JOURNAL OF PALLIATIVE MEDICINE
Volume 13, Number 7, 2010

DOI: 10.1089/jpm.2009.0429

# The Competencies Required by Professional Hospice Palliative Care Spiritual Care Providers

Dan Cooper, B.A., MDiv,[1] Michael Aherne, M.Ed., C.M.C.,[2] and José Pereira, MBChB, D.A., CCFP, M.S.,[3,4]
on behalf of The Pallium Spiritual Care Providers DACUM Group

## Abstract

The Canadian Hospice Palliative Care Association (2002) identifies spiritual care of the dying and their families as a core service for Hospice Palliative Care programs. Yet, until the Spiritual Care Development Initiative of the Canadian Pallium Project, there was no published literature indicating systematic profiling of occupationally relevant core competencies or competency-based training programs specific to this specialized field of practice. This article describes a Canadian Community of Practice process to develop an occupational analysis-based competency profile for the Professional Hospice Palliative Care Spiritual Care Provider utilizing a modified Developing a Curriculum (DACUM) methodology. Competency profiles are important contributions to the development of curricula to train care providers who are recognized by other professions and by institutions as possessing the requisite theoretical and clinical expertise, particularly in academic tertiary care settings.

## Introduction

Persons functioning in Hospice Palliative Care (HPC) specialist spiritual care roles in Canada are drawn from a diversity of mandates, academic qualifications, and training backgrounds. Some possess advanced degrees, significant clinical training, and professional association certifications, while others possess fewer qualifications or credentials. Some have a faith-based mandate to provide care (e.g., ministers, priests, rabbis, imams, persons in religious orders, or religiously authorized lay persons), while others may be multifaith counselors. Some HPC programs have in-house spiritual care providers, while others outsource that care to religious or spiritual care providers in their communities.

The evident lack of standardization with respect to clinical and academic preparation and licensure for this work is a concern. It is argued that working in specialist HPC teams and units requires specialized knowledge and skills. In the context of HPC programs with academic missions, spiritual care providers may require similar academic orientations as their colleagues from other professions to function optimally within academic interprofessional teams.

Cooper has observed that, in Canada, spiritual care in healthcare appears to be an emerging health profession.[1,2] Much foundational work remains undone in terms of clearly stating a scope of practice for the discipline, elucidating its theory base and distinctive methods, and developing national and provincial structures for certification and regulation. At the present time in Canada, spiritual care (and pastoral counseling) is recognized as a self-regulated health-care profession only in the Province of Ontario, through inclusion in the *College of Psychotherapists and Registered Mental Health Therapists*.[3]

[1]Regina Qu'Appelle Health Region, and Pallium Project Consultant for Spiritual Care Development, Regina, Saskatchewan, Canada.
[2]Initiative Development, The Canadian Pallium Project, Edmonton, Alberta, Canada.
[3]The Canadian Pallium Project, Canada.
[4]Division of Palliative Care, University of Ottawa and Bruyère Continuing Care, Ottawa, Canada.
The Pallium Spiritual Care Providers DACUM Group: Dan Cooper, M.Div.; Carol Barwick, B.A.; Catherine Cornutt, D.Min.; Mary E. Dodge Bovaird, M.Div.; Glen Horst, D.Min.; Marc Pepper, B.Th., M.Div. (IP); Rhea Plouffe, M.Div.; Zinia Pritchard, M.A., D.Min. (IP); Shane Sinclair, Ph.D. (Cand); Jan Temple-Jones, M.Div.; Jeremy Wex, D.P.S., M.T.S.
Accepted February 22, 2010.

The Canadian Association for Pastoral Practice and Education (CAPPE) is a multifaith spiritual and religious care organization offering nationally accredited 400-hour clinical training units at Basic, Advanced, and Supervisory levels.[4,*] Students are trained, over multiple units, to provide or facilitate individually appropriate spiritual care or counseling across a range of faith, religious, and spiritual orientations. They may then go on to certify as Specialists and Teaching Supervisors in *Pastoral Care* and/or *Pastoral Counseling*. CAPPE members and students adhere to a Code of Ethics (revised 2009)[5] and Standards of Practice (2004).[6] These documents are in agreement with those of the *Spiritual Care Collaborative* which includes five other leading spiritual care professional associations in the United States.[7] Although CAPPE training and certification may offer a gold standard for providing spiritual care in Canadian health institutions, institutions are currently under no legal requirement to employ CAPPE-trained or -certified members; the exception being in Quebec where a minimum of one Basic unit of CAPPE accredited training is required.[8] While CAPPE's programs provide foundational training in the knowledge, skills, and attitudes requisite for spiritual care in general, they may or may not include significant exposure to HPC-specific concepts or related clinical experience.

The World Health Organization has long endorsed a competency-based approach to education for the health professions.[9] It is suggested that curriculum ought to be based on the competencies required to function optimally in a particular role. As proposed by Epstein and Hundert,[10] professional competencies are sets of cognitive, affective, and psychomotor functions that support the "*habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice*" (italics theirs). Cheetham and Chivers[11] further define competency as the "*overall, effective performance* within an occupation which may range from the basic level of proficiency through to the highest levels of excellence" (italics theirs). Numerous factors influence competencies, including self-awareness, compassion, scientific and humanistic judgment, and practice setting. Competencies should link to local social, political, and economic circumstances, health needs, availability of resources, and the structure of the local health-care system. Educational interventions should describe in detail what specific competencies learners will attain.

With these concerns in mind, and to enhance system capacity to provide access to high quality spiritual care of the dying and their families, the Canadian Pallium Project (Phase II), launched the HPC Spiritual Care Development Initiative (2004–2006). The goals of the Initiative were twofold: from its early western Canadian foundation, to catalyze a pan-Canadian discussion on the emerging training needs of HPC spiritual care providers and to generate related professional development resources. This activity coincided with an emerging literature and evidence base in the area of spiritual care in HPC.[12]

This paper further describes the process and results of identifying and codifying the competencies required by these spiritual care providers in providing spiritual and religious care in HPC programs.

## Methods

### Preliminary environmental scan

The Project Team conducted a preliminary informal analysis of the status of HPC spiritual care development in Canada. This included conversations with spiritual care providers, leaders, and educators in western Canada. A formal occupational analysis of the competencies required for the HPC role had, to our knowledge, never been completed in Canada and there appeared to be no existing peer-reviewed, content-specific core curriculum for continuing professional development of spiritual care providers specifically in HPC.

In 2004, the Pallium Project in 2004 appointed a Consultant (DC) to advance the role of spiritual care in HPC. The Consultant was a certified member of CAPPE with extensive clinical experience in HPC and a profile of national leadership as Chair of the Canadian Hospice Palliative Care Association's (CHPCA) Spiritual Advisors Interest Group.

### Forming a community of practice

As suggested by Wenger's analysis of the ways professional communities create and share knowledge,[13] 12 members of CAPPE from across Canada who provided spiritual care in HPC clinical settings and who were considered by their peers as leaders in the field were engaged as a *Community of Practice*. This Collegial Development and Peer Review Group (CDPRG), represented the range of academic qualifications, professional certifications, religious diversity, and clinical practice found in the Canadian HPC context. The developing process was discussed with key stakeholder organizations, including CAPPE, the CHPCA, and the Health Canada Secretariat on Palliative and End of life Care. These organizations became corresponding members of the group.

The CDPRG, through a series of teleconferences, engaged in a process of reflection upon the major documents emerging from Canada and the United States in the previous 5 years on the subject of standards of practice for HPC and for spiritual care generally,[14,15] as well as upon the implications for practice contained in the CHPCA *Model* (2002) document.[16]

This process led to the conclusion that a core curricular resource was needed for clinical education focused in an HPC context. The Developing a Curriculum (DACUM) method was selected as a suitably rigorous competency-based approach to curriculum design and development.

### The DACUM approach to occupational analysis

DACUM was first conceived in the United States and Canada during the 1960s as a means of designing and developing curricula that would be relevant to the training of persons for the work place.[17,18] Workplace-focused education asks, *what needs to be done, at what level of skill, and what theoretical knowledge, practical skills and personal attitudes or attributes need to be acquired in order to equip a person to perform at that level?* Finally, *how does one know that the desired competencies have been obtained?* The DACUM method has been utilized extensively in industry, the military, government, and a wide range of professions to develop workplace-relevant training programs.

*CAPPE/ACPEP has an affiliated partnership with its Québec peer: Association des Intervenantes et des Intervenants en Soins Spirituels du Québec (AIISSQ).

DACUM charts permit a ready appreciation of major areas of responsibility and related major tasks for any role. They can be utilized as the basis for the development of curricula and learning resources, skills certification, the writing of formal job descriptions and workplace performance evaluation.

The strength of the DACUM method is its focus on the work environment, and upon the expertise of the skilled worker as the most important source for what needs to be learned and what the component tasks of the job are. The process usually begins with a 2- to 5-day focus group workshop involving qualified practitioners, experts, and leaders in the field. Through a process of negotiation and consensus the role is defined and then analyzed into a comprehensive list of its major responsibilities and related major tasks (broad competencies). This process produces an *occupational profile* or *DACUM Chart*. Each DACUM workshop participant is provided with a subsequent opportunity to review the results and write a differing opinion or afterthoughts, which are recorded in the final document.

From the outset we anticipated that the process would be challenging, given the diverse and idiosyncratic nature of spiritual care. We also anticipated that this dialogue would yield significant areas of agreement and a sense of professional community. In January 2005, 11 members of the CDPRG met in Calgary, Alberta (Canada) to complete a 2-day and one evening DACUM Workshop. The workshop was facilitated by trained DACUM facilitators (Wilson Associates—Education Consultants, Inc.). The goal was to establish the normative Scope of Practice, Major Areas of Responsibility, and Related Major Tasks for the role. As a first step, the group agreed to name the role *The Professional Hospice Palliative Care Spiritual Care Provider*.

## Results

### The DACUM workshop and chart

The group activity began by agreeing on a broad Scope of Practice Statement: *"The Professional HPC Spiritual Care Provider practices the art of skilled spiritual companionship, entering into the lives of the suffering and dying."* This was followed by the development a consensus-derived DACUM chart that identified 14 *Major Areas of Responsibility* and 81 *Major Tasks* (Table 1). The major areas were arranged in order of relative importance as perceived by the group. In addition, the group identified characteristics desirable for professional HPC Spiritual Care Providers, as well as broad knowledge and skills that these professionals should possess (Table 2). These supplementary lists emerged as the discussions proceeded and are not exhaustive.

A substantial degree of consensus emerged, allowing the chart to be developed. Some participants expressed surprise that the role contained so many distinct aspects when considered across the range of practice contexts and workplace.

Two areas were particularly controversial. A substantial discussion was generated around whether or not to include the phrase "with therapeutic intent" in the scope statement about the provision of spiritual companionship. The consensus reached was to define the role and not to limit the intent of the action. This seemingly small point was important in terms of recognition that, for spiritual care providers, persons are encountered *as persons* (in and of their own right and for purposes of their own) and not for any ostensible purpose of the caregiver.

The other area of controversy related to the role of assessing spiritual needs ("Major Responsibility A" in Table 1). In health care, the term *assessment* is widely used to describe the process whereby a professional takes a history and forms an opinion about the resources and needs of clients as the basis for communicating with the team and devising a plan of care. After considerable reflection it was agreed that the Spiritual Care Provider's approach needed to be one of *discerning*, in the sense of developing intimacy and being spiritually sensitive to the other.

The first stage of evaluation of the competency profile occurred in the weeks following the workshop during which participants reflected on the workshop experience, validating the results and suggesting alternatives. Of the 11 DACUM workshop key informants, nine completed a review of the final work product. Of these, eight confirmed that the document was consistent with their insights shared during the DACUM process and agreed to a large degree with its contents. One participant felt that tasks B12, E4 and E5 would need to contain "spiritual and religious". This informant also noted that C5 should contain the language "rites and rituals" to be consistent with the group's discussions. The need to include the language of "spiritual and religious" was identified by two other participants, particularly for the G2 task. One observed:

> *"It seems that our role as 'religious' care providers has been gravely overlooked. I know we decided to call ourselves . . . spiritual care providers for many reasons but that does not mean that we are . . . divorcing ourselves of our religious obligations."*

Another participant expressed the concern that the Chart did not really capture who the spiritual care provider *is*.

> *"I think what is missing is who we are as rooted in ministry. DACUM is a valuable exercise in detailing and distilling our function as chaplains. However, what we do and why we do what we do is rooted in our way of being . . . . What I meant is that I did not feel that we, as a whole, gave enough credence to the religious nature of our identity, roots and mission. Why, in other words, are we chaplains doing this and not psychologists? What makes us different from physicians who can adopt these practices or social workers? I believe the answer is an ontological one; it lies in Who we are rather than what we do . . . ".*

### Follow-up to the workshop

The competency profile was presented to the Education Standards Commission of CAPPE. Interest was expressed in the document as a possible starting point for a broader strategy aimed at developing competencies for spiritual care as a discipline. It has been posted on CAPPE's website in their curriculum development section.[19] Overall, the response within CAPPE to the DACUM process and its product was of such a positive nature that the organization convened a workshop in 2006 to develop a competency profile for one of its four current certifications—*The Certified Spiritual Care Professional – Specialist (Pastoral Care*). These two documents were then analyzed for similar and unique elements and, together with emerging counseling competency lists from the Provinces of British Columbia and Ontario, were presented to the membership of CAPPE in 2008 in a National Validation of Competencies Survey utilizing a web-based modified Delphi

Table 1. DACUM Chart of the Scope of Responsibilities of the Professional Hospice Palliative Care Spiritual Care Provider (Copyright © 2005 The Pallium Project—Used With Permission)

**Major Area of Responsibility and Major Task**

**A** Discern, identify & understand spiritual & religious history, resources and care needs
- **A-01** Respect patient's choice to accept or decline spiritual or religious care
- **A-02** Establish rapport
- **A-03** Gather information relevant to spiritual/religious history
- **A-04** Explore spiritual orientation
- **A-05** Determine patient's goals and expectations of spiritual care
- **A-06** Document and revise a spiritual care plan

**B** Provide appropriate, culturally sensitive spiritual care
- **B-01** Be compassionately present
- **B-02** Adapt presence and communication in ways that are appropriate to patient's health status
- **B-03** Create a safe place that holds the whole person
- **B-04** Establish the therapeutic relationship
- **B-05** Engage with patients in their experience of suffering
- **B-06** Listen for the meaning, emotion, intention behind the words and reflect back to the speaker for clarification/verification
- **B-07** Listen for that which is sacred to the patient
- **B-08** Nurture inner spiritual resources for well-being
- **B-09** Journey with patients and their family members
- **B-10** Help patients and families to explore their perceptions of death and dying as and if appropriate
- **B-11** Honor, include and engage symbols, prayer, meditation and other practices that are meaningful to the patient
- **B-12** Protect patient and family from inappropriate or unwanted spiritual intervention
- **B-13** Seek to enhance quality of living and dying as defined by the individual
- **B-14** Design appropriate ceremonies

**C** Provide for appropriate religious care
- **C-01** Explore images of God and the sacred as they inform the experience of illness and dying
- **C-02** Discuss conflicts experienced between beliefs and illness
- **C-03** Invite use of symbols, artifacts, writings, music and art that are sacred to the patient and family
- **C-04** Liaise with community, spiritual and religious representatives
- **C-05** Facilitate provision of religious rites as appropriate to patients health status
- **C-06** Monitor and address issues of religious abuse

**D** Provide spiritual counselling
- **D-01** Create an accepting supportive environment to hold spiritual struggles and dark emotions
- **D-02** Provide crisis counselling
- **D-03** Facilitate the interpretation of experience and existence
- **D-04** Ameliorate suffering as appropriate and possible
- **D-05** Facilitate reconciliation
- **D-06** Facilitate support groups

**E** Collaborate as a member of interdisciplinary team
- **E-01** Integrate spiritual care within clinical case management
- **E-02** Help team to articulate values
- **E-03** Interpret and explore cultural taboos and ambiguities around death and dying
- **E-04** Document spiritual care activities in the patient's health record
- **E-05** Express spiritual needs and resources of patient to the team
- **E-06** Participate in inter-disciplinary rounds
- **E-07** Make/receive referrals/consults in a timely manner
- **E-08** Facilitate advance care planning

**F** Provide leadership in ethical decision making
- **F-01** Participate in ethical decision making process
- **F-02** Educate, encourage and support ethical decision making at end of life
- **F-03** Assist patient's and family's decision making in choosing to obtain, accept or decline medical treatment
- **F-04** Mediate conflictual requests for rituals and other end of life care
- **F-05** Provide support for organ/tissue donation situations
- **F-06** Encourage open/conciliatory responses to error

**G** Advocate on behalf of patient and family
- **G-01** Identify patient's primary needs in order to ascertain and engage appropriate resources
- **G-02** Advocate for appropriate spiritual care
- **G-03** Advocate on behalf of the patient to obtain medical treatment

**H** Provide grief and bereavement care
- **H-01** Facilitate/provide bereavement support services
- **H-02** Facilitate memorial services for individual patients
- **H-03** Provide for group memorial services

(*continued*)

Table 1. (Continued)

**I** Facilitate functional relationships
- **I-01** Use role/authority respectfully/effectively/appropriately
- **I-02** Assist with conflict management
- **I-03** Cultivate relationship between organization/community
- **I-04** Nurture team spirituality

**J** Provide support to staff
- **J-01** Make self available
- **J-02** Facilitate formal and informal activities that promote positive working relationships
- **J-03** Provide for examination of conscience
- **J-04** Join in debriefing activities
- **J-05** Provide counselling

**K** Nurture the organizational soul
- **K-01** Recognize symbolic significance of role
- **K-02** Create a safe, hospitable space
- **K-03** Call upon the organization to act with dignity and respect regarding the spiritual values and worth inherent in each person
- **K-04** Equip and encourage other team members to provide appropriate spiritual care
- **K-05** Participate in designing and conducting corporate memorial observances

**L** Provide education and engage in research
- **L-01** Design/deliver learning & development opportunities
- **L-02** Educate others on diverse spiritual care and cultural expressions
- **L-03** Undertake supervisor/mentorship roles for learners
- **L-04** Write for publication
- **L-05** Participate in and conduct research

**M** Perform administrative duties
- **M-01** Ensure a religious care referral system is in place
- **M-02** Develop policies, procedures, protocols as required
- **M-03** Evaluate, improve and develop services
- **M-04** Contribute to development of spiritual care provision
- **M-05** Participate in appropriate committees
- **M-06** Perform administrative/management duties as required

**N** Commit to personal and professional integration
- **N-01** Practice self care
- **N-02** Discover and recreate self as an instrument of spiritual care
- **N-03** Engage in reflective practice
- **N-04** Practice within a code of ethics and standards of practice

approach.[20] The result was that all competency areas were validated except for the "research" area, which did not meet the 66% support threshold required for validation. This suggests that, at the present time, the majority of CAPPE members are unsure about their mandate regarding research.

The DACUM chart has subsequently been used as a primary datum for development of a collaboratively researched and written *curricular resource* package specific for HPC.[21] It has also been used to revise position descriptions for Chaplains serving HPC clients in a faith-based health organization in Edmonton, Alberta. The Chart has been translated into French.

## Discussion

The Competency Chart is a living document that is open to further dialogue and development. The authors suggest that it be viewed as *normative*, rather than prescriptive. It should catalyze discussion about what HPC spiritual care providers need to be able to do well in practice. It serves to orientate new practitioners to the field and to identify areas for their future professional development. It provides employers with a framework for what they can expect from spiritual care providers. Importantly, the scope and complexity of the competency areas identified validate the role of spiritual care providers as fully fledged members of an academic HPC service. Credibility is added to the role as is recognition that it requires appropriate academic formation and clinical training.

Achieving full consensus in some key areas may be difficult. While the document may not sufficiently describe the identity of the professional spiritual care provider, it does speak strongly to role responsibilities and tasks. While the former issue is of great interest to spiritual care providers, the latter issue is of high relevance to the healthcare workplace. The DACUM Chart provides a starting point for discussion and development of curricula to address learning specific to HPC. It identifies areas where consensus is possible but allows room for the expression of dissenting views.

The Pallium Project's *Spiritual Care Development Initiative* represents a promising early development that may lead to the standardization of clinical training for Canadian HPC spiritual care professionals. Its wider impact on the emergence of a more competency-based discipline of spiritual care in health care has already been noted. The Community of Practice process used to develop the occupational analysis profile and the ensuing curricular resource has moved the field forward, not only in the west but across Canada. The process allowed participants to develop a common language and definitions regarding their role, and to lay a foundation in

Table 2. Examples of Characteristics, Broad Knowledge, and Skills Required of a Professional Hospice Palliative Care Spiritual Care Provider

| | |
|---|---|
| **Characteristics** | ◦ Sensitivity<br>◦ Sensibility to a range of circumstances, family contexts and traditions and how those interact in complex end-of-life care situations<br>◦ Compassionate<br>◦ Covenant-based presence *(* During document review two informants expressed concern that this is open to challenges about meaning and may be poorly understood)*<br>◦ Non-judgmental<br>◦ Reflective practitioner<br>◦ Ability to contain/tolerate ambiguity<br>◦ Tolerance for sadness<br>◦ Courage for moving into the suffering of others<br>◦ Humility—no easy answers/quick solutions—mutual search for meaning<br>◦ Trust that meaning within chaos/suffering exists *(* During document review one informant expressed concern that this may not be universally applicable)* |
| **Broad Knowledge** | ◦ Range of religious traditions and rituals/rites<br>◦ Flags for a range of "abuse" circumstances/history<br>◦ Major non-western cultural considerations/"Flags" in your catchment (e.g., taboos, ambiguities)<br>◦ Bioethical decision frameworks<br>◦ Grief and bereavement theory and practices<br>◦ Family dynamics theory<br>◦ Self-care strategies<br>◦ Conflict management theory and practices<br>◦ Service and program development models and practices<br>◦ Organizational dynamics in large health care environments<br>◦ Constructs of "being" "hope" "suffering" and "redemption"<br>◦ Assessment/protocols appropriate to spiritual care |
| **Broad Skills** | ◦ Leadership in ethical decision making<br>◦ Patient advocacy and "interests" representation<br>◦ Mediation<br>◦ "Boundary" management in personal, family and inter-professional/provider relations<br>◦ Generic negotiation skills<br>◦ Active listening and restating/rephrasing for confirmation of understanding<br>◦ Empathetic listening<br>◦ Asking open questions to invite open responses for building understanding<br>◦ Generic counseling skills applied to several different circumstances<br>◦ Coordination—of people, resources within different care settings<br>◦ Team work and team building<br>◦ Effective teaching-learning strategies and methods<br>◦ Brokering of diverse interests<br>◦ Generic crisis intervention skills applied to a variety of contexts<br>◦ Modeling humanistic and compassionate behaviour<br>◦ Consultative skills |

the curricular resource for the development of an integrated body of theory and practice relevant to the profession.

## Conclusions

The collaborative development process supported by the Spiritual Care Development Initiative of the Canadian Pallium Project provided a first opportunity for persons working in specialized HPC spiritual care contexts to engage in generative professional development activities. The resulting DACUM workshop and occupational profile for *The Professional Hospice Palliative Care Spiritual Care Provide*r (©2005 The Pallium Project) has provided a formal contribution to the growing international discussion about the professional role responsibilities and tasks of spiritual care providers working within an HPC environment. The competency profile may be of benefit for spiritual care providers intending to work in HPC, their employers, and certifying bodies and in the production of curriculum for clinical training purposes. Future project endeavors may include formal study of the utility of the profile for learning and workplace evaluations.

## Acknowledgment

Funding for the Pallium Project was received from the Government of Canada, Health Canada–Primary Health Care Transition Fund (National Envelope). The occupational profile for the *Professional Hospice Palliative Care Spiritual Care Provider* is available online at the CAPPE/ACPEP website and the related curricular resource, Developing Spiritual Care Capacity for Hospice Palliative Care (version 1.0), is available online at the *CHPCA Marketplace*.

## Author Disclosure Statement

The authors have no personal financial interest in the occupational profile or curricular resource described in this article. No competing financial interests exist.

## References


1. Dower C, O'Neil EH, Hough HJ: Profiling the Professions: A Model for Evaluating Emerging Health Professions. San Francisco: Centre for the Health Professions, University of California; 2001.
2. Cooper D: Where is CAPPE/ACPEP heading? Documenting the journey and debating the issues in the development of a profession of spiritual care. In: O'Connor TSt.J, Lashmar C, Meakes E (eds), The Spiritual Care Giver's Guide: Transforming the Honeymoon in Spiritual Care and Therapy. Waterloo, Ontario: Waterloo Lutheran Seminary and CAPPESWONT; 2008:63–77.
3. Legislative Assembly of Ontario: Bill 171, Health Systems Improvements Act, 2007. Chapter Number: S.O. 2007 C.10 of the Statutes of Ontario. http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=519. (Last accessed June 26, 2009).
4. CAPPE/ACPEP: http://www.cappe.org/index.html. (Last accessed June 26, 2009).
5. CAPPE/ACPEP: Code of Ethics for Chaplains, Pastoral Counselors, Pastors, Pastoral Educators and Students. http://www.cappe.org/resources/code_of_ethics/code%202009.DOC. (Last accessed June 26, 2009).
6. CAPPE/ACPEP: Standards of Practice. http://www.cappe.org/resources/common_standards/common_standards.html. (Last accessed June 26, 2009)
7. Spiritual Care Collaborative: http://www.spiritualcarecollaborative.org/standards.asp. (Last accessed June 26, 2009).
8. Province du Québec: *Protocole d'entente entre le ministère de la santé et des services sociaux et les autorités religieuses concernant les services de pastorale des établissements de santé et de services sociaux*. http://www.aiissq.org/francais/documents/Protocole_dentente.pdf. (Last accessed June 26, 2009).
9. McGaghie WC, Miller GE, Sajid AW, Telder TV, Lipson L: Competency-Based Curriculum Development in Medical Education: An Introduction. WHO Public Health Paper No. 68. Geneva, Switzerland: World Health Organization; 1978.
10. Epstein RM, Hundert EM: Defining and assessing professional competence. JAMA 2002;287:226–235.
11. Cheetham G, Chivers GE: Professions, Competence and Informal Learning. Cheltenham, UK: Edward Elgar Publishing; 2005.
12. Van de Creek L, Burton L (eds): Professional chaplaincy: Its role and importance in healthcare. Halifax, Nova Scotia: Canadian Association for Pastoral Practice and Education, et al.; 2001. http://www.cappe.org/publications/whitepaper/index.html. (Last accessed June 26, 2009).
13. Wenger, E: Communities of practice: Learning as a social system. Systems Thinker 1998;9(5):1–11.
14. National Hospice Palliative Care Association: Guidelines for Spiritual Care in Hospice. Professional Development and Resource Series (order # 820015). http://iweb.nhpco.org/iweb/Purchase/ProductDetail.aspx?Product_code=820015. (Last accessed June 26, 2009).
15. The Catholic Health Alliance of Canada, The Canadian Association of Pastoral Practice and Education: Standards of Spiritual and Religious Care for Health Services in Canada. http://www.chac.ca/resources/index.php#standards. (Last accessed June 26, 2009).
16. Ferris FD, Balfour HM, Bowen K, Farley J, Hardwick M, Lamontagne C, Lundy M, Syme A, West PJ: A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. http://www.market-marche.chpca.net/chpca/marketplace.nsf/prodnum/0605ECD!opendocument&language=English. (Last accessed June 26, 2009).
17. DACUM handbook, 2e. Norton RE. Columbus, Ohio: Centre on Education and Training for Employment, College of Education, Ohio State University; 1997.
18. Norton RE. Quality Instruction for the High Performance Workplace: DACUM. Education Resources Information Centre (ERIC # ED419155). http://eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/15/71/4f.pdf. (Last accessed June 26, 2009).
19. CAPPE/ACPEP: Curriculum Development—DACUM Project. http://www.cappe.org/dacum/index.html. (Last accessed June 26, 2009).
20. CAPPE/ACPEP: Provincial College & Provincial Association Development page. http://www.cappe.org/comp_survey/index.html. (Last accessed June 26, 2009).
21. Cooper D, Temple-Jones J, and Associates. Developing Spiritual Care Capacity for Hospice Palliative Care: A Canadian Curricular Resource (Version 1.0); Edmonton: The Pallium Project. www.chpca.net\marketplace\index.htm. (Last accessed June 26, 2009).



Address correspondence to:
*Dan Cooper, B.A., MDiv*
*Palliative Care Services*
*Regina Qu'Appelle Health Region*
*4101 Dewdney Avenue*
*Regina, SK S4T 1A5*
*Canada*

*E-mail:* Dan.Cooper@rqhealth.ca