ESSAY REVIEW

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Introduction

At the 37th Assembly of the World Health Organisation (WHO) in 1984 [1], a historic decision was taken to adopt Resolution WHA 37.13 [2], which made the spiritual dimension of the human person a prominent component of the strategies for health of WHO Member States. The Resolution [3] explicitly understood this dimension "to imply a phenomenon that is not material in nature but belongs to the realm of ideas, beliefs, values and ethics that have arisen in the minds and conscience of human beings, particularly ennobling ideas". It formally considered that the realization of the health ideals that form the moral basis of the goal of health for all by the Year 2000, would itself contribute to people's feelings of wellbeing and it acknowledged that the spiritual dimension of human existence plays a great role in motivating peoples' achievement in all aspects of life. The Resolution concluded by inviting Member States to consider including a spiritual dimension of wellbeing within their strategies for health, in accordance with their social and cultural situations [3], but the WHO stepped back from undertaking a formal revision of its own classical definition of health.

It was not until 22 January 1998, some fourteen years later, that the Executive Board of WHO adopted a Resolution (EB101.R2) recommending that the World Health Assembly reconsider the WHO's definition of health. Here, the proposal was to revise the WHO definition from "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" to "Health is a *dynamic* state of complete physical, mental, *spiritual* and social well-being and not merely the absence of disease or infirmity" [4] (italicisations mine). The 52nd World Health Assembly was held one year later, from 17 - 25 May 1999, but the proposed re-definition of health was not scheduled for discussion, due to opposition from some delegates arguing for further time to consider matters of definition and translation. Here, Masako Nagase provides an interesting account of the reasons that contributed to the disagreement among committee members of the Health Science Council [5]. Nevertheless, a further and more formal recognition by the WHO of the relevance of spiritual care had become available, with the following text frequently cited:

> "Until recently the health professions have largely followed a medical model, which seeks to treat patients by focussing on medicines and surgery, and gives less importance to beliefs and to faith. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process. The value of such 'spiritual' elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension, emphasising the seamless connections between mind and body." [6]

More contemporary calls for a revision of the WHO Definition of Health grow increasingly louder, so that a suitably updated version of the original definition can properly reflect modern understandings of health as a *dynamic* and not in any way a static process – acting to

guide global research and development accordingly [cf. 7,8]. Regrettably, there appears at the time of writing little appetite within the WHO, as currently constituted, to embark on a revision of the current definition of health which would see key references to dynamics and spirituality included. It is true that a definitional consensus on how spirituality should be defined has yet to achieve international consensus [9-11] and it is likewise true that the field of complexity science in health is itself underdeveloped, though it is rapidly attracting greater interest and finding common ground with preceding theories [7,8,12]. But given the current epidemic of long-term co- and multimorbid, socially complex illnesses, identified not least by the WHO itself [13-18], and given that the importance of spiritual care as a dynamic part of modern approaches to the management of such conditions is increasingly acknowledged [19-23], a continued silence from the WHO on the need for a revision of its now essentially archaic definition of health remains difficult to understand. If the WHO maintains its inertia for definitional change in the face of scientific imperatives for revision, then it will be for other organisations - and individual academics – to push forward in its place.

The study of how the spiritual dimension of the human person, however broadly or specifically defined, can be integrated into healthcare practices and imbedded within modern healthcare systems, has been the subject of many textbooks over recent decades [cf. 24]. The current *Essay Review* takes one of these – '*Spiritual Care in Practice. Case Studies in Healthcare Chaplaincy*' [25] - which can be considered a recent, welcome addition to the relative paucity of literature that addresses and describes the work of healthcare chaplains. This book, edited by George Fitchett and Steve Nolan, employs an essentially novel approach in illustrating the work of healthcare chaplains through the use of case study methodology and critique. To date, the volume has attracted much approbation from leading investigators in the field, but, as we shall see, disdain from others. This *Essay Review* begins with an account of the structure and intended purpose of Fitchett and Nolan's book, moving through an analysis of some negative reaction to the text, to some thoughts on the dilemmas chaplains face when bringing their very particular gifts and competencies to the assistance of the sick.

What is a chaplain?

The *Foreword* to Fitchett and Nolan's text has been contributed by Dr. Christina Puchalski, a leading pioneer of spiritual and religious care [cf. 24], who provides the reader with a rapid orientation to the purpose of the text. What, Puchalski asks, is a chaplain? How is a chaplain different from a counsellor? What do chaplains do? These questions are not Puchalski's own, but rather the questions typically posed by those clinical colleagues, and others, who remain unaware of the nature of the chaplain's *modus operandi*. For Puchalski, a textual description of the chaplain's role may not be as powerfully educative as the

understanding that can be gained through case studies of the very type, as we shall see, that are documented and discussed within the volume. She is unequivocal that the chaplain is an essential member of the multidisciplinary healthcare team and recounts the privilege she has experienced in working with chaplains within a wide variety of settings - in hospitals, in outpatient palliative care clinics and in medical schools where trained chaplains are engaged in the co-mentoring of professional development sessions. Puchalski describes how she has, in all cases, been able to observe, at first hand, the power of the narrative approach as part of the evolving relationship between the chaplain and the patient, the chaplain and the clinician, and the chaplain and the student. For her, the unfolding of the patient's story through trustful interaction with the chaplain mirrors that which can occur between the clinician and the patient when the former places his or her expertise at the service of the latter.

Puchalski talks of the need for a spiritual care plan, designed with the healthcare chaplain, that is complete with outcome indicators and forms of measurement that are sufficiently meaningful to be communicated to the clinical team with a view to influencing management, though anticipates that some colleagues will view such an approach as a 'medicalisation' of spiritual care [cf. 26]. For sure, there is a high degree of medicalisation inherent in such a design, but while it is a well recognised truism that not everything of value can be measured and not everything that can be measured is of value, Puchalski's structured approach will appeal to many clinicians. As Puchalski argues, it does nothing more, in reality, than places the spiritual needs of the patient "at the heart of medical care, at the heart of the reductionist medical model", an approach which can, and does, effect transformational changes to the established model of medical care. Such approaches are to be considered vital, perhaps, at our current point in medical history, where patients are typically treated not as persons, but as subjects, objects or complex biological machines [27-29]. Chaplains, as Puchalski points out, do not do this and, in fact, do diametrically the opposite, listening intently to the person of the patient, to what he or she believes and values most. In this way, the chaplain can assist clinical professionals to see not simply a biological dysfunction or disease process, but a whole person who labours under a state of broader illness [27-30]. Spiritual and religious care, as and when appropriate, may be considered, then, an integral component of person-centered healthcare [27-32].

The value of chaplain case studies in understanding the role of the chaplain

The *Introduction* to the book, written by George Fitchett, describes the purpose of the volume as a whole. It is, as Fitchett says, important to understand and document what it is that chaplains actually 'do' for patients, given that there is much ignorance of their work and, at the current

time, a considerable paucity of such information readily available to any individual who might wish to find out. He recognises, rightly in my view, that healthcare chaplaincy needs to a research-informed profession, not only to improve the quality of chaplaincy services, but also to enable chaplains to demonstrate their value to those who commission and pay for the services that chaplains offer. For sure, the development of chaplaincy services in this way is of urgent importance within an increasingly secular Society that cannot understand, or which refuses to recognise, the relevance of the chaplain in dealing with the spiritual distress and religious needs that frequently arise as part of illness - not only in patients with life threatening or definitively terminal conditions, but also in those whose conditions are life changing in their nature. This is important, because in modern health and social care services it has become normative to suspend or terminate any service which cannot demonstrate 'value' in quantitative, cost-economic terms, as if intrinsic worth can only be demonstrated through such positivist assessments.

Fitchett's concern, then, that chaplains should strive to prevent such cuts through an increasing ability to demonstrate hard evidence of the effects of chaplaincy services, such as, for example, attenuation of spiritual distress, increased fortitude, a generation of optimism through which to combat nihilism, etc., is well placed. He is right, too, to claim that formal descriptions of chaplains' work are educative for the training of new chaplains and, in addition, the continuing education of established chaplains, enabling both to contribute effectively to person-centered healthcare strategies.

Fitchett argues that case studies derived from the work of chaplains are a good place to start as part of powerfully educative processes. I agree, in that descriptions of the methodologies and interventions used by chaplains and descriptions of their successes (or failures) are highly illustrative. But while the value of case studies as educative tools is firmly established within medicine and the clinical professions more generally, they are likely to prove less persuasive to non-clinical health service managers and commissioners of healthcare services, so that other means of demonstrating value will be necessary for the future. But this does not mean that the collection and analysis of case studies should be discontinued, or afforded lesser importance. On the contrary, Fitchett is more than insightful in highlighting their ongoing value, as argued separately by such case study advocates as Bent Flyvjerg [33] and Robert Yin [34], Jeffrey Mahan and his colleagues [35], Michael Northcott [36] and Daniel Schipani [37], all of whom Fitchett cites, in addition to his own thinking published earlier [38].

Rightly, Fitchett notes, quoting Folland [39], that the chaplain case study literature is considerably limited. He recognises that "precious little is known about what happens when chaplain and patient meet", an observation which is surprising, given the central role that case studies were afforded in the work of Anton Theophilus Boisen, one of the great luminaries in the development of modern chaplaincy, particularly in the United States of America. Boisen demonstrated an acute interest in the value of case studies (40), an interest which, as Fitchett reminds us, is vividly illustrated by Boisen's own case study of his own

mental illness, captured within his autobiographical study of mental illness and religious experience which he entitled, after Psalm 130, as 'Out of the Depths' (in the Latin *De Profundis*), published in 1960 [41]. But Boisen's own enthusiasm for the value of case studies was not built upon by other early chaplaincy leaders. Indeed, Boisen's own book on his case study research, entitled 'The Exploration of the Inner World' [42], was at least partially eclipsed by Cabot and Dicks' volume, published in the same year, 1936, entitled 'The Art of Ministering to the Sick', a volume which become highly influential within the field [43]. Within that volume, Dicks' own chapter encouraged chaplains to make 'note writing' an established practice, leading to a substitution of the richness of case studies with an altogether different emphasis on *verbatims*, as if objective observational notes of a chaplain-patient interaction could ever substitute for a rich description of the spiritual interaction of two people, the one *needing* and the other *giving,* and the outcome being either qualitatively describable or in some situations quantitatively measurable – or both becoming possible, ideally, together. Of interest here is Fitchett's discussion of a paper entitled, in part, 'Evidence-based pastoral care', a case study which, having defined 'the problems' of the case, then interrogates the literature to seek evidence of the most appropriate interventions and proceeds to document the outcomes of their use. The case study of 'Mary' intrigues Fitchett and has no doubt reinforced his belief that chaplaincy should be a research-informed activity [44,45].

Defining terms and the educative role of chaplaincy case studies

Importantly, Fitchett seeks to define terms and, having searched the chaplaincy literature prior to 2011, was unable to find case studies defined in the way that he and his co-editor use them in their volume[1]. Certainly, it was possible for Fitchett to identify literature such as journal articles and book chapters which contained case studies, with some having 'case study' in their title [cf. 46-49]. But, in these examples, the case reports were found to be generally brief, with a critical reflection on the chaplain's care entirely lacking. Yet, Fitchett is convinced of the educative role of the case study in the training of chaplains and in their continuing education. He laments the absence of chaplaincy case studies, contrasting this deficit with the psychotherapy literature, where entire journals are devoted to case study research and publication and where many books of case studies exist, alongside other such resources such as case databases and case websites.

In early signs that this situation is changing, Fitchett refers to three case studies, each of which had been written in accordance with the methodology that Fitchett and Nolan advocate. For example, in 2011, Cooper, writing in the *Journal of Healthcare Chaplaincy* (JHC), published a case study of her work with a woman suffering with

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[1] For Fitchett and Nolan, a chaplaincy case report is "an in-depth report of a chaplain's care and their critical reflections on that care".

advanced breast cancer who had developed a fear of death and dying [50]. This particular case study was followed by a similar example contributed to the same journal in the following year by King, describing his work with a patient with leukaemia [51, cf. 52]. In 2013, Risk contributed his case study, also in JHC, of a patient whose sense of meaning in life had been shattered by Parkinson's disease [53]. Importantly, the three case studies were followed by commentaries from other chaplains in addition to inputs from health psychologists and pastoral counsellors. The publication of Fitchett and Nolan's book can be seen to build more or less immediately upon such work, adopting the same methodology, but in a book replete with illuminating case study examples drawing from a range of illnesses and the particular types and circumstances of the persons suffering with them.

Methodological perspectives

But how are we to 'trust' the case studies in the book as being 'useful' in studying the importance of the work of the healthcare chaplain? From a methodological perspective, Fitchett and Nolan, in commissioning the individual case study contributions, sent letters of invitation to chaplaincy organisations, groups of chaplains and individual chaplains of their acquaintance in the UK, USA, Canada, across Europe, Australia and Israel, limiting the case collection to chaplains who had at least three years of healthcare chaplaincy experience and with the request for a 800 word summary of the given case. The subsequent selection of cases was made on the basis of three specific criteria – (i) the need for cases from chaplains working in different national contexts, (ii) the need for cases derived from a diversity in the religious traditions of the chaplains, patient and families and (iii) the need for cases that illustrated common or important issues in chaplaincy practice. In developing their case studies for inclusion in the volume, Fitchett and Nolan invited the individual chaplains to address three things - firstly, to give the context for the case, providing information about the patient and/or family and about themselves and their institutional context; secondly, to describe the history of the chaplain-patient relationship, with a focus on significant events and interventions in the relationship, with *verbatim* accounts of important conversations if they were available and, thirdly, to step back from the case, with a description and critical reflection on their assessment of the patient and the interventions employed and to record the changes that did or did not occur as a result.

A notable feature of the case studies recorded in the volume is the inclusion of associated commentaries from other healthcare chaplains and healthcare professionals who work in the areas from which the included case studies have been derived. Here, Fitchett and Nolan required the commentators to focus their critical reflection firstly on the care the chaplains provided and how this contributed to the patients' wellbeing or recovery and to consider also the opportunities the chaplains may have missed or which was considered inappropriate, Secondly, the chaplains were to reflect on their care when writing their assessments, when detailing their interventions, and when describing their outcomes. Commentators' opinions on what the case studies contributed to healthcare chaplaincy and to the care of the patient in general were also sought. With reference to these criteria and the overall inclusion requirements, nine chaplains were subsequently selected for participation in the project and a range of commentators recruited, contributing cases and commentaries in the fields of paediatrics (chapters 1-5), psychiatry (chapters 6-10) and palliative care (chapters 11-15).

The collection of these case studies within Fitchett and Nolan's volume has been careful and systematic. A quick navigation of the book's content, as well as careful study, illustrates the diversity of cases attended to, the stories of illness, the richness of interactions between chaplains and patients, and a consideration of their outcomes. For example, we read the story of a 16-year-old with a belief that God would enable a miraculous recovery from paralysis, to an African man with a history of psychosis and depression whose cultural belief in witches complicated his treatment. We read the story of a Jewish man who is dying and who becomes aggressive and isolated as a function of his life experiences which he has found traumatic. And more. In every case presented and studied, the reader gains an immediate insight into the needs of the given individual patient and of the chaplain's own perspectives in considering the best response to the distress that becomes visible, so that descriptions of the spiritual assessments and spiritual care interventions, as well as accounts of significant encounters and dialogues, are in general terms very well recorded.

Objections to Fitchett and Nolan's volume and advocacy

So far, this essay review of Fitchett and Nolan's book can be considered approbatory, and so it is. But by no means all individuals working within the healthcare chaplaincy field subscribe to the vision of the role of the chaplain shared by Fitchett and Nolan. Indeed, a prominent critic of their work, both in general terms and, specifically, as it is outlined within their book, is Raymond J. Lawrence, General Secretary of the US-based College of Pastoral Supervision and Psychotherapy. Lawrence takes grave exception to the whole purpose of Fitchett and Nolan's text in a series of articles which attempt to deconstruct Fitchett and Nolan's entire volume using negative critique and outright hostility [54-56].

Lawrence opens his assault with his own interpretation of Boisen's legacy [cf. 40-42]. Boisen, Lawrence claims [54-56], changed the face of pastoral work by teaching religious professionals to be healers, by encouraging them to listen to persons suffering mentally or physically in order to obtain their story of life and illness, to make connections where connections were apparent, and to support self-awareness and self-discovery, with reference

to the psychoanalytical techniques of the time. Although Boisen was, Lawrence claims, a "religious giant", it was because of him that many teachers, preachers and evangelists had "morphed by the middle of the century into competent psychanalytically informed counsellors and therapists". For Lawrence, Fitchett and Nolan's book represents an existential threat to Boisen's legacy. Indeed, if Fitchett and Nolan's volume were to succeed in its aspirations and advocacy, Boisen's clinical pastoral movement and all that it represented would, Lawrence claims, be destroyed, "trumped by a new form of evangelism", so that "religious proselytizing and browbeating will have replaced pastoral care and counselling" [54-56]. Lawrence believes Boisen's tradition to be reversed as early on as Chapter One of Fitchett and Nolan's volume. He sees their book as proclaiming, or seeking to consolidate, a "new order of chaplaincy … (or) … spiritual care", which for Lawrence represents an "unhappy" development. From here, Lawrence proceeds with a mechanistic deconstruction of the volume through selecting already critiqued cases, subjecting the original case and its critiques to a second analysis - his own.

In the case of a 12-year old girl profoundly unwell with cystic fibrosis, Lawrence believes the attending chaplain, trained in the Boisen tradition, to have turned the Boisen model on its head. The chaplain, Lawrence says, instead of seeking to hear the voice of the patient, "moves to instruct her in the practices of Christian piety … (being) … hell-bent on persuading her to pray … (being) … as heavy-handed as an evangelist at a tent revival calling for a belief in Jesus". The case study reveals that the chaplain has attended the patient for some five years, during which he has spent significant time with the girl - something which Lawrence almost grudgingly acknowledges, before returning to his invective in claiming that the chaplain "can't wait for the patient to start feeling free to talk … he wants her to pray and to talk to God, and without delay … (and) in nine of the ten noted visits the chaplain lobbies for the girl to talk with God and to pray". Despite the patient coming to acknowledge that God is helping her by inspiring the clinicians in their duties, Lawrence interprets this progress as the patient "grasping for straws, hoping to get the Chaplain off her back". She now has, Lawrence claims, "some God-talk to give back to the eager chaplain". Lawrence's view, in this particular case recorded within the book, is clear - the chaplain has in his view failed to hear the authentic voice of the patient, with the chaplain's "perpetual beating of the drum for prayer and God surely … (voiding) … any hope of the patient sharing anything significant about her own grim experience … (and) … undoubtedly feels harassed by a propagandist". The chaplain's question to the patient, on a routine visit, as to how she and God were doing together, is met with further ire from Lawrence, who labels the chaplain an "inappropriate evangelist". For Lawrence, no human being who is sane can ever know how he or she is 'doing with God' - "if indeed there is a God". Such a claim is surprising, given that Lawrence is an Episcopalian priest, however controversialist.

For Lawrence, more appropriate questions from the chaplain, in the context of the case discussed, may have counted among them: "What's it like for you here in isolation?" or "What's it like for you being so far from home in a strange place?" or "What's it like for you to have to protect yourself with all this gear and equipment?" or "How much do you miss your family?". For sure, these are excellent questions, which on answer may well yield great insight, but Lawrence appears to want such questions to substitute for questions about religious and spiritual concerns, not to supplement them. His mission, it seems, is to securalize the sacred and to denude healthcare chaplaincy of its religious and spiritual component in favour of psychoanalysis. His determination to destroy the efforts of faith-based chaplaincy is to attack the religious chaplain. Indeed, in his own critique of the chaplain's efforts in this particular case, Lawrence suggests that it is the chaplain who is in need of assistance and not the girl. The chaplain, he says, failed to evoke the girl's pain and sorrow and despair, because of the pain in the chaplain's own personal life, so that his own "counter transference inhibited his ability to touch the girl's pain", with the chaplain preferring to take "the role of religious functionary, defending himself against the profound pain he likely would feel in identifying with her should she disclose herself to him". Since Lawrence has not met the chaplain in this case, such a claim is surely absurd, a psychobabble of little relevance to a scholarly assessment of the dynamics and outcomes of the case in question. Arrogantly, Lawrence advocates that the chaplain "would likely benefit from further clinical training, where with a competent supervisor he might understand what is buried in him that leads him to look away from the terrible pain of this 12-year-old". Does it not occur to Lawrence that the chaplain was well aware of the girl's pain and judged it unnecessary to evoke or add to it, but instead to sooth the girl in the manner in which he plainly did? Again, Lawrence seeks to substitute spiritual care for psychoanalysis, in an attempt to transform the healthcare chaplain into a clinical therapist, to make the priest a social worker.

We see further examples of Lawrence's biases in his analysis of the case report in Fitchett and Nolan's book of Angela, a 17-year old patient who had suffered a severed upper spine in a road traffic accident, resulting in paralysis from the neck down and likely to remain a lifelong quadriplegic. Here, Lawrence launches immediately into an extraordinary objection to the Catholic chaplain's use of Puchalski's spiritual care assessment tool [24,26] which recommends that four initial questions be put to the patient. The questions, which will be immediately recognised by any reader familiar with Puchalski's work are: (1) Do you have spiritual or religious beliefs that help you cope during this time? (2) What importance do your beliefs have for you at this time? (3) Are you a member of a religious or spiritual community? & (4) Are there any particular spiritual or religious activities important to your well-being while you are in the hospital? Rather than recognising the clear usefulness of this approach in allowing the patient to respond in the positive or the negative, and then to proceed or not to proceed as a result, Lawrence launches into an astonishing outburst. He writes: "On reading this … my first thought was that if I were a patient suffering from such a catastrophic, life altering event, and a chaplain came asking me such questions, I

would call security and have them removed from my room". He goes on to record his 'second fantasy', which "in the unlikely event I had any spirit left in me I might play with the chaplain and reply to the first question, "Yes. My god is a large cosmic cat who is coming soon to deliver me from this nightmare, and take me to cat heaven." [54-56]

Lawrence dismisses Puchalski's spiritual care assessment technique as "something like a Swiss Army knife, a little tool with many uses that often comes in handy in a pinch … what you get when you turn a physician into an expert on pastoral care and counselling". It is in his view somehow "inhumane". While the chaplain felt the patient, Angela, to be coping well in the immediate aftermath of the accident, and discussed with her how God was working in her life, Lawrence finds the chaplain's assertion to represent "the ultimate *non sequitur* driven by denial". As the relationship between the patient and the chaplain deepens, the two discuss the power of prayer, the power of God, whether God actually reached down and broke Angela's neck or not, and a number of biblical texts become used. For Lawrence, this is far from positive in its nature. Indeed, he sees the chaplain as being "increasingly propelled into a catechetical mode … as if she were instructing a potential novice in the mysteries of the Christian faith … (so that) … pastoral counseling has collapsed and the chaplain has morphed into a catechist or propagandist". In the middle of the patient's distress, the chaplain is concerned to assure Angela that: "I believe that God's will for us is always related to what is truly good for us, but that in the middle of a painful situation, especially one as painful as yours, it's hard to find the good. With time, though, we might see it." Lawrence's reaction is typical: "Yes, perhaps. And with time we might not see it. My thought in first reading this was the wish to be able to send this Pollyanna chaplain down to the underworld to give that bit of pious wisdom to all the dead from Auschwitz. She could report back, "It's hard to see the good in those deaths, but we know it must be there, because God is good."

For Lawrence, the chaplain who was doing the very best for Angela, is a "pocket philosopher", who "has lost her way" in the "midst of sermonizing and religious education". He describes the chaplain's efforts to continue engagement with the patient as "a further display of banality", a person "very protective of God's innocence, as is typical of religious authorities" and a person who has "assumed too much of the role of God's little defense attorney". The case report ends with the chaplain confirming that she had "entered Angela's darkness while keeping my eyes on the light of hope." For Lawrence, this means only that "the chaplain's own countertransference was so strong that she could hardly bear staying focused on the patient. For her own protection - and sanity, perhaps - she piled high her religious teaching and her piety as a defense against the horror of Angela's predicament. But enough humanity broke through her anxiety, enabling the chaplain to reach Angela. Perhaps one day she will be able to do much more". Quite extraordinarily, the fact that the chaplain is teaching other chaplains, medical students and psychiatric residents about the work of chaplaincy, is, for

Lawrence, a source of great anxiety. This should, Lawrence claims, "sound the alarm to any who care about the profession. I do wish this chaplain would get into advanced clinical pastoral training that is psychodynamically oriented, in the Boisen tradition. Her heart seems to be right, but her practice is very much lacking".

For Lawrence, then, Fitchett and Nolan's book is little more than "propaganda" from "purveyors of this new direction in chaplaincy - this new spirituality", so that "the future of a credible, therapeutic pastoral role is at stake", there being an urgent need to counter "this alliance of superficial religiosity" which, should such an effort fail, would result in "the Boisen tradition of the psychologically competent pastoral clinician … (vanishing) … from our culture, and religious leadership will fall entirely in the hands of those with a competency level of used car salesmen and traveling evangelists" [54-56]. These are strong words which appear illustrative only of Lawrence's entirely personal and very deeply entrenched biases.

Discussion

Spirituality, which arises from the spiritual dimension of the human person, is a singularly important experience of meaning in life which, by its nature, transcends an individual's personal circumstances, his/her social situation and the material world itself. Extensive numbers of studies have demonstrated that it sustains patients through the multiple stressors of life and illness [9,19,24]. For sure, the values inculcated by spirituality are in general terms essentially antithetical to the materialism and individualism of contemporary human behaviours and modern cultures, which, by inviting the human person towards attractions that are ephemeral, transient, temporary and fragile, are perfect recipes for the disappointments, disillusionments, depressions and desolations which inevitably result. Spirituality and faith, by seeking the true purpose and meaning of life – and enabling the individual to find them – allow the human person to understand realities that would otherwise remain incomprehensible, representing extraordinary resources on which to draw in times of illness, pain, distress and death [57,58]. Human spirituality and faith are not easily measurable, if measurable realistically at all through the use of empirical, scientific techniques, and a proper understanding of their meanings within the context of healthcare is complicated when clinicians wrongly equate spirituality and faith, believing them to be synonymous, which they are not. Yet, as might intuitively be expected, there is frequently a substantial degree of overlap between them and various investigations indicate how to navigate between them when they present separately and to deal with them when they present in partial or complete integration [59-64].

When illness becomes highly burdensome, or where death approaches, modern technoscientific medicine demonstrates its acute limitations. In such circumstances, patients experience crises and at this time often look profoundly inwards, in a search for answers, consolations,

directions and means of coping [65]. Here, it is far from unusual for the person of faith (or the person who is discovering faith at this point) to cry out to God, imploring help in coping with illness, in dealing with traumas, in reacting to losses, asking for a form of help in dealing with existentially painful transitions. To understand these manifestations of distress as purely emotional in nature is to ignore the reality of the soul, so that calling for psychoanalysts or psychodynamic psychiatrists in such a context may be considered far less appropriate than calling for the chaplain who can bring competencies of his/her own and which differ greatly in essence from sterile forms of counselling. Indeed, many patients express a profound belief that spiritual care can aid recovery from illness and that, as part of such care, personal prayer or prayer jointly with a chaplain, can assist recovery from illness or a coping with an acceptance of its course [cf. 24,59]. Here, patients may ask the assistance of, or draw from, the religious communities with which they are associated, typically through engaging in, or requesting, traditional religious practices and affirming beliefs and values that illustrate their religious faith. In this context, prayer, the reading and study of religious texts, and the observance of individual or group religious rituals derived from their tradition, are all of considerable importance to recovery or an acceptance in serenity of what course the illness is judged likely to take.

Professional chaplains may also be better equipped to elicit the patient's values and preferences than individual clinicians and then to communicate these to the clinical team. They are able to recognise and attend to the fear and loneliness which are so often experienced during serious illness and which generate spiritual crises that by their nature require spiritual care. Illness frightens patients, often isolating them from their support communities when they are most in need of them. In acute or chronic illness, the loss of physical capacity or cognitive ability, the loss of independence, and perhaps also a job, in combination with the grief consequentially experienced, all significantly or seriously impact upon the patient's sense of meaning, purpose and intrinsic personal worth. Such crises can be addressed by professional chaplains through spiritual and religious care, promoting healing and recovery. Professional chaplains, as a function of their work, move across disciplinary boundaries, and have a definitive role to play in caring for the members of multidisciplinary clinical teams who, themselves, experience the stress of patient care on a day to day basis, with the risk of subsequent burn out. The function of chaplains in this context can undoubtedly contribute to a healthy organisational culture and help to counter the rates of flame and burn out in clinicians, not only by assisting coping strategies, but importantly by helping clinicians to recognize the intrinsic meaning and value of their work in ways that they may not previously have considered. In this context, it must not be forgotten that when conflicts arise between clinicians' own values and those decision being made within healthcare systems, healthcare chaplains have a role in assisting a productive navigation through the given dilemmas [66].

Not that healthcare chaplains are the sole providers of spiritual and religious care. On the contrary, a large number of people may assist in this way, ranging from family members and friends and members of the patient's religious community, in addition to institutional staff members. If the patient is a member of a particular faith community, then the local cleric is also well positioned to offer spiritual care given his or her personal knowledge of the individual patient and in accordance with a precise tradition, using specific rites and associated counsel. Indeed, it is well recognised that patients with faith highly value the spiritual assistance that can be provided to them by their own faith leader [67]. Here, the professional chaplain does not actively displace local religious leaders and substitute for them, but rather satisfies the special requirements of the patient that are encountered within typically intensive medical and healthcare environments [68]. In this context, the work of healthcare chaplains may therefore be thought of as in many situations adjunctive to the responsibilities of such faith leaders, so that they join with them in maximising the spiritual resources available to the patient and his/her family and to the healthcare staff. If a person has expressed a need for faith-based care, then it is important to ensure that faith continues to retain a prominent place in the patient's care. It must be remembered, however, that some patients may not wish to receive the care of their local cleric when in hospital if there are concerns about privacy or confidentiality, or where a fear exists that their own religious leader may not understand their illness or situation and may not therefore be adequately supportive of them. It is here that the healthcare chaplain can exercise a great good [31,32].

In 21st Century healthcare, clinicians and healthcare chaplains encounter patients of many different faiths, and patients with no faith at all, yet most will present with diverse forms of spirituality and the needs which arise from them. For sure, religious proselytizing, or attempts at indoctrination, most especially during periods of patient distress, are impermissible and constitute disciplinary offences within the healthcare systems of most developed nations where patients are held in trust and care. However, the rapidly growing interest in person-centered healthcare [27-32], with its acknowledgement of the spiritual dimension of the human person alongside the other vital dimensions of what it is to be human, has re-emphasized the need for spiritual care in dealing with the profound existential crises that are common features of human illness and distress. A failure of attending clinicians to recognise the need for spiritual care may well constitute not simply a failure of healthcare systems, but also a frank negligence [31,32]. This does not mean, emphatically, that the attending clinician is the appropriate person to provide such care, on the contrary. But it does indicate that he or she is empowered to identify a need for spiritual and religious care (cf. Puchalski's spiritual assessment tool [24,26]) and to refer such a need to the care of the appropriate colleagues within the multidisciplinary clinical team, particularly to the healthcare chaplain. It is important to emphasise that, while there is a clear place for psychoanalytics and psychodynamics in the clinical care of distressed patients, there is also a clear place for spiritual and religious care in addition, in their various forms. At all costs, healthcare chaplains should seek to avoid the attempts by secularised societies to convert the priest or pastor, iman or rabbi, into a secular counselor or social

work professional. The distinct facets of the human person require distinct attentions - and since they do not exist in separation or isolation, but rather constitute the integral human being - the work of those who provide explicitly religious or spiritual care, when it has been requested, should enter into contact with and remain close advisers to the multidisciplinary clinical team. Much of this thinking is ether *explicit*, or certainly *implicit*, within Fitchett and Nolan's volume.

The trenchant views of Raymond Lawrence [54-56] on Fitchett and Nolan's volume cannot be ignored and neither should they be. Lawrence makes many very important points, yet the invective which he employs in an attempted destruction of the book is such that one cannot escape the conclusion that he has entered into a form of war on those who would seek to assess, and then aim to provide, forms of religious and spiritual care to those distressed patients who ask for God's love, healing and salvation. In reflecting so recklessly on what he perceives to be the limitations of the chaplains described within Fitchett and Nolan's book, Lawrence would do well to look deep into the mirror and to consider his very own. On re-reading Lawrence's 'library of criticism' of Fitchett and Nolan's book, I wondered what he might have thought of a chaplain discussing, with a chronically or terminally ill patient, the Church's teaching on the *value* of suffering, such as that expounded in *Salvifici Doloris* [57,58]. No doubt, Lawrence would consider it an arrestable offence.

Fitchett and Nolan are clear that the cases published within their book are not to be regarded as specifically representative of what the typical healthcare chaplain does. On the contrary, they point out that while there are common elements in the case studies which will be familiar to most chaplains and those clinicians who work with chaplains, such as listening or offering comfort, guidance and hospitality, they fall short of illustrating the work of a chaplain in its broadest sense and in terms of what is done on any given day or week. Neither do Fitchett and Nolan claim that the positive effects of chaplaincy services on the patients and families discussed in the volume mean that the case studies demonstrate ideal chaplaincy care. Indeed, there are, as these co-editors accept, strengths and weaknesses inherent within each case described, so that the case studies provide a good starting point for discussions about what chaplains do. Fitchett notes that one of the cardinal features of the case studies is their demonstration of the diversity which healthcare chaplains experience in their work, a diversity not only in terms of the clinical presentations of the patients, but in terms of the patients' religious and cultural backgrounds and also in terms of the length of relationship that chaplains enter into with patients, which may extend from only one day, to several weeks or several years, depending on the characteristics of the individual case. For sure, while acute presentations are ever present in medicine, the type of person the healthcare chaplain is now likely to see more and more of, and for extended periods of time, is the patient with chronic illness, given the current epidemic of long term, non-communicable illnesses [13-18,27-30].

Fitchett and Nolan anticipate that their volume will 'kick start', as it were, the publication of more and more

such case studies which, by their nature, will prove powerfully educative for healthcare chaplains themselves and for the clinicians with whom they work. My own view is that the authors are correct in their anticipation and that workers in this field can look forward to the accumulation of a large corpus of documentation and analysis, material which can be employed, as Fitchett suggests, in local, regional and national chaplaincy conferences as part of a system of 'continuous quality improvement' of what chaplains do. As part of this process, case studies, illustrating weaknesses as well as strengths and successes, will greatly assist the progress of the healthcare chaplaincy movement, drawing from clinical contexts much more extensive than those considered in the current volume and demonstrating to clinical colleagues, and also to healthcare payers, the real value and impact of healthcare chaplaincy services to patients. Here, as Fitchett emphasises, it will be important to discuss the results of chaplaincy services at clinical conferences and to publish the cases in clinical journals, in co-authorship with, or with a commentary from, clinical colleagues who have been able to see the result of chaplaincy services first hand.

As I conclude, California, in the United States of America, has become the first US State to require spiritual care in healthcare a "fundamental aspect of compassionate, patient-and family-centered care that honors the dignity of all persons". It is very encouraging, indeed, that the California Department of Health Care Services has recognised the need for palliative care teams in particular "to meet the physical, medical, psychosocial, emotional and *spiritual* needs of you and your family; and recommends that the team include, but is not limited to a doctor of medicine or osteopathy, a registered nurse and/or nurse practitioner, a social worker, as well as a chaplain" (italicisation mine) [69]. The Guidance makes clear that "trained and certified health care chaplains care for people of any and all religious persuasions as well as those who are not religious" and that their work "is about providing spiritual and emotional comfort", so that a chaplain "can help you talk about your concerns, help you communicate with doctors, and bring a sense of calm to situation that worries or frightens you. A health care chaplain can provide a calm reassurance and source of strength". Rightly, the new services draw upon the 2014 Consensus Report of the USA Institute of Medicine, that "ideally, health care should harmonize with social, psychological and *spiritual* support to achieve the highest possible quality of life for people of all ages with serious illnesses or injuries." Moreover, that same Report has also stated that frequent assessment of a patient's spiritual wellbeing, and attention to a patient's spiritual and religious needs, should be among the core components of quality end-of-life care across all settings and providers.

Finally, in completing this *Essay Review*, I was sent details of a new and surely most important book, entitled 'Confession, The Healing of the Soul' [70]. The author, Professor Peter Tyler, of St. Mary's Catholic University in Twickenham, UK, is perhaps rare in being both a Professor of Pastoral Theology and Spirituality, but at the same time a qualified psychotherapist. Tyler has no hesitation in distinguishing between theology and psychology,

explaining that "in theology we are dealing with God and God, by God's nature, will always be greater than any construct we place on Him. In my experience, the experienced confessors whom I have encountered over the years are those who understand the technical science of the situation but who can also let God be God to the person they are sitting with. That is what Gregory the Great meant" [70]. Tyler is clear that clergy are not second-rate psychologists, but performing an important role that builds on the psychological to allow transcendental healing to take place and that the psychological professions need to understand that "there is a limit to what can be achieved in the counselling room - where the psychological ends and the spiritual begins."

Conclusion

Fitchett and Nolan have, in association with the participating chaplains and the external commentators, contributed a new resource to the healthcare chaplaincy literature which provides further insight into how spiritual care and professional chaplaincy can be integrated into clinical care with the aim of making it more person-centered. It breaks new ground in illustrating the educative role of case studies in the training and continuing education of healthcare chaplains and in demonstrating the nature and value of healthcare chaplaincy services to clinicians and healthcare payers. The external reviews of the chaplains' work with their individual patients are particularly useful, typically illustrating deficits and concerns that the participating chaplains may not otherwise have considered - relevant research is cited, emerging theoretical perspectives and theological implications considered and with good cross-referencing to other disciplines. It provides a valuable learning resource for healthcare chaplains to employ in reflecting on their own practice and to consider how they themselves might have handled the cases described. John Swinton's *Afterword*, in talking of the need for a rejuvenation of the healthcare imagination and the hospital as a place of healing stories, brings the volume to an inspiring conclusion. For my part, I can certainly recommend this book as important reading for all healthcare chaplains and to those clinical and managerial colleagues who wish to increase their understanding of the modern healthcare chaplain's role.

Conflicts of Interest

The author declares no conflicts of interest

References

[1] World Health Organisation (1984). Thirty-seventh World Health Assembly. Verbatim Records of Plenary Meetings and Reports of Committees. WHO, Geneva Switzerland. Available at:

http://apps.who.int/iris/bitstream/10665/160775/1/WHA37 _1984-REC-2_eng.pdf (Last accessed 11 December 2017).
[2] World Health Organisation (1984). Decisions and List of Resolutions. WHO, Geneva, Switzerland. Available at: http://apps.who.int/iris/bitstream/10665/160873/1/WHA37 _Div-5_eng.pdf (Last accessed 11 December 2017).
[3] World Health Organisation (1984). The Spiritual Dimension in the Global Strategy for Health for All by the Year 2000. WHO, Geneva, Switzerland. Available at: http://apps.who.int/iris/bitstream/10665/160950/1/WHA37 _R13_eng.pdf (Last accessed 11 December 2017).
[4] World Health Organisation (1998). Review of the Constitution of the World Health Organisation: Report of the Executive Board Special Group of the 101st Session of the WHO Executive Board (EB101.R2). Available at: http://apps.who.int/gb/archive/pdf_files/EB101/pdfangl/an gr2.pdf (Last accessed 11 December 2017).
[5] Nagase, M. (2012). Does a Multi-Dimensional Concept of Health Include Spirituality? Analysis of Japan Health Science Council's Discussions on WHO's 'Definition of Health' (1998). *International Journal of Applied Sociology* 2, 71-77.
[6] World Health Organisation (1998). WHOQOL and Spirituality, Religiousness and Personal Beliefs (SRPB). WHO, Geneva, Switzerland. Available at: http://apps.who.int/iris/bitstream/10665/70897/1/WHO_M SA_MHP_98.2_eng.pdf (Last accessed: 11 December 2017).
[7] Sturmberg, J.P. & Martin, C. (Eds.). (2013). Handbook of Systems and Complexity in Health. Springer-Verlag, New York.
[8] Sturmberg, J.P. (2017). Health System Redesign. How to Make Health Care Person-Centered, Equitable, and Sustainable. Basel Swuitzerland: Springer International Publishing.
[9] Koenig, H.G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *ISRN Psychiatry* 2012, 1- 33. (Article ID 278730: doi:10.5402/2012/278730). Available at: https://www.hindawi.com/journals/isrn/2012/278730/ (Last accessed 11 December 2017).
[10] Garcia, K. & Koenig, H.G. (2013). Re-examining Definitions of Spirituality in Nursing Research. *Journal of Advanced Nursing* 69 (12) 2622-2634.
[11] Zimmer, Z., Jagger, C., Chiu, Chi-Tsun., Ofstedal, M.B., Rojo, F. & Saito, Y. (2016). Spirituality, religiosity, aging and health in global perspective: A review. *SSM - Population Health* 2, 373-381.
[12] Miles, A., & Asbridge, J. E. (2017). Multimorbidity - a manifestation of network disturbances? How to investigate? How to treat? *Journal of Evaluation in Clinical Practice* 23 (1) 193-198.
[13] World Health Organisation. (2011). Global Status Report on Noncommunicable Diseases 2010. Available at: http://www.who.int/nmh/publications/ncd_report2010/en/ (Last accessed 11 December 2017).
[14] World Health Organisation. (2014). Global Status Report on Noncommunicable Diseases. WHO, Geneva, Switzerland. Available at: http://www.who.int/nmh/publications/ncdstatus-report2014/en/ (Last accessed 11 December 2017).

[15] World Health Organisation. (2014). Noncommunicable disease country profiles. WHO, Geneva, Switzerland. Available at: http://www.who.int/nmh/publications/ncd-profiles2014/en/ (Last accessed 11 December 2017).

[16] World Health Organisation. (2015). Health in 2015: from MDGs to SDGs. WHO, Geneva, Switzerland. Available at: http://www.who.int/gho/publications/mdgssdgs/en/ (Last accessed 11 December 2017).

[17] World Health Organisation (2017). Noncommunicable Diseases: the Slow Motion Disaster. WHO, Geneva, Switzerland. Available at: http://www.who.int/publications/10-year-review/ncd/en/ (Last accessed 11 December 2017).

[18] World Health Organisation (2017). WHO to establish high-level commission on noncommunicable diseases. WHO, Geneva, Switzerland. Available at: http://www.who.int/mediacentre/news/statements/2017/ncd-commission/en/ (Last accessed 11 December 2017).

[19] Stoltzfus, M., Green, R. & Schumm, D. (Eds.). (2013). Chronic Illness, Spirituality, and Healing. Diverse Disciplinary, Religious, and Cultural Perspectives. London and New York: Palgrave Macmillan.

[20] Kruizinga, R., Scherer-Rath, M., Schilderman, J., Puchalski, C.M. & van Laarhoven, H.W.M. (2017). Towards a fully-fledged integration of spiritual care and medical care. *Journal of Pain and Symptom Management* In Press (doi: 10.1016/j.jpainsymman.2017.11.015. [Epub ahead of print]).

[21] Steinhauser, K.E., Fitchett, G., Handzo, G.F., Johnson, K.S., Koenig, H.G., Pargament, K.I., Puchalski, C.M., Sinclair, S., Taylor, E.J. & Balboni, T.A. (2017). State of the Science of Spirituality and Palliative Care Research Part I: Definitions, Measurement, and Outcomes. *Journal of Pain and Symptom Management* 54 (3) 428-440.

[22] Balboni, T.A., Fitchett, G., Handzo, G.F., Johnson, K.S., Koenig, H.G., Pargament, K.I., Puchalski, C.M., Sinclair, S., Taylor, E.J. & Steinhauser, K.E. (2017). State of the Science of Spirituality and Palliative Care Research Part II: Screening, Assessment, and Interventions. *Journal of Pain and Symptom Management* 54 (3) 441-453.

[23] Balboni, M.J. & Peteet, J.R. (Eds.). (2017). Spirituality and Religion within the Culture of Medicine. From Evidence to Practice. Oxford: Oxford University Press.

[24] Cobb, M., Puchalski, C. & Rumbold, B. (Eds.). (2014). Oxford Textbook of Spirituality in Healthcare. Oxford: Oxford University Press.

[25] Fitchett, G. & Nolan, S. (Eds.). (2015). Spiritual Care in Practice. Case Studies in Healthcare Chaplaincy. London: Jessica Kingsley Publishers.

[26] Borneman, T., Ferrell, B. & Puchalski, C.M. (2010). Evaluation of the FICA Tool for Spiritual Assessment. *Journal of Pain and Symptom Management* 40 (2) 163-173.

[27] Miles, A. & Asbridge, J E. (2016). The chronic illness problem. The person-centred solution. *European Journal for Person Centered Healthcare* 4 (1) 1-5.

[28] Miles, A. (2017). From evidence-based to evidence-informed, from patient-focussed to person-centered – the ongoing 'energetics' of health and social care discourse as we approach the Third Era of Medicine. *Journal of Evaluation in Clinical Practice* 23 (1) 3-4.

[29] Miles, A., Asbridge, J.E. & Caballero, F. (2015). Towards a person-centered medical education: challenges and imperatives. *Educacion Medica* 16 (1) 25-33.

[30] Miles, A. & Asbridge, J.E. (2017). Person-Centered Healthcare - moving from rhetoric to methods, through implementation to outcomes. *European Journal for Person Centered Healthcare* 5 (1) 1-9.

[31] Miles, A. (2009). On the interface between science, medicine, faith and values in the individualization of clinical practice: a review and analysis of 'Medicine of the Person' Cox, J., Campbell, A. V. & Fulford, K.W.M. (Eds.). (2007). Jessica Kingsley Publishers, London. ISBN-13: 978 184310 397 4, pp. 239. *Journal of Evaluation in Clinical Practice* 15 (6) 1000-1024.

[32] Miles, A. (2017). Catholic Witness in Health Care. [Travaline, J.M. & Mitchell, L.A. (2017)]. An analysis and commentary exploring the potential for a shared philosophical anthropology through person-centered health and social care. *European Journal for Person Centered Healthcare* In Press.

[33] Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry* 12 (2) 219-245.

[34] Yin, R.K. (2014). Case Study Research Designs and Methods (5th edn.). Thousand Oaks, California: Sage Publications.

[35] Mahan, J.H., Troxell, B.B. & Allen, C.J. (1993). Shared Wisdom: A Guide to Case Study Reflection in Ministry. Nashville, Tennessee: Abingdon Press

[36] Northcott, M. (2000). The case study method in theological education. In: Willows, D. & Swinton, J. Eds. Spiritual Dimensions of Pastoral Care, pp. 59 - 65. London Jessica Kingsley Publishers.

[37] Schipani, D.S. (2011). Case study method. In: Miller-McLemore, B, Ed. The Wiley-Blackwell Companion to Practical Theology, pp. 91-101. John Wiley & Sons, Chichester.

[38] Fitchett, G. (2011). Making our case(s). *Journal of Healthcare Chaplaincy* 17, 3-18.

[39] Folland, M. (2006). Opportunity and conflict: evidence-based practice and the modernisation of healthcare chaplaincy. *Contact* 149, 12-20.

[40] Asquith, G.H. (1980). The Case Study Method of Anton T. Boisen. *Journal of Pastoral Care* 34 (2) 84-94.

[41] Boisen, A.T. (1960). Out of the Depths: An Autobiographical Study of Mental Disorder and Religious Experience. New York: Harper & Brothers.

[42] Boisen, A.T. (1971). The Exploration of the Inner World. A Study of Mental Disorder and Religious Experience. Pennsylvania: University of Pennsylvania Press.

[43] Cabot, R.C. & Dicks, R.L. (1936). The Art of Ministering to the Sick. New York: Macmillan.

[44] O'Connor, T.S. & Meakes, E. (1998). Hope in the midst of challenge: evidence-based pastoral care. *Journal of Pastoral Care* 52 (4) 359-367.

[45] Fitchett, G., Nieuwsma, J.A., Bates, J.M., Rhodes, J.E. & Meador, K.G. (2014). Evidence-based chaplaincy care: attitudes and practices in diverse healthcare chaplain samples. *Journal of Healthcare Chaplaincy* 20 (4) 144-160.

[46] Berger, J.A. (2001). A case study: Linda. *Journal of Healthcare Chaplaincy* 10 (2) 35-43.

[47] Gibbons, G.D. (1988). Embodiment, ministry, sacrament and evangelism: a case study. *Ministry, Society and Theology* 2 (2) 1-11.

[48] Isgandarova, N. (2008). Muslim spiritual care and counseling: a case study of a resident with Parkinson's disease. In: O'Connor, T.S., Lashmar, C. & Meakes, E. (Eds). The Spiritual Care Giver's Guide to Identity, Practice and Relationships: Transforming the Honeymoon in Spiritual Care and Therapy. Halifax, NS: South Western Region of the Canadian Association for Pastoral Practice and Education and Waterloo, ON, pp. 235-242. Waterloo: Waterloo Lutheran Seminary.

[49] Pervis-Smith, T.A. (1996). Pediatric pastoral care: a case study. *Journal of Pastoral Care* 50 (2) 171-180.

[50] Cooper, R.S. (2011). Case study of a chaplain's spiritual care for a patient with advanced metastatic breast cancer. *Journal of Healthcare Chaplaincy* 17, 19-37.

[51] King, S.D.W. (2011). Touched by an angel: a chaplain's response to the case study's key interventions, styles, and themes/outcomes. *Journal of Healthcare Chaplaincy* 17, 38-45.

[52] King, S.D.W. (2012). Facing fears and counting blessings: a case study of a chaplain's faithful companioning a cancer patient. *Journal of Healthcare Chaplaincy* 18, 3-22.

[53] Risk, J.L. (2013). Building a new life; a chaplain's theory based case study of chronic illness. *Journal of Healthcare Chaplaincy* 19 (3) 81-98.

[54] Lawrence, R.J. (2015). The Current Crisis in Healthcare Chaplaincy and Spiritual Care - I. *Newsletter of the College of Pastoral Supervision and Psychotherapy* Available at: http://www.cpspoffice.org/the_archives/2015/06/the_current_cri.html (Last accessed 11 December 2017).

[55] Lawrence, R. J. (2015). The Current Crisis in Healthcare Chaplaincy and Spiritual Care – II. *Newsletter of the College of Pastoral Supervision and Psychotherapy* Available at: http://www.cpsp.org/pastoralreportarticles/3416342 (Last accessed 11 December 2017).

[56] Lawrence, R.J. (2015). The Current Crisis in Healthcare Chaplaincy and Spiritual Care – III. *Newsletter of the College of Pastoral Supervision and Psychotherapy* Available at: http://www.cpsp.org/pastoralreportarticles/3487068 (Last accessed 11 December 2017).

[57] John Paul II. (1984). Apostolic Letter *Salvifici Doloris* of the Supreme Pontiff John Paul II to the Bishops, to the Priests, to the Religious Families and to the Faithful of the Catholic Church on the Christian Meaning of Human Suffering. Available at: https://w2.vatican.va/content/john-paul-ii/en/apost_letters/1984/documents/hf_jp-ii_apl_11021984_salvifici-doloris.html (Last accessed 11 December 2017).

[58] Pinyan, J. (2014). Summary of *Salvifici Doloris* (on the Christian meaning of human suffering). Available at: http://www.catholiccrossreference.com/blog/2014/10/09/summary-of-salvifici-doloris-on-the-christian-meaning-of-human-suffering/ (Last accessed 11 December 2017).

[59] Puchalski, C.M. (2001). The role of spirituality in health care. *Proceedings of the Baylor University Medical Center* 14 (4) 352-357.

[60] Roger, K.S. & Hatala, A. (2017). Religion, spirituality & chronic illness: A scoping review and implications for health care practitioners. *Journal of Religion and Spirituality in Social Work*. In Press.

[61] Szaflarski, M. (2013). Spirituality and religion among HIV-infected individuals. *Current HIV/AIDS Reports* 10 (4) 324-332.

[62] Ernecoff, N.C., Curlin, F.A., Buddadhumaruk, P. & White, D.B. (2015). Health Care Professionals' Responses to Religious or Spiritual Statements by Surrogate Decision Makers During Goals-of-Care Discussions. *Journal of the American Medical Association* 175 (10) 1662-1669.

[63] Gollnick, J. (2005). Religion and Spirituality in the Life Cycle. Oxford: Peter Lang Publishing Group.

[64] Peteet, J.R. & Balboni, M.J. (2013). Spirituality and Religion in Oncology. *CA: A Cancer Journal for Clinicians* 63, 280-289.

[65] Pargament, K. (1997). The Psychology of Religion and Coping: Theory, Research, Practice. New York: Guilford Publications.

[66] Fitchett, G. (2017). Recent Progress in Chaplaincy-Related Research, *Journal of Pastoral Care and Counseling* 71, 163-175.

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

[68] Gibbons, J.L. & Miller, S.L. (1989). An Image of Contemporary Hospital Chaplaincy. *Journal of Pastoral Care* 43 (4) 355-361.

[69] Huffington Post (2017). California Is the First State To Require Spiritual Care In Health Care. Available at: https://www.huffingtonpost.com/eric-j-hall/californi-is-the-first-st_b_12249344.html (Last accessed 11 December 2017).

[70] Tyler, P. (2017). Confession. The Healing of the Soul. London: Bloomsbury Publishing.