I t began with a request from a vice president urging the director of the Spiritual Care Department to “come up with some benchmarks” for his department and to compare them with programs from similar healthcare facilities. In order to obtain this information, the director composed an e-mail to approximately twenty chaplain colleagues. Over half were from Georgia, while others were scattered across the United States. Some of these chaplains either had written about their work in this area or simply happened to be chaplains in hospitals similar in size to his. Though the director eventually discovered that healthcare chaplaincy currently has little to offer in terms of his vice president’s original request for benchmarks, he did set in motion a flurry of activity that carried the group of chaplains who authored this article—through

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marklp@armc.org

Chaplains from eight hospitals in north Georgia compiled a grid containing their departmental practices in each of twelve areas that have been identified for developing best practices in chaplaincy. Hospital settings varied from community one- or two-person departments to urban multistaff departments with CPE programs. Ultimately, they identified a continuum of “better practices,” which they view as a collaborative, dynamic, qualitative and relational concept that is more descriptive of and helpful for professional chaplaincy as practiced today. Selected portions of the grid are included with the article. For a copy of the complete grid, contact Mark LaRocca-Pitts (marklp@armc.org).
a series of meetings over the next eighteen months—down an unexpected, yet exciting, road.\(^1\)

Following the initial e-mail, volleys of responding e-mails went back and forth as chaplains’ interests were stimulated. As some of the national response subsided, a group in the north Georgia area agreed to meet at a central location to talk about what they wanted to do. One chaplain volunteered to moderate, and another volunteered to serve as host. The ensuing e-mails were enthusiastic and indicated a hunger both for challenge and for collegiality.

The first meeting was held on July 14, 2006, just a few weeks after the initial e-mail requesting information. The nine chaplains who authored this article met for approximately three hours. The energy level anticipating something new on the horizon was high. There was consensus that direction and commonality from which to launch this endeavor were needed and that a good starting place was George Handzo’s 2006 article, “Best practices in professional pastoral care.”\(^2\)

**Best practice**

In this article, Handzo uniquely addresses this topic, arguing that “In current best practices, chaplains are assigned to specific locations, generally selected for their strategic importance to the institution, and visit patients of all faiths selected according to specific protocols.”\(^3\) He then lists twelve practice areas that in his opinion represent the highest quality in professional pastoral care:

- Based on a Plan with Outcomes
- Targeting of Pastoral Care
- Protocol-based Referrals
- Spiritual Screening and Assessment Processes
- Multifaith Ministry
- Staff Training & Support
- Certification of Pastoral Care Staff
- Contributions to Cost Enhancement
- Participation in Ethics Process
- Involvement in Disaster Preparedness
- Quality Improvement
- Other Institutional Involvements

Handzo’s primary contributions in this article are that of synthesis and selection. The twelve areas selected by Handzo represent topics that have been discussed extensively in pastoral care literature. They also represent areas of primary importance to a professional pastoral care department. Within each of the practice areas, Handzo does not argue for any particular best practice, but simply provides what might be considered a minimum standard of practice. Standards of practice are defined as those “principles and practices that represent the profession and include minimum levels of practice to which professionals are held accountable.”\(^4\) His theory is that by examining these twelve areas and comparing the various practices chaplains employ within their individual settings, we can develop best practice for each area.

Once group consensus clarified the article’s meaning for us, it became an organizing center providing a lens through which each of us could examine how we fleshed out the work of a chaplain in our specific settings. Handzo’s article gave us a language and a descriptive classification.

**Our process**

We first discussed our individual understandings of these twelve areas. We found that ten of the twelve areas were relatively clear, but that two of the areas needed additional discussion. The first of these was “Based on a Plan with Outcomes.” In the majority of pastoral care literature on this topic, outcome-oriented language involves direct patient care. That is, the provision of patient care must be guided by a plan that will achieve certain agreed-upon and measurable outcomes.\(^5\) Handzo’s description of this area, however, indicated he was thinking of departmental plans with outcomes that are aligned with the institution’s goals and mission. Once this was clear, we used our various departmental “scope of service” plans to indicate how our departmental services were based on outcomes.

The second area that we found problematic was “Contributions to Cost Enhancement.” We thought this title was misleading since this section speaks primarily of staff support and indirect cost benefits. We all knew anecdotally that supportive interventions help significantly with staff retention and therefore provide an indirect cost benefit; however, many of the other examples provided by Handzo eas-
ily could fit under the area titled “Staff Training and Support.” We retained this practice area, however, since it did force us to examine with more intention how our staff interventions provided indirect cost benefits. It is also an area where a best practice certainly could surface.

Once we had a fair idea of the various areas and what we were looking for, we delineated the particular practices at our respective hospitals that coincided with each practice area as well as basic demographic information. To provide a measure of anonymity each hospital was identified by a letter. Demographic information for the eight participating hospitals is shown in Table 1 (p. 6).

Our host chaplain’s administrative assistant then plotted this information on a grid of eight rows, one for each participating hospital, and twelve columns, one for each practice area. Compiling our various practices in this fashion allowed us to see what we did in our respective settings with more definition and value. It also allowed us to look into the windows of other settings and to see the inner workings of each other’s shops. Our hope was that by seeing all these various practices together and comparing them, we would discern what we might consider best practice. Such discernment, however, was not our experience. Instead, we made some other, more interesting, discoveries.

Discussion

One of the first things we discovered was that a best practice in one setting would not be possible or feasible in another setting. For example, if we took the practice area “Based on a Plan with Outcomes” and used 24/7 coverage as a standard of practice, we found substantial differences based on setting. (See Table 2, p. 7.) Whereas a large clinical pastoral education (CPE) center with multiple staff chaplains and CPE students could provide an around the clock in-house response time of five minutes, a smaller department might depend on a cadre of community clergy volunteers with some degree of variability in response time. Each of these is based on a plan with an outcome, and each is based on the demands of the particular setting with its particular mission; however, to suggest that one practice is “best” and another is not seemed inappropriate. Each setting suggested its own best practice. Further, within a given setting, there was a continuum of practices.

As another example of the variability of setting and its effect on practice, one of the chaplains in our study discovered an answer as to whether it was practical for his hospital to have a CPE program. A closer look at other hospitals and their programs along with the cost of providing such a program, led him to the conclusion that CPE was not for his hospital at the present time. A less expensive and more effective way to practice chaplaincy in his particular setting was to utilize trained volunteers from local faith communities. This chaplain used this survey to establish a “better practice” for his particular setting—a significant concept that we will discuss further.

This function of the clinical setting as a variable in best practice may be traced throughout all the other practice areas. A large multistaff department of certified chaplains with well-targeted patient populations may be able to provide a more in-depth and comprehensive spiritual assessment than a one- or two-person department that has responsibilities for larger and more diverse patient populations. Nonetheless, within each of these settings best practice may be developed provided that the nature of the chaplain’s setting and the level of staffing are taken into account.

Such differences also may be seen in the twelve practice areas as a whole when considered in light of this variable of setting. The responsibilities of patient care, staff training and support, participation in ethics processes, disaster response, quality improvement, and other institutional involvements are more easily spread among members of a multistaff department. A much smaller pastoral care department, however, may find it difficult to maintain a high level of involvement in all these practice areas and may have to make choices. Thus, it is possible to develop best practices in each of these settings as long as there is awareness that what is a best practice in one may not be realistic or feasible in another.

For example, one of the chaplains in our group is a one-person department. Though he had intentionally developed a very strong role in his hospital’s ethics process, he could clearly identify a best practice in only two or three other areas. The dynamics of his setting and his own interests facilitated these developments even as many of the same dynamics worked against his attempts to establish best practices in other areas. This chaplain claimed a strong affinity with the boy trying to plug holes in the dike. In fact, he almost dropped out of this study as the best practices grid highlighted the
### Demographics of the participating hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Type:</th>
<th>Community, nonprofit, urban/suburban</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Beds:</td>
<td>830 (3 campuses)</td>
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<td></td>
<td>Ann Pt Days:</td>
<td>241,743 (FY2007 estimate, includes newborns)</td>
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<tr>
<td></td>
<td>FTE:</td>
<td>7.5 chaplains for system, 2 PRN, 0.8 administrative assistant</td>
</tr>
<tr>
<td></td>
<td>CPE:</td>
<td>1 SIT, 4 residents, 3 -5 interns</td>
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<tr>
<td></td>
<td>Volunteers:</td>
<td>5 lay, 12 community clergy</td>
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<td>Ann Pt Days:</td>
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<td></td>
<td>FTE:</td>
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<tr>
<td></td>
<td>CPE:</td>
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<td></td>
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<td>FTE:</td>
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<td></td>
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<td></td>
<td>FTE:</td>
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<tr>
<td></td>
<td>CPE:</td>
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<td></td>
<td>FTE:</td>
<td>10</td>
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<td></td>
<td>CPE:</td>
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<td></td>
<td>Volunteers:</td>
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<td></td>
<td>FTE:</td>
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<tr>
<td></td>
<td>CPE:</td>
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<td></td>
<td>Volunteers:</td>
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<td>Beds:</td>
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<td></td>
<td>Ann Pt Days:</td>
<td>69,468</td>
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<tr>
<td></td>
<td>FTE:</td>
<td>1</td>
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<tr>
<td></td>
<td>CPE:</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Volunteers:</td>
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<tbody>
<tr>
<td></td>
<td>Beds:</td>
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</tr>
<tr>
<td></td>
<td>FTE:</td>
<td>2.8</td>
</tr>
<tr>
<td></td>
<td>Contract:</td>
<td>6</td>
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<tr>
<td></td>
<td>CPE:</td>
<td>6 (spring unit)</td>
</tr>
<tr>
<td></td>
<td>Volunteers:</td>
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### Table 2: Based on a plan with outcomes

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Details</th>
</tr>
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</table>
| **Hospital A** | - Scope of service includes two campuses; 24/7 on site coverage at Atlanta campus.  
- Primary service focus in oncology, OB/GYN, medical/surgical units.  
- Expected five-minute response to emergent situations and/or crises.  
- Scope of service includes annual department goals, criteria for assessing acuity, response times expected, services offered, and staffing configuration. |
| **Hospital B** | - Annual department goals with quarterly assessment.  
- Administrative Policy 117 “Spiritual Needs”: Guideline for Pastoral Care Services Department. |
| **Hospital C** | - 24/7 availability: a staff chaplain is on call 24/7; after hours, pages are returned within five minutes, and chaplain arrives within thirty minutes.  
- Chaplains participate in interdisciplinary team rounds in ICU units where chaplain is assigned. |
| **Hospital D** | - 24/7 availability; after hours, pages are answered within five minutes, and the chaplain arrives within sixty minutes.  
- Chaplains participate in interdisciplinary team rounds where chaplain is assigned as part of a pathway plan.  
- Quest Training Chaplain part of training team for chaplains and other ancillary staff for electronic charting.  
- Labyrinth and harp programs provided through the Spiritual Care Services Department in an effort to ease employee stress and retention. |
| **Hospital E** | - System advocates for whole person and family centered care; spiritual needs and chaplaincy are integral to that mission.  
- 24/7 availability utilizing staff and/or CPE students; response times are five minutes on weeknights and thirty minutes on weekends.  
- Annual department goals.  
- Staff/students attend interdisciplinary rounds on a regular basis.  
- Staff chaplains participate in creating electronic documentation.  
- Level II trauma center; chaplains are members of trauma and code teams.  
- Chaplains (with social workers) are responsible for education and completion of advance directives. |
| **Hospital F** | - 24/7 spiritual care coverage in house.  
- Level II trauma center; chaplains are members of trauma response and code blue teams.  
- Department sets goals to support the top three system goals. Each department member sets annual personal goals connected to system goals and system mission/vision.  
- Policy for scope of care – inpatient.  
- Administrative policy for chaplaincy department: Referral for services. |
| **Hospital G** | - No “best practice”; plan is vague and informal. |
| **Hospital H** | - Scope of service includes two campuses; 24/7 onsite coverage at both; daytime coverage, but not on call, for 2 long-term care facilities.  
- Level II Trauma Center – 24/7 coverage. |
differences between his one-person department and multistaff departments. His identified sense of futility related closely to his organization’s lack of reflection and dialogue about best practice beyond the message to “just do the best you can.” Of greater import is the fact that one person is actually in the hospital only 20–25 percent of the total hours the hospital functions. Consistent and reliable response to targeting and/or protocols for spiritual care is therefore very problematic! The chaplain chose to remain in the study both to voice the perspective of one-person departments and to assert that even in this one-person setting, there are best practices to be claimed.

Once we became aware of this variability in best practice as a function of setting, another interesting development occurred within our process. We first noticed this development visually; only later did we understand what it reflected. The administrative assistant who entered our data into the grid changed font color whenever a chaplain changed or added information to one of the practice areas. The result was that our first responses were in black and our secondary and tertiary responses appeared in blue and red. After reflecting on this multilayered grid, we saw that three important things had transpired.

The first reflected our collective learning curve. As we discussed the various practice areas and read what others had included, we learned a new language to articulate our work as well as a new way to categorize it. Much of the pastoral care language we have inherited is theological and congregation based. Translating our pastoral work into the clinical language of outcomes, targeting, protocol-based referrals, screening/assessment processes, cost enhancement and quality improvement was relatively new for some of us. Even for the rest, the process of categorizing all of our work into these specific practice areas was a new exercise that involved a learning curve. The layers of our grid revealed this learning process.

Secondly, this multilayered grid demonstrated that some of us found ways during the process itself to improve our practices. For example, one of the chaplains, who by the nature of his setting had to be something of a generalist, discovered a way to target part of his practice to a strategic population more in line with his hospital’s mission. He then developed protocol-based referrals that helped him triage this particular population more effectively in light of his other duties.

The third reality that our multilayered grid revealed to us was how our trust in one another as colleagues had grown during this process. One of the chaplains described this process in terms of appreciative inquiry, which begins with the search for solutions that already exist within an organization, amplifies what is working and focuses on life-giving forces. The energy released by the collegial process of sharing standards of practice and best practices was similar. We were vulnerable enough to share what we thought was working well, taking the risk that it would not be enough or be adequately impressive to the others. What we discovered was that by sharing what was working well, a synergy developed. We had much more energy and excitement about the work of chaplaincy than had we functioned in isolation. Feelings of inadequacy quickly gave way to appreciation of our own work and enthusiasm about new ideas.

As we looked at our completed multilayered grid, it was suddenly apparent that, regardless of size, budget and setting, each of the chaplaincy programs had made intentional efforts to address each of the focused practice areas. Though these intentions ranged from formal and highly structured to informal and as needed, this outcome suggested that all of us thought these twelve practice areas were important for a professional chaplaincy program.

Our final discovery came with reflection as we were writing about our process. It involves a significant change that is occurring in the practice of professional chaplaincy. Handzo’s twelve practice areas may be divided broadly into two primary foci. The first focus (33 percent) is on direct patient care and includes practice areas 2-5. (See list on p. 4) The second focus (67 percent) is on organizational or institutional concerns and includes the remaining eight practice areas. Some of the latter naturally have an indirect bearing on patient care.

Pastoral care within a healthcare setting traditionally has focused on direct care of patients and staff with administrative, organizational or institutional concerns becoming more apparent only in the past couple of decades. This shift becomes evident in the comparison of the following three books on hospital-based pastoral care: Cabot/Dicks (1945), Holst (1991) and Bueckert/Schipani (2006). With each successive generation, the organizational and institutional concerns related to patient care con-
cerns increase from 9 percent to 47 percent to 63 percent respectively. Though Handzo describes current best practices primarily in terms of patient care, i.e., “chaplains are assigned to specific locations, generally selected for their strategic importance to the institution, and visit patients of all faiths selected according to specific protocols,” his list of practice areas is heavily weighted in favor of organizational or institutional concerns.

This shift in pastoral care priorities came as a surprise to most of us and explains in part why our exercise in best practice was difficult for some of us to complete: we were trained with one set of priorities and now were asked to respond to a different set of priorities. Also, though our professional understanding of the chaplain’s role may be shifting from direct patient care toward more organizational concerns, research has shown that administrators still see this role as revolving primarily around patient care concerns. Educating administrators—as well as professional chaplains—regarding the increasing diversification and complexity of chaplains’ roles constitutes an area of increasing advocacy.

Study limitations

Several limitations of our study should be noted and addressed in future studies. The first involved developing a common language to describe, categorize and compare our practices in terms of best practice. Our learning curve as a group began to level out only toward the end of the study. However, through articulating our results we gained knowledge, and this may accelerate the learning curves for others.

A second limitation concerned the demands of our individual settings on our availability. Some of our hospitals opted not to participate directly, because of time constraints. Now that our study has developed a method and a process, the demands on time and resources should be lessened.

A third limitation surfaced in our attempts to establish consistent measurements for describing our demographic variables. Chaplaincy has no industry standards for translating the various positions, e.g., director, CPE supervisor, staff chaplain, CPE resident, CPE intern, PRN chaplain, into full-time equivalencies (FTE) or some other standard of measurement. Thus it is not possible to make consistent comparison of staffing configurations and chaplain-to-patient ratios among hospitals in different settings. Establishing such a standard would be helpful for future studies.

A final limitation on our study involved its exploratory nature. Effectively and accurately orienting and then mapping a new conceptual landscape integrates numerous attempts from a variety of perspectives. This is one study. Others are needed. A synthetic study then could combine them into a more comprehensive and accurate map. Building on our limitations and weaknesses, future studies may add or subtract practice areas. They may categorize individual practices differently. Looking at our grid of twelve practices, one could argue that the listed practices fit better under another practice area or category. Future studies should analyze our data for both strengths and weaknesses and use it to help define the types of individual practices that are appropriate for a given practice area. The efforts of many contributors may result in a more accurate map to guide us toward best practice in healthcare chaplaincy.

Better practice

Overall this collegial process challenged us to rethink what best practice implies when applied to the discipline of professional chaplaincy. Best practice is quintessentially a quantitative measurement based on evidence-based research, which is certainly the case when speaking of best practice within a scientific milieu such as medicine. Medicine is an objective science that progresses by knowledge accumulated from empirical studies. As such, for any particular practice, there is the standard of practice, which in turn has the best practice, which in turn is supported by evidence-based research. Any hospital—regardless of setting and size—that seeks to offer a particular practice, such as open-heart surgery, must meet the standard of practice. Improvement is then measured by the degree the hospital conforms to the best practice—again regardless of setting and size.

Much of chaplaincy’s professional development as a healthcare discipline hinges on the question of whether medicine’s empirical and scientific model is appropriate to describe our practices. John Gleason argues that this is the threshold where our profession currently is “stalled.” By using the term best practice as well as standard of practice, we already may have bought into medicine’s conceptual landscape. Within chaplaincy, there is certainly a need and a desire to incorporate the quantitative, database methodologies of our clinical...
settings along with our traditionally qualitative understanding of pastoral care.\textsuperscript{13} The question often is one of degree.\textsuperscript{14}

In our work, we found that due to our different settings as well as to our different conceptual and theological landscapes, it was extremely difficult to identify a best practice that could be transplanted successfully to a different setting with a different practitioner. In fact, a one-person department could identify a best practice within a particular practice area that would look entirely different than a best practice in that identical practice area in a multistaff department. Such a situation could render the term “best practices” meaningless.

Rather than throwing up our hands in despair and going home defeated, we shifted the emphasis in best practice from being an indicator of quantity to one of quality. Instead of there being one best practice per practice area against which all individual practices were measured, we considered a continuum of “better” practices within each practice area. By comparing the practices of others in their own settings, we were able to discern if our own practice could become better, and if so, how to make it better.

In addition, better practice within a particular practice area became a function of setting, which is based on integrating the staffing configuration with the hospital’s—and the department’s—mission and vision. Thus, a pastoral care department could qualitatively improve, i.e., better, its particular practice by more effectively integrating its overall practice within its setting. By shifting the question from one of best practice to one of better practice, we switched our focus from one of quantity to one of quality.

A closer examination of the practice area called “Targeting of Pastoral Care” (see Table 3, pp. 12-13) illustrates this concept of better practice. Among the eight hospitals, there is a wide range in practices. Hospital A, a three-campus 830-bed facility with 7.5 FTEs and CPE students, targets onology services, women’s services and ICUs with staff chaplains and the medical-surgical floors with CPE students. Hospital A also focuses on a perinatal loss support program and an adoption care program.

Hospital B, a 410-bed hospital with a 40-bed psych unit, has 2.14 FTEs and 16 volunteers. The focus is on covering the hospital 24/7 with PRN chaplains, on a grief support program, on educational outreach to local faith leaders and on ethics involvement.

Hospital C, a 319-bed facility with 2.3 FTEs, targets the ICUs, cardiac care units and special care nursery, and is heavily involved in the Ethics Committee.

Hospital D, a 500-bed facility with 3.0 FTEs, divides its staff among the hospital units with each chaplain targeting specific units and maintaining involvement with diverse committees.

Hospital E, a 415-bed facility with 10.0 FTEs and CPE students, targets the pediatric and neonatal ICUs and the hematology/oncology units with staff chaplains. CPE students cover the rest of the hospital. All patients are visited within forty-eight hours of admission. In addition, Hospital E focuses on a bereavement program and provides various worship services.

Hospital F, a 500-bed facility with 4.0 FTEs and CPE students, targets the women’s services, rehabilitation units and the ICUs, using a combination of staff chaplains and residents. Patients with a length of stay greater than seven days also are targeted. In addition, there is a staff focus on various programs.

Hospital G, a 304-bed facility with 1.0 FTE, targets ICUs and cardiac care and focuses on requests for advanced directives.

Hospital H, a 461-inpatient hospital with a 60-bed mental health unit and a 261-bed long-term care facility, utilizes 2.8 FTEs, contract chaplains, forty-five volunteers and seasonal CPE students. The targeted response is based on referrals and the worship needs of the different facilities.

Seven of the eight hospitals surveyed (A-G) targeted specific patient populations. These targets were selected in part due to their acuity. It should be noted that the number of selected targets and the nature of the patient population specific to these target areas also is a function of the staffing configuration and their strategic importance to their hospital’s mission. This targeting, according to Handzo, represents “the highest quality in professional pastoral care.”\textsuperscript{15}

All the hospitals in our group target populations—even if informally as in the case of Hospital H—which suggests that this particular practice may be considered a standard of practice. However, since implementing this practice of targeting is subject to a particular hospital’s mission and its chaplaincy staffing configuration, it is extremely difficult to argue for one practice as best compared to another. Having a list of such practices available and correlating it in terms of staffing configurations would allow chaplains to locate their respective programs
on the continuum and possibly to determine ways to better their practices.

The concept of better practice also may empower both professional chaplaincy and the system within which it operates. Each healthcare institution has its own mission and its own vision, and each department must adapt its practices to support these. When it comes to quantitative, evidenced-based best practice, a hospital has minimal leeway in affecting the actual practice. A hospital either offers a particular practice or not according to set standards that are heavily regulated.

Quantitative best practices, however, are embedded within systems that function according to quality, and the latter are guided by the hospital’s mission and vision. It is these quality-driven systems that are subject to better practice. In other words, whereas quantitative best practices increase at intermittent levels, qualitative better practices are continuously improving in light of a more effective integration of staffing configurations with a hospital’s mission and vision.

Chaplaincy is part of this quality-based system; thus, better practice ideally is not a discipline-specific innovation, but a system-wide one. As chaplaincy or any other healthcare discipline develops better practices, it does so as part of, and in response to, its own system. From this perspective, a given practice is better to the degree it more effectively integrates its particular staffing configuration with its department’s mission and vision, which, in turn, supports the hospital’s mission and vision.

**Conclusions**

The inclusion of better practice within our discussions of best practice seems appropriate and helpful for professional chaplaincy. Pastoral care within a healthcare setting—as in any setting—is a dynamic and relational process. The language of better practice captures this dynamic and relational sense more accurately than does best practice, which represents, at most, a series of static snapshots superimposed from without. Due to the hierarchical semantics inherent within the concept of best practice, enculturated competitiveness also may surface, which is anathema to most philosophies of chaplaincy. The semantic field of better practice suggests a dynamic and collaborative, i.e., internal and relational, process instead of a static and competitive, i.e., external and imposed, process.

Shifting the focus of our process from best practice to better practice allowed each of us to benefit directly and immediately from our work.

The language of better practice is also a breath of fresh air that professional chaplaincy needs at this time. Instead of trying to determine which chaplaincy practices are best, it focuses on which practices are better within a particular setting and how to use these better practices to improve individual practices. Developing better practices is a dynamic and collaborative process that will enable professional chaplaincy to move through the establishment of standards of practice and eventually into the creation of best practices. In this sense, better practice functions as an investigative and exploratory method for moving professional chaplaincy and other qualitative-based healthcare disciplines toward best practice.

In addition, creating best practices in professional chaplaincy is difficult at best when standards of practice have not been established. Even with a standard of practice, it still may be difficult to establish a best practice given the many differences in clinical settings and staffing for chaplains. Since the seminal work of Russell Dicks in the late thirties and early forties, there has been an urgent need to define standards of practice.

The standards outlined by Dicks called for the chaplain to

- Be responsible to the administrator of the hospital.
- Cooperate with the other personnel of the hospital.
- Have a rational plan for selecting his [sic] patients.
- Maintain written records of his visits.
- Conduct interdenominational, nonproselytizing worship in the public hospital.
- Have adequate training, which included college and seminary courses at accredited institutions and a course of supervised clinical training.
- Be appointed to the hospital.

Granger Westburg’s 1949 College of Chaplains’ committee recommended eight standards:

1. College and seminary degrees or the equivalent.
2. Ordination.
3. Current ecclesiastical endorsement by one’s denomination.
### Table 3

**Targeting of pastoral care**

| Hospital A | • Hospital mission/focus.  
• 2 FTE chaplains assigned to oncology services, 2 FTE chaplains assigned to women's services, manager and CPE coordinator cover ICU, residents and interns cover medical/surgical units, CPE coordinator serves as liaison with clinical managers regarding students' process.  
• Spiritual care pathways, based on *The Discipline of Pastoral Caregiving* (A. Lucas et al.) for the following patient populations: end-of-life, critical care, bone marrow transplant, gynecology oncology, adoption, de-escalation in neonatal intensive care, perinatal loss and high risk pregnancy.  
• An extensive perinatal loss bereavement support program that serves more than 350 families per year and includes semiannual memorial services.  
• An adoption care program in which care and hospitality are extended to all members of the adoption triad. |
| Hospital B | • PRN chaplain evenings and weekends for goal of 24/7 coverage.  
• Monthly grief support group (open) with a letter sent to the family of each patient who died at hospital. Families kept on mailing list for three months unless they request to be dropped.  
• Contact with community clergy/faith leaders through the Volunteer Chaplains Associations as well as semiannual educational programs (April and November).  
• Be under budget at end of fiscal year.  
• Chaplain serves as Ethics Committee co-chair and assists with ethics consults/referrals. |
| Hospital C | • Priority target: 6 ICUs – chaplain attends daily interdisciplinary rounds.  
• Priority target: cardiac care with protocol based referrals per procedures (CATH, CABG, PPM, ICD).  
• Remainder of hospital divided between the 2 FTEs and targeted based on acuity and referrals.  
• Special care nursery: Chaplain attends weekly interdisciplinary rounds and monthly perinatal rounds.  
• Chaplains provide staff support as needed.  
• One weekly hospital wide prayer service in chapel.  
• Chaplains chair the Ethics Steering Committee, Clinical Ethics Committee, Ethics Education Subcommittee and Ethics Consultation Subcommittee. |
| Hospital D | • 1 FTE assigned to 6 medical/surgical units, ICU blue renal transplant, NICU and women's services. Also serves on IRB, and in charge of perinatal bereavement program.  
• 1 FTE assigned to 4 medical/surgical units, ICU green, post cardiac surgery, oncology, palliative care team, and Ethics Committee.  
• 1 FTE assigned to CCU, cardiology, orthopedics and medical/surgical unit. Also coordinates EAP, director of Employee Sharing Club Committee, employee counseling, administrative responsibilities.  
• Other targeting bases on acuity and referrals. Daily on-call shared by all chaplains. |
### Hospital E
- Chaplaincy staff members are assigned to the pediatric intensive care area (PICU), neonatal intensive care area (NICU) and the hematology/oncology patient care area.
- CPE residents and interns cover all other areas with chaplaincy coordinator serving as back up.
- Chaplaincy considered integral part of system’s mission and vision.
- Chaplaincy provides bereavement support and monthly bereavement support groups as well as an annual memorial service.
- Chaplains provide staff support on a regular basis.
- Chaplains are included in system activities and events.
- Chaplains are expected to visit all patients within 48 hours of admission.
- On-call duty chaplain coverage provided 24/7.
- Priority given to referrals by staff and physicians.
- Twice weekly prayer services.
- Once weekly worship services.
- Other religious services as needed/requested.

### Hospital F
- 1 staff chaplain/1 chaplain resident assigned to Gwinnett Women's Pavilion.
- 1 staff chaplain and 1 chaplain resident assigned to Gwinnett Medical Center-Duluth and Glancy Rehab.
- Spirituality group for Summit Ridge Psychiatric Hospital provided weekly for patients in adult inpatient and adolescents plus adult outpatient.
- Give priority to referrals from staff and physicians.
- Chaplains participate in interdisciplinary rounds on primary patient care units.
- Chaplaincy targets ICU, attending Monday-Friday rounds, and Center for Neuroscience with two rounds per week.
- Also targets patients with length of stay of greater than seven days.
- Weekly devotional service for long-term care center.
- 1 chaplain resident assigned to work with the palliative care nurse specialist.
- 1 chaplain resident assigned to work with staff chaplain at second medical/surgical hospital and physical rehabilitation center.

### Hospital G
- ICU and CCU patients.
- Referrals (loosely understood by staff as patient crisis or grief issue).
- Requests for information regarding advance directives.

### Hospital H
- Chaplain visits driven by referrals, rounds and condition sheet.
- Devotionals conducted at long-term care and mental health facilities.
- Seven chapel services offered on Sunday for patients, visitors and staff.
- Prayer books in both chapels.
- E-mail devotionals three times per week for staff.
4. A minimum of twenty-four weeks (960 hours) of clinical training.

5. Training in a general and mental hospital or a general hospital with psychiatric facilities.

6. Three years parish experience or its equivalent.

7. Written recommendation of the APHA (American Protestant Hospital Association) recognized training center.

8. Certification by the Accreditation Commission of the APHA.¹⁹

Most recently, the Council on Collaboration, comprised of six professional pastoral care organizations has built on the work of Dicks, Westburg and Helen Flanders Dunbar and others. In November 2004, the council, which includes representatives from AAPC, ACPE, APC, CAPPE/ACPEP, NACC and NAJC, published “Common Standards for Professional Chaplains.”²⁰ These documents are available on the APC Web site (www.professional-chaplains.org) in the Reading Room under Professional Resources.

Though extremely important, these common standards only deal with the certification of the pastoral care staff, which is only one of the practice areas outlined by Handzo. Until there are well-defined and agreed-upon standards of practice that establish minimum requirements in a variety of practice areas, it will remain difficult to discuss and develop best practices. This lack is the proverbial thorn in chaplaincy’s collective flesh. The language of better practice is intended to help us extract this thorn.

Developing these standards of practice, however, now will be easier due to Handzo’s work in presenting the twelve practice areas used in this study. In essence, Handzo has provided the basic definitions for, and the structure of, standards of practice to be further refined and codified. His twelve practice areas resonate with and expand upon the eight standards Dicks argued for nearly seventy years ago. They represent well the best of pastoral care literature since the early founders of modern chaplaincy. They also reflect professional chaplaincy’s increasing institutional interrelatedness with the hospital culture as a whole.

The work that we North Georgians did provides examples of how these twelve practice areas are realized in actual chaplaincy settings. This collegial process needs to be replicated in other parts of the country. Once collected, sifted and examined, these data may lead professional chaplaincy toward establishing standards of practice and may even suggest some best practices.

Even if multiple hospitals are unwilling to join in this process, an individual hospital still may benefit from our grid and our process as Hospital E demonstrated. With a new director in place over the division in which chaplaincy was housed, each department was asked to study its practices for consistency and quality.

The chaplaincy coordinator at this hospital had been participating in our study group and believed that our work would be helpful in this process. When the practice grid was completed, she distributed copies to the shared-decision making chaplaincy group as a place to begin examining their own practices across their system in an attempt to find better practices. This group decided they would use the grid to select two categories per year to study as part of their annual goals. This would align the discipline with system goals, assist chaplaincy with implementing a strategy to achieve the goals and function as a continuous quality improvement process as they bettered their practices. As it was late in the year when the grid was presented, they decided to begin with a less ambitious agenda of examining their practices in worship and bereavement rather than two full categories.

At minimum, the data generated by our process and provided in our grid, represent our understanding of standards of practice as actualized in our particular settings and may or may not suggest best practices. The data do represent a process that in itself is a better practice. This better practice is the collegial process we went through in creating the grid of practices. Gathering face-to-face as a group every two months and working together on a focused project provided us with opportunities to expand our education and to enjoy fellowship. Combining intellectual growth with fellowship and self-care that results in a way to better our own individual practices is a winning combination for professional chaplains and itself qualifies as a better practice.³⁶

References

¹ Larry VandeCreek, Eileen Gorey, Karolyann Siegel, Sharon Brown, Rhoda Toperzer, “How many chaplains per 100 inpatients? Benchmarks of health care chaplaincy departments,” Journal of Pastoral Care 55, no. 3 (Fall 2001): 289-301; Susan K. Wintz and George F. Handzo, “Pastoral care staffing and productivity: More than...