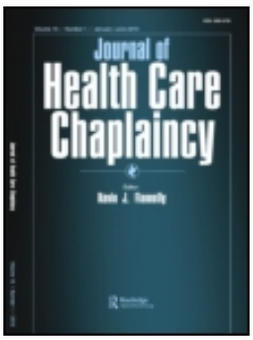

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Making Our Case(s)

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Health care chaplaincy needs to develop a body of published case studies. Chaplains need these case studies to provide a foundation for further research about the efficacy of chaplains' spiritual care. Case studies can also play an important role in training new chaplains and in continuing education for experienced chaplains, not to mention educating health care colleagues and the public about the work of health care chaplains. Guidelines for writing case studies are described, herein, as is a project in which three experienced oncology chaplains worked together to write case studies about their work. Steps that chaplains, and professional chaplain organizations, can take to further the writing and publishing of case studies are described.

KEYWORDS cancer, case study, chaplain, research

WHY CHAPLAIN CASE STUDIES?

There is a growing consensus about the importance of research for the future of health care chaplaincy (Bay & Ivy, 2006; Flannelly, Liu, Oppenheimer, Weaver, & Larson, 2003; Gleason, 2004; Koenig, 2008; O'Connor et al., 2001; VandeCreek, 2002; Weaver, Flannelly, & Liu, 2008). Two reasons for chaplains' increased involvement with research have been described. The first and most important reason is well-stated by O'Connor and Meakes

I am grateful for the feedback on earlier versions of this manuscript from members of the oncology chaplain case study project, Rhonda Cooper, Stephen King, Dick Maddox, Andrea Canada, and Dave McCurdy.

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(1998): "Evidence from research needs to inform our pastoral care. To remove the evidence from pastoral care can create a ministry that is ineffective or possibly even harmful" (p. 367). The second reason is that in order to tell our story effectively to our health care colleagues, in order to build the case that we are productive members of the health care team, we have to provide evidence for the beneficial effects of the care we provide (Bay & Ivy, 2006; Koenig, 2008; Weaver et al., 2008).

This commitment to transforming health care chaplaincy into a research-informed profession is reflected in The Standards of Practice for Professional Chaplains in Acute Care, recently affirmed by the Association for Professional Chaplains (Standards of Practice Acute Care Work Group, 2009). Specifically, Standard 12 states, "The chaplain practices evidence-based care including ongoing evaluation of new practices and, when appropriate, contributes to or conducts research." The Interpretation that accompanies Standard 12 describes different levels of chaplains' involvement in research. At the basic level, it suggests that all chaplains "should be sufficiently familiar with existing evidence to present it to their health care colleagues from other disciplines, read and reflect on new research's potential to change their practice and be willing and able to integrate that which is better for patients, families, or staff." It also describes the possibility of more extensive involvement in research. "In some cases, where the chaplain has sufficient skills and support, this will also mean participating in, or creating, research efforts to improve chaplaincy care." Chaplains in the United Kingdom (UK) and Australia are also actively involved in developing an evidence-based approach to health care chaplaincy (for the UK see Folland, 2006; Mowat, 2008; Speck, 2005. For Australia see the Australian Chaplaincy Utility Research website: http://caperesearch.com.au/).

When the subject of research is raised many chaplains naturally think of complicated studies such as randomized clinical trials (RCTs). The work of William Iler or Paul Bay and their colleagues (Iler, Obershain, & Camac, 2001; Bay, Beckman, Trippi, Gunderman, & Terry, 2008) demonstrates that chaplains can organize successful RCTs of their spiritual care. However, I want to argue that RCTs are not the kind of research that chaplains need at this point in our history. Before we can do good clinical trials about our spiritual care we need good case studies describing our work. Trying to make our case with case studies may initially seem like a bad idea. As many chaplains know, in evidence-based care there is a hierarchy of evidence. In this hierarchy case studies are ranked as the weakest form of evidence (APA Presidential Task Force on Evidence-Based Practice, 2006; Hundley, 1999. See Flyvbjerg, 2006 for a vigorous argument against the view of case studies as an inferior research method.). RCTs and systematic analyses of data from multiple RCTs (meta-analyses) are the strongest form of evidence. But, good RCTs and other more complex types of research require a foundation of theory, practice, and preliminary research. Case studies play a critical role

in developing the foundation from which more advanced studies can be developed.

The research studies that provide evidence for the effectiveness of any health care intervention are actually the result of a process of prior research. One model describes three stages in this process (Rounsaville, Carroll, & Onken, 2001). Stage 1 focuses on developing the basic elements of the intervention and measures of its effects. This stage has two parts. The first, Stage 1A, includes developing a detailed description of the intervention, often called a protocol or manual, demonstrating with a few cases that the intervention is feasible and acceptable, and selecting and testing measures of the effects of the intervention. The second part, Stage 1B consists of pilot testing the intervention with a small number of cases. In Stage 1B investigators focus on whether there is any evidence the intervention has the intended effects, on whether there are any negative effects associated with the intervention, and on maximizing consistency in the delivery of the intervention. It is only after this work has been successfully completed that investigators move to Stage 2, in which the efficacy of the intervention is tested in the familiar RCT. If there is evidence the intervention has the intended effects in the ideal world of the RCT, then investigators move to Stage 3, in which further research examines whether the intervention is effective in the real world of clinical practice.

The argument I wish to make is that before chaplains can do Stage 2 RCTs about their spiritual care, we need to build the Stage 1A and 1B foundations. Weaver and colleagues (2008) make a similar point, "Studying processes must necessarily precede studying outcomes" (p. 12). This is where case studies come in. We need good case studies to provide detailed information about three things that are part of Stage 1A research: 1) descriptions of the patient (or family) to whom we provided care, 2) descriptions of the spiritual care that was provided, and 3) descriptions of the changes that occurred as a result of that spiritual care.

Once we have several case studies about a specific type of spiritual care, we need to link the spiritual care described in them with theories about our work (See Canada, 2011). When we have a sufficient body of theoretically-illuminated case material then we will be in a position to begin Stage 1A, to develop a detailed spiritual care intervention protocol, select appropriate outcomes measures (Again, see Canada, 2011), and test the intervention with a few cases. After making revisions based on the Stage 1A experience we can consider a Stage 1B trial to see if similar spiritual interventions, provided to patients with similar conditions, have the measurable effects on the outcomes that we have specified. It is only if this preliminary trial yields evidence for an effect from the chaplain's visit that it is time to consider a Stage 2 randomized trial in which the effects of the chaplain's care are compared to no care or some other intervention. However, what I want to emphasize here are not the details of the later stages of this process. It is the important role of case studies in the first stage.

I also want to underscore that this new emphasis on research does not mean that all chaplains should become investigators. That is not what is recommended in the new Standards of Practice for Professional Chaplains. Designing and conducting the Stage 1A and 1B studies that lead to Stage 2 RCTs is a job for teams of experienced investigators. These teams should include chaplains with training in research. As the Interpretation for Standard 12 states, "In some cases, where the chaplain has sufficient skills and support, this will also mean participating in, or creating, research efforts to improve chaplaincy care." But in contrast, when it comes to writing case studies about our work, many chaplains should be able to make a contribution. The research process I have described will be best served if we can build on case studies written by skilled and experienced chaplains, not case studies written by students or candidates for certification, the least experienced members of our profession.

In addition to their important role in developing research about chaplains' spiritual care, there are at least two other reasons why chaplains should be writing and publishing case studies. It would improve the training of new chaplains and the continuing education of experienced chaplains if we had a body of published case material that we could read and critique. Right now new chaplains mostly learn from cases written by the least experienced members of our profession, the cases they and their peers share in their clinical pastoral education programs. In addition, published case studies would provide colleagues in other health professions with a better understanding of what chaplains do, especially if some of the cases are published in journals that our colleagues are regularly reading.

FINDING OUR CASE STUDIES

If what I have just said has whet your appetite for reading chaplains' case studies you may be disappointed to discover there are essentially none to be found in print. There are case vignettes, but I have yet to find an extended case study that provides detailed information about the three topics (who was the patient, what was the intervention, what changed) I described previously. This is ironic in light of the early history of our field. Anton Boisen, who was a founder of clinical pastoral education (CPE) and a pioneer in modern mental health chaplaincy, had an intense interest in case studies (Asquith, 1980, 2005). Boisen is best remembered for *Out of the Depths* (1960), his case study about his own experience with mental illness, but throughout his career he was writing case studies and examining patterns in these cases as a way to better understand the relationship between religion and mental illness. Students in his CPE programs spent their time reading and discussing the cases he wrote (Boisen, 1936/1971. Boisen's cases can also be viewed at a website created by Boisen scholar Jesús Rodríguez Sánchez at the

Interamerican University of Puerto Rico. See http://www.metro.inter.edu/facultad/esthumanisticos/anton_boisen.htm).

It may be helpful to briefly mention three examples of case material that chaplains have published. In their article "An Image of Contemporary Hospital Chaplaincy," Gibbons and Miller (1989) tell the story of a chaplain's work with a couple whose child is born with suspected trisomy-13 and dies the next day. They use the case to briefly identify eleven features of the work of hospital chaplains including chaplains' integration into hospital protocols and teams, chaplains' training that enables them to relate effectively to people in the midst of painful crises, and chaplains' ability to recognize and address complex ethical issues.

In what may have been the first paper to use the term "evidence-based pastoral care," O'Connor and Meakes (1998) describe the case of Mary, a 40-year-old woman with cerebral palsy, who lives in a chronic care hospital. After the onset of seizure activity, Mary was no longer able to use her electric wheelchair. This left her feeling depressed, not able to attend church as she had in the past, and wondering why God would not help her. This brief case description (one paragraph) is followed by a review of research that would be relevant to providing spiritual care for Mary, including research about spirituality and disability. As the authors note, there is actually very little research that is directly relevant to this case. After the literature review, the authors describe the spiritual care that was provided to Mary, and the changes that occurred as a result of that care. While brief, these descriptions include a remarkable level of specificity about the counseling interventions that took place.

The final example is a case study published by Julie Berger (2001). The case is a woman in her forties, newly diagnosed with breast cancer. Chaplain Berger uses the case to illustrate Art Lucas' model for spiritual assessment, The Discipline for Pastoral Care Giving (2001). She describes her initial assessment, care plan, and goals ("desired contributing outcomes") both after the initial encounter with the patient and at critical points in the journey with the patient. Of the published cases I have seen, Chaplain Berger's case comes the closest to providing the information I believe must be included in our case studies. The focus on the chaplain's contribution to specific outcomes is one of the strengths of Lucas' model and Chaplain Berger's case. However, there are many details about the patient's background, the care provided by the chaplain, and the conclusion of the case that are not presented.

I have also published some case studies. There are three chapter-length cases in my book, *Assessing Spiritual Needs* (1993/2002). Another case, "Linda Krauss and the Lap of God," was published as an article (1995), and a fifth case, "In the Garden with Andrea," written with Patricia Roberts, was published in an article (Fitchett & Roberts, 2003) and reprinted in a chapter I co-authored (Massey, Fitchett, & Roberts, 2004). Each of these cases was

written to illustrate the 7×7 model for spiritual assessment. As such, they give detailed information about the patients in the cases, especially my spiritual assessment of them, but they do not include detailed information about the spiritual care provided in each case, nor the outcomes of the cases.

My search for case studies about chaplains' spiritual care has been far from exhaustive. I would be very glad to learn of any other case studies of chaplains' spiritual care that have been published in articles or books, from the United States or other national contexts.

BACKGROUND FOR THE ONCOLOGY CHAPLAIN CASE STUDY PROJECT

When I became convinced of the importance of case studies for research about chaplains' spiritual care, and when I realized there were essentially no published cases by chaplains about their spiritual care, I decided to try to change that. I began by trying to recruit a small group of chaplains who would work together to present and publish case studies about their spiritual care. Consistent with my research objectives, it was important for the case studies to be about spiritual care with similar patients. Because I knew colleagues in several cancer centers I decided to begin with spiritual care for adult cancer patients. In March 2009, I sent an e-mail message to a number of colleagues seeking names of "experienced colleagues (at least 3 years since board certification), who work in the area of oncology, who would be willing to prepare and share a case study." As you can see, my criteria for selecting participants for the project were that they were Board Certified Chaplains who were currently working in adult oncology. Since one of my aims was to publish the cases studies, it was a plus for the participating chaplains to have good writing skills, for example having any prior publications.

Case Study Project: The Participants

Within a few weeks I had found three chaplains who were willing to be part of the project: Rhonda Cooper at Johns Hopkins in Baltimore, Stephen King at the Seattle Cancer Care Alliance, and Richard (Dick) Maddox at the M. D. Anderson Cancer Hospital in Houston. The medical centers where these chaplains work are all part of the National Comprehensive Cancer Network, a group of 21 of the nation's leading cancer treatment and research centers. For this article I asked each of them to provide some background about themselves to help me introduce them to you.

Rhonda S. Cooper began hospital chaplaincy work in 1998, after serving congregations for 15 years in Tennessee and Virginia as a United Methodist pastor. She enrolled in CPE as a resident at North Carolina Baptist Medical Center (in Winston-Salem) as a "mid career" opportunity to re-tool her skills

and deepen her understanding of group dynamics. The deep sense of meaning and challenge that she experienced persuaded her that ministry in the hospital setting could be fulfilling. The empathy and support she received from her CPE supervisors became a model for her interactions with patients, family members, and staff.

Rhonda assumed her role as Oncology Chaplain at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins in 2005, a few months after her own father died of lung cancer. She works closely with the oncology social workers as a member of the Patient and Family Services Department as well as the Department of Pastoral Care. She serves the adult inpatient units, including critical care, surgery, and bone marrow transplant, and outpatient units, clinics, and treatment areas housed in the Cancer Center. Rhonda became an APC Board Certified Chaplain during her work on this project. In light of her experience in cancer chaplaincy and being in process with her application for Board Certification, I felt she met the criteria for participation in the project.

Stephen King has been working in chaplaincy for 30 years, primarily in academic health care settings. The past 18 years his work has focused on oncology. He has been at the Seattle Cancer Care Alliance for the last 11 years. During this time, he has served primarily as manager but has also had clinical responsibilities in both inpatient and outpatient contexts. He is ordained in the Christian Church (Disciples of Christ) and is a Board Certified Chaplain (APC). He recently co-chaired the APC Quality Commission Task Force that drafted The Standards of Practice for Professional Chaplains in Acute Care.

Dick T. Maddox is the staff chaplain for the Children's Cancer Hospital at the University of Texas M.D. Anderson Cancer Hospital (UTMDACC/MDACC). He also serves as chaplain for the head and neck cancer surgical unit for UTMDACC. In his seven-year tenure at MDACC, he has served on its Institutional Review Board (current member), Clinical Ethics Committee, and numerous department and division committees and task forces. Dick is a Board Certified Chaplain (APC) and is ordained in the Christian Church (Disciples of Christ). He served local congregations for 15 years before making a career change to chaplaincy. Before entering ministry, Dick had a career in environmental engineering.

Case Study Project: Our Process

Our team met monthly by conference call. Our first meeting, in April 2009, was used to get acquainted and discuss the goals for the project. Our early meetings addressed the question of what should be in a good case study (see the following section) and the ethical issues related to asking a patient for permission to publish or present a case study about them. In July 2009 we discussed our first case, an initial draft of Rhonda's work with a patient she called Doris. In the next few months we discussed case studies written by

Stephen and Dick. We continued to look for and discuss books and articles about case studies.

Soon after we began, we had to turn our attention to planning for the workshop at the APC 2010 meeting. Because of our aims, and the limited time for the workshop, we chose to focus on one case study; Rhonda's report of her work with Doris was selected (See Cooper, 2011). Our approach also included two responses to the case. The first response was from a chaplain colleague (See King, 2011). For us, the chaplain's response to the case was designed to model how chaplains can use case studies to discuss and debate the strengths and weaknesses of the spiritual care described in the case. The second response was designed to show how to build the link between case studies and research. Specifically we wanted to provide a theoretical framework for the spiritual care provided in the case and to describe ways that the changes observed in the case could be measured (See Canada, 2011). Because none of us had the expertise to provide this response, and as a way to model interdisciplinary collaboration in this research process, we invited Andrea Canada, a health psychologist, who specializes in cancer care to provide this response. Andrea is an Assistant Professor in the Department of Behavioral Sciences at Rush University Medical Center. She has a long-standing interest in the role of religion and spirituality in coping with cancer and has collaborated with me and my colleague Patricia Murphy in several research and writing projects (Canada, Murphy, Fitchett, Peterman, & Schover, 2008; Fitchett & Canada, 2010; Murphy, Fitchett, & Canada, 2008).

After a year of conference calls, the APC workshop in April 2010 provided the first opportunity for our team to meet in person. The workshop went well and received positive reviews from the participants, including the following: "Great case study, reflection and responses. Thank you!" "Very well done. Gives a good example of how to do case study research." "We need to add more of this!"

Since the workshop we have continued our monthly calls. Now, our goals include getting all of the case studies published. As I have noted, in some of the team's initial conversations we discussed requesting permission from the patients to use material about them in the case studies the chaplains were writing. Actually we spent a lot of time on this issue and learned a lot about it. Dick gave a brief summary of what we learned at the APC workshop. However, because we realized how important and complex this topic was we decided that it needed to be presented in an article of its own by someone with expertise in the area of ethics. I approached Dave McCurdy to help with this and thankfully he agreed (See McCurdy & Fitchett, 2011). Dave is a Board Certified Chaplain (APC) and a certified supervisor (ACPE). He is presently Senior Ethics Consultant and Director of Organizational Ethics for Advocate Health Care in Park Ridge, Illinois. He was formerly a staff member and director of publications at the Park Ridge Center for the Study of Health, Faith, and Ethics.

Case Study Project: Impact on the Participants

Over the past 15 months, all of us who have participated in this project have learned a great deal. We have tried to share some of what we have learned in the essays in this issue of the *Journal of Health Care Chaplaincy.* The project has given me the opportunity to get to know and work with three talented and committed oncology chaplains. It has also confirmed my belief in the importance of case studies for our profession. I want to close this description of the project by sharing what the team members wrote about the impact of the project on their work as chaplains.

> Rhonda: "As a result of the project, I have gained deeper appreciation for the privacy concerns of the patient, family or staff who are subjects of case studies. Initially I was resistant to asking for authorization from the subject of my study and I did not approach her until our relationship was well established. In writing the case and being in dialogue with colleagues also engaged in spiritual care of oncology patients, I found myself being more aware of the needs-interventions-outcome relationship so that I am more intentional in my approach. I have also come to appreciate the value of peer review and consultation."

> Stephen: "First, participation in the project highlighted the importance both within chaplaincy and to non-chaplain health care providers of chaplains articulating clearly the needs, interventions, and outcomes. The writing of my own case study also enhanced my focus upon desired negotiated outcomes with the patient/family. Second, participation in the project led to a departmental change whereby every chaplain now annually presents a case study to the department. Although time consuming, the chaplains want to continue this practice as a wonderful learning opportunity through writing the case, receiving feedback from other chaplains, and learning about the chaplaincy care provided by others. In both the case study project and the departmental project, the group relationship building via the case discussions was a highlight."

> Dick: "I find myself much more attentive to the construct and implementation of spiritual care assessments, and more disciplined about considering and characterizing spiritual care interventions before applying them and evaluating them afterwards. And I have become far more concerned with how I might be able to measure outcomes and relate them to interventions."

WHAT DOES A GOOD CASE STUDY LOOK LIKE?

One of the things that I hope will result from this project is that more chaplains will be convinced of the importance of case studies for our profession

and will begin to write, publish, and discuss case studies about their spiritual care. As you begin to do that, one of the first issues you will face is what you should include. What does a good case study look like? As we began this project our team faced the same question. As I have already indicated, we did not find anything in the chaplaincy literature to help us.

Next, we looked at the literature in related fields. A number of things we found there went into the description of a good case study that appears in the following. For example, earlier I mentioned that good case studies provide detailed information about three things: 1) descriptions of the patient (throughout this also refers, where appropriate, to the patient's family) to whom care was provided; 2) descriptions of the spiritual care that was provided; and 3) descriptions of the changes that occurred as a result of that spiritual care. I took these three things from a research method known as practice-based evidence (Horn & Gassaway, 2007, 2010). I think they are especially important for case studies that are written to help provide the foundation for research that tests the effects of chaplains' spiritual care.

My earlier interest in self psychology made me familiar with the important role of detailed case studies in psychoanalytic psychology (e.g., Goldberg, 1978; Kohut, 1979). I assumed there might be a similar case study literature in psychology that could be helpful to chaplains. Some searching in that field led me Ronald B. Miller's book, *Facing Human Suffering: Psychology and Psychotherapy as Moral Engagement* (2004), the most important resource for writing about case studies that I have found thus far. Miller's interest is larger than just case studies. His book presents his critique of how psychology and the training of psychotherapists have gotten away from the moral issues that he feels are at the heart of human suffering. In presenting his case for clinicians' need to develop clinical knowledge, he argues for the important role of case studies in developing clinical knowledge. Miller and his students have developed a searchable archive of psychotherapy case studies and his book includes appendices with several lists of psychotherapy case studies. My description of a good case study below has been shaped by my appreciation for Miller's work.

A good case study has the following characteristics:

1. It makes a point or tells an important story.
   In his discussion of psychotherapy case studies, Miller (2004) describes writing case studies, in order to make an argument for the effectiveness of a particular therapeutic approach in a specific case or group of cases. Similarly, chaplains might think of case studies as a way to describe the beneficial effects of their spiritual care with patients or families. There might also be value in writing case studies about the harmful effects for patients whose spiritual needs go unmet because chaplains were not available to them. The introduction is the place to tell the reader why you have written this case.

2. It makes our case with cases.
   To elaborate on the previous point, one of the reasons that chaplains should write case studies is to help colleagues in other professions understand what chaplains do and understand why what we do is important. When this is the point of a case study, chaplains should consider specifically addressing two questions: 1) in what ways does this case demonstrate that the chaplain's care caused a change for the patient that would not have occurred if the care had not been provided; and, 2) are there any ways in which the care provided by the chaplain was different from, or could not have been provided by, a local clergy person or clergy volunteer, or by a professional from another discipline, such as a social worker or psychologist.
3. It begins with background.
   The case study should include detailed information about the patient, the chaplain, and the institutional context in which they meet. The information about the patient should include thorough demographic, medical, psychosocial, and religious characteristics. Providing this thorough background information will help the reader of the case study understand to what other cases one can generalize the spiritual care that was described in the case study. It will also provide the reader of the case study with sufficient information to critically evaluate the chaplain's assessment and spiritual care, (See McCurdy & Fitchett, 2011, for a discussion of the important issue of how to include detailed information about the case while also protecting the confidentiality of the subject of the case study). It is also important to include information about the chaplain(s) who provided the care and who wrote the case study. This should begin with basic demographic information and include information about religious affiliation and professional training. Beyond such basic information, a good case study will also provide information about the chaplain's awareness of his/her feelings about the patient in the case study and their role in that relationship.
4. It describes the chaplain-patient relationship.
   The heart of the case study is the story of the chaplain-patient relationship. Key information here includes a description of the spiritual care provided by the chaplain. We also want to know about any changes in the patient that occurred during or after the relationship with the chaplain, including changes that might be attributed to the care provided by the chaplain. If nothing changed that is also important to know. The general rule is the more detail the better. Chaplains like verbatims and this might be a place to include verbatim reports of selected portions of the chaplain-patient conversation. Narrative summaries of the relationship will be needed to communicate what occurred in longer chaplain-patient relationships. In many cases our spiritual care is provided in the context of consultation with, and care provided by, other members of the health care team.

Important information about the care team's work should be included in the case study.

5. It includes a spiritual assessment.
   Including a spiritual assessment will help the reader know the chaplain's interpretation of the case, including the observations that influenced the chaplain's care plan. The spiritual assessment may have deepened or changed over time and that should be noted. Of course I am partial to the 7×7 model for spiritual assessment (Fitchett, 1993/2002), but other helpful models for spiritual assessment have been published, including the work of Pruyser (1976) and Lucas (2001).
6. It ends with a summary.
   The case study should end with a summary. This is the place to remind readers of the point(s) that you were trying to make with your case. When the case was written to describe the impact of the chaplain's spiritual care this is the place to review the patient's spiritual needs, the spiritual care that was provided, and the effects of the spiritual care on those needs. Here may be the place, if appropriate to the case study, to articulate in what ways, if any, the care that was provided was uniquely spiritual care provided by a professional chaplain.
7. It could include discussions of theory or measurement.
   Improving chaplains' spiritual care, and strengthening the case for it, will require informed descriptions of the theories that support chaplains' interventions or care, and careful attention to measuring the changes that come about as a result of that care. Some chaplains will write case studies to illustrate a theory of spiritual care or to illustrate the kinds of changes that come about as a result of spiritual care. In the introduction the chaplain can indicate if any of these are the aims of the case study. Such case studies would also include an extended discussion of the theory or measurement issue after the case has been presented.

NEXT STEPS: MAKING OUR CASE(S)

As I described earlier, the work of the oncology chaplain case study team is nearing completion and will end when all three cases have been published. To help promote chaplain case studies I plan to recruit a new team, with a different clinical specialty, and help those chaplains present and publish their cases. However, for our profession to realize the full benefit of this focus on case studies, many chaplains need to get involved. Let me conclude this essay by sharing some suggestions for how our profession can encourage case studies and use case studies to improve our care and make our case.

I begin with several things we can do within our profession to further the use of case studies. First, we can make case studies a common part of training for chaplains. Writing case studies is encouraged in some CPE

residency programs, but it would help build a familiarity with case studies and their importance if reading, writing, and critiquing them were a well-integrated element of the curriculum in the second half of all residency programs. Publishing the best CPE case study outlines and curricula that integrate case study work will help this to happen. Second, we should make a case study one of the required pieces of clinical work for Board Certified Chaplains. Third, we should amend the continuing education requirements for chaplains to make writing, presenting, and publishing case studies an area of emphasis. Fourth, we should encourage workshops about case studies at state, regional, and national chaplaincy conferences. These could include beginning workshops about how to write case studies, as well as more advanced workshops where experienced chaplains discuss the strengths and weaknesses of one or more case studies. Finally, we should encourage the publication of case studies in chaplaincy journals. To advance our field it is especially important for some of those case studies to be accompanied by the kind of critical responses that are included with the case study published in this issue of this journal.

Beyond what we do within our profession, it is important for chaplains to share their cases with health care colleagues in other professions, at their meetings and in their journals. The importance of this was underscored by the comment of a chaplain who was a participant in a study about chaplains and quality improvement. "[A colleague] and I did a presentation to a palliative care conference. . . . And what we did was [role play] a verbatim. . . . We brought down the house because it was like they never . . . experienced a chaplain's visit before" (Lyndes, Fitchett, Thomason, Berlinger, & Jacobs, 2008, p. 74).

The majority of our health care colleagues have little or no education to help them gain a meaningful appreciation for what we contribute to the care of patients and their families. This is not going to change quickly so chaplains must be persistent and creative in looking for ways to tell the story of who we are and what we do. Case studies presented at the professional meetings of other health professions and published in the journals of those professions can be a very effective way to help our colleagues develop a better understanding of what we do.

SUMMARY

Case studies were central to what Anton Boisen, a founder of modern chaplaincy and clinical pastoral education, was about as a chaplain, pastoral educator, and researcher. They play a central role in developing the foundations for research about the effects of chaplains' spiritual care. They can also be an effective way to help colleagues in other health care professions develop a better understanding of the chaplains' contribution to care for patients and

families. Health care chaplaincy is in the process of becoming a research-informed profession. Every chaplain can play an important role in that process, not by conducting RCTs or other quantitative research, but by writing case studies about the work they do every day.

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