ACPE RESEARCH NETWORK

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Edited by Chaplain John Ehman, Network Convener

Network members are encouraged to submit articles for upcoming issues.
The *Newsletter* is published three times a year: Fall, Winter, and Spring-Summer.

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1. Research Update from VCU's Program in Patient Counseling

"Exploring the Role of Women in the Donation Consent Decision: Building on Prior Research," by Dr. Diane Dodd-McCue and Dr. Alexander Tartaglia of VCU's Program in Patient Counseling, with Robin Cowherd of LifeNet Health, appears in the September issue of *Progress in Transplantation* (17,3:209-214). The study findings highlight the unique communication role women play in these critical discussions and how their network position may serve to influence other family members.

"African American Consent and Non-Consent Cases: Are There Significant Differences?" (*Progress in Transplantation* 17,3:215-219) is an analysis of potential donation case records by Drs. Dodd-McCue and Tartaglia using data collected between 1997-2004 from chaplains' donor tracking tools. Compared to non-consent cases, consent cases differed significantly in three areas: next-of-kin knowledge of donor wishes, frequent involvement of parents, and infrequent involvement of spouses.

Dr. Ann Charlescraft was awarded a grant from the Massage Therapy Foundation to fund the study, "Massage Therapy for Post-operative Gynecology and Gynecology-Oncology Patients." The study will be implemented in the Virginia Commonwealth University Women's Surgical Care Wing. Providing massage therapy will increase options for patients to use to relieve pain and anxiety related to their surgery, prognosis, and recovery, and empower patients to manage their recovery and plan of care.

Dr. Diane Dodd-McCue presented a summary of progress on "Increasing Organ Donation Among the 50 Plus Age Demographic" at the September 2007 meeting of Donate Life Virginia. She serves as researcher for this three-year

project funded by the US Department of Health and Human Services, HRSA's Division of Transplantation, and will participate in the upcoming HRSA Extramural Grant Technical Workshop in Nashville, TN.

Chaplains Tim Ford and Angela Duncan are involved in ongoing research projects. Chaplain Ford is evaluating a newly developed training module that focuses on spirituality among residents. Chaplain Duncan is developing clinical triggers for spirituality pathways for end stage heart failure patients. In addition to these projects, preliminary work is underway by members of the department to pilot questions on spirituality for future incorporation in Virginia Commonwealth University Health System's bi-annual employee survey.

For more information, contact Diane Dodd-McCue at ddoddmccue@vcu.edu.

[*See also the report of work with standardized patients at the VCU Program in Patient Counseling in the Winter 2007 Newsletter (§2), and visit the Program's website at http://www.sahp.vcu.edu/ptc.*]

2. "A Morning Rumination," by Jackson Kytle, Ph.D.[1], Vice President, Academic Affairs, The HealthCare Chaplaincy, October 2, 2007

As sometimes happens in a professional life, yesterday was a good day. Three intellectual puzzles came to mind, each provoked by a lively conversation with colleagues. It helps, you see, if the mind has puzzles with which to play. At a minimum, having ideas in play structures time and gives welcome focus to mental life.[2]

Theory building is mental exercise. It is fun to think about relationships among variables, to ponder cause and effect. Theory need not be abstruse fol-de-rol, a gaudy construction not worth the effort to make, much less to understand. To some people, theory has a bad reputation because of the way it is taught. But I think of theory as social psychologist Kurt Lewin did when he wrote, "There is nothing so practical as a good theory."[3] The puzzles I describe next are quite different. But if pursued, each might cast a light on the practice and fortunes of being a healthcare chaplain, in particular, and a caring professional, in general. Puzzles in hand, time has to be found to move intellectual play toward theory and research. Sometimes I think of my puzzles as companions.

Each puzzle challenges us to think in new ways about an unexplored issue for theory, measurement, and practice. The first one sounds easy enough and came up in a recent incident at, say, Big Metro Hospital. A kindly chaplain was challenged during her presentation at Grand Rounds by a staff psychiatrist who wanted to know why she was helping patients with their "feelings," which he said was his business. (I don't know if he said "business" but that is what he meant.) If not his concern, surely emotions are the business of a psychologist or social worker, other care competitors on a hospital floor. It can't be the work of a busy doctor. Perhaps a nurse has the time and inclination.

So, here is the puzzle: *What exactly does a chaplain add to the healthcare team?* How does the role of chaplain that addresses the "spiritual" interact with other professional roles and the domains of patient and family experience they claim as theirs? Other questions follow. What special insights and skills does the chaplain add to the team? By what means are these competencies acquired and maintained? How important is self-selection to ministry or chaplaincy compared to training in theological reflection and pastoral counseling? Compared to other roles, is it something about the mental models brought to working with a patient's experience, or the methods used, or both? No lack of questions here.

To state the second puzzle succinctly is difficult. It, too, comes from a practical observation in healthcare, this one having to do with intense financial pressures on hospitals. In response to pressures for accountability in a competitive, regulated industry, hospitals are focusing intensely on patient satisfaction with services. Respected national measures like the Press Ganey index are used to compare hospitals and, then, administrators use such metrics to monitor and improve hospital services.[4] The measures may not be the best on technical grounds, but they have been widely used. Recently, the Federal government has begun a major initiative to collect standardized data from American hospitals, called HCAHPS, that will permit comparisons of quality, including measures of responsiveness to patient need, patient satisfaction, and willingness to recommend the service.[5] This massive undertaking was voluntary, initially, but now is connected to reimbursement upon which hospitals so depend. So, by the end of 2008, we'll be seeing public data on some 4,000 hospitals! The instrument will be a powerful research tool, and the public dataset will likely be used for both accountability and for competitive advantage.

More important for our purposes, the focus on patient satisfaction as an outcome measure may give chaplains an opening by which to advance their legitimacy, if not authority, on the treatment team. The opening, if indirect, comes from the observed empirical relationship between patient satisfaction, increasingly a focus of hospital administrators and boards, and correlates like responsiveness to patient spiritual needs and locus of control.

Now, to the puzzle. *What does patient satisfaction mean, and what are its predictors?* I've seen empirical evidence to support the idea that satisfaction correlates modestly with two related dimensions of patient experience: degree of individualized service afforded patients and families, and responsiveness to patient spiritual needs. (Both variables, individualized treatment and spiritual responsiveness, are also correlated in some datasets, and we need to know why.) Good chaplains provide both ingredients, to be sure, and implications come to mind for research and education. But, first, we need to say something about the context of care in contemporary hospitals and, most importantly, the patient experience in the particular, odd circumstance of a hospital stay.

Even though hospitals, I believe, want to offer a humane environment for healing, the economics of modern healthcare seem to mandate an anomic assembly line where patients and families come and go without much individualized attention.[6] Hard-pressed professionals try to respond to patients and families who are confused and anxious, but staff members "don't have the time." That is what staff say, and we should believe them. Efficient doctors under the gaze of regulators are supposed to spend, oh, 12.5 minutes with a patient! More generally, the division of labor situates the patient alone in a strange room surrounded by technicist professionals, each with his or her role, special insights and fetishized methods, what Onora O'Neill describes as "strangers at the bedside."[7]

Of course, we want expert interventions in the surgery or pharmacy or counseling--Western medicine has made great advances. But has the progress in *techne* been at the expense of *telos*, especially how human beings are treated in the hospital "system": patients, staff, and families, alike? When we are hurting, or our lives are at risk, we want to be treated as whole people, as human beings who are deeply social beings. We also want technical excellence in the choice of chemotherapy or recommended procedure.

Most people I know have no idea what it is like to be a hospital patient until, suddenly, it is the only experience and the mind is totally captured. Being a patient may be feared, but it is "out there"--someday in the future--until, of course, it is *Now!*--impossibly surreal in comparison to most human environs. Lying alone in a hospital bed tethered to machines, perhaps in pain and drugged, looking at one's experience up there on the surface as if under water, is like no other experience in life. Few are prepared for it. I know I was not.

When staff and friends visit, only for a brief instant is the isolation lifted, and the enduring sense I had after dumping a bicycle on a remote Ohio road is acute loneliness. The morphine pump by my bed helped control the pain of broken ribs and collar bone, but added to the alienation. As hospital visits go, mine was a minor event, but the psychological experience remains with me to this day. If my characterization is not exaggerated, what *should* a hospital team provide to ease this psychological burden? *Who* will provide it? The point is: no role on the modern healthcare team *except* the chaplain has the mission, the training, and the time to respond to the existential loneliness of the whole person, which is what worried patients and their families may want most of all.[8]

What research is needed? Given this context, the challenge is to take this understanding to an exploration of the cognitive space and clustered attitudes that patients develop about expectations and quality of service. Part of the work is *theory building* with constructs like satisfaction, spiritual need, individualized treatment, and possible correlates like self-confidence, resilience, and locus of control. Can we map this multidimensional space and posit causal relationships among the most important dimensions of patient psychological experience in hospital? Then, prosaic empirical research is needed to assess the validity and reliability of measures of the constructs and to determine the discriminant validity of the most important ones. The Spears Research Center at HCC is doing some of this work.

The third puzzle of the morning has to do with the education of chaplains, especially the education of the faculty who educate and supervise chaplains. The Chaplaincy is revising its curriculum for preparing supervisors, and that challenge is raising all manner of questions about what the "chaplain of tomorrow" and her professor-supervisor need, and how to organize resources toward those ends. What is the *theory of teaching and learning* behind the curriculum? What is the pedagogy's *active elements*, and how are they defined and studied?

Over the years, I've taught in graduate clinical psychology programs. CPE training seems superior to traditional clinical models in psychology in two ways: more often than not, a certified chaplain has a refined sense of self in role. My words may not be right, but chaplains seem comfortable in "their skin." The best have a spiritual presence and know how to use this presence in healthcare settings.

The second vital element is that the professional chaplain has learned to listen, broadly defined: to *self* and internal variations in mood and awareness, and to others, especially the feelings of others. Chaplains I have met seem less technique-focused than psychologists. As Rabbi Naomi Kalish of HCC might put it, chaplains listen for the "tiny voices" so easily missed in the strange environment of a hospital. The best know how to enter a room with great respect and serenity. Perhaps they just enter the sick room and bear witness, keeping silent for hours as one chaplain I know has done.

So, as we re-envision the new curriculum for supervisors, we want to protect the defining competencies of clinical pastoral education, which need better terms and validation, and to add new competencies. This work has begun. My morning rumination also leads me to conclude that The Chaplaincy might try to be known for its "good theory" as Lewin would want, probing theory built to address the needs of chaplains in contemporary healthcare environs.

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[1] Comments are welcome, care of the author at: jkytle@healthcarechaplaincy.org.
[2] Mihaly Csikszentmihalyi. *Flow*. New York: Harper Perennial, 1991.
[3] Kurt Lewin. *Field Theory in Social Science*. New York: Harper, 1951, p. 169.
[4] Press Ganey claims it has 7,000 hospitals as clients for its patient satisfaction measures. See: www.pressganey.com.
[5] To learn more about HCAHPS, go to: www.cms.hhs.gov/HospitalQualityInits/30_HospitalHCAHPS.asp or http://www.HCAHPSonline.org. The survey has 27 items plus options to include a customized set of hospital-specific items.
[6] Some institutions try to create a wholistic healthcare environ, notably the Duke Center for Integrative Medicine (www.dukeintegrativemedicine.org) and the "Plaintree model" used at Griffin Hospital (www.griffinhealth.org) and elsewhere. In the spirit of disclosure, The Chaplaincy provides chaplain services to Griffin Hospital as well as fifteen other regional hospitals.
[7] Onora O'Neill. *Autonomy and Trust in Bioethics*. Cambridge, UK: Cambridge University Press, 2001. Mark Cobb reports that this work is based on her 2001 Gifford Lectures, the same venue used in 1901 to good effect by William James to develop his thinking later published in *The Varieties of Religious Experience*. See Mark Cobb, "Change and Challenge: The Dynamic of Chaplaincy," *Scottish Journal of Healthcare Chaplaincy* 10, no. 1 (June 2007): 4-10.
[8] Nurses can and do provide some of this care, which makes them natural allies of chaplains on the healthcare team, another puzzle of interest.

3. Ideal Intervention Paper (IIP) Project Continues to Develop

Beginning with the Spring 2004 Newsletter, Fr. Henry Heffernan, a Jesuit priest and veteran chaplain of 40 years, proposed in a series of articles the idea of developing specifications for chaplaincy interventions. In the following Newsletter issue (Fall 2004), ACPE Supervisor John Gleason wrote of the importance of pastoral research for professional chaplaincy:

> Like it or not, ready or not, all clinical chaplains have a four-fold moral imperative: to stay abreast of Religious and Pastoral Research findings, to test those findings in the cause of improving our own quality of care, to further examine our practice, and to share what we find. Our professional colleagues from other disciplines have proclaimed that message to us. [ACPE Research Network Newsletter (on line), vol. 2, no. 2, §1].

Over the two years since, Dr. Gleason and Fr. Heffernan have collaborated and developed the Ideal Intervention Paper (IIP) Project, to collect illustrations of "ideal interventions" from a process that builds upon the use of verbatims in CPE. The IIP allows for follow-up on verbatims after students' have processed them with peers and supervisors --they are challenged to refocus on the patient visit and consider what might be a pastoral care "best practice" in the case. [For a sample memo to students explaining the IIP, see APPENDIX 1.]

The project has grown with two goals in mind: The first goal is for the CPE student to use the IIP to consolidate learnings gained from having presented a particular verbatim in the traditional group format. The second goal is to collect IIPs in a national interactive database inductively organized by central issues. This will provide the basis for a succession of steps leading to the verification of evidence-based spiritual care best practices.

Five supervisors have now joined with John Gleason to incorporate the IIP into their programs, and more have expressed strong interest in doing so in the immediate future. The ACPE Board of Representatives has also endorsed a

grant funding effort that would expand the use of IIPs and create an intervention database for research into pastoral care best practices. At present, this project is still in an early phase, but the potential for CPE curriculum enhancement and for pastoral care research is great. Supervisors are encouraged to join this initiative. For more information, contact Jack Gleason at: J_MGLEASON@JUNO.COM

4. Thoughts on William Osler's "Study of the Act of Dying"

Chaplains may find interesting, for a couple of reasons, the findings of a 1900-1904 "Study of the Act of Dying," by the pioneering and celebrated physician William Osler, at Johns Hopkins Hospital. The results were never published as a paper, but they were summarized by Osler in a 1904 lecture at Harvard, claiming that relatively few patients actually suffered physically, mentally, or spiritually in their dying.

> I have careful records of about five hundred death-beds, studied particularly with reference to the modes of death and the sensations of dying. The latter alone concerns us here. Ninety suffered bodily pain or distress of one form or another, eleven showed mental apprehension, two positive terror, one expressed spiritual exultation, one bitter remorse. The great majority gave no sign one way or the other; like their birth, their death was a deep sleep and a forgetting. [--see Mueller (below), p. 55]

Osler's summary of findings has now been challenged by Paul S. Mueller in "William Osler's Study of the Act of Dying: An Analysis of the Original Data" [*Journal of Medical Biography* 15, suppl. 1 (2007): 55-63]. According to Mueller, while Osler reported that only 21% of the patients in the study experienced discomforts, his original data spreadsheet showed the percentage at 27%, and his data collection cards indicated it at 38%. However, even Mueller's revisiting of the data apparently revealed only one instance of *spiritual* distress. (The original data collections cards, depicted in an illustration by Mueller [p. 56], provided three spaces under the heading, "*if any fear or apprehension, of what nature*": for "*Bodily* [e.g.] *a pain*," "*Mental*," and "*Spiritual* [e.g.] *remorse, etc.*")

Mueller suggests various reasons for the discrepancy between the raw data, the spreadsheet tally, and Osler's report--and the article is worth reading purely as a cautionary tale about the handling of data--but he does not directly address what chaplains would surely find stunning: namely, that spiritual distress was barely noted among the 486 patients in the study. Mueller hints at the wider context of religious issues, but only that. It would seem--to this reader--that unless those patients were most extraordinary in their spiritual peacefulness, then Osler did not register the sorts of things that we today would regognize as spiritual distress.

Osler's own disposition with regard to religion/spirituality is a matter of dispute, as can be seen in the exchanges in a special symposium section of the Winter 2001 issue of the *Bulletin of the History of Medicine* --see, for instance, the sparring between Joseph W. Lella [75(4):760-766] and Michael Bliss [75(4): 767-770] over Bliss' biography, *William Osler: A Life in Medicine* [New York: Oxford University Press, 1999]. He clearly had strong personal familiarity with religion (and he had once intended to enter the Christian ministry). However, the lack of notation of spiritual distress in the 1900-1904 study is more than a matter of understanding Osler; it suggests at least two things about the detection of spiritual concerns in the clinical setting, in general: For one, it may illustrate the importance of *definition*: whether the concept of spirituality is defined narrowly or broadly may translate directly into what gets noticed by clinicians. For another, it may be erroneous to assume that clinicians' familiarity with the topic of spirituality will necessarily lead to good identification of spiritual issues.

Osler's data collection cards prompted for attention to spirituality, but almost no data came of this. Similarly, many clinical patient assessments today include spirituality items that go unmarked. Are we appropriately capturing information in this area? The absence of an observation of patients' spiritual distress should not be confused with an *actual* absence of spiritual distress, and any instrument that produces little indication of spiritual concerns amid health crises deserves some scrutiny. Every study is at least as much a test of its methodology as it is a window into its subject matter. We will never know if Osler's patients really did not have much "fear or apprehension," since that depends on whether one views his methodology as sound or suspect. Nevertheless, the study itself may be a call for chaplains to bring their keen and practical insight about patients' lived experience of illness to bear upon the continued development and critique of research methodology and clinical assessment, so that spirituality & health instruments and those who use them may detect patients' needs with increasing sensitivity. --*JE*

5. Recent Journal Theme Issues on Spirituality

The Article-of-the-Month section of our website highlights individual works, but it is also worth noting those journals which address spirituality & health in collections of articles in special issues. In recent months, theme issues have been published by:

I. *American Journal of Bioethics* -- The July 2007 issue (vol. 7, no. 7) offers 12 articles about spirituality in the clinical setting. While not focused on research, these pieces do reflect topics relevant to chaplain researchers and include some good bibliographies. Note especially: Robinson, M. R., Thiel, M. M. and Meyer, E. C., "**On being a spiritual care generalist**, on pp. 24-26 (--Mary R. Robinson and Mary Martha Thiel are chaplains and are two of the authors of a previously featured Article-of-the-Month from November 2006).

II. *Southern Medical Journal* -- The journal produces special sections regularly, in an ongoing series on Spirituality and Medicine. The June issue (vol. 100, no. 6) looked at spirituality and mental health, and the September issue (vol. 100, no. 9) examined the role of spirituality and chaplains in disasters. The articles tend to be brief expositions, though sometimes the series includes major research reports, and chaplains are often authors. Regarding the newly published **September issue (vol. 100, no. 9)**, chaplains should find especially interesting the following articles:

Gunn, F. X., "**Spiritual issues in the aftermath of disaster**," pp. 936-937.

Larimore, W. L., Duininck, M. W. and Morsch, G. B., "**Spiritual needs of physicians during and following a catastrophe**," pp. 940-941.

Feldbush, M. W., "**The role of clergy in responding to disaster events**," pp. 942-943.

Massey, K. and Sutton, J., "**Faith community's role in responding to disasters**," pp. 944-945.

Trevino, K. M. and Pargament, K. I., "**Religious coping with terrorism and natural disaster**," pp. 946-947.

Pollock, D. M., "**Therefore choose life: the Jewish perspective on coping with catastrophe**," pp. 948-949.

Basit, A., "**An Islamic perspective on coping with catastrophe**," pp. 950-951.

Chhean, V. K., "**A Buddhist perspective on coping with catastrophe**," pp. 952-953.

Koenig, H. G., "**Case discussion--religion and coping with natural disaster**," p. 954.

III. *Journal of Clinical Psychology* -- October's Special Issue on Spirituality and Psychotherapy (vol. 63, no. 10) presents the following introduction and seven studies:

Pargament, K. I. and Saunders, S. M., "**Introduction to the special issue on spirituality and psychotherapy**," pp. 903-907.

Arnette, N. C., Mascaro, N., Santana, M. C., Davis, S. and Kaslow, N. J., "**Enhancing spiritual well-being among suicidal African American female survivors of intimate partner violence**," pp. 909-924.

Huppert, J. D., Siev, J. and Kushner, E. S., "**When religion and obsessive-compulsive disorder collide: treating scrupulosity in ultra-orthodox Jews**," pp. 925-941.

Martinez, J. S., Smith, T. B. and Barlow, S. H., "**Spiritual interventions in psychotherapy: evaluations by highly religious clients**," pp. 943-960.

Gurney, A. G. and Rogers, S. A., "**Object-relations and spirituality: revisiting a clinical dialogue**," pp. 961-977.

Margolin, A., Schuman-Olivier, Z., Beitel, M., Arnold, R. M., Fulwiler, C. E. and Avants, S. K., "**A preliminary study of spiritual self-schema (3-S(+)) therapy for reducing impulsivity in HIV-positive drug users**," pp. 979-999.

Goldstein, E. D., "**Sacred moments: implications on well-being and stress**," pp. 1001-1019.

Desrosiers, A. and Miller, L., "**Relational spirituality and depression in adolescent girls**," pp. 1021-1037.

IV. *The Journal of Behavioral Medicine* -- The August 2007 issue (vol. 30, no. 4) on Religiosity/Spirituality and Behavioral Medicine includes Worthington, E. L., Jr., Witvliet, C. V., Pietrini, P. and Miller, A. J., "**Forgiveness, health, and well-being: a review of evidence for emotional versus decisional forgiveness, dispositional forgiveness, and reduced unforgiveness**," pp. 291-302 (which is our October 2007 Article of the Month), and also the following:

Masters, K. S., "**Religiosity/spirituality and behavioral medicine: investigations concerning the integration of spirit with body**," pp. 287-289.

Seybold, K. S., "**Physiological mechanisms involved in religiosity/spirituality and health**," pp. 303-309.

Wachholtz, A. B., Pearce, M. J. and Koenig, H., "**Exploring the relationship between spirituality, coping, and pain**," pp. 311-318.

Park, C. L., "**Religiousness/spirituality and health: a meaning systems perspective**," pp. 319-328.

Masters, K. S. and Spielmans, G. I., "**Prayer and health: review, meta-analysis, and research agenda**," pp. 329-338.

V. *Revista de Psiquiatria Clinica* -- This journal from the Medical Faculty of the University of Sao Paulo, Brazil, has just issued a special supplement (vol. 34, suppl. 1) on Spirituality & Health, with contributions from American and Brazilian authors. It is available online at www.hcnet.usp.br/ipq/revista --for English, click "ENGLISH" and then the link for "VOLUME 34 - SUPPLEMENTO 1 - 2007." Note especially the review articles:

Koenig, H. G., "**Religion, spirituality and psychotic disorders**," pp. 40-48.

Greyson, B., "**Near-death experience: clinical implications**," pp. 49-57.

Peres, J. F. P., Simao, M. J. P. and Nasello, A. G., "**Spirituality, religiousness, and psychotherapy**," pp. 58-66.

6. Announcement of the Annual Network Meeting, and a Note from the Convener

Our annual Network meeting will be Friday, October 26th, at 9:00 AM in the Adolphus Hotel, Dallas TX --as part of the ACPE's national conference. A flyer [See APPENDIX 2] has been included in the general packet of information for all ACPE conferees. We will be discussing individual research initiatives, the Ideal Intervention Project, membership, and the website.

***A note from John Ehman*:** It has been five years since I became Convener. In 2002, we decided at our annual meeting to develop a website, and that has since been my primary focus. The site has to date registered over 13,500 visitors and gets typically between 50-100 hits per day. Our Article-of-the-Month draws the most attention, and it now covers over 60 topics represented by major articles and supported by hundreds of other articles of related interest. It is a well-used resource for all members of the ACPE and beyond. Our online Newsletter, published in the Fall, Winter, and Spring-Summer, has continued the tradition of our previously *printed and mailed* Newsletter (for years published with generous effort by Anne V. Sutherland). With contributions of content by Margot Hover, Jackson Kytle, Jack Gleason, Kyle Johnson, Diane Dodd-McCue, Henry Heffernan, and others, it remains a good source for information and commentaries for chaplains involved in research.

Feedback about the site is overwhelmingly positive, and it has come from unexpected sources. Just last week I received an email from a chaplain in the Midwest who wrote, "Just found your site and wanted to say thanks." One time I chanced to meet a congregational rabbi from London who expressed an interest in research: when I mentioned the Research Network, he said, "Oh, I know the site --it's bookmarked on my computer, and I read it every month." The global reach of our Internet strategy for the Network was made very real to me.

As we move ahead, I feel that we should continue to discuss how our website can be developed and used in new ways. I also believe that we need to focus more attention on membership (and dues) from within the ACPE. Perhaps a separate "membership and advertisement" officer could concentrate efforts in this area and could encourage more chaplains to report their research initiatives and share their work. Students, too, could be more involved by reporting their CPE projects and submitting material for our Network awards.

Research into spirituality & health continues to grow year by year, and it is vital that chaplains remain "plugged in" to all the activity in the field. I believe the Network has served this goal well. It is my hope that we can, in addition, begin to look more at the role of research in the *educational* process of the ACPE. This was an emphasis of our late President, Joan Hemenway, who offered great support to our Network. In the future, I would like to see more content on our website devoted to educational research.

I look forward to discussing these and other issues in Dallas. --*JE*

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