# CPE Unit 2 Syllabus

**Unit:** ICPT CPE Unit 2
**Prerequisites:** ICPT CPE Unit 1
**Clock Hours:** 400 (100 clock hours didactic study and class time and 300 clock hours clinical/applied learning)
**Unit Length:** 12 weeks (full-time)

**Instructional Methods:**

- Didactic Study and Class Time (Instructor-led Onsite and/or Interactive Distance Learning*)
- Clinical (applied learning)
- Customized Coaching
- Peer-to-Peer Projects and Assessments

***Interactive Distance Learning** course content is accessed in the ICPT Learning Center where students work through weekly modules that include readings, research and other articles, case studies, and activities in which they reflect upon and apply the information learned.

**Unit Requirements:**

- **100 hours of Didactic Learning:** Students are required to participate in 100 hours of didactic study and class time offered live and/or via interactive distance learning (IDL).

- **1 Orientation Paper:** Students must submit an orientation paper the first week of the unit that is no more than 2 pages that discusses their position on one of the following subjects:

    - a theology of person;
    - how do you picture and talk about illness;
    - how you picture human suffering especially among the innocent;
    - how do you picture pain and destruction; or
    - a subject of your own choosing in discussion with your supervisor.

  The orientation paper must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.

- **10 Reflection Reports:** Students must submit 10 reflection reports that detail what they experienced, learned, and thought about regarding ministry during their training. Reflection reports are due each week starting the 2nd week of the unit and completing the final report in the 11th week of CPE training. Reflections should be no more than two pages in length. Topics may include but are not limited to:

    - Significant events that occurred with patients, peers or the CPE Supervisor;
    - Steps taken to meet learning contract and CPE objectives; and
    - Significant learning events in the student's personal and professional life.

  All reflection reports must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.

- **6 Case Studies:** Students must submit a minimum of 6 case studies that reflect interactions with patients or clients. Case studies help students understand their strengths and weaknesses during visits with patients or clients. Case studies are written in a specific format outlined in the appendix of this handbook. Students must present at least 1 case study to their classmates in their cohort. Smaller cohorts may require students to present additional case studies.

- All case studies must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.
- Students must also review and evaluate other classmates case studies and provide peer-to-peer feedback.
- Students must upload case studies 2 days in advance of the scheduled due date for peer review in the ICPT Learning Center.
    - Onsite students may provide in person peer-to-peer feedback.
    - Interactive Distance Education (IDL) students must engage in live case study discussion forums and post peer-to-peer feedback in the interactive chat-board. All IDL students must evaluate peer case studies during each unit.

- **Customized Coaching/Supervision:** Students are responsible for scheduling a weekly coaching/supervision meeting with their CPE supervisor. The weekly supervision meetings allow students to discuss, one-on-one, with their supervisor, any concerns they have, reflection reports, and how they are progressing with their learning contract. All supervisory meetings are held in the strictest confidence. Please note, sessions may be recorded or transcribed to ensure compliance with ICPT academic standards.

- **Group Discussion:** Students must participate in group discussions. Group discussions may be live or via computer mediated live conferencing such as Zoom. Note, these sessions may be recorded or transcribed to ensure compliance with ICPT academic standards.

- **Mid-Unit and Final Unit Self-Evaluations:** Students must complete mid-unit and final unit self-evaluations. The peer review portion of the evaluations may be shared with classmates. These evaluations are codified in a specific format detailed in the appendix of this manual. Students must submit evaluations by file upload, in the ICPT Learning Center for the CPE Supervisor(s) review and academic feedback.

- **Didactic Modules:** Students must complete the didactic modules denoted on the unit syllabus. There will be one test at the end of each module within each unit. Each unit includes at least two or more required modules. Participants will receive a Pass/Fail notification after completing the test in each module. Participants have a total of three attempts to pass the test at the end of each unit with a score of 80 or better. The three attempts must be made within seven days of the unit completion date denoted on the syllabus.

- **300 hours of Clinical/Applied Learning CPE Units:** Each student is responsible for completing a minimum of 300 hours of clinical ministry during the unit. Clinical hours may be completed at your current place of ministry (if you are currently employed as a Chaplain or Pastor of a church), or any number of institutions including but not limited to; hospitals, hospice houses, corporate settings, prison systems, skilled nursing facilities, nursing homes, assisted living facilities, and community services. Your hours may be paid or volunteer. Each student is responsible for keeping track of these hours on the *CPE Weekly Clinical Hours Log* provided in the appendix of the student handbook, and having this form signed by the proctor at the clinical site. The form must be submitted by file upload, in the ICPT Learning Center for the CPE Supervisor(s) weekly verification.

**Unit 2 Learning Center Courses:**
Unit 2 is comprised of the following required courses:
1. F2CMT – Powerful Communication Techniques
2. F6ETH – Values, Obligations, and Rights: Health Care Ethics

3. F9EPC – When It's Time to Say Goodbye: Introduction to Spiritual Care at the End of Life

**Unit 2, Course 1 - Overview:**
**F2CMT – Powerful Communication Techniques**
This course educates on the topic of how and why communication does or does not work. It begins by looking at both definitions and theories of communication to better understand the many variables that impact effective communication. Discussed and practiced will be active listening skills, the impact nonverbal communication has on face to face interactions, and group communication including its stages, roles, and norms. Emphasis will be on better understanding one's own styles of communication, as well as understanding how one's communication habits work for or against one in different situations. The course will also discuss strategies for resolving interpersonal conflict and techniques for effectively negotiating with patients, families, and staff. Participation in Family Physician Conferences will be discussed, and steps that can be taken to enhance goal clarification and advanced care planning with patients, families, and staff.

**Course Competencies:**
**F2CMT – Powerful Communication Techniques aligns with the following Quality Indicators in What is Quality Spiritual Care in Health Care and How Do You Measure It? (HCCN. 2016):**

- **Structural Indicator 1.A.** Chaplains as certified or credentialed spiritual care professional(s) are provided proportionate to the size and complexity of the unit served and officially recognized as integrated/embedded members of the clinical staff.
- **Structural Indicator 1.C.** Information is provided about the availability of spiritual care services.
- **Structural Indicator 1.D.** Professional education and development programs in spiritual care are provided for all disciplines on the team to improve their provision of generalist spiritual care.
- **Structural Indicator 1.E.** Spiritual care quality measures are reported regularly as part of the organization's overall quality program and are used to improve practice.
- **Process Indicator 2.B.** All clients are offered the opportunity to have a discussion of religious/spiritual concerns.
- **Process Indicator 2.D.** Spiritual, religious, cultural practices are facilitated for clients, the people important to them, and staff.
- **Process Indicator 2.E.** Families are offered the opportunity to discuss spiritual issues during goals of care conferences.

**Module Descriptions and Learning Objectives:**
**F2CMT – Powerful Communication Techniques**

**1. Introduction to Communication and Miscommunication Concepts**

Communication is often tricky in the best of circumstances. There are many layers of difference between two people attempting to understand one another These can include age, gender, race, ethnicity, culture, religion, dialect, language, social skills, emotional intelligence and facility, educational background, socioeconomic context, power or positional authority differentials among others. These can lead to an infinite number of opportunities in which the two people can misunderstand one another. Some of the same principles that govern cultural humility as discussed in the knowledge base module Cultural Competence, Inclusion, and Vulnerable Populations also apply to communication between two people. A chaplain or spiritual care provider must constantly be self-aware of the many layers of difference between himself and the person with whom he is interacting.

**Module Learning Objectives:**

- Define communication and explain its importance in the provision of spiritual care.

## 2. Understand effective Listening Habits and Skills and a Systematic Method of Listening Behavior.

There is a difference between hearing and listening. The sense of hearing is the physiological process of sounds entering someone's ear canal and the brain of that person translating the vibration of the eardrum into an interpretation of the sound. Listening, however, is being engaged with someone or something that commands the attention of the hearer. This module will look at three different models of active listening, one from Zeuschner another from Carkhuff, and one from Kidd. They overlap in many ways, but each takes a different approach. This can yield insights when studied side by side.

**Module Learning Objectives:**

- Understand effective listening habits and skills and a systematic method of listening behavior.
- Define and describe effective verbal communication practices and skills.

## 3. Nonverbal Communication

A significant component of face to face interaction is nonverbal communication. This does not involve sitting across from someone silently trying to communicate exclusively through pantomime or gesturing. Nonverbal communication is defined as "a process whereby people, through the intentional or unintentional manipulation of normative actions and expectations (other than words themselves) express experiences, feelings, and attitudes to relate to and control themselves, others, and their environments" (Hickson, 1992).

**Module Learning Objectives:**

- Define and describe effective non-verbal communication practices and skills.

## 4. Group Communication

Chaplains and spiritual care providers will often be asked to participate in small groups. This may be an ongoing group such as an ethics or another organizational committee, clinical unit group, or palliative care interdisciplinary team. Or it may be a Critical Incident Stress Debriefing, a family / physician plan of care conference, or a Spirituality Support Group in a mental health unit. Whatever the group situation, chaplains and spiritual care providers should have a basic understanding of stages of group development, and different roles people in groups tend to play.

**Module Learning Objectives:**

- Identify the principles of effective group communication and various roles and norms in a group communication process.

## 5. Conflict Resolution & Negotiation

Conflict happens daily, and conflict resolution is imperative in a clinical setting. Chaplains or spiritual care providers are often involved integrally in situations of conflict and need to be equipped for conflict resolution and negotiation to arrive at creative and constructive solutions

**Module Learning Objectives:**

- Identify conflict resolution strategies and develop a personal, constructive approach to dealing with conflict situations.

- Understand and describe the concept and competencies of negotiation when working with patients, families, and staff.

**6. Communication to Enhance Goal Clarification**

Medical decisions are being made daily in almost every patient's situation. The biomedical ethical principle of patient autonomy dictates that the patient, and/or the patient's health care power of attorney or proxy, should be responsible for making those decisions. However, it is the interdisciplinary health care team that possess the training, experience, and expertise to make the most informed and rational decisions. Chaplains or spiritual care providers are in the unique position of having the experience and awareness of the medical realities to help serve as an interpreter between families and staff as discussions are held to identify goals of care.

**Module Learning Objectives:**

- Summarize steps involved in communication to enhance goal clarification.

**Unit 2, Course 2 Overview:**
**F6ETH – Values, Obligations, and Rights: Health Care Ethics**

This course introduces the concepts of biomedical ethics and assist chaplains and spiritual care providers in understanding and applying those concepts to daily professional practice. It includes information on how diverse beliefs and values due to cultural, religious, spiritual, and/or existential beliefs may impact a patient or family's experience and decision-making. Chaplains and spiritual care providers are in the unique position of serving as mediators and facilitators in the interaction of and care for patients, families, and staff. This course will explore the ethical issues in health care, including the nuanced applications of ethical principles and theories in a case study example.

**Course Competencies:**
**F6ETH – Values, Obligations, and Rights: Health Care Ethics aligns with the following Quality Indicators in What is Quality Spiritual Care in Health Care and How Do You Measure It? (HCCN. 2016):**

- **Structural Indicator 1.C.** Information is provided about the availability of spiritual care services.
- **Process Indicator 2.B.** All clients are offered the opportunity to have a discussion of religious/spiritual concerns.
- **Process Indicator 2.E.** Families are offered the opportunity to discuss spiritual issues during goals of care conferences

**Module Descriptions and Learning Objectives:**
**F6ETH – Values, Obligations, and Rights: Health Care Ethics**

**1. Introduction to Health Care Ethics and the Four Principles**

The study of medical ethics involves the analysis of concepts such as competence, autonomy, beneficence, compassion, personhood, quality and sanctity of life, informed consent, truth-telling, confidentiality, end-of-life care, pain relief, patient care best interests and just resource allocation. It also involves consideration of how issues of beliefs, values, spirituality/religion, culture, family issues, and other contextual issues enter into decisions made within an ethical framework when challenges occur. There are four broadly accepted principles that underlie the ethical culture of "patient-centered medicine" and "shared decision making" that is at the heart of modern health care: autonomy, beneficence, nonmaleficence, and justice.

**Module Learning Objectives:**

- Describe the four ethical principles of respect, justice, nonmaleficence, and beneficence.

**2. Medical Decision Making. Life-Prolonging Medical Interventions, Medical Futility, and Palliative Sedation**

The heart of clinical medical ethics is the question of how decisions are made, by whom decisions are made, and by what standards. The most important goal in decision-making is that the patient or his/her surrogate has the opportunity to be an informed participant in their health decisions. They, and the chaplain providing spiritual care to them, should understand and be able to articulate both the benefits and burdens of each intervention. The most common ethical medical care issue faced and disagreed upon by medical providers and family members is that of futility, the definition of which is often a challenge to be defined. Another issue that raises ethical questions are around the provision of palliative sedation.

**Module Learning Objectives:**

- Identify the ethical and moral challenges that may occur in relation to health care

**3. Role of the Professional Chaplain**

Chaplains have a working knowledge of the ethical and moral challenges that may occur in relation to spiritual care, as well as the ethical principles of respect, justice, non-maleficence, and beneficence. Through a spiritual assessment, chaplaincy interventions such as life review, conducting a values history, or engaging persons in dignity therapy, evidence-based outcomes, and documentation, the chaplain provides invaluable information that can be helpful when an ethical issue or conflict arises. Chaplains facilitate communication between patients, families, and the interdisciplinary team and assist in conflict management and resolution.

**Module Learning Objectives:**

- Describe the role of the chaplain or spiritual care provider when ethical situations arise, including assessment, interventions, seeking consults, the chaplain's role on the ethics team, and documentation
- Identify the importance of and how to secure information on faith tradition directives regarding medical interventions such as termination of pregnancy, use of certain medications or ingredients, provision, withholding or withdrawing of life-sustaining treatments
- Gain understanding about interventions and demonstrate ability to create care plans that accurately incorporates the patient or surrogate's stated beliefs, values, culture, and preferences without inserting one's own beliefs

**4. When the Culture Avoids Ethical Issues and Ethics Consultation Committees**

It is important to recognize that there are some organizational cultures that avoid the discussion of ethical dilemmas as well as ways in which chaplains can support a change in such a culture. Within the discipline's scope of practice, the chaplain participates effectively in the process of ethical decision-making, including with the ethics committee as appropriate to the setting, in such a way that theological, spiritual, and cultural values of patients and families are supported. Additionally, chaplains have an opportunity and a responsibility to participate in strengthening this service, so it provides value to clinicians, the organization, and ultimately to patients and families affected by practice and policy.

**Module Learning Objectives:**

- Identify the components of an ethics referral and the role of an ethics committee and consult

**Unit 2, Course 3 Overview:**

**F9EPC – When It's Time to Say Goodbye: Introduction to Spiritual Care at the End of Life**
Chaplains provide care to persons within their communities at all stages of life, including that of terminal illness, the process of dying, and death itself. This course addresses the various aspects of end of life, including the dying process and physiological changes, advance care planning, conflicts that may occur between dying persons and families, palliative care, and hospice. Issues of emotional and spiritual, religious, and existential distress will be identified as well as appropriate interventions, cultural, religious, spiritual and existential practices, and care of the family.

**Course Competencies:**
**F9EPC – When it's Time to Say Goodbye: Introduction to Spiritual Care at the End of Life aligns with the following Quality Indicators in What is Quality Spiritual Care in Health Care and How Do You Measure It? (HCCN. 2016):**

- **Process Indicator 2.B.** All clients are offered the opportunity to have a discussion of religious/spiritual concerns.
- **Process Indicator 2.E.** Families are offered the opportunity to discuss spiritual issues during goals of care conferences.
- **Process Indicator 2.G.** End of life and Bereavement Care is provided as appropriate to the population served.

**Module Descriptions and Learning Objectives:**
**F9EPC – When it's Time to Say Goodbye: Introduction to Spiritual Care at the End of Life**

1. **End of Life and the Processes of Death**
   Those who provide spiritual, chaplaincy, or pastoral care to persons – whether as a chaplain or spiritual care provider in a health care setting who deals with death on a regular (if not daily basis) or as a community religious leader, must possess a good foundation of knowledge regarding end of life issues in order to provide the best care. Dying is not only a medical event. It is a personal, social, communal, and spiritual experience.

   **Module Learning Objectives:**
   - Recognize and understand the physiological, emotional, and spiritual changes that occur during the dying process.

2. **Providing End of Life Care**
   Those who provide spiritual, chaplaincy, or pastoral care to persons are those who are best able to address the existential, spiritual, and religious distress surrounding hope and meaning. To do so requires an ability to introduce what might be a difficult and painful topic with persons facing the end of life, particularly in the midst of what may be significant physical discomfort or pain in addition to the spiritual and psychosocial distress.

   **Module Learning Objectives:**
   - Understand and articulate the different spiritual, religious, and existential beliefs about dying and death and articulate the appropriate interventions.
   - Understand the conflicts that can occur between the dying person, family/family of choice, and associated communities and articulate appropriate interventions.

3. **Spiritual Distress and Pain**
   Spiritual distress and pain at the end of life and throughout the dying process can manifest itself in several unique ways. By becoming familiar and competent in the use of the National Comprehensive Cancer Network's Practice Guidelines in Oncology Distress Management and other models and distress assessment tools, chaplains can provide effective interventions to

patients and families.

**Module Learning Objectives:**

- Identify the issues of emotional and spiritual distress that are experienced by patients facing the end of life, articulate appropriate interventions and demonstrate their application.

**4. Care after Death**

Circumstances of a death require different types of support and care from the interdisciplinary team, including chaplains who respond to spiritual distress and pain that may vary within a bereaved family. Cultural and religious norms may be required in how a body is viewed, treated, and prepared for transport. Chaplains provide support not only in the grieving process, but in facilitating the cultural, spiritual, and religious needs of families following the death of a loved one and should be familiar with processes as well as how to facilitate conversation about norms and next steps.

**Module Learning Objectives**

- Articulate the role of spiritual, religious or existential support, practices, and cultural norms in coping, dying, grief, bereavement, and after death care of the body.

**CPE Unit 2 Schedule – Full-time Student:**

| Week | Topic | Assignments |
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| 1 | **Powerful Communication Techniques**<br><br>**Introduction to Communication and Miscommunication Concepts**<br>• Introduction to Communication<br>• Definition of Communication<br>• Communication Process Models<br><br>**Understand Effective Listening Habits and Skills and a Systematic Method of Listening Behavior**<br>• Define Active Listening<br>• Zeushner's Model of "Active Listening"<br>• Carkhuff's Model of "The Art of Helping"<br>• Kidd's Model of "Supportive Spiritual Listening"<br>• Paradigms for Listening | 1. Introduction to course and requirements; Q&A<br>• Getting Started<br>• Welcome to the Course<br>• Pre-test<br>2. Student Introductions<br>3. Review material, required articles, videos, and the application activities.<br>4. Case study and/or group discussion<br><br>Videos:<br>• Treasure J. Conscious Living. TEDxDanubia. 2011.<br><br>Articles:<br>• A "Burnout Prevention" Tool for Improving Healthcare Provider Health and Wellbeing: Mantram Repetition. Borman J. 2007. |
| 2 | **Nonverbal Communication**<br>• Definition and Categories of Nonverbal Communication<br>• Touch<br>• Personal Space, Territory, and the Environment<br>• Physical Appearance<br>• Body Movement<br>• Facial Expressions<br>• Vocal Gestures<br>• Use of Time<br><br>**Group Communication**<br>• Introduction and Stages of Group Communication<br>• Roles in Group Communication | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br><br>Videos:<br>• Non-Verbal Communication: For the Birds. 2016.<br>• Social Awareness-Close Talker. 2009. NBC.<br><br>Articles:<br>• Research Roots of Planetree Patient-Centered Design. Schweitzer M. 2016.<br>• Healing Spaces: Elements of Environmental Design that Make an Impact on Health. Schweitzer M, et al. 2004.<br>• Nonverbal Interpersonal Interactions in Clinical Encounters and Patient Perceptions of Empathy. Montague E et al. 2013.<br>• Facial Expression of Emotion. Keltner D, Ekman P. 2002. |

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| | • Task Roles<br>• Personal and/or Social Roles<br>• Dysfunctional and/or Individualistic Roles<br>• Groups in which Spiritual Care May Be Involved | • Benne and Sheats' Group Roles. MindTools. 2015.<br>• Interpersonal Communication Principles for Group Members. Adams K. 2005. |
| **3** | **Conflict Resolution and Negotiation**<br>• The Basics of Engaging with Conflict<br>• Two Models of Engaging in Conflict Constructively<br>• Crucial Confrontations<br>• Nonviolent Communication<br>• Verbal De-Escalation<br><br>**Communication to Enhance Goal Clarification**<br>• Advance Care Planning and Family/Physician Conferences<br>• How to Run a Family/Physician Conference<br>• Processes for Family/Physician Conferences<br>• Debriefing the Family<br>• Debriefing the Interprofessional Team<br>• The Art of the Family Conference<br>• The Chronically Ill<br><br>**Post-Test** | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br><br>Videos:<br>• Brene Brown on Empathy. The RSA. 2013.<br>• Nonviolent Communication: A Brief Introduction. The Center for Nonviolent Communication.<br>• Your Body Language Shapes Who You Are. Cuddy A. 2012.<br><br>Articles:<br>• Executive Book Summary: Crucial Confrontations, Patterson. Keller J. 2010.<br>• Needs Inventory. Center for Nonviolent Communications. 2005.<br>• Communication – the Most Challenging Procedure. Nakagawa S. 2015.<br>• Educational Modules for the Critical Care Communication (C#) Course – A Communication Skills Training Program for Intensive Care Fellows. Arnold R. 2010. |
| **4** | **Group Introduction to Course 2: F6ETH – Values, Obligations, and Rights: Health Care Ethics**<br><br>**Introduction to Health Care Ethics and the Four Principles**<br>• Major Philosophical Theories<br>• Four Principles of Biomedical Ethics<br>• Patient Autonomy<br>• Beneficence<br>• Nonmaleficence<br>• Justice<br><br>**Medical Decision Making. Life-Prolonging Medical Interventions, Medical Futility, and Palliative Sedation**<br>• Informed Consent<br>• Substituted Judgement Standard<br>• Life-Prolonging Medical Interventions<br>• Medical Futility<br>• Palliative Sedation | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br><br>Videos:<br>• Utilitarianism: Crash Course Philosophy #36. PBS Digital Studios. 2016.<br>• Kant and Categorical Imperatives: Crash Course Philosophy #35. PBS Digital Studios. 2014.<br>• The Ethics of WD Ross. Yukov J. 2009.<br>• An Introduction to John Rawl's a Theory of Justice. Macat. 2015.<br>• Natural Law Theory: Crash Course Philosophy #4. PBS Digital Studios. 2016.<br>• Reflections on Substitute Decision-Making for End of Life Care. Geriatric Services Conference. 2014.<br>• Palliative Sedation in Palliative Care. Canadian Virtual Hospice. 2011.<br><br>Articles:<br>• Informed Consent: Respecting Patient Autonomy. Norman G. 2012.<br>• Beneficence and the Professional's Moral Imperative. Kinsinger F. 2009.<br>• Cultural Diversity at the End of Life. Searight and Gafford. 2005.<br>• Clinical and Ethical Judgment. Daly S et al. 2014.<br>• New Perspectives on the Theory of Justice: Implications for Physical Therapy Ethics and Clinical Practice. Edwards I et al. 2011. |

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| | | • Assessment of Patient's Competence to Consent to Treatment. Appelbaum P. 2007.<br>• Evaluating a Patient's Request for Life-Prolonging Treatment: An Ethical Framework. Winkler et al. 2013.<br>• Life-Sustaining Treatment Preferences: Matches and Mismatches between Patients' Preferences and Clinicians' Perceptions. Downey et al. 2012.<br>• Ten Common Questions (And Their Answers) About Medical Futility. Swentz et al. 2014.<br>• Palliative Sedation: Challenging the Professional Competency of Health Care Providers and Staff: A Qualitative Focus. Leboul and Guirimand. 2017. |
| **5** | **Role of the Professional Chaplain**<br>• Guidelines from the Profession<br>• Spiritual Assessment<br>• Interventions: Life Review, Values History, Dignity Therapy<br>• Documentation<br>• Communication<br>• Conflict Management and Resolution<br>• Setting up a Decision-Making Framework<br>• Ross and Bayley Framework<br>• Legal Issues<br>• Facilitating Medical Decision Making<br>• Decision Making and Diversity<br>• Food and Feeding at the End of Life<br>• Discussing "Hope"<br>• Religious Accommodations and Religious Objectives | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br><br>Articles:<br>• Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference. Puchalski, et al. 2009<br>• What Do I Do Developing Taxonomy Chaplaincy Activities? Massey, et al. 2015.<br>• Documentation and Confidentiality for Chaplains Handzo G and Wintz S. 2015.<br>• Outcome Oriented Chaplaincy. Wintz. HealthCare Chaplaincy Network. 2005<br>• Effective Communication Skills: Resolving Conflicts, Brower and Darrington. 2012.<br>• Developing and Testing a Checklist to Enhance Quality in Ethics Consultation. Flicker, et al. 2014.<br>• Shared Decision Making: Examining Key Elements and Barriers to Adoption into Routine Clinical Practice. Legare and Witteman. 2013.<br>• Artificial Nutrition and Hydration. Coyle and Todaro-Franceschi. 2012.<br>• AMEN in Challenging Conversations: Bridging the Gaps between Faith, Hope, and Medicine. Cooper, et al. 2014.<br>• Many Terminal Cancer Patients Mistakenly Believe a Cure Is Possible. Schultz. 2012.<br>• Brain Stem Death: Managing Care when Accepted Medical Guidelines and Religious Beliefs are in Conflict. Inwald, et al. 2000 |
| **6** | **When the Culture Avoid Ethical Issues and Ethics Consultation Committees**<br>• When the Culture Avoids Ethical Issues<br>• Consultations Services and Committees<br>• Advocating for the Role of Chaplains in Ethics Consults and Committees<br><br>**Post-test** | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br>3. Course post-test.<br>4. Mid-unit self-evaluation<br><br>Articles:<br>5. A Culture of Avoidance: Voices from Inside Ethically Different Clinical Situations. Pavlish, et.al, 2015.<br>6. Ethics Committee Handbook: For New Members Orientation. Flanigan R. 2018.<br>7. Health Care Chaplains and their Role on Institutional Ethics Committees: An Australia Study. Carey L, Cohen J. 2010.<br>8. Chaplaincy and Clinical Ethics: A Common Set of Questions. Smith ML. 2008. |
| **7** | **Group Introduction to Course 3: F9EPC – When It's Time to Say Goodbye: Introduction to Spiritual Care at the End of Life** | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion |

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| | **End of Life and the Processes of Death**<br>• Introduction to End of Life<br>• Physiological Processes of Death<br>• Sudden or Trauma Deaths<br>• Death from Disease<br>• Emotional Processes of Death<br>• Cicely Saunders and Total Pain<br>• Anticipatory Grief and Mourning<br>• Spiritual Processes: Death Anxiety<br>• Hope and Meaning | Videos:<br>• Don't Mean to Dwell on this Dying Thing. Brown R. TedTalksPsychology. 2013.<br>• Signs of Approaching Death. Elwanda Adams. 2009.<br>• Elisabeth Kubler-Ross, Early Speech - Experiences with dying patients, 1975.<br>• Elisabeth Kubler-Ross - Speaks to a dying patient, Nova Interview, 1983.<br>• Elisabeth Kubler-Ross - On Spirituality.<br>• Cicely Saunders: Total Pain and Modern Hospice Movement. OrangeDork. 2014.<br>• Dr. Ira Byrock: The Four Things That Matter Most. Canadian Virtual Hospice.<br><br>Articles:<br>• Spiritual Care at End of Life: Some Clergy Lack Training in End of Life Care. Norris, Byrock, et.al. 2004.<br>• Physiological Changes and Symptom Management during the Dying Process. End Link: An Internet-based End of Life Care Education Project. Northwestern University. 2003.<br>• Understanding the Concept of "Total Pain": A Prerequisite for Pain Control. Mehta and Chan. 2008.<br>• Distinguishing Symptoms of Grief and Depression in a Cohort of Advanced Cancer. Jacobsen, et.al. 2010.<br>• Caring When Cure is no Longer Possible. Byrock and Corbeil. 2014.<br>• Death Anxiety: Analysis of an Evolving Concept. Lehto and Stein. 2009.<br>• Anxiety in Terminally Ill Cancer Patients. Kolva, et.al. 2011.<br>• Fostering and Coping and Nurturing Hope When Discussing the Future with Terminally Ill Cancer Patients and Their Caregivers. Clayton, et.al. 2015.<br>• The Preference to Discuss Expected Survival Rates is Associated with Loss of Meaning and Purpose in Terminally Ill Cancer Patients. Vehling, et.al. 2015. |
| **8** | **Providing End of Life Care**<br>• Being, Doing, Believing<br>• End of Life Interventions<br>• Conflict at End of Life | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br><br>Articles:<br>• How Community Clergy Provide Spiritual Care: Toward a Conceptual Framework for Clergy End-of-Life Education. LeBaron, Baboni, et.al. 2016.<br>• Care of the Human Spirit and the Role of Dignity Therapy: A Systematic Review of Dignity Therapy Research. Fitchett, et.al. 2015.<br>• Meaning, Relational Mediation and the Facilitation of "Momentary Glimpses" Micklewright. 2016.<br>• Amen in Challenging Conversations: Bridging the Gaps between Faith, Hope, and Medicine. Cooper, et.al. 2014.<br>• Conflict at the End of Life. Ian Anderson Continuing Education Program in End of Life Care. 2001.<br>• Predictors of Family Conflict at the End of Life: The Experiences of Spouses and Adult Children of Persons with Lung Cancer. Kramer B, Kavanaugh M, et.al. 2010. |
| **9** | **Spiritual Distress and Pain**<br>• Guidelines in Oncology Distress Management<br>• Groves' Model of Spiritual Pain<br>• Spiritual Distress Tool (SDAT) | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion |

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| | • Cultural Components of Pain<br>• Ferrell and Coyle: "Non-Religious Questions"<br>• Goals of Care Family Meeting | Video:<br>• Discussing Goals of Care: Divergent Family Views. Pallium Canada. 2012.<br><br>Articles:<br>• NCCN Guidelines for Distress Management. National Comprehensive Cancer Network. 2015.<br>• The Spiritual Distress Assessment Tool: an instrument to assess spiritual distress in hospitalized elderly persons. Monod S, Rochat E. et.al 2010.<br>• Lisa Bonchek Adams. Writings on Metastatic Breast Cancer, Grief and Loss, Life, and Family. Blog. Web. 2015.<br>• Summer Camp and Update. Lisa Bonchek Adams. July 9, 2014.<br>• Spirituality in Goals of Care: 10 Stages and Tools for Goals of Care Conversations. Supportive Care Coalition. 2007.<br>• Validation of the Spiritual Distress Assessment Tool in older hospitalized patients. Monod S, Rochat E. et.al. 2010. |
| **10** | **Advance Care Planning**<br>• Talking about Death and Dying<br>• Definitions in Advance Care Planning<br>• Hesitancy in Having the Discussion<br>• Spiritual Care and Advance Directives<br>• History and Definitions of Hospice and Palliative Care<br>• The Palliative Care Team<br>• What Hospice Is | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br><br>Videos:<br>• Why Dying Matters to Me. Dying Matters. 2016.<br>• What Five Questions Can Save your Life or End It. Alexandra Drane. TEDMed. 2010.<br>• Palliative Care Myths. Pallium Canada. 2015<br>• Palliative Care: Improving Quality of Life for People with Serious Illnesses. RevDebSeattle. 2010.<br>• Hospice Basics Videos Series National Hospice and Palliative Care Organization. 2010.<br>• An Interview with a Hospice Chaplain. Community HCH. 2011.<br>• A Lesson in Dying: A Nurse with Cancer Offers Herself as an Instruction in Caring. The New York Times. 2013<br><br>Articles:<br>• *Palliative Care: What You Should Know.* Center to Advance Palliative Care. 2012.<br>• *Members of the Palliative Care Team and their Roles.* Edmonton Zone Palliative Care Program. 2016<br>• As Nurse Lay Dying, Offering Herself as Instruction in Caring Goodnough A. New York Times. 2013. |
| **11** | **Care After Death**<br>• Body Care<br>• Family Care<br>• Follow Up<br><br>**Post-Test** | 1. Review material, required articles and videos, and submit assignments.<br>2. Case study and/or group discussion<br>3. Course post-test.<br><br>Video:<br>• Mother Sings a Precious Song. SykoPlayz. 2013.<br>• What Really Matters at the End of Life. B.J. Miller. Zen Hospice Project. TED. 2015. |
| **12** | **Unit Final Evaluation** | 1. Review material, required articles and videos, and submit assignments.<br>2. Final unit self-evaluation |

*This unit schedule is subject to change at the discretion of the CPE Supervisor.*