience at The Royal Children's Hospital Melbourne, points to connectedness as the single most important aspect of a child's presentation and subsequent hospitalization.

This connectedness finds expression in spiritual themes such as, but not limited to:

<b>Connection with Child</b>	To maintain relationship with the child through presence, words, or symbols.
<b>Truth in Communication</b>	To have information expressed openly and entirely without barriers that mislead or prevent full understanding.
<b>Truth in Knowledge Truth in Being</b>	Accurate understanding of the child's condition. Acceptance of the child's death.
<b>Compassion</b>	Care and empathy demonstrated by words, actions, and body language.
<b>Prayer, ritual, sacred Text</b>	Activities that strengthen one's bond with transcendent reality and one's faith tradition.
<b>Connection with Others</b>	Relationships with others as a source of spiritual support.
<b>Bereavement Support</b>	Acknowledgment of suffering and grief, and guidance through the dying process.
<b>Gratitude</b>	Thankfulness for life and one's children's lives.
<b>Meaning and Purpose</b>	Reasons for one's being and the ways in which one's being contributes to the greater body of human good.
<b>Trust</b>	To perceive that health professionals have integrity and ability and the will to do their best to care for one's child.
<b>Dignity</b>	To be recognized as human and as having worth. <sup>1</sup>

Given these spiritual themes, the emphasis of connectedness and professionalization of chaplaincy, how do we adequately prepare for such a pastoral/spiritual role? How does the professionalization of pastoral care impact the training and identification of our role in the broader healthcare system that appears to be in a time of transition itself?

---

<sup>1</sup> "The Spiritual Needs of Parents at the Time of their Child's Death in Paediatric Intensive Care Unit and during Bereavement: A Qualitative Study."  
Kathleen L Meert, MD Celia S. Thurston Dmin; Sherylyn H. Briller PhD.  
Paediatric Crit Care Med 2005 Vol6 No4.

**b. NHS SCOTLAND – How chaplaincy is unfolding in changing cultural and faith mix circumstances.**

I began with a visit to Scotland where, in a meeting with a Government Representative and the Programme Director for Healthcare Chaplaincy and Spiritual Care NHS Education for Scotland, I spent a few hours reviewing the historical events that have led to the publication of various documents and standards for pastoral care and chaplaincy across Scotland.

In essence, and not unlike the experience in Australia, there has been a decline in membership of the mainstream churches in Scotland. At the same time, religious groups such as Muslim, Hindu, Sikh, Buddhist and new age religions have gained some prominence. Historically, chaplains in the hospital setting have offered 'religious' care (usually Christian) to members of their own tradition, a situation which is under review in light of the demographic changes that have taken place.

The working group responsible for preparing the Scottish reports agreed on the following definitions for religious and spiritual care.

Religious Care - is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a faith community;

Spiritual Care - is usually given in a one-to-one relationship, is completely person-centered and makes no assumptions about personal conviction or life orientation.<sup>2</sup>

The use of spiritual care as a broader term to describe the search for that which is of 'ultimate concern' is evidence enough of the serious intent to meet changing community need and indeed, expectation. I have attempted to capture something of the Government initiative in the healthcare system that has moved Scotland into a more patient centered focus.

**Patient Focus and Public Involvement (PFPI)**

The original vision was for NHS Boards (and there are 14 of these across Scotland - each responsible for the management of pastoral care in healthcare settings) to embrace a service where *"people are respected, treated as individuals and involved in their own care. A service where individuals, groups and communities are involved in planning and improving services."*<sup>3</sup> Driven in part by the changes in demographics, it seems to me that there is also a desire to ensure consistency across Scotland when it comes to honouring and respecting the diverse religious groups now in evidence.

As such, the original vision falls within the legislative evolution of equality and diversity across NHS Scotland. A new publication "The NHS and You"<sup>4</sup> was prepared and launched after appropriate consultation.

Direct involvement of local communities became a requirement –*"...to fulfill its responsibilities for public involvement, NHS Boards must routinely communicate and involve the people and communities they serve to inform them about their plans and performance..."*<sup>5</sup>

---

<sup>2</sup> Spiritual Care & Chaplaincy Scottish Government 2009 page 6  
<sup>3</sup> [www.scotland.gov.uk/library3/health/pfpi-oo.asp](http://www.scotland.gov.uk/library3/health/pfpi-oo.asp)  
<sup>4</sup> [www.hris.org.au/index.aspx?o=1021](http://www.hris.org.au/index.aspx?o=1021)  
<sup>5</sup> webpage [www.communitiesscotland.gov.uk](http://www.communitiesscotland.gov.uk)

Professor David Kerr, in his report *"Building a Health Service Fit for the Future"*<sup>6</sup> remained "committed the NHS to continuing to give patients an influential voice in the future of the health service and in their individual care..." This has meant inclusion (through elections) of patients and community members onto healthcare Boards. While there seems to be a desire to become consistent across Scotland, there is also, in Professor Kerr's report, a 'presumption against centralization' implying that principles and guidelines are always designed after giving due weight/consideration to the opinions of public opinion (local).

PFPI is now a standing agenda item for the Minister's Annual Review of each Board's stewardship of the local health service. The Scottish Health Council's annual assessment of the Board's delivery of its PFPI responsibilities is the basis of a meeting between the Minister and a representative group of patients chosen by the SHC.

A centrally coordinated Patient Experience Program was launched in February 2008 to systematically assess patient's experience across NHS Scotland and to support Boards to act on information to improve service delivery and make year-on improvements in patient experience.

The Scottish Government's initiative into the healthcare system impacts directly on chaplaincy, where the expectation is compliance with these new understandings. While it is early days, the program Director for Chaplaincy in Scotland is working toward implementation of these directives.

The need to conform to standards carries with it both promise and risk. While it can lead to more effective and uniform spiritual care, it may also mute spiritual creativity. Standardization with sufficient scope to meet local need is a complex task; and I wonder about over involvement of legislation. The balance between the spiritual assessment task/care and meeting a political agenda/resource limitation is an 'interesting' path.

### **Observation and Comment.**

1. The key to increasing professionalism in 'chaplaincy' ('chaplain' is a term widely accepted/validated by all faith traditions in Scotland) lies in continuing education. This could range from workshop activities to Masters' level (or higher) education. The Scottish experience has enshrined a way forward that takes chaplaincy out of the religious into the more appropriate for this day and age chaplaincy. Professionalism demands systematic and ongoing education and also challenges the traditional notion of chaplain, to now include the possibility of paid representatives of other faiths other than Christian.
2. Programme Director advised that Basic CPE courses have been available for a while but for various reasons haven't "taken off." However, reflective practice is becoming increasingly normative in various forms - supervision, reflective groups etc. How this is developed nationally ensuring some consistency and competency in this important area is on the agenda. With current human resources/lack of training in advanced CPE, it is not likely that CPE will become normative/mandatory, but hopefully part of the menu of reflective practice methodologies from which chaplains can choose to engage with to facilitate reflection. A UK wide group APSE - Association of Pastoral Supervisors and Educators - has just been formed and will contribute to this process. In support of this need for resourcing, a connection with the CPE Director at Rush University Medical Center in Chicago has been made - there appears to be a desire to forge a stronger link with Scotland.

---

<sup>6</sup> [www.scotland.gov.uk/resource/doc/924/0012113.pdf](http://www.scotland.gov.uk/resource/doc/924/0012113.pdf)

3. Accountability, through patient/community consultation, ensures adherence to Government legislation. This 'adherence' would be subject to annual review by the Minister responsible for healthcare matters. My understanding is that it is not intended for the Government to micro-manage pastoral care, but rather to oversee the entire healthcare system of which chaplaincy and pastoral care is now seen as an equal partner. What does this mean for the advisory committee we have at RCH? Do we need to broaden its outlook by inclusion of people of other faiths, greater input from hospital staff and, of prime importance, 'end users' of our care? How far does legislative compliance mute chaplaincy?
4. Accountability in 'evidence-based' chaplaincy is a vital component and preparation of appropriate data input scheduling for pastoral diagnosis and interventions has commenced. This, when also combined with research into how to assess and direct chaplaincy resources, is a valuable asset in the provision of appropriate and timely pastoral care. Here again, contact between Associate Professor George Fitchett; Researcher Rush University Medical Center Chicago (USA), an expert in the field and Programme Director for Healthcare Chaplaincy and Spiritual Care NHS Education for Scotland has been encouraged.

The financial commitment by the Scottish Government is also a factor that needs to be considered. While the changes envisaged are designed to meet the changing need, the move towards greater professionalism and accountability in the field of pastoral care is also the possible challenge to the 'autonomy' of this discipline.

At the same time, there is the need for the chaplaincy and pastoral care discipline to articulate more clearly what is unique and distinctive about what we bring to the healthcare table. The work done in Scotland is especially impressive from this point of view. The uniqueness and distinctiveness of spiritual care will be explored more fully in the 'spiritual assessment' section of the report. It is a question also raised in the next section on 'theoretical models of healthcare chaplaincies.'

The approach to professional practice is detailed in a series of booklets prepared through a consultation process since 2002. These booklets include: Spiritual Care and Chaplaincy - The Scottish Government. Edinburgh 2009.

Supporting documents explain 'why spiritual care matters' and 'competencies for chaplaincy.'

Other publications include:

- Chaplaincy Standards 2007
- Spiritual Care Competencies
- Multi Faith Resource
- Spiritual Care Matters
- Religion and Belief Matter

**c. Theoretical models of healthcare chaplaincy service and practice,<sup>7</sup>  
South Yorkshire NHS, England, May 2006.**

When speaking with the Great Ormond Street Hospital Chaplaincy team, I became aware of something of the history of chaplaincy and the likely path of this vocation in healthcare settings into the future. The struggle of chaplaincy to engage a changing healthcare setting, linked to competitive funding arrangements, challenges historical models of chaplaincy and spiritual care. This is not only in response to a changing financial situation, but also within the more cosmopolitan demographic and faith community mix that is now Britain.

As is the case in Scotland, the Government in England has, since 2004, become more focused on increasing patient choice within a competitive market. Development of “Independent Treatment Centres” alongside NHS services has ensured a system where quality is regulated through payment by results. Evidence-based practice, which prioritizes researched ‘best practice,’ is very much a part of the ‘results’ these changes have demanded.

Chaplaincy departments have had to reassess what they do and how pastoral or spiritual care is delivered. There has been a need to describe and articulate what it is we do that adds to the healthcare mix. The report I am referring to, starts with definitions as such – “...*service models* which explain how we do what we do; *practice models* concern the specific work we do...*In order for spiritual and religious care to be effective within the healthcare system, it is crucial that systematic and practical link is made between models of assessment and models of practice*”.<sup>7</sup>

This is a telling point for me, one upon which I will comment further, when reflecting on Associate Professor George Fitchett’s 7X7 spiritual assessment model. Further, how this spiritual assessment model identifies the very clear distinctiveness of spiritual care in the collaborative healthcare setting.

### **Some Historical Perspectives.**

In 1948, the Ministry of Health issued guidance to Regional Hospital Boards on meeting the spiritual needs of patients and staff. Numbers of chaplains were determined by the number of beds, were essentially Christian based and simply did not take into account the changing needs of the patients. In 2003, guidelines provided for a more multi-faith perspective.

The report states this religious or ‘parochial model’ (common in 1948) is still practiced in England even now. The local parish Priest offering pastoral care, comes into sharper focus with an emerging professionalism that demands contact with other or no-faith patients, as well as staff. Then follows the need to make connection in the community, as healthcare evolves, into a more community-based expression of care.

Writing in 1988, Peter Speck refers to the distinction between religious and spiritual care and in his publication “Being There – Pastoral Care in Times of Illness” he describes the heart of his model of care as “presence” and timely interventions of the chaplain - a role he suggests “*is a myriad of things and sentiments including organised religion, ministry, a spiritual dimension, a source of hope and a sign of contradiction*.”<sup>8</sup>

---

<sup>7</sup> Caring for the Spirit Implementation Plan: Guidance Note  
A review of some theoretical models of healthcare chaplaincy service and practice  
South Yorkshire NHS: Strategic Health Authority. May 2006. P2

<sup>8</sup> Ibid p. 5

For Speck, the religious model, based on the Christian concern for the welfare of others, comes under critical scrutiny when it deals with people who do not have a religious framework or language within which to speak of, or make sense of, matters of ultimate concern. The evolving service and practice model assumes all patients have spiritual needs alongside physical, psychological and social ones (not just those who stipulate adherence to a particular religious group).

*"It is here that CPE offers a way forward. In CPE training the 'verbatim report' is a way of recording and reflecting on pastoral conversations with patients. The written verbatim becomes the focus in supervisory conversation between chaplain and supervisor for the purpose of personal and professional development. While it may never become a central approach to chaplaincy practice in England (despite the recently formed United Kingdom Association for Clinical Pastoral Education UKACPE) CPE remains an influential model of service and practice.*

*The 'Caring for the Spirit' document mentions the contribution of CPE ... While the strategy does not venture how this approach or aspects of it might be developed within NHS in England, the Spiritual Healthcare Development Units and Chaplaincy Collaboratives may focus on the verbatim report and its use in supervision when considering the education of chaplains from foundation courses through the Continuous Professional Development (CPD)."<sup>9</sup>*

The implication of the underlined section, for me at least, is the awareness of continuing education over and beyond 'foundation' courses. This underscores the growth towards a more professional discipline in the ever-changing healthcare system and desire to meet the opportunities cultural diversity brings. ie. there seems to be a movement from the church-based education criteria (parochial model) to a more professional structure which might include enhanced hospital based-training programs (such as at St. Thomas'), University level courses and Clinical Pastoral Education.

The danger of 'melding' spiritual need 'into a myriad of other needs,' threatens to diminish the distinctive nature of spiritual care. Again, education and continuing development of a professional criteria for spiritual care is underlined.

---

<sup>9</sup> Caring for the Spirit Implementation Plan: Guidance Note  
A review of some theoretical models of healthcare chaplaincy service and practice  
South Yorkshire NHS: Strategic Health Authority. May 2006 p.10

#### d. 'Professionalization' of Chaplaincy and Pastoral Care.

When looking at the emerging professionalism of pastoral care, I was struck by the efforts to define clearly what it is we bring to the healthcare setting. Research tells us spiritual well-being is a key factor in the healing process, but what does 'spiritual well-being,' mean for us, as spiritual carers - the holders of the keys to the kingdom, as Dr Corn (Page 6 of this report) suggested?.

As the Senior Chaplain at GOSH suggested "... *the spiritual side of our humanity is an important aspect which finds closer scrutiny in times of crisis...* "

With this in mind, Great Ormond Street Hospital patients and their families are given an information brochure, as part of the chaplaincy support offered – in part this brochure states:

*"Everyone has a spiritual side. This can help us deal with life's challenges, gives us hope and meaning, and lets us see how our experiences are part of a bigger picture. There are times when our spiritual side needs support. We understand that it can be stressful when your child is ill or in hospital. You might feel lonely, confused, angry or without hope. Spiritual support can take many forms, such as listening, talking, praying together or just being there. Belonging to a religious or faith community nurtures the spiritual side for some. Others maintain their spirituality in other ways. Regardless of whether you belong to a religious or faith community or not, members of the chaplaincy and spiritual care team at GOSH are here for you."<sup>10</sup>*

For the Chaplaincy team at Birmingham Children's Hospital this means, in practice

*"...accompanying, sharing the bereavement journey with families. We don't seek to offer easy answers or platitudes to their grief or questions, but to travel with them, supporting them from alongside... We currently have resources to cover Christian, Muslim and Non-specified religious affiliation..."*

The transition from Christian religious pastoral care, into a more expansive spiritual quest, carries with it both challenges and opportunities. I am mindful of the cultural influences that impact across the different countries visited and also the growing acceptance of spiritual care as part of the healthcare team approach. What language do we use to provide opportunities for multi-faith or no-faith patients and assist families find meaning that is truth for them? What is the distinctiveness of what we do? What is it that spiritual carers add to the healthcare team? As we struggle with these questions and engage the collaborative healthcare team, we are led to a place where "*boundaries between one profession and another are increasingly fluid.*"<sup>11</sup>

In exploring the professionalism, I will relate anecdotally on aspects of pastoral care as I observed them in practice across the hospitals I visited. These comments by no means say all that could be said, rather, they are an insight into a deeper and more complex unfolding relationship of spiritual care and the healthcare system - (both in terms of the changing nature of society and also the delivery of healthcare services in a more regulated society with considerable resourcing challenges.)

---

<sup>10</sup> Pamphlet handed to parents about the services offered by the Chaplaincy Department.

<sup>11</sup> Caring for the Spirit Implementation Plan: Guidance Note

A review of some theoretical models of healthcare chaplaincy service and practice  
South Yorkshire NHS: Strategic Health Authority

May 2006

## i. Spirituality

We are human, finite and we live in relationship with creation that is continually changing and evolving. However we understand our finitude and relationship with existence; these issues lie at the heart of the spiritual quest. What gives our life meaning and purpose? A question that can be shaped and manipulated by religion, culture and historical perspective. "What is truth?" might be one question that underpins the spiritual quest of the sick and dying. It is certainly a question asked by parents of sick and dying children. (refer comments page 9). A/Prof Fitchett offers this insight - "*Spiritual is the search for the sacred...Religion is the context within which some people conduct that search.*"

Spirituality embraces a wide range of belief systems, both sacred and secular. I have attempted to articulate one or two approaches to this issue in this paper. For me, it is in the experience of life itself, 'the going,' that the quest for meaning and purpose is to be found. The very essence of Anton Boisen's model of CPE.

Given this insight, the relational aspect of a person's life takes on a more urgent focus. How do we integrate the experience of a critically ill child with the family's (and our) life's journey, shaped, informed and, in some cases, distorted by the value system that informs our relational and decision making processes? In many ways, the spiritual quest is about the integration of all these factors – spirituality always happens within a context.

For instance, can a child's spirituality be separated from parental influence or for that matter, from Teachers peer groups and society more generally? Research by Piaget on 'How Children Learn,' Erikson's study on 'Forming Relationships,' combined with Fowler's research on 'Faith Development,' all inform the spiritual carer about what might be an appropriate model of spiritual care.

In essence, in the paediatric setting, we must care for the spiritual needs of the primary caregivers – the parents, accounting for all the factors which impact these needs.

The NHS Scotland Publication - Spiritual Care & Chaplaincy (Edinburgh 2009) offers this insight – Section 1.3

*"The awareness of self, of relationship with others and with creation, the finitude of life, the search for meaning, for the transcendent, and the need to be acknowledged, accepted, valued and loved, are all parts of this dimension. Many have reported profound experiences of wonder, joy, inner peace, transcendence and connection to nature and others, in ways they can only describe as spiritual. Many express these understandings and experiences through a belief system, by holding to a set of values, or through belonging with and participating in the life of a faith community"*

*"Among basic spiritual needs that might be addressed within the normal, daily activity of healthcare are:*

*The need to give and receive love  
The need to be understood  
The need to be valued as a human being  
The need for forgiveness, hope and trust  
The need to explore beliefs and values  
The need to express feelings honestly  
The need to find meaning and purpose in life"<sup>12</sup>*

In other words, the practical acceptance of, and being valued for, who we are in the sacredness that is our story of life - context.

---

<sup>12</sup> Spiritual Care & Chaplaincy NHS Scotland  
The Scottish Government: Edinburgh 2009 Page 5-6

To shift the focus from parents to teenagers for a moment, I saw an example of this valuing of the individual sacred story at CCHMC: College Hill Campus (Cincinnati) -

“... a spirituality session with troubled youth engaging them in a wonderfully non-threatening conversation... Using poetry and song, the chaplain had volunteers from within the group read the words out loud. This was done individually or in tandem with another... People in the bible faced really bad situations too and they were always trying to work things out - and they wrote about the experience... Bit like those people who wrote the songs and poems... So now we are going to do the same sort of thing.

Each teenager was then invited to take a pencil and a piece of paper and write, or draw if that was preferred, their own version of whatever grabbed their attention (copies of the poems and songs having previously been given out). Called back into the group, each shared their response – some were only one or two words, others were very deep reflections on their personal pain – prayer was mentioned... and this was discussed in a non-threatening way.

Each individual participant was applauded, encouraged and valued for the work they had done – not only was spirituality discussed (in terms appropriate to the situation) but each teenager was also affirmed and encouraged...a deeply spiritual act.

## ii. The Art of Spiritual Assessment – Why we do what we do!

In his book,<sup>13</sup> Associate Professor George Fitchett defines spiritual and assessment as: Spiritual - is the dimension of life and reflects the need to find meaning in existence and in which we respond to the sacred.

Assessment - is both a statement of perception and a process of information gathering and interpreting.

For A/Prof Fitchett, the importance of spiritual assessment is that it provides an indication as to why we do what we do. In light of my experience in Scotland, England, Canada and the USA, the action of spiritual assessment takes on increasing importance as we define and claim our role in the ‘collaborative’ healthcare setting.

One of the most significant events of the Churchill Trust sponsored study program was the opportunity to study with A/Prof Fitchett, at Chicago’s Rush University Medical Center, his 7X 7 spiritual assessment model.

The model directs the chaplain’s activities to areas of greatest need and provides a framework for clinically determined actions/interventions. A/Prof Fitchett developed three levels of intensity of care: These can be broadly stated as -

- Level 1: low needs and high resources are the lowest priority and are generally only providing information about pastoral care, what a chaplain is and does, and their availability.
- Level 2: needs and resources, roughly in balance, are second priority. Their care is less frequent and less intense than care typically offered to those considered to be level 3.
- Level 3: These persons, who have high needs and low resources, are the chaplain’s highest priority for contact.

Aiming to take the ‘guess work’ out of spiritual assessment, this model ensures all the information that can be gathered is gathered and considered before a pastoral diagnosis and/or plan for intervention is enacted. It is not intended to blunt the intuitive bent of chaplains, but rather it is a tool to confirm intuitive assessment and inform accurate and professional interventions in support of the wider healthcare team context.

---

<sup>13</sup> Fitchett, George      Assessing Spiritual Needs: A Guide for Caregivers  
First Academic Renewal Press Edition 2002

***A case study on spiritual assessment using George Fitchett's  
7x7 spiritual assessment model including insights into how this  
model can be used and taught.***

The structure of this education session was:

1. Presentation of the case study.
2. Time for reflection and sharing what in the presentation touched each of us.
3. The 7x7 model of spiritual assessment engaged
4. Process moves to formulation of an assessment
5. Recording a note in the patient's chart.
6. In an educational reflection process, a final question – having done the assessment, what would you now do differently?

**1. Presentation of the Case Study** (Please note that names and details of this case study have been changed to protect the privacy of the people involved)

Jeremy is almost 18 years old. It was on his 17<sup>th</sup> birthday he was told of the diagnosis of cancer. He attended the hospital for a few days each week to undergo chemotherapy. After almost a year of therapy, Jeremy was now in remission and going home. Jewish by faith, intelligent, with dreams of a future which included going to college, Jeremy presented with seizures about a month after going home. The reason for these seizures is currently unknown.

Jeremy's father is said to be a 'religious soul' although far from traditional. Key biblical themes discussed by the chaplain with Jeremy included biblical heroes Abraham, Hannah and Esther. Jeremy was reported to have said in these conversations, "if you only love God when life is good, you don't have faith." Jeremy is also reported to have said, he needs "to work through the tasks set..." and "maybe I am being tested. I can learn and grow..."

Jeremy's mother appears to have more faith than his father. When Jeremy was asked about candles as part of a celebration, he replied "oh yeah, she would really love that."

Open and able to converse freely, Jeremy has struck up a meaningful relationship with the chaplain (who happened to have a similar faith background to Jeremy) even to the point of putting his 'laptop' aside for a conversation. Jeremy continued with his plans to go to college and wrote an essay about his experiences which, rather than being morbid, was positive in outlook.

Jeremy's dad has pushed him for treatment and, while generally strong and optimistic, has had his more fragile moments. Some of the presenting issues for the chaplain include - What are Jeremy's goals and what are the ethical issues involved? What is the relationship with his father?

**2. Time for reflection and sharing what, in the presentation, touched each of us.**

Before starting the assessment process, the first question asked of the group was - having heard the brief introduction, what were the predominant feelings experienced by those of us who heard the information? Feelings ranged through positive identification with Jeremy's optimistic approach to sadness. "The positive centre but with frayed edges."

### 3. The 7x7 Model of Spiritual Assessment engaged

#### PART 1 - HOLISTIC ASSESSMENT

##### MEDICAL

Evidence gathered about what is happening – in this case – after completing chemotherapy and going home, we then have seizures – so severe they broke his back – they came out of nowhere. All this is happening in someone who is otherwise healthy. Possible loss of leg. When Jeremy has the ‘bad’ chemotherapy, he has a ‘bad’ after affect.

##### PSYCHOLOGICAL

Begin with past treatment, noting that he had experienced ‘depressive episodes’ - ‘situational’ depression being treated appropriately. Noted mood changes – when anxious, he spoke more rapidly. Anger perhaps over loss of independence?

##### FAMILY SITUATION

One sibling. Younger brother. Close or not close? Dynamics – any conflicted relationships? Are the relationships intense? Over involved? Any ‘triangles’? Emotional connectedness? Closer to mother?

##### PSYCHOSOCIAL

17 yo male - lives with parents - at high school - plans for college. Economically well off and has health insurance. Stages of family and individual development. Occurring in late adolescence, he is on the cusp of leaving home and this illness “screws” up his plans. Being delayed – a judgment on his own life? Decision to have chemo is a big one with impact on future relationships?

##### RACIAL/CULTURAL/ETHNIC

White, Jewish and intimately connected with spiritual religious life.

##### SOCIAL ISSUES

Social policy – is it easier for Jeremy and his family because of the policy/institutional decisions that have been made? Will he be able to graduate on time? For example, is the school flexible in its approach to Jeremy’s situation? Legally, Jeremy is a minor and the position of the law must be considered. Staff would look for his assent at the very least.

### 4. Process moves to formulation of a Spiritual Assessment

#### PART 2 - SPIRITUAL ASSESSMENT

This is a flexible sequence of considerations, some of which may not be appropriate in every case. Some may be more or less significant than others as well.

##### BELIEF AND MEANING

Is Jeremy in a time of transition? Social network – friends and family, also those people on the wards he has befriended - This is a characteristic of adolescence –

He is an extrovert and finds meaning in these relationships.

Is belief and meaning in crisis, as illness threatens his making these connections?

Does his illness put this in jeopardy?

Does his illness therefore heighten his activities in this regard?

Does his illness threaten a deeper meaning as he refers to Hebrew scriptures and the heroes of his faith tradition? His illness is 'messing' with his sense of meaning and he responds to this in ways that are helpful to him.

Meaning is also about HOPE – these words are connected.

For example, college is a hope and also gives him a sense of meaning. He continues with this project.

Hope is the "Future Story". What is he telling himself? How has he had to modify/able to maintain 'future story' for himself. Religious beliefs - Why God is testing me?

### **VOCATION AND OBLIGATIONS**

"Give thanks for the rain and the sunshine" is evidence of a mature characteristic.

What grows out of religious beliefs? What do they hold for him? What is his moral connection? His, 'ought to do his duty?'

E.g. Candles for mother (she will like that): Observe the Sabbath.

The duty to his father. e.g. This is the treatment I want to take, This is the treatment you should take. Of course I have to go to college - this is what young men ought to do.

### **EXPERIENCE AND EMOTIONS**

Is it prayer? Mysticism? Conversations with spirits? - is a cultural possibility – There are some cultures where this is important, although it does not appear to be in this case.

### **COURAGE AND GROWTH**

The word courage is taken from Paul Tillich's writings and is to highlight 'the virtue associated with handling doubt in a particular way.' (mindfully embracing doubt).

The word courage is not intended to denote bravery, but rather how he handled the issue of religious doubt.

Whether or not illness is causing doubts about religious belief - these are important questions, but in Jeremy's case, it is not doubt so much as challenge.

For example, 'maybe I am being tested, I can learn and grow' and 'work through the tasks set.'

In the context of crisis, some religious/spiritual growth occurs. Will Jeremy have an accelerated spiritual and religious maturity because illness has occurred at this stage in his life and he has had to wrestle with it?

Crisis can cause re-evaluation – met in this crisis, religious and spiritual has become a little more mature.

### **RITUAL AND PRACTICE**

Candles - Biblical Stories - Talking and meeting people - (Illness cuts into this practice). Transitory impact of chemotherapy.

The 'laptop' is it part of a ritual? – normal? – soothes calms and reassures.

### **COMMUNITY**

This aspect is central for Jeremy - for him it is essential - to be in community is to be 'alive!' He has an important role to play in this community and is an 'initiator', creates new community - with family and new friends.

### **AUTHORITY AND GUIDANCE**

This was obtained through stories, family, Rabbi and perhaps, also significantly, through the chaplain - his conversation partner.

## Formulation of an Assessment

What are three main themes that recur or come to you from the data you have collected?

1. Identity - what is my understanding of myself? Sense of belonging (community). His illness threatens this and so Jeremy needs to sustain his identity in ways that reduce the threat.
2. Rituals that give expression to key parts of his identity.
3. Is there a duty to parents and does this prevent him from being more candid - a little overwhelmed by things?

### Should we intervene in this case?

What should we do with an optimism that does not seem to be addressing reality?

### One assessment expressed was -

"...if the way Jeremy is responding is harming himself or someone else, then we probably need to do something. If not, it may be the best way he can cope. In the context of this crisis, it may not be smart to make changes..."

## 5. Recording a note in the Patient's Chart.

Jeremy is facing illness and appears to be coping reasonably well and talks readily with the chaplain.... Chaplain will continue to supply supportive care.

## 7. In an educational reflection process, a final question – having done the assessment, what would you now do differently?

**In Cincinnati, USA – CCHMC: College Hill Campus**, I had the opportunity to speak with the chaplains there about spiritual assessment when working with troubled teenagers. It involves two parts:

1. Personal narrative - there is a form for those who have a religious background and a form for, so called, 'atheists.'
2. Assessment Form - Interestingly, the 7X7 – '3 levels of care' form the basis of the spiritual assessment criteria used.

The challenges here are gaining the confidence of abused teenagers or those who are suffering mental illness. The challenge – what is hallmark psychiatric illness? Answer, distorted thinking! So just how do you diagnose and interpret such distorted perception.

In this context, spiritual assessment is about trying to locate that 'safe place' – as it might become (has been) and the chaplain is always listening for this, 'safe place.' The personal narrative is a good place to start – one good friend in their life that they know cares/believes in them/companionship/affirms them – can be enough.

Some of the teenagers have no-one! Perhaps this is because behaviour prevents development of meaningful relationships, distorted thinking and mistrust.

Trust issues emerge here - family issues also embrace the question – who do you think of as being in your family? As many as 20% trace a change in life to the death of a grandparent. The theory goes, “In a reasonably healthy family, grandparents are first source of unconditional love and regard.” When the grandparent dies, a teenager may feel as though they will never have that love and stability again – even if they can’t name that feeling. Families are often not skilled at helping children processing grief and, in a broken family, this lack of stability becomes more focused. It becomes important for the chaplain to discern “where is your sanctuary/safe place?”

Faith history opens up all sorts of issues that might include clergy abuse. So when trying to assess spiritual needs, it might be that trust is so broken, it is impossible – at least in any formal sense. Nevertheless, it is an important question, because it will influence the pastoral care plan.

The chaplains were clear about defining their role - Teenagers are always told what to expect from a chaplain – so an attempt is made to locate the role in the lived experience of the teenager as it is now. In the hospital - this might look like,

*“...Not here because you want to be here; but you are, and what I want to do is to help you make this time here as helpful as it can possibly be.” As a Chaplain, I want to partner with you in that in whatever way makes sense to you, but I will look to you to help me understand how I can help you. Available to meet you one-on-one. Staff know how to “page” me...”*

### iii. Bereavement Care.

Common to all the hospitals I visited, was an involvement in bereavement care by the chaplains. The nature of this involvement varied, as did the nature of the collaborative element of healthcare providers.

When a child dies at **Birmingham Children's Hospital, England**, a booklet is handed to parents by attending staff. The role of chaplaincy is explained by staff and contained in the booklet is the following introduction – *“You and your family may like to have a short blessing or ceremony for your child. The hospital chaplain and the chaplaincy team can arrange this for you. They can also call your own religious leader for you...”*

As such, chaplains are included in the end-of-life process and are often called upon when the 'Rainbow Room' is used. The 'Rainbow Room,' is signposted around the hospital and is very much like a small motel room with separate bathroom and bedroom. It is located right next door to the mortuary and, should the parents wish to leave and return, access to their child is a relatively simple process.

'When a child dies pathway documentation' is extensive and staff are well informed of processes, including the role of the chaplain.

Cards and booklets are part of the response from Birmingham Children's Hospital (BCH). A booklet is sent out within a week of the death of a child. This will be either a religious or spiritual resource according to information on the notification of death form. The books are:

- No Religion 'When You Lose Someone You Love.' Susan Squellati Florence
- Christian 'You're Never Alone.' Elizabeth Rundle
- Muslim 'Jannah: The Garden from the Qur'an and Hadith.' Adem Yakup

About two months after the death of a child, chaplains at BCH write and offer parents the opportunity to have an inscription in the Trust's Memorial Book (Trust is the Hospital). The letter is bi-lingual if appropriate. The Memorial Book is kept in the chapel and is turned to today's date by the chaplaincy team. If a chaplain is off-site, the Clinical Coordinator has the key to the book and can make the changes to the book as necessary.

The book is in a glass case for protection, inscribed by a professional and, if required, a family can arrange to see the page with their child's name written on it at any time.

At **Great Ormond Street Hospital, London, England** I met with The End-of-Life Co-ordinator who outlined hospital policy. Documentation is also extensive here as is the training of staff in matters of bereavement. Booklets given to parents include the following (located at the very beginning of the information) *“...Some parents find it helpful to have a brief ceremony of blessing for their child, even if they are not particularly religious. Please ask your nurse if you would like the chaplain to be called, or your own faith representative contacted...you will be able to hold your child and to spend as long as you wish together. Staff will be with you but will give you time alone...”*

One innovation by GOSH is establishment of “The Death of a Child Hotline” which is run by the end-of-life care team. A program is in place that sees people trained for telephone counselling of the bereaved. Volunteers are all bereaved parents, so it is about three years post-death before any bereaved parent is allowed to even 'try out'.

Educating staff, trained for success (meaning getting better and leaving hospital) makes it a challenge to effectively prepare staff for death of a child. It challenges their professional training. While training does take place, liaison nurses deal with the practical matters, including the “calling in” of chaplains. To facilitate the training of staff, the hospital end-of-life care team has produced a guide called *“When a child dies: Information for staff”*. (available at GOSWEB). It covers issues before death and what happens from a medical/nursing/registration of death point of view. Post mortems and the reporting of a case to the Coroner, funeral information and resources for on-going care are also included.

At **Children’s Memorial Hospital Chicago, USA** Chaplains must also sign for the release of a body. As a part of their activities, chaplains are also responsible for the Advance Directives Documentation. These include - Durable Power of Attorney - Living Will – Proxy. There is also a chaplains “to do” list which includes:

1. Organ Donation Protocol
2. Autopsy
3. Contact residential accommodation eg Ronald McDonald House to inform them of death.
4. Team Notification of Death form (given to bereavement representative in each of the units.
5. Release of Remains Form.
6. Expiration interview
7. Childs belongings and mementos.
8. Bereavement Folder (information for families).
9. Release of remains and expiration interview.

In **Cincinnati Children’s Hospital Medical Centre (CCHMC) USA**, I met with the Bereavement Coordinator, a new position located in the Pastoral Care department and accountable to the Senior Director. This offers a different approach.

In essence, chaplains respond to all deaths in the hospital and, unlike other hospitals where the histopathology staff and Clinical coordinators are the usual personnel who release the child from the mortuary, the body of the deceased cannot be released until the Chaplain has signed the Release of Body Form. This is essentially to ensure contact between the family and pastoral care actually happens in this difficult time. There is an End-of-Life packet given to families which outlines what happens now? The Chaplain is also present when discussions with families occur about post-mortem examination; autopsy; Life Centre Procurement (organ donation).

A record of the death is maintained and the Bereavement Coordinator is responsible for ensuring that all departments (especially the billing department) and staff are informed. One complication is the transportation of bodies to other countries, say, for example, Saudi Arabia. In this instance, it is the chaplain who is responsible for liaising with the embassy.

The Bereavement Coordinator also arranges for cards to be signed by staff, including physicians, and posts the card to family. The ‘day’ is important and cards are sent with this in mind. For example, the second of the month might be an important day, so the day (rather than the month) reflects the support offered.

Details of deaths and follow-up are recorded on an excel sheet and all relevant information is easily accessed for this task. About 14/15 months out from death, a Bereavement Survey is sent to families for completion. The question is always before the Bereavement Coordinator as to how they might do things better.

At **Children's Hospital Boston, USA**, a review of 2008 deaths showed that chaplains provided care to 98% of the families and were present at the time of death 94% of the time. They are not required to complete any paperwork other than charting in the medical record.

The Director of Chaplaincy indicated that the hospital has a well-developed bereavement program that is unit-based. Bereavement follow-up is coordinated by designated RN's who provide materials at the time of death and follow up at regular intervals, including anniversary dates. There are three memorial services held annually in the hospital and chaplains share in their planning, along with nursing, physicians, child-life, (play therapists) social work, environmental services, aides and so-on. (The services are for (1) oncology, (2) domestic violence/child abuse, and (3) the 'all-hospital' memorial service.)

Chaplains are often called to perform a religious ritual and can play a significant role if a longstanding relationship has been formed. Chaplains send cards on important anniversary dates, but this is left largely to the individual chaplain.

There is an Annual Memorial Service (held in May) in which chaplains participate. I have been given a copy of the May 2009 service (Not too dissimilar from the RCH).

**At The Children's Hospital of Philadelphia (CHOP), USA**, Chaplains are called to about 80% of deaths and do not get involved in paperwork. There are 15,000 staff at CHOP, 100 social workers and 60 child life workers (roughly equivalent to play therapists). Pastoral care is limited only by numbers of staff available, three (3). An Annual Memorial Service is held and one of the unique offerings to parents is completion of a book with the children's photo in it and a poem or sacred memory recorded. While this raises some questions about public airing of personal pain, it has been a great success.

#### **iv. A Note about Palliative Care**

The palliative care programs at all hospitals visited is worthy of mention, I mention two briefly to highlight the significance and design to meet the specific needs of the context in which the programmes find expression.

**Toronto 'SickKids,' Canada** –The Information for Parents booklet begins with -

*"Palliative Care means providing medical, physical, emotional and spiritual support for your child and your whole family when it seems your child may not survive an illness or medical condition... We support children and families as they face the fears, needs and challenges of the end of life period."*

The booklet also includes reference to consultation with local healthcare providers, for support after the child is discharged from hospital. Comprising three (3) members who work in the hospital and who also offer training courses outside, the work is effectively carried out with the support of associated members. These associated members include play therapists, music therapists, art therapists etc. This group of three work with outside organisations to whom the children are referred and continue the liaison during the final days sending cards for up to a year after death.

The palliative care team works during the day; there is no on-call or weekend work – hence the importance of training PICU and NICU staff. I have also been given a copy of - Living Dying "A Guide for Adults Supporting Grieving Children and Teenagers" written by Ceilidh Eaton Russell. I was impressed by the commitment of the palliative care team who take referrals from units in the hospital. In conversation it seems there is a strong resemblance between how I understand our palliative care team working at the RCH and what happens here at Toronto 'SickKids.'

**Children’s Memorial Hospital Chicago, USA**, has developed a program called ‘Bridges’ to help families cope with decisions and feelings related to a child’s life limiting medical condition.

The ‘Bridges’ team operates normal week day working hours with an on call service in the evening and on weekends. As a principle and guide, the CMH quotes the British Royal College of Paediatrics and Child Health and the Association for Children With Life-threatening Conditions and their Families, definition of palliative care –

*“Palliative care for children and young people with life threatening conditions is an active and total approach to care, embracing physical, emotional, social and spiritual elements. It focuses on enhancement of quality of life for the child and support for the family and includes the management of distressing symptoms, provision of respite and care through (disease), death and bereavement.”*

**Cincinnati Children’s Hospital Medical Center (CCHMC), USA**  
**“Starshine” Hospice Programme.**

*“In the dark night of the end of life there is a small shining light in support of you at this time...”*

The hospice programme, while originally operating independently of CCHMC is now included under the Bereavement Coordinator within the Chaplaincy and Pastoral Care Department. The hospice programme is based on the English model and is in part funded through “medicade,” or through private insurance. The programme is dependent upon donations and community support to meet the financial shortfall.

Cicely Saunders (UK), founded the modern hospice in the early 1900’s, with the understanding “...we do everything we can to help you live...” With this in mind, and in making the most of the time left, the “Starshine” motto is “making every moment count.” Making every moment count includes the spiritual, as well as the emotional and sociological. Quality of life includes, personal reconciliation, sometimes the reconciliation of families and the setting of goals ‘day-by-day.’

Conditions of participation in the hospice programme (set Federally) must be met – these include “...a physician must sign a certificate of terminal illness (6 months or less)...” which is a standard medicade requirement, even for adults. Spiritual care is mandated and it is a widely held view here, that chaplains are best qualified to support this dimension of care within “Starshine.” Spiritual care, in this context, is defined as “What gives your life meaning and purpose,” (a general question) and then to the religious question (a specific question).”

The experience of “Starhsine” is that parents tend to focus on the physical progress, of their child, rather than the spiritual – meaning/purpose questions. Spiritual questions generally emerge after the death, when the wrestle to comprehend what has occurred floods and sometimes overwhelms parents and families. For this reason, the “Starshine” hospice program follows families for two years after death (Bereavement care for the first year is mandated under medicade). The reason for two years is that experience has shown that the second year is particularly tough.

CCHMC is the only experience I am aware of where a “hospice” programme has been included in the Chaplaincy and Pastoral Care Department as part of the bereavement coordinator’s role.

v. **Pastoral Care Departments – A brief overview of area served and some unique features.**

<b>Hospital</b>	<b>Beds</b>	<b>Staff Levels</b>	<b>On Call</b>	<b>Education</b>
Birmingham	270	3FTE + volunteers	Staff on roster	No CPE
GOSH	360	2.9 + Volunteers	Staff on Roster	No CPE
Toronto	266	3FTE + 3P/T`	Contract Staff Weekends CPE residents during week.	CPE via CPSP
Children's Memorial Chicago	250	5FTE + 2 FTE Nightshift	Contract when required	CPE RUSH Memorial
Cincinnati	500	14FTE +CPE Residents	Staff on call	CPE
Boston	400	7.2 FTE + volunteers	Staff on call Catholic Chaplains funded externally	No CPE
Philadelphia	510	3FTE + 1 P/T	Contract (x6)	Ltd CPE

**Birmingham Children's Hospital – England.**

The hospital is located centrally to the city of almost two million people (wider area - the West Midlands - approximately four million). A large and fluid immigrant population forms a significant proportion of the patient population and this creates a unique challenge in the provision of chaplaincy services and pastoral care. A 270 bed hospital, BCH treats about 200,000 children each year. Everyday there are 400 outpatient visits; 120 accident and emergency presentations and 300 inpatients.

Those who identify themselves as Christian number about 45% of the hospital patient population, (more than 30% are Church of England): None or Not Known 27%; Muslim 23%; Sikh 2%; Other 3% - are the major components of the inpatient religious mix.

The entire chaplaincy team is paid for by the Trust, with a FTE of three staff which I understand to be in line with the Government-set-patient-chaplain ratios. There are actually eight chaplains who work in the department most on a part-time basis. Seven volunteers also support the group including Youth Workers.

**Great Ormond Street Hospital London, England.**

In this hospital located in the West End of London lies one of the leading paediatric hospitals in the world. Opened on the 14<sup>th</sup> February, 1852 by Dr Charles West at No 49 Great Ormond Street, the hospital has grown through acquisition of neighbouring sties and rebuilding programmes. The President of the hospital (1989-1997) was Diana, Princess of Wales – and her memory remains an important emotional tie to the hospital. Her continuing influence is not to be underestimated.

London is a city of about eight million people. GOSH does not have an Accident and Emergency facility and receives children from other hospitals across the country or from outpatient referrals. Overseas patients also attend.

It is widely regarded as the best hospital in the land and patient/family hopes are often raised whenever a referral to the hospital is made (whether this is realistic or not). This is a 360 bed hospital with approximate number of admissions (2008): 32,041 approximate number of outpatients (2008):118,896

One of the special features of the hospital is the number of Muslim families who attend. For the most part, these families come from the United Arab Emirates, Kuwait or Dubai seeking the specialist care available in the Private Hospital at GOSH. This is a different cultural mix from that experienced in Birmingham.

All chaplains are paid for by the Government and the structure is Senior Chaplain (1.0) Greek Orthodox (0.3); Muslim 0.3; C of E (2X0.5); Muslim women unpaid (x2) – it is hoped ‘charity’ funding will enable payment for another Muslim Chaplain (female) at 0.3

### **Toronto ‘SickKids,’ Canada.**

Serving a diverse population, Toronto ‘SickKids’ is a hospital where daily attendance figures show had an average of 266 inpatients for 2008. There were almost 62000 presentations to emergency and 324,997 outpatient visits in 2008. Over 150 languages are spoken in the city.

Contained in the Annual Report (2008) is the following overview –

*“People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funders and essential participants in the healthcare system.”*

*Roy Romanow “Building on Values: The Future of Healthcare in Canada.”*

The need to include patients and their families in the healthcare process is evident and forms part of the vision of pastoral care. As mentioned in the education section of this report, the issue of multi-faith participation/inclusion in the CPE process is evidence of this focus.

Structure of chaplaincy services – Director; Anglican; Roman Catholic; Jewish; Muslim and two teaching chaplains (7<sup>th</sup> Day Adventist & Catholic) and resident chaplains (CPE students). All ‘staff’ chaplains are paid for by the hospital, although not all are paid full stipend. Director and teaching chaplains are paid for by the hospital (FTE). Anglican is ‘gifted’ by the church. Remainder work in the community to supplement limited funding by hospital.

### **Children’s Memorial Hospital Chicago, USA.**

A hospital of approximately 250 beds, Children’s Memorial Hospital is a stand alone paediatric hospital. It serves an area where there is a large ‘Latino’ population and some 40% of the hospital population speaks Spanish. Two of the chaplains are fluent in Spanish and another is studying the language part- time.

Each day there are about 200 presentations to emergency with a rate of presentation of over 400 per day during the recent swine flu scare. It is a level one trauma hospital.

There are seen full time staff (including a Manager) paid for by the hospital.  
Each FTE chaplain is assigned wards - usually two wards each.  
There are two night-only chaplains who work from about 8.30 pm until 8.00 am.

These chaplains work set nights and are required to be at the hospital. There is no sleeping and they are constantly moving through the hospital on their rounds. This is quite a departure from the normal on-call and is the only hospital I visited where this 'on deck at night' chaplaincy occurred. A handover sheet is signed off and a verbal handover given each morning.

### **Cincinnati Children's Hospital Medical Centre, USA.**

The Pastoral Care Department at Cincinnati Children's is one of the largest I have encountered. In addition to the staff team, there are four CPE residents doing a full 12 months and each is paid an annual stipend. This money comes from an endowment fund which was established in the 'early years' and has built up to a substantial sum over time. The hospital has another campus at College Hill, specifically designed to cater for troubled youth. Sadly, it is well used.

In 1987, CPE students returned (after an absence of many years) and so the current system began in earnest. The appointment of a CPE Supervisor was a significant part of this story. The hospital was established by the Episcopal Church in 1925 and the Bishop is always (ex-officio) a member of the Board of Trustees. This ensures spiritual matters are firmly in view although anecdotal evidence also suggests a strong faith outlook exists within the medical staff.

Around 1989, pastoral care had become fully integrated into the hospital system. Providing 24/7 coverage of the hospital when no one else would, pastoral care firmly entrenched itself as first-call in emergencies and critical times/end-of-life times. At present there is an increasing focus on end of life with expansion of bereavement care (refer comments under bereavement care section of this report).

### **Boston Children's Hospital, USA.**

Located about 200 miles from New York, Boston boasts a population of about 4/5million people. Spanish is spoken by many and it is not uncommon to see two translations of any instruction, guide or pamphlet. The hospital has about 400 beds and boasts a chaplaincy department of 7.2 FTE. - Director of Chaplaincy (UCC -1.0 FTE); 4 Catholic (1 is Spanish/PT spkg) 2.2 FTE; Jewish (Hebrew spkg), 0.2 FTE; Muslim (Arabic spkg) 0.2 FTE; Episcopal/Hindu (1.0 FTE): Night chaplains (on-call from home 5P-8A) 2.6 FTE (105 hrs/week)

There are Roman Catholic priests on-call for emergency sacraments, paid for by the Boston diocese. There is also an active team of volunteers, ranging from Eucharistic ministers, to lay communion service leaders, and CPE trained lay and clergy. These volunteers are not included in the above numbers.

## **Children's Hospital of Philadelphia , USA.**

Rated the number one paediatric hospital in the USA for the 7<sup>th</sup> consecutive year, all staff are rightly proud of their achievement.

The Chaplaincy Department is no different – made up of less than three FTE (all paid for by the hospital) the team supports children, parents and staff in this 510 bed hospital. The hospital has a number of satellite institutions as well and these are not included in the bed numbers.

Located in the 'University' section of the city it is an area known locally as the 'badlands.' In looking at the context, I was informed of the exponential growth in violence in the city. There are some 300 ER visits each day.

Chaplaincy is set to grow and this has the strong support of the hospital executive. There are no formal records kept of 'occasions of visits/pastoral support,' – hospital executive being aware of the vital role played by chaplains. This will need to change as the department grows and plans for a recording system (on line) are in train.

In looking at increasing the size of the department, it is a goal to recruit chaplains who are not 'religious specific' in outlook. That is, they are hospital chaplains – capable of visiting anyone – rather than being denominational visitors.

### Proposed Structure

3 FTE and 1 P/T: on-call chaplains (X6) with another approved for employment. A further 2 P/T chaplains will have a roving commission visiting satellite centres; and a further 2 new (P/T) positions within 2 years.

The hospital will pay for these extra staff although 'grant' funding from external sources is being researched. There are local organisations who can grant funds and give these in blocks of 2/3 years (eg. Penn Foundation). There is also work being done in the "Development Department" on obtaining support through wills and bequests.

## vi. Some Aspects of Multi Faith

### A story...

My wife and I went to dinner with the Senior Chaplain and his wife. We went to a restaurant in the eastern end of Birmingham for curry (a Balti). The food and company were excellent, so too was the service. At one stage during the evening, we noticed that we and perhaps 5/6 other westerners were sitting in the front of the building. At the rear were some 30 or 40 'locals.' Such segregation may not have been intended, but gave a powerful insight into the challenges faced in the life of the Birmingham community.

### Another story...

I did not get to meet the Muslim Chaplain as she was away in Pakistan working with a charity group to which she belongs. It was a disappointment after all that I had heard about her. In conversation with the Senior Chaplain, he shared a story from her "She said to him one day - I much prefer Easter to Christmas - Easter is much more in the spirit of how we should live..."

Herein lies the complex nature of working in chaplaincy at Birmingham Children's Hospital. The chaplaincy team is determined to ensure acceptance and respect are part of the compassion and caring offered at the hospital. To this end, materials are prepared for use by staff and issues of culture and religion dealt with in a dignified way.

Appointment of a female Muslim chaplain was a need expressed by female adherents to Islam. The female chaplain is open and active in her work and has made a significant contribution to the chaplaincy department and to the PICU in particular. There are times when information about the family dynamic (obtained by the Muslim chaplain) has proved helpful in the relaying of important medical information.

In welcoming a female Muslim chaplain, the Imam, attached to the **Great Ormond Street Hospital, London, England**, said *"It is often more fundamental in a hospital like this, from the Muslim perspective, that mums have another woman that they can talk with freely and unreservedly"*

**Birmingham Children's Hospital, England**, has also initiated the preparation of a set of written information pamphlets for Muslim patients and their families. This has been made possible through the financial support of the BCH Charities. This is a further indication of the integration of the multi-faith network into the hospital's life, and of the support for pastoral care in this hospital.

Planning is in place to produce materials for families, hospital staff and the community in palliative, end of life and bereavement care, with a focus on Islamic traditions and beliefs. In a national conference, these resources will then be shared.

### **Muslim Council of Britain - Aspects of Chaplaincy in a Paediatric Setting**

I was privileged to be a part of a training day for Muslim Chaplains at Chigwell, East of London, about half an hour by train from Great Ormond Street Hospital.

Twenty-four chaplains attended (9 female and 15 male) and were introduced to team chaplaincy at Great Ormond Street by the Senior Chaplain and the Muslim chaplain. Case studies were offered which generally challenged Muslim belief in the context of extraordinary and critical situations. How would you respond? What are the issues you would need to consider? Who can you turn to for support and advice? The responses were shared by the group and fielded by both presenters.

## **Muslim Perspective**

The Muslim chaplaincy service is driven by Quaranic guidance – *“O believers, bow down and prostrate and worship your lord and do good to others that you may be successful.”* 22:77 and Prophetic Instruction – *“Whoever doesn’t respect the elderly and doesn’t show kindness to the young, he is not on our path.”*

**Consolidation** of these teachings includes things like Kind words; Words of sympathy; A trial from God; Submission to God; Message of Hope – the prophet’s use of the word ‘saleen’ for stung or poisoned.

**Five Ingredients of a Muslim Chaplain** include Knowledge of faith; Positive attitude and interaction; Readiness for service; end-of-life preparation; Informed decision on matters of great stake, such as withdrawal of life support.

## **Summary Comment**

Muslims must have a loving and compassionate nature. Towards anyone who is sick (especially children) we must give comfort.

Visiting the child is about advocating for the child, to Allah, even above/over the doctors. Words can negatively impact on the family and the religion and must be carefully chosen. Presence is just as important. For all that, the words “Allah knows what is best for your child” can give some kind of consolation.

One of the case studies was where the use of pork was the only nutritional supplement for a child was discussed - are there any alternatives? And what is in the interests of the child? To not use the food supplement, the child dies. In this instance where there was no other alternative, permission was given as the food was to save a life. The law of necessity applies. However, Muslim chaplains asked that clarification of content of foods be noted and the question, why was this the only food? be put to treating physicians first.

What is significant is that Muslim chaplains are being trained in how to work with the medical professionals in the NHS system. They are actively engaging the process of determining the best course of action given the intersection of religious imperatives and the need of the medical profession to save lives.

The result may mean clearer and better communication between all parties as we move into the future. From what the Muslim chaplain said, it might also be discerned that what was offered was appropriate only for Muslims. The ‘comforting words’ to other faiths or westerners may not be appropriate. What this may imply is that to become hospital chaplains authorised to visit generally, further training would be required.

Interestingly, at **Toronto ‘SickKids,’ Canada**, I was privileged to meet the President of the multi faith group (a Muslim) who advises on matters multi cultural to the Ontario Government. The issue of extending CPE, or the education of chaplains in the broader issues of spirituality, forms part of the agenda of this group. This new comprehensive education program is an important initiative at ‘SickKids.’

## vii. An Ethical Issue surrounding Modern Technology and Hospitals

At Toronto 'SickKids,' Canada, a discussion surrounding the growing use of My-Space U-Tube, Twitter and the like, issues of privacy and safety were discussed. Ever-growing use of these mediums to communicate create different challenges for staff dealing with children or teenagers and for the staff themselves who use the media for communication. Face Book is another way of doing the same thing. In some cases, parents have included photo's of their child on the Face Book

Some of the ethical questions which emerge are - Who is looking after the child's rights here? What if the child would not wish to have a photo published in such a way?

In a discussion, the benefits and concerns were aired. In summarising this discussion, significant issues arise and a conclusion reached. At Toronto 'SickKids,' a formal policy is being prepared to cover such issues – it has wider implications for other hospitals as I understand over 250 hospitals in the USA are involved in this technological method of communication. It is not just individuals and families, but organisations too, who are impacted by the possible implications of privacy and ethical considerations.

Benefits include: Efficient method to keep friends and family up-to-date on their child's health and progress.  
Enables receipt of encouragement and support.  
Share personal information and disseminate beliefs.  
Express gratitude towards providers and institution.

Concerns: Confidentiality (private information in public spaces).  
Persistence required.  
Searchability  
Replica ability (once it is there it is there for good)  
Invisible audience. (who says all will support and encourage)  
High levels of self disclosure  
Dis - inhibited personal expression  
Sexual soliciting and harassment.  
Electronic bullying, repeated contact phone calls and other electronic devices.

Ethical Issues.: Autonomy  
Vulnerable population  
Best interests of child versus parents.  
Beneficence - parent versus child.  
Patients say that prevalence of information on these modes of communication suggests sexual behaviour, substance use and violence. Is this what we want vulnerable parents and children (say teenagers) to be engaged in when at the hospital?  
What about photos which include faces of staff?  
What about information that is incorrect?

There is also the placing of 'incriminating' photos on the electronic media with likely/possible implications for future employment prospects.

The reality is that professional identity impacts on the private life in Face Book publication. Media Education "What you put there today you may regret tomorrow."

'SickKids' is in the process of writing a set of guidelines for use of Face Book/Blogging/ U-Tube and the like. The message is, if in doubt don't do it.

### Viii. PICU Some Observations.

I had the privilege of shadowing chaplains working in the PICU at several hospitals across England and the USA. Working with families involves building relationships of trust and here, continuity was a key factor. Cincinnati was one such hospital and Toronto SickKids another, where a strong relationship with a chaplain was a significant part of the support for staff and families alike. In all hospitals I visited, chaplains were seen as an integral part of the PICU environment.

As is the case in all PICU's, death of children is a reality and the care for parents and families includes effective support during dying and death. At some hospitals, chaplains are heavily involved in every stage of the dying process, even to the point of signing for the release of the body. While many aspects of the work of chaplains is encompassed in bereavement care, there is also the caring for parents and families where important pastoral connections can be nourished between families and their sick or dying child.

Most PICU's I visited operated along similar lines to the RCH in Melbourne. One of the differences is the more formalised arrangement where a patient has already established a relationship with a chaplain on another ward, that chaplain continues to visit and maintain contact with the patient. The PICU chaplain continues to visit also, but at a less intense level. This practice appears to be common in most of the hospitals I have visited in the UK, Canada and the USA.

One of the other important initiatives observed in Cincinnati, is the automatic paging of chaplains in the event of a trauma or emergency event. That is, the chaplain is not called when needed, so much as called 'as part of' the integrated healthcare team. If Emergency Department is aware that a trauma is on the way, a chaplain will be paged at least 10 minutes beforehand. In this way, all resources are available to the family, patient and staff right from the outset.

In Cincinnati in particular, the proximity to or location in, the unit of the designated chaplain is encouraged and supported by management (pastoral care and hospital).

At **Birmingham Children's Hospital, England**, the ICU is to expand to 32 beds in the near future. There is only one PICU at BCH and it also covers neo natal admissions as well.

Support for staff is excellent born of a relationship of trust. There is no sense of being counsellors and the pastoral care team is very clear about the difference. At least one chaplain is a trained counsellor and, in an attempt to combine roles during a test, discovered that the roles were incompatible, given the need to continue relationships on another level ie. spiritual care.

Staff support is crucial and while this is done through a senior nurse who takes responsibility for 20 nurses junior to her/him, a referral is made to the chaplain or other professional as appropriate. In reality, staff seek out support as they need it and formal debrief sessions are few.

**ix. Models of Pastoral Care – recording system at Children’s Hospital Boston, USA.**

What became evident for me on my travels was the variation in how chaplains are integrated into the healthcare team. While for much of the time the restrictions are based on lack of resources, where sufficient spiritual care support was in evidence, greater use was made of the resource by hospital staff.

An example of this was in Cincinnati Children’s Hospital Medical Centre (CCHMC) where the Liver Transplant Chaplain is seen an ‘indispensable’ part of the team – “who do not do anything without him.” The chaplain attends surgery, prays with staff, offers support to families prior to, during and after surgery. The chaplain also deals with those families where disappointments are inevitable. I had the privilege of working with the chaplain when one family was beginning the process of ‘work up’ for transplant.

What I found different here was, in this instance, the chaplain introduced himself, not only as a chaplain, but also as an integral part of the healthcare team. It was not as if there was a question, “will we call the chaplain?” The chaplain is already there, talking to parents about what chaplains do and what a resource he can be for those times when extra support is needed. The religious questions were never raised so much as they were ever present.

**Children’s Hospital Boston, USA.**

The model of pastoral care offered at Boston Children’s is “Faith and Language Based (Religious)” which sees a number of challenges as the hospital moves into the future – a growing number of persons who consider themselves spiritual but don’t identify with a religious tradition, a growing diversity of religious traditions, and many languages.

Chaplains each have several ICU’s (there are six in the hospital) and are expected to also visit denominationally throughout the hospital. The chaplains work 8-5 each day and each chaplain carries a pager. A Catholic service is held Monday, Wednesday, Friday in the Chapel and Sunday in the Patient Entertainment Centre which is strategically placed close to the entry.

The multi-faith chapel is used by those who seek a quiet place; it is small but conducive to meditation and prayer. Jewish prayer shawls, Muslim prayer rug and Qibla, Buddhist cushions, pews with kneelers, anointing oil, and various devotional materials are provided. It is located next to the chaplaincy staff office on the first floor.

Much of the interactions with patients and families encompasses establishing a relationship of trust which, in turn, empowers and encourages a vulnerable person to ask the meaning and purpose questions they need to ask. It is a model I am very familiar with.

What strikes me is the impression of movement away from the more faith-based model of pastoral care to a new professional/technical/evidence-based model. I am oversimplifying and perhaps not doing justice to the position; however, the new recording system stands as a way of chaplains being accountable (by numbers) for the work they do and the money they receive.

### **Birmingham Children's Hospital, England.**

Chaplaincy at BCH is based upon respect for the individual's right to choose. Relationships are built up with patients, families and staff that nurtures an environment of trust. Within this environment, there are a variety of outcomes.

Not wishing to make too much of a distinction between spiritual care and religious care, there is a very clear understanding of the difference. While all families and children are offered spiritual care, the Christian chaplains offer Christian support in ways that find expression in things such as the Annual Memorial Service; Bible stories; 'Godly Play' and the like.

The 'religious needs' of non Christians, such as the Muslim community, are catered for through visiting Imams or the hospital's own male and female Muslim chaplains. The team works coherently and I wonder if the clear religious component takes away the grey area and relationships are therefore clearer and roles more clearly defined. It is a credit to the Senior Chaplain who has taken steps to adapt chaplaincy to the new circumstances in which he and BCH find themselves.

### **Recording of Chaplains Visits - Children's Hospital Boston, USA.**

The chaplaincy team has its own data base in which each visit and assessment/plan is recorded. This is linked to the wider hospital stat system, so the 'census' tells us: name/location/religious preferences if any/ primary chaplain/primary language/ length of stay/time since last seen by a chaplain during this admission/ communion requests. This generates useful statistics as well as increasing the efficiency. Last year, there were 26,600 inpatient visits. Statistics on staff support or outpatient care are not kept.

There is a developing hospital-wide computer system which prompts nurses to do a simple spiritual assessment for each patient, inquire re spiritual or religious needs during stay - (Kosher, Sabbath arrangements, need for Qibla to be marked in the room, pre-op prayer, communion etc), and sends an automatic referral to the chaplaincy team.

Chaplains are able to record directly onto the computerized patient charts, both assessments and progress notes. Chaplains currently chart in the medical record when a patient is near the end-of-life, followed by the palliative care team, or have information that needs to be shared with the mutli-disciplinary care team. It is a work in progress and the practicalities given the volume and nature of visiting to be carefully considered. This 'Power Chart System,' appears new to the hospital too.

## e. Education and Pastoral Care Informed by Research.

### I. Education and Pastoral Care

In the quest for greater professionalism, as defined by the emerging healthcare collaborative model of care, education finds its evolving place. There are a variety of educational models which are 'shaped' by local need (cultural, religious and financial) as well as historical context. In this next section, I would like to list some educational models I was privileged to experience/see, which offer unique insight into education for pastoral/spiritual care. The list is by no means exhaustive.

1. Great Ormond Street Hospital London (GOSH)
2. Guy's and St. Thomas' (Evelina) Hospitals London
3. Toronto 'SickKids' Canada
4. Cincinnati Children's Hospital
5. Boston Children's Hospital
6. Children's Hospital of Philadelphia (CHOP)

1. At **GOSH** there is no Clinical Pastoral Education. Chaplains are appointed by the trust (hospital) in consultation with the churches. One member of the chaplaincy team, a candidate for the ordained ministry in the Church of England (and to my knowledge the only non-ordained person on the team), indicated she has spent two years training on Health Care Chaplaincy at St Mary's in Twickenham. The course includes topics such as Multi-faith; the NHS; Christology; Psychology and Health; Chaplaincy 1 & 2 and How to Engage Reflective Practice. The training appears to cover all aspects of pastoral/spiritual care and is consolidated in 'on the job' experience.

2. **Guy's and St. Thomas' NHS Foundation Trust, London (Evelina)**. In a different training model, I am grateful to the chaplains at St. Thomas' for an insight into the way they train chaplains and develop resources for on-call responsibilities. I did not have time to become fully conversant with this model, but from what I did see, it appeared inventive in meeting the unique pressures of a large adult/paediatric conglomeration of hospitals.

As I understand it, trainee assistant chaplains attend for a half-day a month training, plus another short-day of supervised pastoral practice and supervised on-call shifts for emergency cover. There is no charge for this course, but students are expected to sign-on for one year at a time, up to a maximum of three years. Training takes place in a multi-faith environment.

Each assistant chaplain will, usually after six months, be expected to sign on as a 'bank' assistant chaplain according to the 'bank' standards of employment. My understanding is that this operates a little like a resource for when shortages of staff is apparent or increased demand is evident.

The training scheme consists of up to 10 participants who work in traumatic situations. A 'robust' theology is important, as is the capacity to work in a multi-faith team. The training program is extensive, subject to evaluation and review, and attempts to deal with all situations that chaplains are likely to encounter (theoretical/theological/practical).

It appears to me that what is significant here is the formulation of a locally based system of training that meets an ever-increasing demand. It is a system that requires long term commitment, but does not demand full-time attendance. It is therefore attractive to a broader community of spiritual carers than a full-time study program.

While it could be argued that a relationship of trust between patient/chaplain and medical team may not be as robust, given the relatively short attendance times, it is also true that the sheer size and complexity of the hospitals may well dictate this model of pastoral care. The education program also provides a 'pool' of chaplains who can be called upon to assist in time of need.

I wondered, given the move in Britain to a more community based model of healthcare and the changing healthcare landscape in Australia, whether this educational model might not be more closely studied.

### **3. Toronto 'SickKids,' Canada**

As I understand the Canadian experience (at least in Toronto) with different ethnic groups settling, a variety of views and experiences are challenging the status quo. There are over 150 languages spoken in Toronto. I was introduced to the philosophy of "The College of Pastoral Supervision and Psychotherapy (CPSP)." This group has been established, challenging what it sees as the focus on Christian values, by the Canadian Association for Pastoral Education – CAPE – (responsible for accrediting CPE in Canada). CPSP sees that the more narrow views/focuses and the 'over' emphasis on written evaluations in many ways denies engagement with the lived experience of the individual which was so important to Boisen, the founder of the CPE "movement."

At Toronto 'SickKids,' CPE structure has been adapted accordingly. While written reflections and evaluations are still required (perhaps not emphasised), one difference is that the program appears to have something of a 'rollover' nature with people leaving and joining at different times. For example, one participant might knock on the Director's door and, subject to conversation with the supervisors and the current group, this person could be added to the group mid stream. Another involved in the group may leave for a few months (for faith community work for example) before returning later in the year. While at the hospital each CPE participant is required to attend all group and supervisory sessions. It is clear that overlapping of groups is part of the structure/program.

The group meets with the two education supervisors twice each week. They also meet with the Director twice per week as a group and then once per week for individual supervision. The program is well respected in the region and advertising for participants is not necessary.

Accreditation is completed through CPSP and usually involves interview. (Not sure what written materials are required, if any) Rather, it is based on an assessment of readiness to act. The local chapter of CPSP will make a recommendation to the Board (made up of representatives from CPSP chapters) and from there accreditation will be awarded.

In an interesting and unscripted encounter, I was fortunate to meet the President of the Inter and Intra Faith Relations Chaplaincy (multi faith) group which advises on matters multi cultural at 'SickKids' (amongst other Institutions). The issue of extending CPE or the education of chaplains into the broader issues of spirituality forms part of the agenda of this group and has influenced to some degree the CPE educational content/process.

### **4. Cincinnati, CCHMC, USA.**

Cincinnati is well structured in its education and research facilities. CPE is extensive as is the integration of chaplaincy and pastoral care into the life of the Children's Hospital. There are two features I had the privilege of learning about that I share in this section.

#### **a. Fellowship Learning**

Preparation of a Senior Chaplain to Paediatric Intensive Care Unit and Emergency Department involved Fellowship learning. A one-month learning experience – the chaplain had the opportunity to fly with the air ambulance to meet families and to support paramedics "at the scene."

This gave insight as to the stresses of a traumatic event; provided initial contact with families and enhanced his capacity to offer pastoral care in the hospital setting. There were times when the chaplain had to find his own way home, usually by road.

The difficulties of intubating a child “in the field” and the added trauma of highly emotional parents, helped the chaplain to be more fully present to the needs of families and staff in the hospital. Further, the circumstances of air travel were not always traumatic. There were also hospital transfers. The first port of call for these chronically ill children is always the ED and so the chaplain has also had an opportunity to explore the differences and similarities in family/patient needs - spiritually/emotionally/mentally. There are 93,000 to 96,000 visits to ED every year for a population of 500,000 (Cincinnati Centre) and 1.2 million in the greater Cincinnati area. Application of this knowledge in the ED is important for staff and families – the ‘how to care for professionals’ a vital part of the caring role for chaplains at CCHMC.

#### **b. CPE – Residency Program.**

It is possible to bring a person into a residency program should a vacancy occur, not part way through a current unit, but at the beginning of the next unit in the residency program.

It is not dissimilar to a medical interdisciplinary team which changes often. CPE is no different and encourages the group to explore change – how we let go/how we let in and how the dynamics of the group shifts.

Remaining residents support the newcomer with a senior resident acting as a mentor acclimatising the newcomer to the hospital/relationships. Residents also do didactics in their 4th unit for integration of their learning. There is also written into the ACPE standards accreditation, a half unit of CPE.

### **5. Children’s Hospital Boston, USA**

There is no CPE program at CHB, per se. Children’s Hospital Boston has opted for a staff chaplain based model in order to provide long-term relationships of staff support and on-going primary care for chronically ill children. This has been an intentional strategy.

Further, paediatric pastoral care is an advanced practice, something of a sub-specialty that requires additional developmental competencies over and above basic CPE first units. Advanced CPE residents at the neighbouring Brigham and Women’s Hospital (across the bridge) can apply for elective units in paediatrics in coordination with the CHB Chaplaincy.

Continuing education is rich and makes use of the many resources available within Harvard and Boston Theological Schools Institute. For example, because they are a field education site for Harvard Divinity School, their staff are able to audit or take courses at Hebrew College, Boston College, Andover Newton Theological College, Episcopal Divinity school, Harvard Divinity School and, in some cases, Harvard Medical School. The Chaplaincy provides full tuition reimbursement for additional CPE training, as well as a paid three month sabbatical for spiritual renewal after seven years of full-time service.

## **6. Children's Hospital of Philadelphia (CHOP), USA.**

There is no CPE at the Children's Hospital of Philadelphia, although students are sometimes placed from the University of Pennsylvania Hospital which is next door and linked by a passageway. For the most part, students are accepted from seminaries – one day per week in most cases, but occasionally, two days per week.

Students who practice pastoral care at CHOP are all regarded as 'volunteers.' They are attached to another section and must undergo all the appropriate checks (FBI, Fingerprinting, Orientation Program and Probationary period). Seminaries set the training up and supervise it. Clinical time/supervision/written reports/learning covenants and goals all speak of a well structured system. In this structure, the chaplaincy team are responsible only for the on-site supervision. All faiths are included in this 'program' which is usually run along time frames set by the Seminaries.

Palmer Baptist Seminary has requested that seminarians who are attached to CHOP "shadow" chaplains (as distinct from working independently). What this means is that students (including other colleges and seminaries) may or may not be on wards allocated to the full-time chaplains.

Use of internships is another proposal for undergraduates (from another discipline). The chaplaincy team is keen to develop a program to encourage growth in this area as they are aware of a number of potential chaplains; people seeking new directions in life.

## **II. Current Research – Dr Daniel H Grosseohme (CCHMC, USA)**

At the Spiritual Care Collaborative Summit '09, earlier this year, the question as to whether evidenced based spiritual care was desirable or even feasible received the attention of a panel of researchers including Dr Grosseohme.

Dr Grosseohme contends *"...lack of demonstrated outcomes leads other healthcare team members to ignore religion/spirituality altogether or reduce it to generic psychological mechanisms that any other discipline can handle. As professionals who work in hospitals and medical centres, like St Paul n Athens, we need to deliver our message in words our healthcare colleagues understand."*<sup>14</sup>

Dr Grosseohme went on to say that, while some work was already being done in the field, the work needs to be done by the "theologian in residence" on the healthcare delivery team. What Dr Grosseohme suggests is a major shift in the way chaplaincy has been 'done' in the past. Elements of this need for evidence-based spiritual care is visible across all the hospitals I visited and usually finds expression through the reflection/evaluating processes of CPE; the individually constructed hospital programs such as St. Thomas' and in the diagnosis/intervention data input systems which reflect again evidence-based outcomes.

Moreover, evidence based outcome has clear links with spiritual assessment as defined in the 7X7 model, where a clinical approach offers other professionals an opportunity to engage 'spiritual care' language.

Associate Professor Fitchett has incorporated into the training of chaplains at Rush University Medical Centre, a research seminar where chaplains read a research paper and, once a month, gather to discuss the findings; how to do research and more importantly how to interpret it. This initiative aims to develop skills in chaplains that embraces change.

---

<sup>14</sup> Spiritual Care Collaborative Summit09 Course Notes. Evidence-Based Spiritual Care: Desirable? Feasible? How do we get there?

Dr Grosseohme suggests "...Transforming spiritual care into an evidence based-profession will require a major change in our culture..."

Another researcher, Michele LeDoux Sakauri, linked the CPE 'verbatim' and the role of reflection/evaluation as a way of measuring patient responses through increased sense of hope. Measuring effectiveness through results.

LeDoux Sakauri goes on to suggest:

*"...when asked what made these shifts toward healing possible, the chaplain-respondents first lifted up the importance of inviting the story of the other. They affirmed that this invitation, coupled with a listening presence that stays engaged to the story, created a space for healing. Second they described the chaplains non judgemental presence as playing an important part in the healing in each scenario. They also identified additional behaviours that gave the chaplains in the verbatims credibility: openness, honesty and the ability to risk/be vulnerable. This study affirmed the value of the chaplain at the bedside. Through the use of the verbatim as a tool for inquiry, these chaplain respondents showed they could critique chaplain interactions, assess spiritual pain, and articulate interventional elements that promoted spiritual healing."<sup>15</sup>*

Tom St. James O'Connor pushes research a little harder:

*"My journey with evidence based spiritual care and therapy has been mixed...One thing that I have done is to require my CPE students to take a graduate course in research. They are also required to do literature review on spiritual care and therapy of a population that they work with clinically. Then they are required to put their literature review into a poster and present it at the University, the hospital, a conference and/or to peers. There is huge anxiety over this and some students give up on it, many complete it. ..."<sup>16</sup>*

I had the privilege of participating in a training session on the importance of research led by Dr Grosseohme. In this session the importance of research and what it brings to pastoral care was demonstrated simply and effectively using the hospitals own documentation.

Research contributes to our store of knowledge and establishes community – in effect, it ends professional isolation by staying in conversation with peers.

Research provides

- ii. the opportunity to improve clinical performance,
- iii. can lead to creation of new positions to meet increasing pastoral needs through evidence based research.
- iv. Intellectual stimulation.

There are two kinds of research:

Descriptive Research  
Numerical Research

### **Descriptive Research (QUALITATIVE)**

An example is this: - Do parents of a sick child pray to 'control' the situation or seek comfort from God? And if you, as a pastoral carer, knew the answer would this affect the way you offered pastoral care?

Most chaplains in the session, when asked to consider what they would seek as support for parents in such a prayer, opted for the 'seeking of comfort and support to endure what needs to be endured.'

---

<sup>15</sup> Spiritual Care Collaborative Summit09 Course Notes. Evidence-Based Spiritual Care: Desirable? Feasible? How do we get there?

<sup>16</sup> Ibid

Evidence: Prayer book in chapel lists 1000 prayers over a set time frame – research shows that prayer directed to control out numbered comfort 5 to 1. (prayer to an active interventionist God!) The challenge is, do we support families in their stated belief system even when we might not be comfortable with the spiritual care implications?

### **Numerical Research (QUANTITATIVE)**

This requires some statistics, but no computer mathematical knowledge.  
Computers crunch numbers, but you do need to know what test to run  
For instance, we must have some understanding of what we need.

Back to the prayer book - the list of 1000 prayers was typed into a word document. We know from previous research that writing about trauma or illness promotes healing, especially mental health – Does writing a prayer have the same affect on health? What about just a letter to God?

If writing a narrative is good, then what happens with prayer, how does it impact health? Using a sophisticated program linguistic enquiry and word count software, the results of scanning prayers from book in the chapel were categorised into 72 categories.

There were three major categories

- Positive and negative emotion words (happy, sad)
- Causality words (because, therefore)
- Insight (meaning, how)

In a controlled test the following results emerged.

- letters to God shared 2 of the above properties.
- narrative and prayer were as good as each other, with the same percentages in all 3 categories.
- Evidence shows that writing a prayer is as good as a narrative.

Evidence/research informs us of what is happening and can provide insight as to how this might impact on our provision of pastoral care.

**Current Research** by Dr Grosseohme is directed toward The ‘First Year’ (How parents use religion in the first year after their child has been diagnosed with Cystic Fibrosis) Some aspects of this research are listed below -

#### **Beliefs that contribute to meaning making.**

- Active personal, interventionist God.
- Parents feel supported by God.
- Beliefs give hope.
- Beliefs contribute to decision making and adherence.

A so called spin-off paper: “Religious Coping Styles” is under way. In this new study, Dr Grosseohme and others are exploring coping styles with a particular focus on children with Sickle Cell Disease.

In an innovative way, children were engaged in an educational day where, through various activities, they were able to express how they use faith to deal with illness (for example; 8/12 year olds draw pictures etc).

Further, research into how religious constructs affect adherence? Will also be undertaken. Part of this research will explore, through video evidence, how a chaplain interacts with patient and family. How can a chaplain make a difference in a very short period of time?

A spiritual intervention, in a medical home for young adults with Sickle Cell Disease, is explored in Ken Ragament's "Winding Way" - a further study of coping strategies.

Another question involves an understanding of the body as a temple of God's love. In adhering to this belief (body as God's temple), how does the disease of the body impact on belief?

Associate Professor Fitchett, in a recent communication, suggested that

*"My colleagues and I are waiting to hear news about a proposal we submitted to study religious struggle in 700 patients with a new diagnosis of cancer..."*

In concluding this very brief comment on current research, I would observe that the research appears to be directed at the struggle of religion and faith in face of illness – how faith is impacted and how people respond to the tensions between religious belief and the vulnerability of illness. This struggle and tension, forms the interface of our work in pastoral/spiritual care in the hospital setting.

## **Conclusions and Recommendations**

Concluding Comment and points for consideration in Australia.

### **a. Cross Pollination – ideas and initiatives.**

The 'cross pollination' of ideas across chaplaincy and pastoral care has been one of the great bonuses of this study program. Good and meaningful relationships have been established in all centres visited and I am hopeful of continuing contact and reciprocal visits over time.

Associate Professor Fitchett has made the observation that, in his understanding, such a study program encompassing the 'shadowing' of so many chaplains across the world is unprecedented. As such, this may well be the 'vanguard' of greater international 'hands on' sharing. The following is a brief comment on the 'cross pollination' made possible by the Churchill Trust.

Churchill Trust has been made known across the UK, Canada and USA. At least two people in England have expressed interest in pursuing such a Fellowship through the Churchill Trust in Britain (which includes possible visitation programs to sites in the USA, Canada and Australia).

I have given three presentations in the USA –

1. Chicago, to CPE interns and senior Pastoral Care Department staff.
2. Cincinnati, to CPE interns and
3. Cincinnati, to the wider pastoral care team at CCHMC.

The essence of these presentations was to share something of my impressions and understanding of what I had experienced in pastoral care in different contexts.

It has been possible to support the establishment of links between Chicago and Edinburgh where the possibility of re-establishing CPE is the subject of discussion. It is possible that a member of the Rush University Medical Centre will spend time in Scotland assisting in the establishment of a set of standards and a permanent CPE presence (refer comment page 11).

Links have been established and, in some cases, links have been renewed, wherein the possibility and framework for future chaplaincy exchanges is possible.

There has been an opportunity to facilitate increased contact between Great Ormond Street London and Cincinnati Children's Hospital Medical Center. Contact between the chaplaincy departments in both hospitals has been encouraged by the experiences of my Fellowship journey.

I was able to network with researchers in Chicago and Cincinnati – as I understand it these sites are the only dedicated sites for research into chaplaincy and pastoral care in the USA.

I have shared a copy of my Spiritual Care Collaborative Summit '09 report and examples of the services I use in ritual, in critical care situations. The use of a children's story in these rituals has also been one contribution I have made in the field of pastoral care education. It is part of the essence of how to use ritual to enable a dignified death when surrounded by medical machinery and seeming chaos.

## **b. Recommendations and Points for Consideration in Australia.**

There is a variety of models for pastoral/spiritual care that embrace differing contexts. For Australia, changes to healthcare delivery suggests a system in transition. What model of pastoral/spiritual care is most appropriate in these circumstances? While this is a matter for further reflection, some interesting and relevant data is available overseas.

For instance, there are full-time chaplains who are fully integrated into the healthcare team. In these examples, hospital support has assisted the development of a pastoral care team that works seamlessly with Trauma teams and Intensive Care Units (among others) toward hospital objectives aimed at best practice (Cincinnati Children's Hospital Medical Centre and Children's Memorial Chicago are just two examples).

In other locations this goal of best practice finds expression in a part-time approach that embraces the need for differing cultural, linguistic and religious affiliations. (Birmingham Children's Hospital and Great Ormond Street are examples of this).

In another model, part-time chaplains are being recruited to support satellite programs or facilities run by the hospitals (Children's Hospital of Philadelphia is an example of this).

A combination of 'staff' chaplains and CPE participants are utilized to meet 'best practice' objectives. (Toronto 'SickKids' and Children's Hospital Boston are examples of this).

It follows that, with a variety of pastoral/spiritual care models, comes a variety of educational opportunities.

This 'variety' includes:

- a. hospital-based training such as that at St. Thomas' London;
- b. adaptation of CPE at Toronto 'SickKids,' to more appropriately meet the needs encountered in that context;
- c. the integration of University based education and research, so much a part of Rush University Medical Center and related hospitals;
- d. CPE residencies working alongside staff chaplains, such as (but by no means limited to) Cincinnati Children's Hospital medical Center.

As healthcare delivery changes, the need to train chaplains to facilitate care in the community is also an issue that might need further consideration as the trend to more home-based care unfolds.

With these issues in mind, the following is offered for further consideration in Australia:-

Raise awareness of the move to evidence-based pastoral care in paediatric environments and recommend closer connection to research both overseas and local which could form the basis of ongoing internal education. Further, a research placement (short term or longer term project) might be considered within RCH/Melbourne University to foster a growing professional outlook for paediatric chaplaincy. This may include educational programs to connect more effectively with the changing demands of the healthcare sector based on multi faith and cultural imperatives, due in part to the continuing influx of refugees.

Raise awareness of Associate Professor George Fitchett's 7X7 spiritual assessment model. The art of spiritual assessment defines who we are and what we do; it identifies our distinctive role in the more 'collaborative' nature of the healthcare system. Such spiritual assessment is clinically based and adds to the professional, holistic care of the patient/child and, by association, families and staff. More than this it provides a 'centre,' knowing who we are as pastoral carers, in the middle of systemic transitions both in healthcare and in the way in which traditional religious care is seen and understood.

Raise awareness of the possibility of pastoral care being more effectively integrated into healthcare teams such as trauma and transplant teams. While this does happen in Australia to some extent (especially transplant teams) expansion to target more effectively specific needs is an important factor for consideration for the delivery of spiritual/pastoral care. Evidence for this is contained within the role expected of chaplains in the USA where designated chaplains form part of the integrated trauma and transplant teams.

Explore the possibility of chaplaincy exchanges for a period of training and professional development. With greater mobility of people across the globe, many issues we face are similar and the sharing of ideas is a way to encourage best practice.

Explore models of pastoral care that involve contract chaplains to complete on-call responsibilities or chaplains employed specifically to cover the nightshift.

Explore the possibility of appointment by hospitals of chaplains from other faiths or multi-lingual skills to meet specific and local needs.

I have been privileged to be able to 'shadow' chaplains in hospitals in the UK, Canada and the USA; to speak with Program Directors and Researchers in the UK and USA and to experience differing models of education and witness differing models of pastoral care in action. **For all of these experiences, I am grateful for the generous welcome and support of so many people from across the world.**

Spiritual care/pastoral care is an integral part of the healthcare strategy of all hospitals visited. In some hospitals, this is limited due to financial considerations. In others, the extensive chaplaincy presence has become an indispensable part of paediatric care. The care of parents or the primary carers of children, forms part of the overall care plan and the research example from Cincinnati is indicative of the process of identifying need and responding to it.

In addition to the general points for consideration listed above, I would also recommend consideration of the following:

1. Education for pastoral care of children and their families is distinctive and I found it helpful to hear what makes paediatric chaplaincy distinctive, specifically the issues of ethics and research as we embrace a distinctive role within the collaborative healthcare setting. I believe the ethical dilemmas facing patients and their families is an increasingly complex task - chaplains and pastoral care workers will need to be more fully trained in this area.
2. Appointment of chaplains to meet the cultural context within which spiritual care is offered. Examples of this are in Birmingham where a female Muslim chaplain has been appointed; similarly at Great Ormond Street, London. In Chicago, at Children's Memorial Hospital, chaplains with dual language capability have been specifically employed to meet the known need of the local population.

3. Muslim Council of Britain - Chaplain Training Day. This was an exciting opportunity to share with a different faith, aspects that are brought to bear in the healthcare setting. Can we encourage similar initiatives here in Australia?
4. Setting up a Remembrance Book – (Birmingham Children’s Hospital and Great Ormond Street London are examples), Chaplains write to parents about two months after the death of a child and offer parents the opportunity to have an inscription in the Trust’s (Trust is the Hospital) Memorial Book. This is kept in the chapel and is turned to today’s date by the chaplaincy team. If a chaplain is off site, the Clinical Coordinator has the key to the book.
5. Books as gifts to parents and families at time of death. The books given by Birmingham Children’s Hospital are funded by the charities group or religious denominations. Further, and separate from this, the Muslim community, are writing their own support material at the time of death. This small initiative is a vital link with the family and the gift of these books is reportedly well received. Consider we should explore the possibility of use in paediatric settings.
6. We have struggled to come up with a formula to bring more children into the chapel at the RCH. The idea of ‘cuddly toys’ might be one such initiative to support this goal. Great Ormond Street Hospital, London, is an example of how this has encouraged parents and children –
 

*“...At one stage a child left a teddy bear in the chapel as a kind of offering to God – saying thank you for getting well. This act of thanks giving has evolved and now sees children often leave a soft cuddly toy in the chapel to say thank you to God. The Chapel is now in possession of hundreds and hundreds of thank you’s which line the walls well out of reach of sticky fingers...It is a good idea and parents also use this as a way of helping their children to say thank you in a special way.”* Senior Chaplain
7. National Memorial Arboretum. Not all people appreciate a ‘religious’ memorial service and Birmingham Children’s Hospital has introduced a unique way of reaching those people with no faith or religious affiliation. A Riverside Walk stretching, 800 metres long, invites bereaved families to walk and reflect culminating in a brief memorial service. Can we establish something similar in Royal Park?
8. End-of-life documentation - As is the case at Rush Memorial Hospital Chicago, Children’s Memorial Hospital, Chicago and Cincinnati Children’s Hospital Medical Center, chaplains sign for the release of a body. This involvement is seen as a measure of the level of integration of the chaplaincy service into the life of the healthcare team. Should we, as part of a growing professionalisation, consider how we might be more effectively utilised in the end-of-life process?
9. Recording on a hospital charting system - Children’s Memorial Hospital, Chicago, is one example, where chaplains are able to chart on a hospital wide system. Chaplains are able to access and add their notes to the hospital system. They are able to read the medical notes which have been input by the doctors and other allied health staff. Chaplains are able to see who has visited and what might have transpired. A further indication of professionalism and integration into the healthcare team.