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A Morning Rumination

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As sometimes happens in a professional life, yesterday was a good day. Three intellectual puzzles came to mind, each provoked by a lively conversation with colleagues. It helps, you see, if the mind has puzzles with which to play. At a minimum, having ideas in play structures time and gives welcome focus to mental life.[2]

Theory building is mental exercise. It is fun to think about relationships among variables, to ponder cause and effect. Theory need not be abstruse fol-de-rol, a gaudy construction not worth the effort to make, much less to understand. To some people, theory has a bad reputation because of the way it is taught. But I think of theory as social psychologist Kurt Lewin did when he wrote, "There is nothing so practical as a good theory."[3] The puzzles I describe next are quite different. But if pursued, each might cast a light on the practice and fortunes of being a healthcare chaplain, in particular, and a caring professional, in general. Puzzles in hand, time has to be found to move intellectual play toward theory and research. Sometimes I think of my puzzles as companions.

Each puzzle challenges us to think in new ways about an unexplored issue for theory, measurement, and practice. The first one sounds easy enough and came up in a recent incident at, say, Big Metro Hospital. A kindly chaplain was challenged during her presentation at Grand Rounds by a staff psychiatrist who wanted to know why she was helping patients with their "feelings," which he said was <u>his</u> business. (I don't know if he said "business" but that is what he meant.) If not his concern, surely emotions are the business of a psychologist or social worker, other care competitors on a hospital floor. It can't be the work of a busy doctor. Perhaps a nurse has the time and inclination.

So, here is the puzzle: What exactly does a chaplain add to the healthcare team? How does the role of chaplain that addresses the "spiritual" interact with other professional roles and the domains of patient and family experience they claim as theirs? Other questions follow. What special insights and skills does the chaplain add to the team? By what means are these competencies acquired and maintained? How important is self-selection to ministry or chaplaincy compared to training in theological reflection and pastoral counseling? Compared to other roles, is it something about the mental models brought to working with a patient's experience, or the methods used, or both? No lack of questions here.

To state the second puzzle succinctly is difficult. It, too, comes from a practical observation in healthcare, this one having to do with intense financial pressures on hospitals. In response to pressures for accountability in a competitive, regulated industry, hospitals are focusing intensely on patient satisfaction with services. Respected national measures like the Press Ganey index are used to compare hospitals and, then, administrators use such metrics to monitor and improve hospital services.[4] The measures may not be the best on technical grounds, but they have been widely used. Recently, the Federal government has begun a major initiative to collect standardized data from American hospitals, called HCAHPS, that will permit comparisons of quality, including measures of responsiveness to patient need, patient satisfaction, and willingness to recommend the service.[5] This massive undertaking was voluntary, initially, but now is connected to reimbursement upon which hospitals so depend. So, by the end of 2008, we'll be seeing public data on some 4,000 hospitals! The instrument will be a powerful research tool, and the public dataset will likely be used for both accountability and for competitive advantage.

More important for our purposes, the focus on patient satisfaction as an outcome measure may give chaplains an opening by which to advance their legitimacy, if not authority, on the treatment team. The opening, if indirect, comes from the observed empirical relationship between patient satisfaction, increasingly a focus of hospital administrators and boards, and correlates like responsiveness to patient spiritual needs and locus of control.

Now, to the puzzle. What does patient satisfaction mean and what are its predictors? I've seen empirical evidence to support the idea that satisfaction correlates modestly with two related dimensions of patient experience: degree of individualized service afforded patients and families, and responsiveness to patient spiritual needs. (Both variables, individualized treatment and spiritual responsiveness, are also correlated in some datasets, and we need to know why.) Good chaplains provide both ingredients, to be sure, and implications come to mind for research and education. But, first, we need to say something about the context of care in contemporary hospitals and, most importantly, the patient experience in the particular, odd circumstance of a hospital stay.

Even though hospitals, I believe, want to offer a humane environment for healing, the economics of modern healthcare seem to mandate an anomic assembly line where patients and families come and go without much individualized attention.[6] Hard-pressed professionals try to respond to patients and families who are confused and anxious, but staff members "don't have the time." That is what staff say and we should believe them. Efficient doctors under the gaze of regulators are supposed to spend, oh, 12.5 minutes with a patient! More generally, the division of labor situates the patient alone in a strange room surrounded by technicist professionals, each with his or her role, special insights and fetishized methods, what Onora O'Neill describes as "strangers at the bedside." [7]

Of course, we want expert interventions in the surgery or pharmacy or counseling—Western medicine has made great advances. But has the progress in *techne* been at the expense of *telos*, especially how human beings are treated in the hospital "system": patients, staff, and families, alike? When we are hurting, or our lives are at risk, we want to be treated as whole people, as human beings who are deeply social beings. We also want technical excellence in the choice of chemotherapy or recommended procedure.

Most people I know have no idea what it is like to be a hospital patient until, suddenly, it is the only experience and the mind is totally captured. Being a patient may be feared, but it is "out there"—someday in the future—until, of course, it is Now!—impossibly surreal in comparison to most human environs. Lying alone in a hospital bed tethered to machines, perhaps in pain and drugged, looking at one's experience up there on the surface as if under water, is like no other experience in life. Few are prepared for it. I know I was not.

When staff and friends visit, only for a brief instant is the isolation lifted, and the enduring sense I had after dumping a bicycle on a remote Ohio road is acute loneliness. The morphine pump by my bed helped control the pain of broken ribs and collar bone, but added to the alienation. As hospital visits go, mine was a minor event, but the psychological experience remains with me to this day. If my characterization is not exaggerated, what should a hospital team provide to ease this psychological burden? Who will provide it? The point is: no role on the modern healthcare team except the chaplain has the mission, the training, and the time to respond to the existential loneliness of the whole person, which is what worried patients and their families may want most of all.[8]

What research is needed? Given this context, the challenge is to take this understanding to an exploration of the cognitive space and clustered attitudes that patients

develop about expectations and quality of service. Part of the work is theory building with constructs like satisfaction, spiritual need, individualized treatment and possible correlates like self-confidence, resilience, and locus of control. Can we map this multidimensional space and posit causal relationships among the most important dimensions of patient psychological experience in hospital? Then, prosaic empirical research is needed to assess the validity and reliability of measures of the constructs and to determine the discriminant validity of the most important ones. The Spears Research Center at HCC is doing some of this work.

The third puzzle of the morning has to do with the education of chaplains, especially the education of the faculty who educate and supervise chaplains. The Chaplaincy is revising its curriculum for preparing supervisors and that challenge is raising all manner of questions about what the "chaplain of tomorrow" and her professor-supervisor need, and how to organize resources toward those ends. What is the theory of teaching and learning behind the curriculum? What is the pedagogy's active elements and how are they defined and studied?

Over the years, I've taught in graduate clinical psychology programs. CPE training seems superior to traditional clinical models in psychology in two ways: more often than not, a certified chaplain has a refined sense of self in role. My words may not be right, but chaplains seem comfortable in "their skin." The best have a spiritual presence and know how to use this presence in healthcare settings.

The second vital element is that the professional chaplain has learned to listen, broadly defined: to self and internal variations in mood and awareness, and to others, especially the feelings of others. Chaplains I have met seem less technique-focused than psychologists. As Rabbi Naomi Kalish of HCC might put it, chaplains listen for the "tiny voices" so easily missed in the strange environment of a hospital. The best know how to enter a room with

great respect and serenity. Perhaps they just enter the sick room and bear witness, keeping silent for hours as one chaplain I know has done.

So, as we re-envision the new curriculum for supervisors, we want to protect the defining competencies of clinical pastoral education, which need better terms and validation, and to add new competencies. This work has begun. My morning rumination also leads me to conclude that The Chaplaincy might try to be known for its "good theory" as Lewin would want, probing theory built to address the needs of chaplains in contemporary healthcare environs.

Endnotes

[1] Comments are welcome care of the author at: jkytle@healthcarechaplaincy.org.

[2] Mihaly Csikszentmihalyi. *Flow*. New York: HarperPerennial, 1991.

[3] Kurt Lewin. *Field Theory in Social Science.* New York: Harper, 1951, p. 169.

[4] Press Ganey claims it has 7,000 hospitals as clients for its patient satisfaction measures. www.pressganey.com

[5] To learn more about HCAHPS, go to: www.cms.hhs.gov/HospitalQualityInits/30_HospitalHCAHPS.asp or http://www.HCAHPSonline.org. The survey has 27 items plus options to include a customized set of hospital-specific items.

[6] Some institutions try to create a wholistic healthcare environ, notably the Duke Center for Integrative Medicine (www.dukeintegrativemedicine.org/) and the "Plaintree model" used at Griffin Hospital and elsewhere (www.griffinhealth.org/). In the spirit of disclosure, The Chaplaincy provides chaplain services to Griffin Hospital as well as fifteen other regional hospitals.

[7] Onora O'Neill. *Autonomy and Trust in Bioethics*. Cambridge, UK: Cambridge University Press, 2001. Mark Cobb reports that this work is based on her 2001 Gifford Lectures, the same venue used in 1901 to good effect by William James to develop his thinking later published in *The Varieties of Religious Experience*. See Mark Cobb, "Change and Challenge: The Dynamic of Chaplaincy," *Scottish Journal of Healthcare Chaplaincy* 10 (2007): 4-10.

[8] Nurses can and do provide some of this care, which makes them natural allies of chaplains on the healthcare team, another puzzle of interest.