What Are We Doing Here? *Chaplains in Contemporary Health Care*

BY MARTHA R. JACOBS

It can be really hard—or really easy—to explain what I do for a living. Chaplains share academic training with clergy, but we complete clinical residencies and work in health care organizations. Our affinities are with the patient and family, but we may also chair the ethics committee or serve on the institutional review board, and we spend a lot of time with staff. We must demonstrate a relationship with an established religious tradition (in my case, United Church of Christ), but we serve patients of all faiths, and of no faith, and seek to protect patients against proselytizing. We provide something that may be called "pastoral" care, "spiritual" care, or just "chaplaincy"—but even among ourselves, we do not always agree about what that thing is.

There are many, many definitions of "spiritual care" in the context of health care.[1] They all tend to have something to do with transcendence: how the suffering individual grapples with issues of identity, meaning, and purpose. They may or may not be expressed in terms of religion or culture. While any caregiver can tend to the spiritual needs of a suffering person, the chaplain is the health care professional expert in providing spiritual care.[2]

Chaplains do what needs to be done, in the setting in which they find themselves, to ensure that care is focused on the emotional and spiritual needs of the patient and the patient's family, particularly in times of suffering, stress, or grief. When I worked as the solo chaplain in a community hospital, I was paged to the emergency room for codes. If the patient did not survive, I would help the nurses clean the body—and also the room—as part of caring for the grieving family, who were about to come in and say their goodbyes. I had learned from experience to see this scene through their eyes: Had we treated their loved one with respect? Had we tried hard enough? In that job, I also became experienced at translating the signs and symptoms of imminent death for families sitting by the bedside: What is happening to the body as the organs are shutting down? What do those lines and numbers on the monitor mean? Why does the breathing sound like that? Nurses and physicians know these things without having to think about them; the chaplain is often the one who observes what the family does not know, and who offers comfort by explaining what can be explained.

And sometimes, we sit with the patient and family and say nothing. Our presence seems to comfort them, and remind them that they are neither alone nor forgotten during this most difficult time.

Sometimes, too, chaplains do what needs to be done simply by showing up, hanging around, and making time for staff. Sitting with staff, even joking with them, may help them defuse and debrief after a difficult clinical situation. A chaplain tends to know if a particular death—an unexpected death, or the death of a well-liked patient—was a hard death for a team, and will check in with them. Sometimes the staff members for whom chaplains make time are senior administrators, who rely on chaplains to help them keep the patient, and the family, and the staff, and the community in mind, lest any be forgotten in the ever-tightening reimbursement market. In my community hospital, our CEO had me sit in on

Martha R. Jacobs, "What Are We Doing Here? Chaplains in Contemporary Health Care," *Hastings Center Report* 38, no. 6 (2008): 15-18.

all disclosures of medical errors: as he put it, my presence in the room was a reminder that the institution took the patient's and family's suffering seriously. Among ourselves, chaplains may consider this a part of our "prophetic" role, although it is a role we do not always claim for ourselves.

There was a time when chaplains got their jobs by default because they could not lead a congregation. This may say something about how religious denominations used to view the care of the sick: as a fall-back option, rather than as a vocation in its own right. Today, professional chaplains—like physicians, nurses, mental health professionals, and social workers—are called to care for the sick and the suffering: this is where we all want to be; this is our vocation. From the perspective of "religion," chaplaincy is a specialized form of ministry: our academic training is in seminary, and after receiving a masters-level graduate education, we complete at least 1,600 hours of supervised clinical pastoral education training in an accredited, hospital-based program and demonstrate our competency in twenty-nine different areas.[3] For example, we must have a working knowledge of the psychology and sociology of religion and be attentive to the diversity of culture, gender, sexual orientation, and spiritual and religious practice among patients and families.[4] We are also trained to assess patients' spiritual and religious resources and needs and to work with them on the specific issues and concerns that arise when a person is hospitalized. The goal of our specialized, hospital-based training is to prepare chaplains to work in "intense medical environments."[5] Very intense: professional chaplains typically work in end-of-life care, in the intensive care unit, and in trauma. The chaplain is the one staff member whose job description allows her to sit with a dying patient, or with a grieving family, *as long as needed*. The nurses and physicians may want to do this, but they have to move onto other patients, other families, other needs.

Sitting with a dying patient or a grieving family is not only intense: it is also time-intensive. If a hospital defines "quality" as "making the numbers"—that is, counting the number of visits—and a chaplain spends five hours with one family in the ER, as I did more than once during traumas, then the chaplain's numbers are not going to look good. And this is one of the challenges chaplaincy faces as it professionalizes: do we define quality as quantity, care as customer service? (That would make some administrators very happy.) Or do we claim that prophetic role, and use it to advocate for better health care? And can we make the case that better health care includes better care of the *whole* person, with attention to the role of religion and culture in a patient and family's ability to cope with illness? Can we make the case that better health care includes better care of the whole *staff* as well?

Like other health care professions, the structure of contemporary health care chaplaincy is shaped in part by the standards of the Joint Commission, which accredits and certifies more than fifteen thousand health care organizations and programs in the United States. To satisfy standards that recognize a patient's "right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected," and that require hospitals to accommodate patients' "right to pastoral and other spiritual services," hospitals may hire one or more professional chaplains, with the one-person department being the norm even in some large hospitals.[6] The Quality Commission of the Association of Professional Chaplains endorses a ratio of one chaplain for every fifty patients hospitalized for more than three days, one chaplain for every seventy-five patients with shorter stays, and one chaplain for every one hundred outpatients undergoing dialysis, chemotherapy, and other procedures.[7] However, these are not one-size-fits-all formulas, and hospitals of equivalent size serving similar populations may vary greatly in the size of their professional chaplaincy staffs. As the Joint Commission does not specify that their standards must be met by *professional* chaplains, some hospitals, especially in rural areas, may rely on an on-call list of local clergy, or they may employ a chaplain who has some pastoral care training but lacks board certification.[8] This is an acknowledged tension in our profession. While all chaplains are accustomed to working with local clergy, our colleagues in ministry are not usually accustomed to working in "intense medical environments," nor are they trained to care for patients from religious traditions other than their own. A chaplain who is not board-certified may also lack training in the care of diverse patient populations. We worry about practice variation just as other health care professionals do.

We also worry about job security. Most chaplaincy services are not reimbursed, so hospitals must choose to make the investment in us.[9] We tend to be a good return on investment. Press Ganey, a patient satisfaction survey used by approximately two thousand of the five thousand hospitals in the United States, reports that patient satisfaction with how well their emotional and spiritual needs were met highly correlates with their overall satisfaction.[10] However, this presents another tension: the patients that chaplains spend the most time with—dying patients—do not fill out patient satisfaction surveys. Therefore, we may not ever be graded on our best work. Are hospitals equally concerned about meeting the needs of their dying patients, as well as the needs of patients who recover? If so, there should be a better way to quantify what chaplains do for patients.

Quality in end-of-life care and quality in chaplaincy are intertwined: we are—or should be—the people in any hospital who are genuinely good at death and dying. The National Hospice and Palliative Care Organization's *Guidelines for Spiritual Care in Hospice* describes the hospice chaplain as "an integral member of the hospice team" in charge of "the spiritual plan of care" that will be carried out by team members in response to the needs of a patient and family.[11] Any patient may experience troubling questions as part of a serious illness or a major loss, whether that loss is a limb or a function (such as mobility, memory, or language). These questions may be expressed in religious or nonreligious terms. A patient of religious faith may ask, What is the point of this suffering? A patient with no religious faith may ask, How am I going to get through this? Sometimes, patients who do not have religious

faith nonetheless use religious language, as this language may be part of their culture. The chaplain helps the patient and family discuss the questions that matter most deeply to them and that may be essential for them to express candidly as they consider their treatment decisions, hopes, and fears.

What chaplains do is most needed and best used when a patient is dying, has a poor prognosis, or has suffered a life-altering loss. Terminally ill patients acknowledge a greater spiritual perspective and orientation than other patients, and spiritual care has been part of the hospice movement since St. Christopher's was founded by Dame Cicely Saunders in 1967.[12] As hospice has moved "upstream," with the recognition by the palliative care movement that the values of hospice also resonate with patients who are living with chronic, progressive conditions but are not end-stage, chaplaincy has moved with it. Many chaplains are now members of their hospitals' palliative care teams, helping the patients served by these teams grapple with the encroachment of disease or disability on life as they have known it.

Any caregiver can tend to the spiritual needs of the suffering, but a chaplain is the expert, helping the patient and the family discuss the questions that matter most deeply to them.

As chaplaincy has grown in professional training and stature, and as chaplains have grown into our own profession, we recognize that we need to standardize our practices, both in the interest of quality and so that we can negotiate with institutions over funding and deployment. The six major chaplaincy cognate groups—the American Association of Pastoral Counselors, the Association of Clinical Pastoral Education, the Association of Professional Chaplains, the Canadian Association for Pastoral Practice and Education, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains—have created common standards for certification and a common code of ethics, and are now working on practice standards. HealthCare Chaplaincy and other organizations in our field are working on developing better ways to define and measure "quality" in the settings in which chaplains work—long-term care facilities and hospices in addition to various types of hospitals.[13] Empirically minded chaplains have called on their colleagues to do more and better research into our patients' spiritual needs so that we can legitimately claim pastoral care as our area of expertise. These researchers remind us that "chaplains must decide what questions to ask and how to try to answer them."[14] If we believe—and we do—that the usual patient satisfaction tools have not adequately reflected our work, then we have a professional responsibility to develop tools that allow our contribution to health care quality improvement to be assessed accurately and thus give us a basis for further improvement. Compared to other health care professions, however, we do not undertake enough research, and we do not write and publish enough. As managing editor of *PlainViews*, an electronic newsletter read by more than 7,800 chaplains worldwide, I am continually urging my colleagues to put aside their reluctance to write about and claim what they do.

Part of the work of growing into a profession is bringing other professions into conversations. The essays that follow grew out of an October 2007 meeting at The Hastings Center that brought chaplains together with bioethicists, clinicians, and health services researchers to discuss the role of chaplaincy in efforts to improve health care. The set includes a sociological account of chaplaincy, a critical perspective on the ethical theories that may ground our practice, a call for chaplaincy to embrace patient-centered care as a concrete, interdisciplinary quality improvement goal, and a proposal for chaplaincy and clinical ethics to work together on QI. This essay set also includes a summary of a focus group study that asked chaplains something they had never been asked before: what *we* think about QI. May the dialogue continue.

1. See the "principles of spiritual care" in the National Hospice and Palliative Care Organization's *Guidelines for Spiritual Care in Hospice*, (Alexandria, Va.: National Hospice and Palliative Care Organization, 2001), 4.

2. Ibid., 5.

3. There are also long-term care, congregation-based, and prison-based CPE programs.

4. Common Standards for Professional Chaplaincy, http://professionalchaplains.org/uploadedFiles/pdf/common-standards-professional-chaplaincy.pdf, accessed July 19, 2007.

5. J.L. Gibbons and S.L. Miller, "An Image of Contemporary Hospital Chaplaincy," *Journal of Pastoral Care* 43, no. 4 (1989): 355-61.

6. Joint Commission on Accreditation of Healthcare Organizations, *Comprehensive Accreditation Manual for Hospitals: The Official Handbook* (Oak Brook, Ill.: Joint Commission Resources, 2005), standards RI2.10.2 and 2.10.4.

7. S.K. Wintz and G.F. Handzo, "Pastoral Care Staffing and Productivity: More than Ratios," *Chaplaincy Today* 21, no. 1 (2005): 4.

8. K.J. Flannelly, G.F. Handzo, and A.J. Weaver, "Factors Affecting Healthcare Chaplaincy and the Provision of Pastoral Care in the United States," *Journal of Pastoral Care and Counseling* 58, nos. 1-2 (2004): 127-30.

9. The Association of Clinical Pastoral Education establishes standards, certifies supervisors (faculty), and accredits programs for clinical pastoral education. The ACPE, Inc., is nationally recognized as an accrediting agency in the field of clinical pastoral education by the U.S.

Secretary of Education through the Department of Education. Such recognition enables the ACPE, Inc., and/or its programs and students to participate in federal programs such as the International Student Visitor Program, the veterans' educational benefits program, Medicare Pass-Through reimbursement funding, and in some cases the federal student loan deferment program. Recognition by the U.S. Department of Education requires regular and rigorous review of the agency and its standards and processes for accreditation.

10. P.A. Clark, M. Drain, and M.P. Malone, "Addressing Patients' Emotional and Spiritual Needs," *Joint Commission Journal on Quality and Safety* 29, no. 12 (2003): 662.

11. National Hospice and Palliative Care Organization, *Guidelines for Spiritual Care in Hospice*, 5.

12. T.P. Daaleman and L. VandeCreek, "Placing Religion and Spirituality in End-of-Life Care," *Journal of the American Medical Association* 284 (2000): 2515.

13. Other important centers of research on quality in pastoral care include the Department of Religion, Health and Human Values at Rush University Medical Center, the Department of Pastoral Care and Education of the University of Pennsylvania Health System, and the Department of Chaplain Services at the Mayo Clinic.

14. A.J. Weaver, K.J. Flannelly, and C. Liu, "Chaplaincy Research: Its Value, Its Quality and Its Future," *Journal of Health Care Chaplaincy* 14, no. 1 (2008): 16.