

## A Chaplaincy Fetter From America

### *Noel Brown*

As hospital chaplaincy in the United States prepares to enter the 21st century it is facing many challenges and opportunities. Some of them are old issues recast in new ways. Others are genuinely new in nature suggesting to me that chaplaincy has opportunities such as it has never had before. As you read what follows you will be struck by what appear to be contradictory descriptions. The reason for this is simple - chaplaincy in the US is highly variable. Some chaplains continue to function as they did half a century ago. Others are working to establish new paradigms for chaplaincy.

### Issues from the Recent Past

The decade of the 90's has seen major changes in the ways that health care is conceived and delivered in the US. These changes have been well-documented in both the popular and professional press - the calls for greater efficiency, the movement of the management of hospitals from the hands of physicians to trained administrators, the formation of health care delivery systems, managed care, advertising and open competition for patients ("clients" and "customers" no less!), not to mention dramatic advances in medical knowledge and practice.

One of the major issues for chaplains has been the realignment of funding priorities which in some hospitals has seen the number of chaplains decreased or chaplaincy services terminated completely, as happened to the State-funded chaplains in the State of Georgia. The anxiety about this issue has decreased somewhat during the past two years and, in general, chaplains are not fearing for the security of their positions as they were earlier in the decade. This could change, however, as future financial projections for health care look difficult for the years 2000-2001, especially in hospitals associated with medical schools.

### Issues of the Present

The issues of today are many and exciting, some of them holding great potential, I believe, for the future development of hospital chaplaincy, and with implications for the ministry of the wider Church.

### Implications for Research

#### *1. Researching the relationship between religion and health*

Over the last ten years there has been a growing scientific identification of the fundamental unitary nature of the human person. Theologically we clergy have long claimed that human personhood should be understood in a holistic way - the late Granger Westburg was talking and writing about this in the 1950s. However, it appears to me that for most chaplains this has been more of a theological tenet used to, in part, justify the place of chaplains in hospitals than a fact used to help clarify our functioning in the world of health care delivery. Now on the basis of new discoveries from within the medical world itself we have the opportunity to amplify our vision of our place in the world of health care delivery based on important insights from medical research.

The work of many persons, some of them religiously committed doctors, but also researchers who have no interest in religion per se has brought us to a place where it is only possible for persons blinded by prejudice not to acknowledge the clear positive relationship between religion and health. The entire issue of this Journal could be filled with citations from the medical literature concerning this relationship. A book such as Harold G. Koenig's *Is Religion Good for Your Health: The Effects of Religion on Physical and Mental Health* (Haworth Pastoral Press 1997) is a good place to start reviewing this literature. The bi-monthly publication I edit (The Orere Source, a bi-monthly compilation of summaries of recent pastoral care literature) is built on a database containing among others, abstracts describing over 500 articles from the medical literature dealing with the relationships between religion and health. It does need to be noted that as yet, how specifically this relationship "works" is not fully understood, and as chaplains we must be cautious and not over-claim based on what is known to date. But at the very least, it has to be acknowledged that effective chaplains represent a force on the side of health and healing, and not in some sentimental, magical or supernatural way. Historically, there have been various substantial reasons advanced for the importance of chaplaincy in health care. To those reasons must now be added this reason: that it is the realm of the chaplain to work with patients as

an agent of healing, physical, emotional and spiritual, based on medicine's own findings.

## *2. Researching chaplaincy practice*

As we begin to make our entry into a new millennium, we are becoming aware of and have started to use some of the research that both chaplains and others have done concerning chaplaincy practice itself that has implications for our future ministry. The work of two chaplains, Larry VandeCreek in New York, and George Fitchett in Chicago comes to mind.

Many hospital chaplains in the US continue to visit the patients with whom they feel most comfortable, or who make them feel the most welcome when they come to the bedside. But should this be the basis for deciding who has priority when a busy day means that it is not possible to spend equal time with everyone? Surely ethical ministry requires that we attempt to identify those patients who most need pastoral care? This would mean that chaplains could direct their energies towards those persons who are in the most spiritual need or distress rather than spending time in situations where the chaplain feels most comfortable or welcomed. This is an area of current research attention. Can we identify patients who are in religious or spiritual distress, and can the degree of that distress be quantified in any way? If it could, then chaplains could make informed decisions as to whom they will devote their time and energy.

There are chaplains who feel that such research efforts are ill-advised. Their reactions are well represented in a paper by Australian chaplain Allison Whitby in her response to George Fitchett's paper: "Spiritual risk and spiritual care." (Whitby 1998) Whitby starts by describing her initial reactions to Fitchett's concepts: "I experienced significant resistance..... I resented it.... I paced and fumed, chewing on my frustration...." But then she describes the situation of a patient in the hospital, an angry, difficult patient and in light of her reflections about that woman and the ministry that she had to be given, the chaplain decides:

A tool for early screening for such people, for those at spiritual risk, along with greater cooperation with other health care disciplines, I believe, would be a significant contribution to addressing these [the woman's] difficulties. (p.40)

If we can identify persons with specific and unmet spiritual needs, we will then be in a position to educate nurses and doctors who can then assist us in identifying sooner rather than later, the persons who might most benefit from our pastoral care. (I am not presupposing that such persons will wish to

receive care, only that identification should be followed by the offer of pastoral care, and not its imposition.)

There are other significant research findings concerning the practice of chaplaincy. A number of them are to be found in the work of Larry VandeCreek which was published in an issue of the *Journal of Health Care Chaplaincy*. (JHC 1997) Over 2000 patients in 33 hospitals in three countries - the US, Canada and New Zealand - were asked about the ministry that had been provided them by chaplains, and what they found helpful and what was not. The findings confirm some things we already knew, that the visits of chaplains are very appreciated, that prayer is the element of the chaplain's visit that is considered far and away as being most important and most helpful, that the spiritual sensitivity of the chaplain is a major strength. (We now have to discover exactly what people mean by this!)

On the other hand, there are some surprising findings:

- (a) The visit of the chaplain tends to scare older patients more than it does younger patients.
- (b) One or two visits are appreciated by patients, but additional visits seem to be even more appreciated.
- (c) Why did Canadian patients feel significantly more positively about their pastoral care than did US patients?
- (d) Why were the pastoral care visits by student chaplains rated more positively than the visits by experienced staff chaplains?

These were just a few of the findings that have raised yet more questions about our practice of pastoral care. The chaplaincy of the 21st century in the US will need to look at such findings and engage in some serious thinking about them. We will also need to do more research.

## *3. Researching pastoral style*

When I first became a hospital chaplain in the late 1960s, the chaplain's "style" of engagement with people shared many of the characteristics and paralleled the styles of parish clergy. The influence of Carl Roger's ideas reinforced a non-directive, supportive, waiting style when we first met new patients. It was a style that worked well until the advent of the era of managed care, when the relentless pressure to shorten hospital stay and the implementation of care plans meant that people who were to be hospitalized on a non-emergency basis came to our doors at 5:30 or 6:00 a.m. on the day of their surgery. Such situations allow only minutes, not days, in a first time contact for the establishing of a relationship within which to offer pastoral care. In such cir-

cumstances, who sets the agenda for that visit, and how? Many generations of students in clinical pastoral education (CPE) here in the US have been indoctrinated to remember to let the patient set the agenda for the visit. Some may argue that this was never an appropriate stance to adopt anyway, but it clearly has serious limitations today, as Alexander Cairns has described in a recent article. (Cairns 1999) While I do not find the resolution of his initial question satisfying, I think that he describes well the issues that need to be considered in our planning for visits that we wish to be pastoral rather than social in nature. Such a change is going to be resisted by chaplains, and they will be increasingly relegated to situations where they provide only crisis pastoral care, for example when someone is dying or has died.

### **Chaplains and the Team: True Integration**

For various reasons, the work of chaplains have been steadily integrated into the organised life of health care in the US over the past fifty years. It is still possible, though increasingly difficult, for a chaplain to be a lone-ranger in a hospital, especially if it is mid-sized (200+ beds) or larger. One recent important reason is the contribution of the work of a group which represents all of the organisations which accredit pastoral care services. It is known as the Joint Commission on the Accreditation of Pastoral Services (JCAPS). They have represented the work of chaplains to the Joint Commission for Accreditation of Health Care Organisations (JCAHO). This latter body is the most important body to review the functioning of hospitals in the US. Every 3-5 years, a team of surveyors visit every hospital for several days and examines its operations from top to bottom. They review policies, check the charts, interview staff, patients and anyone they wish to talk with. Hospitals spend many months preparing for those days. (One hospital I worked in some years ago spent over \$50,000 to help staff prepare our review, and that does not include the cost of staff time which were devoted to the preparations that were made.)

A full description of what has been accomplished by the dialogue between JCAPS and the JCAHO can be found in a recent issue of *The CareGiver Journal* (cf Tartaglia and Waff 1998.) One outcome is that JCAHO has now formally defined what a trained chaplain is. (p. 53) The crucial elements in the definition are the recognition that credentials are fundamental in the process of assessing the competence and professional ethics of a chaplain. Self-proclamation or ecclesiastical proclamation are no longer a basis for a claim that a person is a chaplain. A second change concerns the language used by JCAHO to describe what competent pastoral care looks like. While as I

write (May 1, 1999) formal ratification has yet to be made, the new description will in all likelihood be adopted in the near future. In summary form, this is what will be expected of hospitals when they have a department of pastoral care:

-there will be sufficient staff to meet the goals of a department;

- pastoral services will be expected to identify resources they need for spiritual direction, pastoral counseling and other specific spiritual services;

- there will be a formal documented arrangement when there is no chaplain in the hospital, but the resources of the community are being used to ensure pastoral care;

- recognition of spiritual needs must be reflected within the policies of the hospital as a whole;
- the director of a pastoral services department must be certified by a national body and have a graduate theological degree or one year of clinical pastoral education;
- pastoral care givers must be able to document their continuing education;
- pastoral care staff must be able to demonstrate that they can minister to a diverse population both culturally and religiously;
- the work of the spiritual services staff must be documented. (The author can provide readers with a full text of these Standards)

These are much more than words on paper. For a hospital to keep its doors open, it must keep its accreditation. These religious/spiritual care standards are now examined in the on-site visit performed by the JCAHO surveyors. Until 1997, standards of care relating to religion and spirituality were already included, but the scoring for the adequacy of services was "capped." Before 1997, a hospital could not receive a failing grade concerning religious/spiritual care. As of January 1998, the cap has been removed, and so a hospital can now receive a citation for deficiencies in pastoral care. At the very least, such a notation generates bad publicity. In company with other type citations, there are more and rather unpleasant consequences for a hospital.

These changes have been experienced as a blessing by some chaplains. At last, here we have official recognition of our place on the health care team! But some chaplains are experiencing them as something of a curse because they now cannot just do their chaplaincy thing without involvement

with and some accountability to the other health care professionals where they minister. I can supply an interesting list of rejoinders given by chaplains who are unwilling to chart their patient care activities in some manner. ("It takes too much time, takes me away from my patients." "What the patient and I talk about is confidential." "Doctors would not be interested in what I wrote." "But there is nothing to write about after some visits." etc. etc.) As chaplains, we are finding that if we are going to be part of the health care team that there are certain responsibilities that we must accept that we must find ways of talking to non-chaplains about what we do and why.

Part of the anxiety experienced by chaplains about recording their pastoral work arises from the fact that they have had no training to do so, nor do we as a profession have an agreed upon body of knowledge and practice that we can use as we "make sense" of what we are doing. Our history in the area of religious and spiritual assessment is relatively brief and is still being clarified. (Stoddard and Burns-Haley 1990, Fitchett 1993) It would be valuable if chaplains from outside the US took part in this discussion, not just for the value of their insights and perspectives, but also so that we can be aware of cultural considerations in this aspect of chaplaincy's development.

If making assessments and charting the results are causing some controversy, the creating of spiritual care plans and creating clinical pastoral pathways is causing even greater controversy. The only comfort (small though it is and perhaps comfort is not the best word) is that doctors and nurses before us have raised exactly the same objections when they were first introduced to the concept of care plans and pathways some years ago.

What is a clinical pathway? Essentially it is the recognition that when a person is sick, their overall course of treatment and response will usually follow a generally predictable "pathway." Keeping such a pathway in mind, it is easier to be prepared for and thinking about not only the patient's situation today. There can also be planning for an anticipated tomorrow. (Cusick 1998) Cusick not only provides a brief description of a clinical pathway from the perspective of the chaplain, he describes their value as a resource for ministry, and includes the full description of one pathway. It is for ministry with bone marrow transplants and stem cell transfers. He also describes the spiritual themes that have been found to emerge for these persons. (p.27) The work of George Handzo should also be mentioned here. The National Comprehensive Cancer Network (NCCN) has been examining how to set stan-

dards for the delivery of the highest quality cancer care, and that group they have also been identifying treatment paths. Their Psychosocial Guidelines include spiritual care in the treatment of all patients with cancer, and Handzo has been a member of the group. The Psychosocial Guidelines Panel have now created a pathway for pastoral care, and Handzo hopes that it can be a model for the development of spiritual care guidelines pertaining to other diseases as well. (1998).

Now it is not difficult to imagine that this is a going to be the subject of heated discussion here in the US. In fact, such discussion has already begun and the same issue of *The CareGiver Journal* includes a well-articulated response by Timothy Madison. (1998) It is a discussion that again I hope will become a transatlantic one. I believe that in the next century as chaplains we shall be held more accountable for who we see, for what we do and why, and the pathway and care plan approach are ways in which we shall be able to do so.

## From Outside the Hospital Walls

### *1. Multi-Cultural Issues*

Although the US has been referred to as a cultural melting pot, in actual fact, as a whole, the country has been more or less ghetto-ized and so, with exceptions in a few medical centers, the patient population has been fairly homogenous. In the last decade, though, that has all begun to change and with the change has come the challenge for chaplains to be knowledgeable concerning numerous unfamiliar cultural beliefs and practices concerning health and health care. Hospital chaplaincy in the US used to mean chaplaincy with only Judeo-Christian roots and practices. This is no longer the case and C.P.E. programs and pastoral care departments are working to know what it means to be able to provide culturally sensitive, religiously appropriate, informed pastoral care. Chaplain's publications have moved from running articles that teach the basics of a particular faith, most usually Islam, to including articles in which imams and other religious leaders share their struggles in ministry. It is more than a little embarrassing to learn of hospitals who have a committee or task force working on the problem of cross-cultural sensitivity that do not have a chaplain included. However, this seems to be the exception rather than the rule, and chaplains seem to be strongly involved in the work of sensitizing staff to beliefs and practices that to date have been unknown.

## 2. The Parish Nurse

The parish nurse movement was begun by Granger Westburg in the late 1940s. It was an idea that smoldered in the hearts of a few for a long time, until in the early 1990s a group of nurses in collaboration with a few parish clergy and some hospital administrators began to create greater visibility for the idea of the parish nurse (Lovinus 1996). To date, chaplains have not grasped the fact that parish nurses are of potentially inestimable value in linking the care they provide within a hospital's walls, with the wider community and especially the faith community which is the locus of a patient's on-going spiritual support, and the home-base of the parish nurse. It is not too late for such linkages to be created.

## 3. The Values Driving Health Care

Chaplains have always been at their best functioning within the walls of their institutions, bringing their priestly and kingly functions into the clinical setting. We have not been a strong nor an effective voice in our prophetic role. I do not say this as a rebuke to my brothers and sisters in chaplaincy, we simply have had too much to pray over near the bedsides.

But there is a revolution going on which concerns US society as a whole. It is organizing of the health care delivery system, the values that drive it, and motivate the persons in power within it. The rising costs of such care, the unequal distribution of health care resources, the absolute takeover of the health care planning and delivery system by Mammon which has supplanted the 5th of the six acts of mercy (see Matthew 25:35-36) - all of these changes have had a devastating effect upon the context within which chaplaincy takes place. They are changes that have affected how we function as chaplains, the way that doctors and nurses think about the work they do. Some of the changes have been beneficial. Some of the most damaging concern safety, moral and motivation. They are not so easy to quantify. As chaplains we see the results, we hear the stories, but can we find the time and the means to ensure that such stories are heard in places where they may affect the way our society thinks and plans its future? Only time will tell.

## Conclusion

It is an exciting time for chaplains. The recent (March) annual conference of the Association of Professional Chaplains had a good spirit to it, chaplains are not daunted by the challenges ahead. But there are important changes that will be required of us. I hope that we will receive the benefit of the reflections of those reading these words in Scotland and the United Kingdom.

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*The Rev. Noel Brown is an ordained minister of the Presbyterian Church in the USA. He received his undergraduate and theological education in New Zealand, and at Dubuque Theological Seminary in the US. He is a board certified chaplain in the Association of Professional Chaplains and a supervisor in the Association for Clinical Pastoral Education. He is a member of the Presbytery of Chicago.*