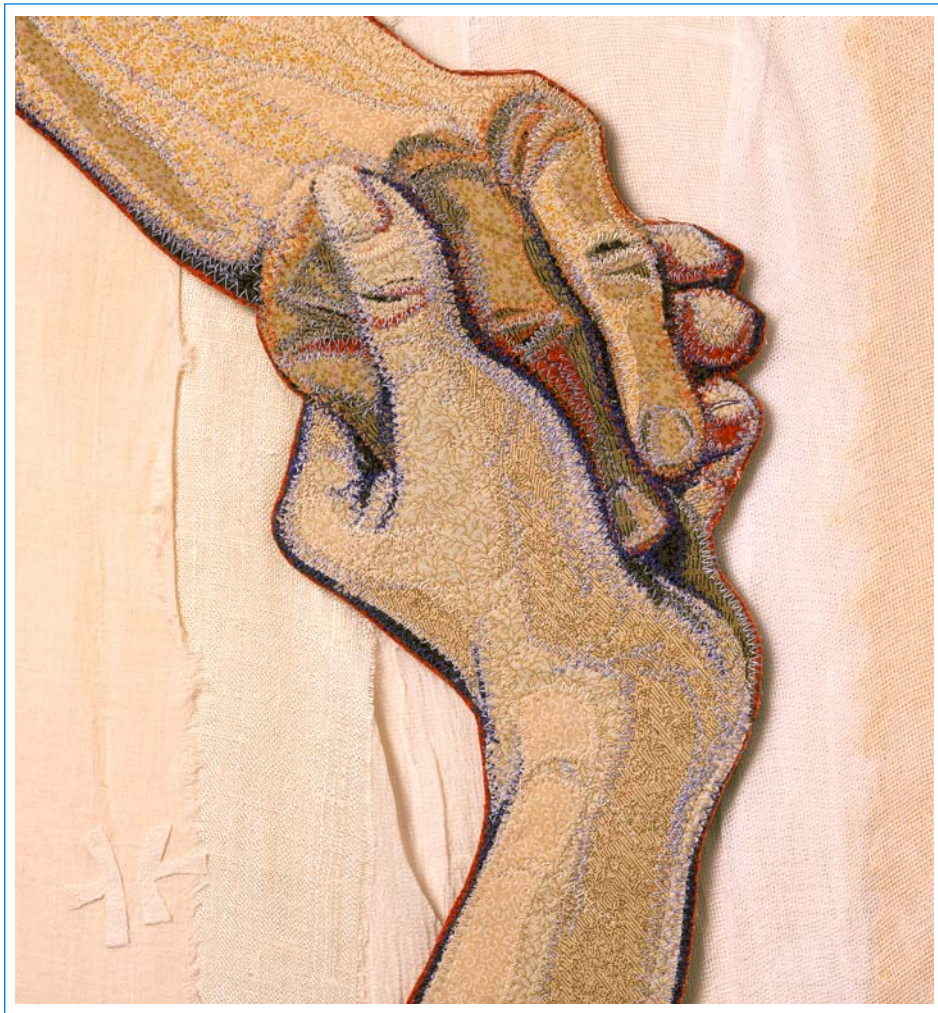


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Can we measure good chaplaincy?

A new professional identity is tied to quality improvement

*A set of essays from the November-December 2008 issue of the
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Can We Measure Good Chaplaincy?

The essays collected here examine the “professionalizing” profession of chaplaincy, the goal of patient-centered care, and the special challenges of defining, measuring, and improving quality in less-standardized areas of health care delivery. The essays emerge from the research project, Professional Chaplains and Health Care Quality Improvement, which was undertaken collaboratively by The Hastings Center and HealthCare Chaplaincy, a multifaith, not-for-profit center for pastoral care, education, research, and consulting. The project was made possible by a generous grant from the Arthur Vining Davis Foundations. ■

—Gregory E. Kaebnick
Editor
Hastings Center Report

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 reli-

gion 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 prefer-

ences 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.

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.

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.

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.

Ethical Grounding for a Profession of Hospital Chaplaincy

BY MARGARET E. MOHRMANN

Hospital chaplains do not have a monopoly on the spiritual care of patients, just as teachers do not have a monopoly on teaching. Spiritual care of the ill and dying—compassionate and thoughtful attention to a patient's explanations of suffering, yearnings for transcendence, constructions of meaning, expressions of faith or loss of it, re-

Margaret E. Mohrmann, "Ethical Grounding for a Profession of Hospital Chaplaincy," *Hastings Center Report* 38, no. 6 (2008): 18-23.

liance on prayer or ritual, bafflement, fear, hope, or any of the many other possible manifestations of spirituality in crisis—has long been within the domain of good nurses and good doctors. Nevertheless, spiritual care is the primary and arguably the sole focus of chaplains' work, and just as we recognize a teaching profession even though "nonprofessionals" also teach, we can justifiably recognize hospital chaplaincy as a profession that specializes in spiritual care of patients—and then turn to the task of specifying the defining criteria for the profession, including its ethical grounding and governing tenets.

As chaplains acknowledge, physicians, nurses, and other clinicians may—and often do—offer patients "spiritual" care that attends to the deep questions of meaning, purpose, and connection to others that arise during a serious illness. (Although some patients may frame their questions in religious terms, it should be noted that "religious" is not a synonym for "spiritual," but rather describes a sizable subset within the category of the spiritual.) The difference between chaplains and other clinicians is that chaplains are specialists in spiritual care; it is what they do, rather than part of what they do.

Chaplains tend to distinguish themselves and their work from clinicians who also offer spiritual care by referring to what they do as "pastoral" care. But for this distinction to represent a salient difference, it will have to be explained. One way of understanding the distinction would be to regard spiritual care as only vaguely or incidentally (if not tentatively) religious, whereas pastoral care hones in on the specific religiousness of the patient. This understanding would highlight a potential difficulty lurking for an avowedly "interfaith" profession in its use of the term "pastoral," a word closely tied to the Christian tradition's fondness for shepherd imagery.

Alternatively, is the spiritual care provided by clinicians a form of screening only, perhaps with some empathic connection added, and are chaplains then the professionals equipped to take the conversation further, into realms of assessment and some analogous sort of therapy? Adept practitioners of ancient moral philosophies, such as Stoicism and Epicureanism, understood and often referred to their teaching as therapy. They seem to have considered their therapeutic task to be identification (diagnosis) of the student/patient's specific "disease"—his particular erring thoughts and bad habits—followed by provision of appropriate bracing, life-altering theories and methods intended to redirect and heal the supplicant.¹ If chaplaincy seeks to be something more or other than a form of palliation, then an analysis of the ways in which the practice is and is not intended to be therapeutic may be useful for elucidating professional goals and methods. It is also the case that a language of therapy will affect, for good and for ill, the communication bridge of translation and interpretation that is sometimes necessary when justifying the presence of clerical professionals within a secular health care institution.

Thus, one fundamental challenge for the nascent profession of chaplaincy is to assert that which not only defines but also distinguishes the kind of care provided by trained and

certified chaplains. Theologian John Cobb's admonition is relevant here:

The pastor's task is to be present with and to "hear" the sufferer, to let the parishioner know that expressing fear, anger, and loneliness is acceptable. I do not dispute the validity of this approach, which in many cases is no doubt the best one possible.

The question of why can be appropriately understood and dealt with psychologically, but to treat it only that way fails to take the questioner with full seriousness as a human being. A pastor who has not reflected about the question, who has nothing to say, has a truncated ministry.²

Cobb is referring here to a clergyperson's response to a parishioner asking difficult questions about God in the face of suffering—questions also likely to be encountered by hospital chaplains. He distinguishes between psychologically significant methods of presence and acceptance and the more specifically pastoral task of reflective response to the questions themselves. He thereby provides a way of expressing the distinction between, on the one hand, the "spiritual" care that may also be offered by other clinicians, and on the other, chaplains' professional "pastoral" care. The implication is that chaplains' claim to offer "pastoral" care entails an obligation to provide care with substantive content, reflecting their professional education and training—care that includes but goes beyond the comfort of a listening ear.

Defining what hospital chaplains do—and whether "pastoral" is an appropriate adjective for the sort of care they give—is one fundamental task inherent in becoming a recognized profession. The move toward "professionalizing" also brings with it the need for professional ethics. This requirement raises not only the question of what the specific ethical tenets of chaplaincy are or should be, but also a more basic question about what constitutes its theoretical grounding: How and on what basis should professional ethics for hospital chaplaincy be conceptualized? In what follows, I consider a few approaches to answering this basic question, none of which is likely to be the winning response and each of which likely should have a place in a fully formulated chaplaincy ethic.

Chaplaincy Ethics as a Form of Medical Ethics

Is a professional ethic for hospital chaplaincy better understood as a theological-religious ethic for a particular kind of health care professional, or as a health care ethic for a particular kind of theological-religious-pastoral professional? The multiple alternative terms employed in that question point out a complication attributable to the interfaith designation of chaplaincy. The interfaith commitment constrains any reliance by the profession on the settled ethical frameworks of specific religious traditions and suggests that chaplaincy must look beyond the religious stances of its practitioners to con-

sider how the practice itself, located in and defined by the provision of medical care, shapes and even determines the profession's ethical obligations.

This issue, however, brings up a significant distinction between chaplains and other health care professionals. Doctors, nurses, pharmacists, and respiratory therapists are each part of a single profession. Nurses, with rare exceptions, are nurses only; the nursing profession is their one source of professional obligation. Hospital chaplains, on the other hand, are members of two professions: They are ordained or otherwise officially recognized as trained leaders by their faith traditions (a requirement for board certification as a hospital

chaplain), and are thus members of the clerical profession. They are also members of this newly forming profession of hospital chaplaincy, which is seeking to establish itself as something other than a variant wholly subsumed within the clergy. Hospital chaplains then have differing, and potentially conflicting, moral obligations entailed by their adherence to two relatively distinct professions—an issue I explore further only after setting out ways in which chaplaincy ethics and medical ethics may coincide.

What are the similarities between the ethics characteristic of faith traditions and the professional ethical understandings that govern nurses, physicians, and clinical therapists of various sorts? Clearly each formulation is identifiably *ethics*, since each is concerned with, among other things, how we conduct ourselves, interact with one another, and care for those dependent on us. When situated within the health care setting, each insists on the primacy of the patient. Medical ethics tends to ground the patient's central status in general principles of respect for persons and in more specific, relationship-generated obligations of care for others' well-being. Theological or religious ethics tends to base similar principles and

Chaplains are obligated to provide care with substantive content, reflecting their professional education and training—care that includes but goes beyond the comfort of a listening ear.

obligations on claims about common humanity, with or without reference to a creator-god, and on (divine) injunctions to love others. But the two ethical frameworks are agreed on much that might be called an ethic of caring for patients, the practice that forms the large area of overlap in the work of these professions.

Another way in which these versions of professional ethics, and others, are similar is in the matter of multiple fidelity commitments. Both clinicians and chaplains have personal obligations—to self, family, and friends—that at times rival the call to attend to patients. Chaplains and health care professionals alike have moral obligations toward the institution of which they are a part, and these, too, may at times conflict with other professional commitments.

But obligations *within* each profession may also conflict. Physicians may find that their commitment to the care of a patient conflicts with important duties to train future doctors or to carry out research likely to be of benefit to others. Good and compelling imperatives to educate and to create new knowledge do not simply fade away upon hearing of the primacy of the patient's need. Part of a physician's professional ethical obligation is to find the morally appropriate balance among his or her commitments in each situation. Chaplains, too, have obligations to their profession of chaplaincy—including the education of future practitioners—that may on occasion interfere with optimal care of the patient. Both clinical and clerical professionals find themselves in the position of deciding between the need of the trainee to gain experience and the need of the patient for the most experienced caregiver. It does not help either profession to have a code of ethics that speaks only of the primacy of the patient without regard to how this necessary balance is to be recognized and managed morally.

Some health care professionals struggle with whether their work is or should be governed primarily by the ethical codes of their profession or by their "personal" ethic, which is often based on religious beliefs. Current controversies surrounding conscientious objection to providing certain legal medical treatments indicate that professional ethical assertions and practitioner behaviors do not track together in every instance.

However, this marks a point at which the problem of multiple fidelity commitments diverges for chaplains, whose position within two professions complicates the issue further. Regardless of the interfaith aspirations and intentions of the profession of chaplaincy, its practitioners are situated—not only by personal belief, but by prior training and professional initiation—within a specific faith tradition that compels their allegiance. The conflict between chaplains' professional obligations to patients and their professional obligations to their own faith tradition is not equivalent to the conflict of professional and personal ethics characteristic of clinician dilemmas. For clinicians, there are arguments available to justify the primacy of the professional commitment or, on the other hand, to recognize exceptions to that primacy. For the chaplain, however, who or what adjudicates between commitments to two professional codes? How should a chaplain—who upon

entering a tradition-specific clerical profession promised to witness faithfully and overtly to the existence of God, understood in specific, tradition-determined ways—balance that professional obligation with what appear to be generally accepted obligations of interfaith chaplaincy not to so witness to one's patients?³

I have no doubt that most, if not all, chaplains and hospital teaching programs have managed to resolve this potential conflict. If they have not, they are not likely to be serving as chaplains or surviving as programs. My point is not that the conflicts are unresolvable, but that this matter of dual professional allegiances must be explicitly considered when drawing up a professional ethic for hospital chaplains, in terms of what is being asked of those who profess chaplaincy in relation to their other professional commitments, and in terms of what constitutes an authentic description of chaplaincy ethics.

This fundamental question about the various moral responsibilities of chaplains raises a related question—to whom are chaplains responsible?—and leads us to consider a second way of conceptualizing the ethics of hospital chaplaincy.

Chaplaincy Ethics as an Ethic of Accountability

Whatever the relation of chaplaincy ethics to medical ethics (or, for that matter, to business ethics, which seems to have more to do with medicine than ever before), there is a real need for a shared ethical language within the health care enterprise. The best candidate for a common idiom is likely to be some version of the language of responsibility, of accountability. An ethic of accountability for a profession entails that the profession should be able to give an account of:

- 1) what its professionals do—which requires criteria that define the field and distinguish it from others;
- 2) whether they do it well, and how—which requires modes of evaluation, requiring explicit descriptions of what counts as "doing it well" that can serve as the profession's standards of quality; and
- 3) whether they could do it better, and how—which requires mechanisms for enforcement of standards and improvement of quality.

Thus, for the nascent profession of hospital chaplaincy, the moral requirement of accountability encompasses both an obligation to set standards of practice (and then to monitor and enforce them) and an obligation to participate in efforts directed at quality improvement.

The focus on accountability does not remove but may help us maneuver the chaplain's conflicting fidelity commitments. It seems clear that, for chaplaincy as well as for medicine, accountability is most particularly owed to patients. Even if patients are not the ones to whom chaplains must give their account, they are nevertheless the ones to whom and for whom chaplains are responsible, and the ones whose vulnerability

demands high standards of professional activity and constant efforts toward higher quality work.

This matter of setting standards, monitoring and enforcing them, and working to improve the quality of chaplain interventions generates consternation and resistance in some chaplains, who understandably find it difficult to imagine ways of categorizing and judging their work that do not outrageously distort it. It is one thing to measure the prompt delivery of accurate doses of appropriate medications, quite another to gauge the quality or the effect of a chaplain's discussion of spiritual matters at the bedside—and the unmodified imposition of methods used for assessing the former may well not do justice to the latter.

On the other hand, programs for clinical pastoral education (CPE) have long considered themselves able to make judgments about their trainees on the basis of such nonquantifiable characteristics as their “presence” with patients, responsiveness to the needs and views of patients and colleagues, willingness to change and grow within their work, ability to refrain from preaching to patients or staff, and some degree of adherence to the interfaith commitments of chaplaincy. There are processes already in place for professional board certification of hospital chaplains and supervisors of chaplaincy training, and for accreditation of CPE programs. In other words, standards of practice for hospital chaplains clearly exist, even if they need some modification. These standards can be evaluated, codified, and adopted, and they can then form the basis for trajectories of quality improvement.

That said, an ethic of accountability would press the profession of chaplaincy to ask itself, What else? Beyond these traits that make for a good chaplain at the bedside—openness and responsiveness, perhaps also gentleness, calm, and an aversion to preaching—what else may be the responsibility of chaplains in a health care setting? There is certainly the issue, revealed by Cobb's injunction to pastors, of some yet-to-be-delineated obligation to provide care with substantive content. But aside from these aspects of direct bedside interaction, what are the moral implications for the profession of the fact that chaplains' work happens in a hospital, or hospice, or other setting in which medical care is being delivered?

Chaplain and theological educator Martha Jacobs has said that chaplains, rather than espousing theology, should be asking the kinds of questions that theology raises. Her cogent claim brings to mind Paul Tillich's expansive definition of a theologian as not necessarily a theist, a believer, but as some-

one whose primary focus is on matters of ultimate concern. The kinds of questions theology raises are about matters of ultimate concern, and I would argue that medicine needs often to be reminded that such matters are always present in the work of health care, whether recognized or not, whether couched in transcendent language or not. Chaplains bear responsibility not for answering or solving them, but for keeping them visible, recognized, no longer ignored.

Sociologist Daniel Chambliss has identified the hospital as a site of thorough-going routinization, one important consequence of which is that moral issues often go unnoticed. He writes, “The great ethical danger, I think, is not that when faced with an important decision one makes the wrong choice, but rather that one never realizes that one is facing a decision at all.”⁴

The same may be said of recognizing and responding to spiritual issues in the health care setting. Such issues pervade serious illness, childbirth, disability, dying, and the difficult decisions that so often attend them, and they are indeed matters of ultimate concern for most people, regardless of their religious affiliation or belief. In the midst of the routines of the setting, health care professionals and even patients may fail to recognize that questions of lasting spiritual significance are at stake in daily, recurring, predictable events that typify the hospital.

Chaplains are the professionals obligated to respond to these questions when they arise, but they are also responsible for seeing that the issues are noticed in the first place and then taken seriously. The fact that the work of health care is shot through with spiritual significance, for recipients and providers alike, needs to be held up to the light daily, spoken of openly, acknowledged, wrestled with, celebrated, and mourned—and this is surely the responsibility of the chaplains, the “spiritual professionals” in the hospital.

Philosopher Margaret Urban Walker asserts that ethicists in the health care setting should be regarded less as expert engineers, offering technical problem-solving approaches to moral dilemmas, than as skilled architects, creating “moral space” within which those who work with the sick and the dying can freely air both their certainties and their bafflement, and discern together ways of proceeding morally in the face of irreducible ambiguities and conflicting commitments.⁵ The development of such spaces—locations and opportunities within the hospital for interprofessional conversations about what matters morally—can potentially convert the entire enterprise into one truly moral space in which the inevitable

Chaplains should be candid about what they do that can be done as well by someone else, what they generally do better than others, and what can be done well only by them.

ethical dilemmas of medicine are consistently acknowledged and are dealt with inclusively, early, and well.

Taking Walker's lead, I suggest that chaplains see themselves as professionals responsible for creating "sacred space" within the hospital, space in which it can be openly acknowledged that holy things are happening, things that are "set apart"—the fundamental meaning of "holy"—things that matter spiritually to everyone involved. A hospital chapel is only the most obvious example of sacred space (although the effect of its existence on the institution's self-understanding should not be underestimated or, for that matter, overvalued). Patients' bedrooms and family waiting rooms surely also qualify, but we need to be reminded of that. And we look to chaplains to denominate even more spaces as sacred—operating rooms, nurses' stations, clinics—by taking them seriously as places where important spiritual transactions are occurring and by calling the rest of us to do likewise. The ultimate goal would be recognition, by the institution as a whole, that the entire health care enterprise—now including board rooms, kitchens, record rooms, and communication centers as well—is sacred space, full of infinite meaning.

A commitment to reclaim the sacredness of the place where human suffering, frailty, and hope come for help, and where help of various kinds and efficacy is provided, may entail a further commitment for chaplains to be courageous participants in and critics of their hospital's organizational structures and ethics—to be an effective voice at the table where the decisions about space, money, and their uses are being made. Might this also be a standard for chaplaincy practice, a measure of quality that can be improved?

Whatever the answer to that question, the idea of sacred space puts the accountability of the chaplain squarely within the "pastoral" aspect of the profession that distinguishes it from other professions engaged in the care of the sick and dying. Therefore, it is time to turn to a model for ethics that may seem to be most surely suited to the work of chaplains as the ministers they are.

Chaplaincy Ethics as an Ethic of Ministry

To minister is to serve; an ethic of ministry is, therefore, an ethic of service. Although "ministry," like "pastoral," is a term that bears the weight of one particular religious tradition, it is nevertheless a word that chaplains of all faiths can claim as an appropriate tag for the patient-centered services they offer. In what follows, "ministry" could be replaced with "service" and "minister" with "servant," but the latter term brings its own baggage—some of which plays into problems with ministry/service discussed below. Like the other approaches explored in this essay, an ethic of ministry keeps the needs of the patient—the one being served—at the forefront. And, like an ethic of accountability, it also diminishes, without eliminating, the strength of moral obligations that do not directly involve the patient's welfare.

A ministerial ethic may seem the most "natural" candidate for a professional ethic for chaplaincy, but there are problems

with it that require the corrective lenses of other ethical approaches, especially that of justice. I have already alluded to the difficulty entailed by the profession's interfaith designation as it limits chaplaincy's ability to call on the ethical understandings of specific religious traditions—which are, however, likely to be the source for individual chaplains' senses of their ethics of ministry. In addition, perhaps the most important thing to be said about any ethic of ministry is that it is potentially dangerous, both to the servant and the served.

There are apt lessons in this regard to be found within the decades-long debate over the feminist "ethic of care." The correctives offered by more recent entries in that discussion highlight two salient dangers for ethical frameworks centered on caring, and both dangers seem equally applicable to an ethic centered on ministry. The first concern has to do with the power of the servant over the served, a sort of "imperialism of empathy" in which the actual needs and desires of the one cared for may be ignored or overwhelmed by the caregiver's interpretation of what service is called for. For example, the depth and seriousness of a patient's questions about personal responsibility in relation to illness may be swept aside by a chaplain's certainty that self-blame is spiritually toxic; a patient's desire to prepare spiritually for death may be overridden by a chaplain whose focus is on healing and hope for an earthly future. In those who choose to care for others, the rescue impulse is often quite strong and can distract attention from what is actually going on in an encounter. In the context of medical care, where the vulnerability of patients and the dominance of caregivers is already manifest and largely inescapable, a responsible ethic of ministry will include safeguards—or, at least, warnings—against a well-intentioned but powerful and potentially heedless urge to help.

The second concern arising from consideration of an ethic of care can be construed as the reverse of the first. Without clear boundaries in place, it is possible for the needs of the one cared for to take precedence over any needs of the caregiver—for the served to so dominate the servant that ministry becomes a form of bondage. Persons, including chaplains, who are involved in the direct care of the sick are vulnerable, for example, to the patient who claims to derive comfort from the ministrations of only one particular caregiver, engendering in that clinician a feeling of obligation that may keep him or her in the hospital well beyond reasonable work hours. As mentioned previously, the work of health care is characterized by conflicts among fidelity commitments for all its various professionals. Physicians, nurses, and chaplains alike are pulled simultaneously by their obligations to patients, to the hospital, to their trainees, to their colleagues, and to the creation of new knowledge. They also experience conflicts between these multiple work-related duties and the duties of their nonprofessional lives—their commitments to self, family, and friends. A responsible ethic of ministry will include explicit attention to the chaplain's welfare and the limits of the work's demands.⁶

This matter of setting limits also raises the issue of professional boundaries, already mentioned in terms of the profession's need to distinguish the care it gives from the sort of spir-

itual care offered by other health care providers. To clarify and promote recognition of such boundaries, chaplains should be candid about what they do that can be done by someone else as well as it is done by chaplains, what they do that is generally done better by chaplains, and what they do that can be done well only by chaplains. Further, chaplains must consider what should not be done by chaplains. For example, it is not unusual for an experienced chaplain, well versed in the language and practices of the hospital, to act as the interpreter of unintelligible or minimalist medical explanations to patients and families. Is this an appropriate role? Are chaplains trained to carry out this task—and should they be? Should it be a standard of practice?

There are other questions, of similar practical relevance, that should be asked: Should chaplains serve as cultural brokers? As mediators and conflict resolution facilitators? The process of defining chaplaincy as a profession calls for setting limits, even if broad, on what counts as appropriate professional work for chaplains. Setting these limits must precede the establishment of standards for the performance of that work, and it can only then be followed by consideration of quality improvement.

There are obviously more questions than answers in this discussion, questions that are rightly answered only by the chaplains forming this profession. However, it does seem that any professional ethic for chaplaincy must contain a thoughtful consideration and explanation of the particular ethical obligations entailed by the health care context of chaplaincy, not only because of the central status and vulnerability of patients, but also because of the intensity of commitment and the confusion that characterize the work of health care providers. It must include careful attention to the demands, dangers, and limitations inherent in a moral practice of ministry, justifying the practice and safeguarding both the practitioners and their patients. And it must delineate and justify the responsibilities of chaplains, transforming their multiple lines of accountability into an ethical framework for chaplaincy as responsible health care ministry.

1. M.N. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton, N.J.: Princeton University Press, 1994).

2. J.B. Cobb, Jr., "The Problem of Evil and the Task of Ministry," in *Encountering Evil: Live Options in Theodicy*, second ed., ed. S.T. Davis (Louisville, Ky.: Westminster John Knox Press, 2001), 181.

3. There are now interfaith seminaries in the United States, some of whose students enroll in order to become hospital chaplains. It remains to be seen whether the educational content of their professional vocational preparation is sufficiently robust to constitute its own tradition, especially if "interfaith" includes both theist and nontheist faiths, and to engender allegiances that produce the sorts of conflicts I refer to here. That is, the hypothetical conflict of a deeply theist chaplain asked to avoid talk of God with a nonreligious patient could be mirrored in that of a thoroughly "interfaith" chaplain confronted by a deeply traditionally religious patient who desires specific practices and references to a very particular God.

4. D.F. Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics* (Chicago, Ill.: University of Chicago Press, 1996), 59.

5. M.U. Walker, "Keeping Moral Space Open: New Images of Ethics Consulting," *Hastings Center Report* 23, no. 2 (1993): 33–40.

6. In many medical centers, chaplain trainees are categorized as medical house staff, subject to the same limitations on work hours that apply to interns and residents. In some medical departments, the constraints on house staff time have led to significantly increased demands on the time of junior faculty, a development that the profession of chaplaincy should certainly try to avoid as it works to protect the well-being and the time of both its members and its aspirants.

Lost in Translation: *The Chaplain's Role in Health Care*

BY RAYMOND DE VRIES, NANCY BERLINGER, AND WENDY CADGE

Chaplains often describe their work in health care as "translation" between the world of the patient and the world of hospital medicine. Translators usually work with texts, interpreters with words. However, when chaplains use this metaphor, it describes something other than a discrete task associated with the meaning of words. While medical professionals focus on patients' medical conditions, chaplains seek to read the whole person, asking questions about what people's lives are like outside of the hospital, what they care about most, and where they find joy and support in the world. Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns. Some chaplains are skilled at translating patients' experiences and sources of meaning in real time, allowing medical teams to better understand the person they are treating. "Translation" is also defined as metamorphosis. Chaplains

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provide this sort of translation when they are alone with patients, listening to their deepest concerns, helping them redefine their lives.

Unlike a professional interpreter, who helps patients and clinicians communicate when they do not share a common language, the chaplain is not just a conveyor of the spoken words of others. A patient, family member, nurse, or physician may seek out the chaplain for help in translating a situation: Is the family in denial? Is the team giving up? Is the patient ready to go home, like her husband says, or ready to rest, like she says?

Ironically, chaplains—skilled at mediating between patients and hospital staff—often have no one they can rely on to advocate for them at budget time, no one who can “translate” the tangible benefits chaplains provide to patients, families, and staff into terms hospital administrators can understand.

The Professional Chaplaincy and Health Care Quality Improvement research project was initiated, in part, in response to this dilemma: If chaplains wish to be recognized as a health care profession, they need to be able to describe, to themselves and to others, what constitutes “quality” in their area of patient care. Like other health care professionals, they need to specify how their profession and their day-to-day work in the hospital contribute to the ongoing task of quality improvement in health care. This is no easy task. The work that chaplains do is difficult to measure in conventional QI terms: the precise duties of their job are unspecified, and chaplains often find themselves improvising to meet the needs of patients and caregivers. In this situation, how can chaplains define their role in improving health care? External perceptions of chaplains and chaplaincy also complicate this translational task: is chaplaincy best understood as a specialized form of religious ministry, in—but not of—the health care setting? Or is it truly a *health care* profession, and if so, what is the nature of the health care service that chaplains provide, and how is it relevant to patients’ health care needs and their treatment? Is it, in some way, both of these? Without attention to these broader sociological questions, it is difficult for chaplains to see themselves as a “professionalizing profession,” and to make the special nature of their work understood to the administrators who must make decisions about investing in services that have no reimbursement code.

Raymond de Vries and Wendy Cadge, two of the authors of this essay, were invited by project codirector Nancy Berlinger, the third author, to participate in this project as sociologists who would observe, reflect, and offer a series of thinking points about the profession and future of hospital chaplaincy. De Vries comes to the project as a sociologist of bioethics (another occupation struggling with its identity and place in worlds of medicine and science) and with expertise in the sociology of culture and the professions. Cadge is a sociologist of religion who studies, among other things, the formal and informal presence of religion and spirituality in hospitals. The three of us offer our thinking in the spirit of continued

conversation and with deep respect for the work of health care chaplains.

The Road to Professionalization

Seen from the point of view of the social sciences, the desire of chaplains to strengthen their profession—to more clearly define their work and to establish agreed-upon standards of practice for those eligible to be called “chaplain”—is a predictable stage in the natural history of an occupational group. Changes in society and technology bring with them changes in the division of labor. Not only does the nature of and need for work change (think of the new occupations created by the computer revolution); so, too, does the way the work of society is divided among occupational groups.

Sociologists have long observed the comings and goings of occupational groups, and they pay particularly close attention to the strategies and social conditions associated with the successful and unsuccessful efforts of these groups to secure a place in the division of labor.¹ As chaplains consider the work they must do to establish their profession, insights derived from the sociology of occupations are useful. The following metaphor, drawn from the sociology of work and occupations, offers a helpful perspective on chaplains’ place among other occupational groups:

Think of all the work that has to get done in a society as the landform upon which a city is based. The division of labor is the street grid that defines this landform: some areas are zoned for manufacturing, others for services, some for respectable tasks, others for deviant ones; some areas are identified for the market, others for domestic labor. Each zone . . . is a site for potential ecological struggle. Some are securely occupied by well-entrenched occupations. Others are scrapped over: some want to annex new areas to territory they already control; some wish to abandon a declining area in order to colonize a more desirable one; others desire to take over a neglected patch and displace or organize the existing occupants to improve it.²

Similarly, as chaplains seek to “stake a claim” in the terrain of health care they are, in some cases, seeking to “annex” areas that others control, and in other cases they are moving into territory abandoned by other professions.

Also relevant to the situation of chaplains are the ideas about labor markets developed by Eliot Freidson, the preeminent twentieth century sociologist of the professions. According to Freidson, human labor may be divided into four “economies of work” based on the nature of labor markets. Best known, of course, is the *official* labor market, where work is legally and economically recognized, included in measures of production, and categorized in the census lists of job titles. But alongside the official market for work exist three other markets: the *criminal* labor market, the *informal* labor market, and the *subjective* labor market. It is this last market—the subjective—that is most pertinent to chaplaincy. Freidson defined this arena as the market where goods and services are traded

without direct economic exchange, and he saw it as both the cradle and the grave of many occupations. Chaplaincy can be understood as work that moved, or perhaps is moving, from the “subjective” to the “official” labor force: having begun as “volunteer” work by clergy whose “real” job was ministering to a congregation, it is now an occupation paid to be a pastoral presence in health care settings.

As chaplains seek to map out their territory in the world of work—to move their occupation from the subjective labor market to the official labor market—they must overcome certain challenges generated by their history and the nature of their work.

No clear jurisdiction. First, hospital chaplains do many things. This “jack-of-all-trades” approach serves the needs of a new occupation well—in seeking to establish a foothold, occupational groups are wise to serve the needs of established professionals and ingratiate themselves with occupations that have more political power. But what works to get one’s foot in the occupational door harms efforts to professionalize. In some ways, being a chaplain is a “vacuum identity”—the work of chaplains can be seen as filling the many vacuums that arise among the jobs of other professions in medical settings. Chaplains fill a void rather than offering a well-defined service. In order to secure a place as a profession, an occupational group must have a clear boundary around its work. It is difficult to stake a jurisdictional claim with an ambiguous definition of one’s jurisdiction.

Disagreement within the occupational group. Not surprisingly given the many tasks and varied educational backgrounds of chaplains, disagreement exists within the group about the proper definition of a chaplain. The leaders of the main professional groups of chaplains have established credentialing standards to answer two basic questions: What must a professional chaplain know, and what kind of training is required to gain that knowledge? On the other hand, these same leaders have not yet reached agreement on standards or scope of practice: What should all chaplains do, or refrain from doing, in recognition of a duty of care? What are the boundaries in which they do these things? Disagreements about the answers to these questions slow the move toward full professional status. Those who prefer the status quo and those who feel threatened by the move toward professional status can undermine efforts by the occupational group to professionalize.

Self-defining. Because chaplaincy is not yet broadly recognized as a distinct profession, others may feel entitled to use or

be granted the title “chaplain” when they are doing certain things. For example, clergy who do not work as health care chaplains may claim the title “chaplain” when they are visiting hospitalized members of their congregation. Volunteers in chaplaincy departments are frequently called “chaplain” by patients and family members. These realities work against efforts to distinguish the work of professional chaplains, and they make it difficult for other professional groups, and the public, to see chaplaincy as a distinct health care profession. A patient in a U.S. hospital is unlikely to encounter a “volunteer” physician—the category of “physician” is understood to be a professional category. However, understaffed pastoral

care departments rely on volunteers to meet specific, often religious, needs of particular patient groups. An internist would be professionally remiss if she called herself a “surgeon” solely on the grounds that both internists and surgeons have medical degrees. However, a community clergyperson might defend his right to be called “chaplain” even though the only thing he or she shares with a health care chaplain is the same postgraduate degree. Defining what professional chaplains do, what volunteers do, and what community clergy do with respect to “chaplaincy,” and determining which of these activities are health care services and which are religious services,

are further challenges for this profession.

Challenging others’ turf. In staking their claim for a piece of property in the world of medical work, chaplains trespass on the work of others. Some occupational groups will not mind giving up a bit of their property (see “dirty work” below), but others will be more reluctant. Two groups that may resist incursions in their work are social workers and local clergy. Many of the tasks that chaplains do can be seen as tasks that social workers do—for example, making arrangements for family members or helping to solve disputes between medical staff and patients and families. It is likely that some medical social workers will not look kindly on those who threaten their livelihood. Also, local clergy may see professional, hospital-based chaplains as encroaching on the important work they do with members of their congregations.

Taking over “dirty work.” Sociologist C. Everett Hughes was the first to examine how dirty work is passed among and within occupational groups, typically flowing down the ladder of prestige. Chaplains may not regard the work they do as being “dirty,” but in the eyes of more established professions—such as physicians—talking with patients about spiritual concerns or ensuring that their pastoral care needs are

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met are distractions from the “real” work of medicine and can be a source of discomfort for members of these professions. As a presence that relieves physicians from this unpleasant work, chaplains can use this aspect of their job description to advance their efforts to professionalize.

The “theology problem.” Chaplains are products of recognized faith traditions: they graduate from seminaries, divinity schools, or rabbinical schools; most are ordained; and they are required to document their relationship to a recognized faith tradition as one of the requirements for chaplaincy certification. However, once certified, many are called on to be “multifaith” and to be available to patients who reply “none” when asked if they have a religious preference. Deploying chaplains outside of the religious traditions in which they were trained further confuses their professional identity: most other professions do not work this way. (One that does is clinical bioethics, an interdisciplinary field in which many practitioners were trained in a specific academic or professional discipline, rather than in “bioethics.” However, this may change as more universities offer bioethics degrees that can function as a professional credential.)

This problem is compounded by the fact that some chaplains work in faith-based institutions that have their own religious ethos. In these situations, chaplains may be responsible for adhering to religious guidelines in delivering health care services, but they may also be called to serve a multifaith patient population. How chaplains in these settings negotiate the institutional religious ethos is an open question.

No agreement on best practices. As part of the health care work force, chaplains are being asked to join the quality improvement movement. But unlike medical work where interventions can be tested in rigorously controlled clinical trials, chaplaincy work is difficult to measure. Quantity is frequently substituted for quality: chaplains may be encouraged to “make the numbers” by focusing on the number of patients visited each day, rather than on the quality of the encounter with each patient and the outcomes for that patient’s care. The lack of evidence for the medical efficacy of practices that may promote patient well-being presents another challenge to chaplaincy. (It is a challenge sometimes shared with palliative care and integrative medicine: these services differ from chaplaincy in that they are not perceived as “religious,” however, and they are done by members of recognized medical professions.) In this climate, chaplains are inclined to argue among themselves over best practices, once again dividing the occupational group and slowing efforts to professionalize. If members of the occupation cannot agree on how to define and

measure their own work, then why should society grant them professional status?

Many credentials, no license to practice. Chaplains who are ordained clergy are already members of a professional category. (Some chaplains come from faith traditions that do not ordain clergy or do not ordain women.) However, ordination, board certification, or specialized certifications available to chaplains are not the equivalent of a state license to practice medicine, nursing, clinical social work, or clinical psychology. This is one important mark of a “profession”—state recognition of an occupation as a profession by using licensure to “close the market”—to prevent competition from those not properly certified. Sociologists disagree about the politics of licensure. Some believe that state licensure is given in response to the demands of a well-organized occupational group, while others believe that states grant licensure only when “closing the market” is in the interest of the state. Chaplains do not have to settle this debate, but regardless of which theory is correct, they do have work to do if they are to gain the advantages of licensure.

Soft skills. The work of medicine is often divided into curing and caring, with the “hard” skills of curing or controlling disease accorded much more respect than the “soft” skills of

caring or “healing.” The “harder” the skill, the more the prestige: thus the status of surgeons is much higher than that of family doctors or palliative care specialists. Chaplains are clearly on the caring, soft side of medicine, and while this will not prevent them from claiming professional turf, it will be the turf of the ancillary medical occupations.

Salaried, yet responsible to patients and families. Like nurses, chaplains who are paid by health care organizations are in a difficult position. Their paycheck makes them answerable to their employer, but their duty is to meet the needs of patients, families, and staff. Often, these obligations coincide—good care for patients and staff members benefits the hospital—but there are cases where chaplains (and nurses) are asked to bite the hand that feeds them by calling attention to care that is not as good as it could be and to unreasonable organizational demands on staff. This situation presents challenges to the autonomy of the occupation that more established professions do not face. Also, while nurses are a large profession that is often unionized and whose services are in demand, chaplains are a small profession that lacks the collective power to protect their autonomy at the negotiating table.

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Self-Interest and Public Interest

In their journey toward professional status, chaplains must find a way to balance professional self-interest and the interest of the people they serve. The official party line of most professions is that all their organizational efforts are undertaken on behalf of their clients, but decades of sociological analysis show this claim to be hollow. The best-known examples of professional self-interest come from the field of medicine, where we have seen doctors in the United States consistently resisting changes that would improve access to health care. The American Medical Association famously fought the legislation that created Medicare (health care for the elderly and disabled) in the 1960s, arguing—with a strong dose of self-interest—that the plan would reduce the quality of care for all. More recently, “white coat” rallies calling for malpractice reform have at times cast physicians as the victims of greedy, litigious patients.

The “bedside” orientation of chaplains may make them less likely to put professional interests ahead of the interests of patients and families. However, some chaplains tell us that they avoid these uncomfortable conflicts by “flying under the radar.” This metaphor suggests that chaplains may view their employing institutions or their professions as antagonistic to their interests: a pilot flies under the radar to avoid getting shot down by the enemy, not merely to avoid being noticed.

Our review of the strategic plan of the Association of Professional Chaplains shows how easy it is to conflate professional and patient interests. Here are the seven goals of the APC described in their 2007–2008 strategic plan:

Goal A: Increase collaboration and interaction with other appropriate chaplaincy, spiritual care, and human service organizations.

Goal B: Increase awareness of the value of Board Certified Chaplains.

Goal C: Increase members’ ownership of the APC.

Goal D: Increase the participation by those of diverse backgrounds in activities of the APC at all levels.

Goal E: Identify and develop resources sufficient to fund and accomplish APC programs.

Goal F: Nurture the spiritual life of APC members.³

The first five of these goals are about building the credentialing organization itself. With the possible exception of the final item, none of these goals seeks to improve the capacity of chaplains to meet the spiritual, emotional, and physical needs of patients, families, or health care workers. Also absent from these explicit goals is a commitment to conduct or contribute to research that could provide empirical evidence of the value of chaplains to patients. Doubtless the drafters of these goals

sincerely believe that strengthening the credentialing organization will improve service to clients. However, the sociology of organizations teaches us that means often become ends.

How can chaplaincy avoid the extremes of “flying below the radar” (which works against unifying the profession) and the self-interested move of reducing the goals of health care to the goals of health care organizations? How can the profession correct these errors of translation—self-understandings that seem to offer security but in fact may create barriers to professional maturation by perpetuating a vision of a profession as insular or marginal?

Here are our recommendations. Chaplains and their organizations should think about how to translate the meaning and value of their work into terms that hospital administrators and others in decision-making positions can understand. In health care, translations must be clear and accurate if they are to provide an adequate basis for understanding and policy. Chaplains should make a practice of translating *from* the terminology of health care systems *into* that of their own profession. By paying close attention to the nature of institutional decisions about patient care, how various patient care professions are deployed, and the concerns of decision-makers in general, chaplains will be able to identify research questions that can yield reliable information about the chaplain’s contribution to patient care. These activities should not be confused with “making the numbers” or merely reacting to institutional concerns.

We also encourage chaplains and their organizations to look for examples of individual chaplains or chaplaincy departments that are proficient translators and to analyze what makes them good at explaining the value of what they do to others.

Finally, because chaplains seek to work in the complex culture of health care delivery, and because claiming a professional role in this culture means acknowledging one’s organizational responsibilities, we encourage chaplains who aspire to lead chaplaincy departments to receive some training in health care organization and management. We also encourage organizations that offer continuing education to chaplains to recognize this need and provide credit for this training.

Acknowledgments

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1. This discussion of the sociology of occupations is borrowed from an analysis of the professionalization of bioethics found in R. de Vries, R. Dingwall, and K. Orfali, “The Moral Organization of the Professions: Bioethics in the United States and France,” forthcoming in *Current Sociology* 57, no. 4 (July 2009).

2. Ibid.

3. Association of Professional Chaplains, “2007–2008 Strategic Plan,” <http://www.professionalchaplains.org/uploadedFiles/pdf/Strategic%20Plan%202007-2008%20-%20no%20imp%20points-portrait.pdf>.

Chaplaincy and Clinical Ethics: *A Common Set of Questions*

BY MARTIN L. SMITH

The ethical imperative for quality improvement in health care requires that all health care personnel engage in attentive observation, reflection, innovative thinking, and action. A core QI question for everyone working in a clinical setting is this: How can the delivery and service systems I participate in be improved to enhance and improve quality of care for patients and families? Chaplains, chaplaincy programs, clinical ethics consultants, and ethics committees all share this commitment. A challenge for both chaplains and ethics consultants is to articulate their unique roles, purposes, goals, and objectives so that they can establish adequate educational and training standards and programs, measure what they are doing against what they should be doing, and initiate, participate in, and maintain QI initiatives.

Both chaplains and ethics consultants generally claim to have distinctive roles, activities, knowledge, skills, and competencies. Nevertheless, similarities in their activities suggest that advantages may result from partnering as each group searches for its place in the health care system and for ways to best introduce QI interventions. Chaplains and clinical ethicists together could identify, recommend, and promote methods useful to both groups in the clinical context.

Chaplains and ethics consultants engage in many similar activities. For example, both meet with patients and their fam-

ilies one-on-one and during patient care conferences; both serve on interdisciplinary teams and participate in multidisciplinary clinical rounds; both document their interventions in patients' medical records; both provide services to and routinely interact with clinical staff and other employees; both participate as members of ethics committees and may lead ethics committees; and both participate as members of other organizational groups, such as institutional review boards and conflict of interest committees. In some hospitals and other health care settings, a chaplain may be the ethics consultant (where the individual consultant model is used) or may be included routinely as a member of ethics consultation teams. Both chaplains and clinical ethicists can serve as patient advocates, assist with advance care planning, facilitate communication and reduce conflicts among various stakeholders, and refer patients, families, and staff to other organizational resources after identifying their needs.

As a result, both chaplains and clinical ethicists need similar skill sets, knowledge areas, and character traits. They should be attentive listeners who are able to communicate interest, respect, support, and empathy. They must be adept at recognizing verbal and nonverbal cues, especially during difficult conversations, and they must be able to assertively articulate their own assessments, insights, and recommendations. Both groups must understand not only the health care systems and clinical contexts in which they work (including relevant institutional policies, procedures, and practices), but also any special beliefs and perspectives of patients, families, and staff. Character traits both groups share include compassion, integrity, humility, honesty, courage, and self-knowledge. Further, the activities and services of both chaplains and clinical ethicists usually do not generate income, and so both groups must demonstrate their "value-added" impact in ways other than by just adding up billable hours.

Neither chaplains nor clinical ethicists can claim a monopoly on expertise in their principle areas of service and focus—spirituality and ethical decision-making, respectively. Other members of the health care team and staff may have significant expertise in these areas as well. Further, in addition to certified chaplains, some health care organizations use chaplain volunteers, some with less—but some with more—knowledge, skills, and experience than their certified colleagues. Similarly, in addition to (or instead of) paid clinical ethicists, many organizations have volunteer ethics committee consultants, some with less—but some with more—knowledge, skills, and experience than their paid counterparts.

Both chaplains and clinical ethicists, then, struggle with a common set of questions: What are our unique roles and contributions? What are the core elements of our work that only we can bring to the health care encounter? What character traits enable someone to become a contributing practitioner of a "professionalizing profession"? What measures of effectiveness should we use to evaluate our work and inform quality improvement? Should clinical ethics permit multiple certifying bodies (as currently exist for chaplains) or one centralized certifying organization? Should clinical ethics follow

Martin L. Smith, "Chaplaincy and Clinical Ethics: A Common Set of Questions," *Hastings Center Report* 38, no. 6 (2008): 28-29.

chaplains in establishing standards for training programs and competencies for trainees?

At this stage in the evolution of chaplaincy and clinical ethics, each profession has some clear accomplishments and foundational elements upon which to build, but there are more for chaplaincy than for clinical ethics. Despite some diversity among chaplaincy interest groups, chaplains, pastoral counselors, pastoral educators, and students regulate themselves through a common professional code of ethics that offers basic values, standards of practice, and a mechanism for accountability. Accreditation is available for clinical pastoral education (CPE) programs that adhere to requirements for the admission of trainees and to explicit standards related to CPE's specialized teaching, training, and supervision. Programs for training future CPE supervisors also exist. The U.S. Department of Education and the Centers for Medicare and Medicaid Services provide a "stamp of approval" for these chaplaincy and supervisory training programs by reimbursing for the trainees' supervised hours of pastoral care. Successful chaplain trainees completing the required number of units and hours of CPE training can be "certified" (not licensed) as chaplains. The Spiritual Care Collaborative, representing the various chaplaincy certifying bodies, has identified a common set of competencies and expertise for certification. Certification affirms that core competencies have been achieved, and it provides credentialing for providing pastoral care services in a clinical setting. Continuing education credits are required annually to maintain certifications.

Clinical ethicists lag behind. A set of core competencies limited to ethics consultation was developed by a national task force made up of twenty-one scholars from medicine, nursing, law, philosophy, religious studies, regulatory agencies, and the College of Chaplains (the precursor to the current Association of Professional Chaplains). The core competencies were set forth as voluntary guidelines, and the task force members unanimously concluded, when their report was published in 1998, "that certification of individuals or groups to do ethics consultation is, at best, premature."¹ Although various academic and training programs in bioethics and clinical ethics have emerged and some grant academic degrees, no clinically based training or fellowship programs are accredited or provide a basis for certification because no accrediting or certifying body exists. Based on the identified core competencies for ethics consultation, the American Society for Bioethics and

Humanities will soon publish a recommended and voluntary "education guide" for improving proficiencies in the core competencies for ethics consultation. The ASBH's leadership and members have debated whether to develop a code of ethics for the organization, or at least for clinical ethicists, and a task force has studied the issue. To date, however, there is a lack of consensus about moving forward with such a document. Finally, absent certification (or licensure), continuing education units are not required for clinical ethicists.

Despite their respective progress toward emerging identities, gaps remain for both chaplains and clinical ethicists, especially in the areas of evaluation and, correspondingly, quality improvement. In an evidence-based environment such as health care, a clear need exists for concrete methods and mechanisms to evaluate effectiveness and impact based on standards of performance. But to date, the efforts of both chaplaincy and clinical ethics have been limited. Simply counting the number of pastoral care visits or ethics consultations addresses quantity but not quality. Patient and family satisfaction scores can be deceiving, and they do not take into account the nuances and subtleties of chaplains' and clinical ethicists' proper roles. Indeed, chaplains' and clinical ethicists' work may not always contribute to "satisfied clients." Some who are served by them—for instance, a patient who orders a chaplain out of a hospital room because the chaplain is a woman, or a family member who strongly disagrees with an ethics consultant's recommendation to disclose medical prognosis to an adult patient with decision-making capacity—may express high dissatisfaction with the respective services rendered. And even if a patient is satisfied, a hospital may be unable to measure that satisfaction according to the same scale it uses to gauge success in more objective areas. For instance, the work both chaplains and clinical ethicists do advocating for patients will not necessarily decrease a patient's length of stay or help to more efficiently utilize hospital resources.

Although neither chaplaincy nor clinical ethics has been able to fully identify or develop its role in modern health care, both make their own unique contributions to the care of patients, families, and staff. The many commonalities of both "professionalizing professions" warrants their increased collaboration to address the similar challenges that each faces.

1. American Society for Bioethics and Humanities, *Core Competencies for Health Care Ethics Consultation* (Glenview, Ill.: 1998), 31.

Chaplains and clinical ethicists together could identify, recommend, and promote quality improvement methods useful to both groups in the clinical context.

The Nature of Chaplaincy and the Goals of QI: *Patient-Centered Care as Professional Responsibility*

BY NANCY BERLINGER

Seasoned clinical ethicists have a saying: You cannot bite a wall. The saying refers to that demoralizing moment of taking in the scale of a (really) big challenge in health care. We have two options when we find ourselves up against this wall. One is to ignore it. This means ignoring the needs of people who are sick, or lack access to health care, or could be harmed by care that is not as good as it could be. A health care professional's duty of care is a duty to act in the interests of those for whom one cares. Merely feeling awful—it's a shame about that wall—is the same as ignoring the wall, from the perspective of those who suffer because of the wall's existence.

The second is to be ethical. We can find a crack in the wall and work away at it. The trick is to avoid the temptation to bite off just a bit and declare victory, rather than staying connected to others working on the whole wall. It would be a pity to take down just enough of the wall to build a silo.

Quality improvement in health care can look like yet another unbitable wall. And yet, the Institute of Medicine gave us six ways of looking at the QI wall in its influential 2001 report, *Crossing the Quality Chasm*. The report described six goals, or "aims," for QI in health care: it should aim to make

health care safe, effective, patient-centered, timely, efficient, and equitable.¹

Different health care professions have focused on one or more of these now-classic six, with particular attention to safety and effectiveness. Health care, as an enterprise, has a fundamental obligation to distinguish safe from unsafe and effective from ineffective. Certain health care professions and clinical specialties—pharmacists and anesthesiologists, among others—have acknowledged safety to be their distinctive QI goal. They have described problems—medication labeling, equipment design—and have recommended solutions intended to increase safety and also effectiveness, given that unsafe care is ineffective care. They have pledged, as a matter of professional ethics, to keep working away on this bit of the QI wall.

It is now time for health care chaplains to step up to this wall. The goal of patient-centered care should be strongly identified with this profession. Patient-centered care is a worthy goal and one that chaplains can contribute to, significantly and measurably.

Why QI? Ethics and Tactics

But why should chaplains choose any QI goal? And why patient-centered care in particular?

If chaplaincy wants to be taken seriously as a health care service—if chaplains want to be taken seriously as health care professionals—then they cannot hold themselves apart from the ethical obligations of the health care enterprise. Doing so would reduce the delivery of spiritual care to something that one does for one's own fulfillment and for the incidental or occasional benefit of others.

It is the nature of chaplaincy to be in solidarity with the suffering person, which in health care is usually the patient or the patient's caregiver. It is also the nature of most chaplains to prefer to be "at the bedside." If chaplaincy cannot identify with patient-centered care as its distinctive QI goal, then it is hard to make the case that another profession ought to. And it's hard to imagine why chaplains would not want to work to make care better for the patients in the other beds, mindful that they themselves cannot be at every bedside.

Also, it makes good tactical sense for the profession of chaplaincy to commit itself to patient-centered care as its QI goal. Thanks to the wide dissemination and discussion of the IOM report, no health care institution can easily argue for a definition of QI that does not include these six. If chaplaincy, as an institutional service, went on record as saying, in effect, "We'll help you with the goal of patient-centered care," then chaplaincy can claim to share the credit for institutional progress, even as it will be held more accountable for showing progress. Good tactics can converge with good ethics.

Defining "QI." If we accept that the price of admission to professional status includes involvement in QI, and if we accept that chaplains, as a matter of ethics and tactics, may have a particular affinity for QI activities aimed at advancing pa-

Nancy Berlinger, "The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility," *Hastings Center Report* 38, no. 6 (2008): 30-33.

tient-centered care, then how should chaplains go about doing this?

First, they should become familiar with a good working definition of QI. A recent Hastings Center project on the ethical issues raised by quality improvement defined “QI” as “systematic, data-guided activities designed to bring about immediate, positive changes in the delivery of health care in particular settings.”² Conducting systematic, data-guided activities to advance patient-centered care is different from the desire, however sincere, to provide patient-centered care—or the belief, however sincere, that one is already doing so.³

Defining “patient-centered care.” Next, chaplains should become familiar with how the most influential organizations within the QI movement define “patient-centered care”:

- *Institute for Healthcare Improvement:* “Care that is truly patient-centered considers patients’ cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the patient and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions. [It] puts responsibility for important aspects of self-care and monitoring in patients’ hands—along with the tools and support they need to carry out that responsibility. [It] ensures that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient.”⁴

- *Agency for Healthcare Research and Quality:* “In a patient-centered model, patients become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to advice and counsel from health professionals.”⁵

- *IOM:* “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”⁶

- *National Quality Forum:* “care [that] is centered on what patients need and want, rather than on what is convenient for providers.”⁷

These definitions are not identical, but they are quite similar. “Patient-centered care” encompasses both the individual patient and the coordination of care in the interests of all patients. In a four-hundred-bed hospital, there should not be four hundred customized models of patient-centered care, but rather one model that can reflect the needs and preferences of each patient with respect to his or her diagnosis and treatment goals, as well as how this patient uses health care and receives support from family and other caregivers.

If this institution uses “patient-centered care” only as a marketing slogan for the billboards—“Where *you* are the center of our care”—but does not show its staff a convincing model of patient-centered care nor give them permission and incentives to make continuous improvements to the working model, then it will be discouraging for this staff to contemplate what the Agency for Healthcare Research and Quality calls the “quality gap”: the observable difference “between health care processes or outcomes observed in practice, and those potentially obtainable on the basis of current professional knowledge.”⁸ This is also, as we say in bioethics, the gap between “is” and “ought.” And if any health care profes-

sional or profession uses “patient-centered care” to describe an attitude or aspiration, but not an action—then nothing has happened yet that will help these patients. Identifying with patients is not the same as actively looking for ways to bridge the quality gap between their current care and the better care they could be receiving.

From “ought” to “is”—advancing patient-centered care through the work of chaplains.

If opinion leaders in chaplaincy were to decide that this field could and should embrace patient-centered care as its collective and distinctive quality improvement goal, what could they then do to help working

chaplains bridge the quality gap in their own institutions? And what could this field do within the quality improvement movement?

In addition to the basics—clarifying their own professional practice standards, supplying definitions and examples of chaplains’ work that can be easily understood by professionals in other health care fields—chaplaincy would need to go where the QI consensus is. They would need to look for opportunities to join ongoing conversations on patient-centered care organized by the leading QI organizations. They would need to conduct and support research on the chaplain’s role in patient-centered care and advocate for better ways to assess chaplains’ work and impact in this area. They would need to sponsor workshops to teach chaplains how to design and evaluate QI activities aimed at promoting patient-centered care, or support chaplains’ efforts to obtain this training elsewhere. And they would need to nurture visionaries: research-minded chaplains who are passionate about the goal of patient-centered care and who can encourage their colleagues, and the field, to embrace and take pride in collective action toward this goal.

This may seem a bit too much like biting a wall. If so, then chaplaincy—like other health care professions—may want to

If chaplaincy cannot identify patient-centered care as its distinctive quality improvement goal, then it is hard to make the case that another profession ought to.

identify a particular challenge in patient-centered care and work away at it. Improving palliative care offers one such challenge. Chaplains may work on palliative care teams, and palliative care is an interdisciplinary field congenial to chaplains and chaplaincy. The clinical practice guidelines released in 2004 by the National Consensus Project for Quality Palliative Care are notably detailed in their attention to “spiritual, religious, and existential aspects of care” as part of the “patient-and-family-centered-care” that should characterize quality palliative care.⁹ The guidelines emphasize that quality in “spiritual, religious, and existential aspects of care,” like quality in any other aspect of palliative care, should be evidence-based, consistently practiced, and continuously improved.¹⁰

There are acknowledged quality gaps in palliative care, and there are acknowledged research gaps, too: practices that are not yet fully informed by evidence or professional consensus.¹¹ Chaplaincy could partner with researchers—and visionaries—in palliative care to conduct research on quality in spiritual, religious, and existential aspects of care, to disseminate research findings, and to advocate for the application of research to practice. If chaplaincy becomes—and is seen to be—an ally of experts who seek to improve quality in palliative care, then chaplains will be invited to contribute to future clinical practice guidelines. These actions, over time, will improve palliative care, advance patient-centered care, and—*not incidentally*—add to the stature of chaplaincy as a field. Again, good tactics and good ethics.

Not all of the QI action takes place at the “profession” or “field” level. Working chaplains can also make patient-centered care their *institutional* QI goal. This will be easier to do if their institution has already made its commitment to patient-centered care clear by encouraging its departments to develop QI projects toward this goal. It may also be easier for chaplains to develop substantive QI projects if their own profession has already embraced patient-centered care as its collective QI goal. If chaplaincy is understood to be a QI-driven profession, then the institutional investment in professional chaplaincy will be understood to bring QI benefits to the institution.

From Theory to Practice

If a chaplaincy department embraced patient-centered care as its QI responsibility, institutionally as well as at the bedside, what would that look like? How does a chaplain take the plunge to design and test a patient-centered model of care? Here’s what the chaplaincy director at one hospital did.¹² In the waiting rooms of the outpatient cancer program, posters and brochures invite outpatients and family caregivers to directly contact various social support services—social work, psychiatry, chaplaincy, and patient representatives. Few patients or families did so. Most referrals came from hospital staff, usually after a crisis erupted. Patients and families who were referred to these services consistently reported, via follow-up surveys, that they were highly satisfied with the care they received. The verbal surveys conducted by a team com-

What Do Health Care Chaplains Think about QI?

There is little data about chaplains’ involvement in or attitudes toward QI in the institutions where they work. To fill this gap, the Professional Chaplains and Health Care Quality Improvement project conducted focus groups in 2007 with chaplains in New York, Illinois, Arizona, and California. This IRB-approved study was designed and directed by George Fitchett, director of research in the Department of Religion, Health and Human Values at Rush University Medical Center, with colleagues Clayton Thomason and Kathryn A. Lyndes.

Most focus group participants were board-certified chaplains (74 percent) who worked in hospitals (82 percent); the average participant had worked as a chaplain for thirteen years.

Key findings:

- Chaplains have a strong commitment to providing quality spiritual care. However, they are frequently skeptical about QI as an institutional activity. They may resist QI language and methods that focus on quantity of care—“making the numbers”—rather than quality of care.
- Chaplains who are involved in quality improvement in their own departments may not use QI language or connect their efforts to institutional QI.
- Chaplains are eager to learn more about promising efforts to improve quality in chaplaincy and how to conduct meaningful quality improvement projects.

Research findings will be reported in journal articles. For a summary of this study, go to the project’s Web page, <http://www.thehastingscenter.org/Research/Detail.aspx?id=1212>.

posed of representatives of the supportive services also revealed that these patients and families had not found those posters and brochures to be helpful. It was only after they had met the social workers, counselors, chaplains, or patient reps that they understood what these staff members did and how they could help.

Guided by the survey responses, and working from the hypothesis that introducing patients and families to services they might need and want (and could request on their own) would advance patient-centered care, team members began to talk about developing an orientation session for all new patients in this system. But how to broach this with hospital administration? One team member, the chaplaincy director, took advantage of a training session offered as part of the hospital’s QI program. Through this training, she made new contacts in

her institution and was able to bring fresh insights to her team on how to develop their idea into a full-fledged QI project.

The orientation sessions, which are optional and open to longstanding patients as well as new patients, are now offered twice a month in the waiting rooms of the outpatient clinics. At each session, at least three members of the project team—consisting of a social worker, case manager, patient representative, chaplain, and psychologist—introduce themselves and describe what they and their departments can do for patients and families, based on what other patients and families have found helpful in managing similar diagnoses and treatments. Team members have noticed that the interactive format of the orientation prompts patients and families to pick up and ask questions about the existing educational material they had previously overlooked, even though it was in plain sight in every waiting room. Team members have also drafted a new brochure describing some of the common issues faced by cancer patients and their families. This brochure is “patient-centered,” not “discipline-centered,” so patients will not be required to think about their own needs in terms of medical jargon or departmental boundaries.

The project is ongoing, but to date, the outcomes have included:

- immediate and positive feedback from orientation participants, who appreciate the opportunity to meet hospital staff person-to-person, in the outpatient setting, where there is no crisis-driven agenda to increase tension;
- an increase in direct referrals from patients and family members; and
- far greater awareness of supportive services among the oncologists and nurses who work in the outpatient clinics.

These clinicians are now asking members of the orientation team for detailed guidance on making referrals. Team members have collaboratively developed a referral algorithm and referral form to help direct clinicians’ referrals to the appropriate departments. These tools are patient-centered in that they allow medical staff to be guided by their patient’s expressed concerns and their own clinical observations, rather than requiring them to guess which department should get the referral. The referrals come to the team, whose members collaborate to sort them in terms of the interventions needed. Since the start of this QI project, referrals to supportive services from outpatient medical staff have doubled. As these new referrals are not crisis-driven, they can be managed by existing supportive services staff.

The chaplaincy director and the other project designers have observed another, unanticipated outcome. The same

medical staff has begun to ask them for help in talking with another group of patients and families about another problem: the transition from outpatient medical care to hospice. These clinicians had been unsure about when it was appropriate to bring up hospice in the outpatient setting, and they had fallen into a habit of admitting patients with end-stage disease to the hospital for the transition to hospice. By providing patients and families with support at the beginning of their relationship with cancer care providers, and by becoming an ongoing resource to medical professionals, this team is improving the quality of care in their institution in another way, by helping patients near the end of life avoid an unnecessary hospital admission.

Innovation begets innovation. And steadily, the wall comes down.

1. Institute of Medicine, *Crossing the Quality Chasm* (Washington, D.C.: Institute of Medicine, 2001), 5-6; <http://www.nap.edu/openbook.php?isbn=0309072808>.

2. M.A. Baily et al., “The Ethics of Using QI Methods to Improve Health Care Quality and Safety,” *Hastings Center Report* Special Report 36, no. 4 (2006): S3.

3. Some hospitals use “PI”—performance improvement—methods, which emphasize the role of human performance in the delivery of health care, but both PI and QI are systematic and data-guided, and according to one recent assessment, “there is no discrete boundary between them.” T. Bornstein, “Quality Improvement and Performance Improvement: Different Means to the Same End?” *QA Brief*, USAID-sponsored Quality Assurance Project, Spring 2001. This working definition of QI should, therefore, work for chaplains in “PI” institutions. Similarly, this working definition should work for chaplains in institutions that may use a particular QI method, such as Six Sigma.

4. Institute for Healthcare Improvement, “Patient-Centered Care: General,” <http://www.ihl.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/>.

5. Agency for Healthcare Research and Quality, “Expanding Patient-Centered Care To Empower Patients and Assist Providers,” *Research in Action*, issue 5 (2002), under subtitle, “Health Care Evolves Toward a Patient-Centered Model,” <http://www.ahrq.gov/qual/ptcareria.htm>.

6. Institute of Medicine, *Crossing the Quality Chasm*, 6.

7. National Quality Forum, “NQF Brochure,” 2004, <http://216.122.138.39/pdf/NQFbrochure2004.pdf>.

8. Agency for Healthcare Research and Quality, “Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies,” *Technical Review* 9 (2005): 1, <http://www.ahrq.gov/downloads/pub/evidence/pdf/qualgap3/qualgap3.pdf>.

9. National Consensus Project for Quality Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care*, 5-6, <http://www.national-consensusproject.org>.

10. *Ibid.*, 29.

11. *Ibid.*, 41-42.

12. Unpublished case study supplied to author by a chaplaincy director, May 2008. Some identifying details have been changed.

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