

**George Fitchett and Steve Nolan, eds., *Spiritual Care in Practice: Case Studies in Healthcare Chaplaincy* (New York: Jessica Kingsley, 2015), 320pp.**

There is little chance that either Fitchett or Nolan could publish something I would not devour quickly. Teaching the history and models of spiritual assessment, as well as the importance of research literacy, to chaplains in formation, we who teach chaplains do well to familiarize ourselves with whatever latest project Fitchett offers. Similarly, after reading Nolan's *Spiritual Care at the End of Life* years ago as a CPE resident myself, I resolved to follow his scholarship and wisdom with close attention. This latest volume does not disappoint.

The primary purpose of this volume is to sharply articulate the contours of how spiritual care providers assess, intervene, and measure the outcomes of their work. The secondary intention is to use case studies to train new chaplains. I have also been thinking about how to use this book to fulfill their third aim—to educate other members of interdisciplinary teams about who chaplains are and what exactly we do.

During the first month of our CPE residency this year, I facilitated discussion using two case studies: LeeAnn and Chaplain Grossoehme (chapter 1) and the encounters of Esmerelda's family with Chaplain Weyls (chapter 13). After examining the entire book, these two cases most readily addressed my need as an educator to present encounters most relevant to the everyday experience of our students. I did this by attending to two aspects of clinical resonance: patient population and circumstances requiring a chaplain. Pediatrics and cystic fibrosis are clinical specialties of our institutions, and a case that takes place in a one-day, on-call situation is very common to our CPE residents' experience. They readily welcomed attending to these cases because they recognized them as relevant to their daily work. I invited board-certified staff chaplains with specialized experience in pediatrics and cystic fibrosis to attend our discussion of LeeAnn's case study; I invited palliative care and ICU chaplains to attend the seminar addressing Esmerelda and her family.

It was valuable to bring staff chaplains together with CPE residents to examine a case together. In the firehose that is a CPE orientation, the case study changed the tone of that first month from bombarding the student with logistics to inviting them to glimpse the aim of all this training. I facilitated the seminar so that the first voices heard in response to the reading were those of our seasoned chaplains. Around our long table in the library, a chaplain who works with adults with cystic fibrosis shared how her years spent understanding this disease inform her interventions and spiritual care plans with cystic fibrosis careseekers. Two pediatric chaplains chimed in with how their perspectives on child development and their own training in a pediatric healthcare setting would have led them to similar and

different assessments than Grossoehme's. Some residents expressed feeling overwhelmed because they did not know their own theories of human development, nor did they have this depth of knowledge of cystic fibrosis, and they therefore wondered aloud whether they were qualified to function as chaplains. In the next phase of the seminar, I invited the residents to ask staff chaplains more about how they came to know what they know and choose what they choose in their daily work. Sometimes this moved the discussion away from the case itself and into the diversity of theologies and theories informing spiritual care; I let these unfold a little and then guided the focus back to the patient and chaplain in the case. I urged the residents to put themselves in the place of the chaplain and to set learning goals for themselves based on the gaps they assessed in their own theory and practice of spiritual care.

Fitchett and Nolan's work balanced and grounded our residents' experience of entry into the discipline of spiritual caregiving. In the midst of those critical seminars addressing everything from HIPAA to basic skills for pastoral conversation, discussing case studies illustrated how all these disparate orientation matters are meant to culminate and integrate. For some time, Fitchett has been warning supervisors against the dangers of teaching spiritual care using the verbatims of novices as our main teaching tool.

I affirm Nolan and Fitchett's wish that more case study volumes like these will emerge for publication because, for all the breadth available in this collection, only one case (chapter 13) resembles a case that our residents are likely to experience, especially in the first half of their learning year. Contemporary healthcare in acute medical settings involves many one-time visits. In order for our residents to relate to the material and appreciate the value of the case study for teaching spiritual care, more short-term relationships must be depicted and explored. Otherwise, we risk relegating this method of studying and researching spiritual care to chaplains in relationships unfolding over long periods of time.

As a spiritual care educator and practitioner, I believe the work of Fitchett and Nolan is a vital contribution to the advancement of our work both within our colleague circle and in collaboration with other healthcare disciplines. These seminars in our residency program were one of the highlights students identified from their first unit of CPE. I will continue to mine the material to teach spiritual care, from its most basic building blocks to its integrated end.

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