Protecting the Soul of Spiritual Care

For the last several years, thoughtful experts in our field have been calling for more research to validate standards of practice and document chaplaincy outcomes. In a 2012 COMISS Network Forum address, former HealthCare Chaplaincy President and CEO Walter J. Smith opined:

*Without a credible body of research to support it, [certification] standards . . . will accomplish little in advancing chaplaincy as a profession. Professional chaplaincy today still lacks the models and methods on which to build a strong empirical foundation that will help define what chaplains do and measure how successful are their interventions.*[i]

Rev. Smith expressed concern that “much of current chaplaincy care remains intuitive and insufficiently documented,” noting that: *The chaplain . . . enters patients’ worlds with the desire to help individuals to make sense of and find meaning in what they are experiencing. The chaplain comes to this task with a reasonably sufficient training and experience, but only exceptionally equipped with theories or methods to critically assess the effectiveness of what he or she actually says or does in the clinical setting.*[ii]

He elaborated that “in general, chaplaincy practice issues are not routinely subjected to the rigors of scientific inquiry” and that “remedying this deficiency” does not appear to be a priority. [iii]

Rev. Smith’s concern is rooted in a very pragmatic recognition that the modern health care environment expects all professional disciplines to document and assess the outcomes of every intervention, concluding that “chaplaincy care is no longer immune from this requirement.” Here is the crux of Rev. Smith’s position:

*I would venture to assert that health care chaplaincy, as a professional discipline, may be as aligned to medicine, nursing and social work as it is to its many spiritual and religious roots. And I further believe that assisting chaplains and chaplain educators to better understand and embrace the functional relationships chaplaincy shares with the other cognate health professions will accelerate the development of more integrated and effective approaches to multidisciplinary care.*[iv]

Rev. Smith’s call to action was recently reasserted by his successor, Rev. Eric J. Hall. [v] Rev. Hall has also called for ongoing comment and contributions to the conversation from all chaplains. [vi]

I appreciate the openness and commitment to ongoing discussion, as well as the thoughtful and passionate concern of many pioneers in our field. And I agree with much of it. For certain, we must dispel the stereotype that the function of the professional chaplain is limited to offering an opening reflection at meetings and praying with people. I also agree that chaplains are grossly underpaid in view
of the extensive education and training most bring to their work, often from other well-developed and successful careers. Educating dollar-driven hospital administrators surely does require us to be able to demonstrate the value-added service we provide to patients, families, staff, and—as a result—health care organizations.

I share the view that the development of evidence-based practices and quality indicators through sound research endeavors can help to provide a solid foundation for our professional activities. As we strengthen the still relatively nascent field of professional chaplaincy, we need this sturdy foundation on which to “build the house.” Without question, we would do well to create a substantial body of literature—theoretical, narrative and empirical—that illuminates the work that chaplains do and how they contribute to the well-being of individuals in crisis and transition. At the same time, I am concerned that we may fall into the trap of believing that theories, methods, and models alone are sufficient to ensure the provision of competent spiritual care. Like many professions, ours is a delicate balance of science and art. Perhaps we have until now focused exclusively on the art without proper consideration of observable scientific underpinnings to support it. If we have been in error about this, we should not make the same mistake by allowing the pendulum to swing completely in the opposite direction, i.e., focusing exclusively on the science without appreciating the necessary place of art in spiritual care. In particular, we need to recognize the appropriate and essential role of intuition in the practice of competent chaplaincy.

Chaplaincy and the Medical Model

Embedded in the views proffered by Rev. Smith and Rev. Hall as well as other recent actions such as the formation of the Spiritual Care Association (SCA) is at least an implicit acceptance of the idea that we are obligated to justify our existence and our work by fitting it into a framework (i.e. medical model) that looks like and feels familiar to other cognate health professions with which we collaborate. In other words, we earn our place on the interdisciplinary care team by being able to point to measurable “evidence” of our value and by using common language and terminology, such as “assessment tools,” “care plans,” “interventions,” and “best practices.”

It is undeniably true that the medical model demands that practitioners place their focus on science rather than art. The result is that cognate disciplines like medicine and nursing have become much more transaction-oriented rather than relationship-oriented, burying physicians and nurses in endless power plans, pathways, core measures and task lists. Dotting all the “i’s” and crossing all the “t’s” has become so overwhelming that additional positions have been created in health care systems for the primary purpose of monitoring for missing documentation and keeping clinicians on task. Precious little time is left for the vital yet unquantifiable work of creating and fostering meaningful relationship between health care providers and patients—the art of health care: listening to patients’ stories; learning patients’ goals and values; engaging patients’ questions, anxieties and concerns; partnering with patients in decision-making that reflects both providers’ clinical judgment and patients’ personal priorities.

Significant problems associated with this shift toward transacting rather than relating are documented by research. Studies consistently demonstrate that career dissatisfaction is on the rise among physicians and nurses and is rooted, in large part, in the growing emphasis on burdensome task-completion, particularly tasks that do not require the clinical expertise of those disciplines.[vii] This pressure, both internal and external, to make tasking the priority detracts from the aspect of their work that is well-documented to produce the highest levels of professional satisfaction—cultivating meaningful relationships with patients and co-workers.[viii] Research further reveals that patients, too, are highly dissatisfied. Surveys undertaken to evaluate issues of patient satisfaction repeatedly demonstrate that the corporate approach of modern health care does not correlate well with the ideas patients and families have about what makes for a positive health care experience.[ix] The goal may authentically be
to improve quality, but the ramifications of such high levels of dissatisfaction actually pose threats to both providers and patients. [x]

Our evolving profession needs to stay mindful about these research findings, lest we allow ourselves to become similarly demoralized and less effective. We cannot permit professional chaplaincy to be forced into a task-oriented model. Spiritual care at its core is and needs to remain relationship-oriented. I can stick my head into 25 hospital rooms each day and document that I ‘saw’ the patient in order to meet a measurable productivity standard, but did I provide spiritual care? I can commit to doing a spiritual assessment using a structured instrument, but if my determination to perform this task is inconsistent with the patient’s agenda and priorities for the conversation with the chaplain, then my persistence in the quest to satisfy the quality indicator does not constitute competent spiritual care. In our efforts to define, describe and justify our activities and our value, we need to guard against elevating form over substance. I believe we do this by giving art its rightful place in chaplaincy practice. In doing so, we model for our colleagues in related disciplines how they, too, can more effectively balance science and art for the benefit of their patients and themselves.

**Healing Relationship and the Crucial Role of Intuition in Competent Spiritual Care**

Acknowledging the limitations of the medical model liberates and empowers us to examine more broadly the qualities and characteristics that define spiritual care and, accordingly, are needed to serve competently as a chaplain. Developing a set of evidence-based practices and quality indicators along with objective testing for basic proficiency can be a valuable starting point in our efforts to professionalize; [xi] however, I do not think that this alone will be sufficient to ensure competent spiritual care. True competency lies in the chaplain’s demonstrated ability to know what to do with the objectively-identifiable information and skills in a particular situation. It is the capacity to transition from knowledge to wisdom. Competent spiritual care requires the chaplain to be aware and to be able to act on the awareness that the “best” way to “assess” or “treat” [xii] spiritual and emotional distress inevitably will vary from individual to individual, both the person being served as well as the chaplain—and how those individuals interrelate with one another.

The core of the chaplain’s effectiveness is rooted in the ability to form healing relationship. Among other things, this requires that the competent chaplain cultivate and utilize well-honed intuition. We need to re-evaluate the negative value judgment we attach to the use of intuition in our profession. I believe that well-developed yet unobservable and unquantifiable intuition is an essential component of the art of chaplaincy practice.

Perhaps a better model for the field of professional chaplaincy to emulate is one that is not routinely present at the interdisciplinary care table (but arguably should be): psychotherapy. Like chaplaincy, modern realities and pressures have similarly pushed the field of psychotherapy toward evidence-based practice models. [xiii] And like chaplaincy, there appears to be general consensus that this has been helpful in establishing a starting point for practitioners. But to be truly effective, this foundation must be enhanced holistically and creatively through the use of intuition in the actual encounter between therapist and client. Importantly, research in that field demonstrates that therapists believe the single most important factor in promoting change and healing in their clients is the quality of the relationship between them:

*The evidence based model of quantitative measurement leaves little room for creating therapeutic interventions that respond holistically to individual clients. Evidence based practice models are necessary roadmaps from which to navigate through the complicated journey of change, yet ultimately require the creativity of the practitioners who employ them...*
The therapeutic enterprise . . . is a moment-to-moment dance between two people, where the therapist must be attuned to what is salient in the exchange, what should be focused on, and ultimately, what intervention to employ. Essentially, “there is no algorithm that therapists can follow”, and the use of evidence based practice interventions in psychotherapy depend on the intuitive application by the therapists using them.

In evidence based practice research it has been acknowledged that perhaps one of the best indicators for client change in the therapeutic process is not the intervention itself, but the therapeutic alliance between the therapist and patient. [xiv]

Rev. Smith predicts that we will integrate more quickly when we align ourselves with other cognate health professions. I wholeheartedly agree that chaplains cannot operate effectively with a silo mentality. We must integrate fully into the interdisciplinary care team, but I think we need to protect our professional integrity by doing so in ways that are faithful to who we are and what we do, and with a clear understanding of what our function is on the team—and what it is not. We take our place at the interdisciplinary care table as the embodiment of the commitment to holistic, person-centered care and as the experts in promoting it. Unlike most other practitioners in the health care setting, chaplains do not “fix” or “help” others; we serve others. We are not curers (at least not directly); we are healers. In Rachel Naomi Remen’s eloquent words:

Serving requires us to know that our humanity is more powerful than our expertise . . . . Service is not an experience of strength or expertise; service is an experience of mystery, surrender and awe . . . . Those who serve have traded a sense of mastery for an experience of mystery, and in so doing have transformed their work and their lives into practice. [xv]

We make a positive difference in people’s experiences of health care. We alleviate suffering. We offer encouragement and empowerment in an environment that is intrinsically disempowering. We restore a sense of personhood where dehumanization is the norm. But we can only do that when we are allowed and encouraged to see each person with whom we interact as a unique individual and to tailor our approach accordingly—in other words, to use our well-honed intuition. Moreover, we can only do this when we recognize ourselves as unique and trust our intuition to be in relationship with another in a way that will effectuate healing in that particular circumstance. We need to be able to trust in the ability of others to know what they need to promote their own healing. And we need to trust in ourselves to be able to figure out how to serve in each singular and sacred instance.

As Dr. Remen urges, we need to “trust the mystery of healing, not as a theory but from lived experience.”[xvi] In our quest to integrate fully into the interdisciplinary care team, evidence-based practices and quality indicators certainly have their place. But heaven forbid we succumb to the pressure to become cogs in the wheel of corporate health care. Chaplains, perhaps most of all, can appreciate that selling the soul of our profession in order to fit in will not improve the quality of spiritual care or our own spiritual well-being. Let’s integrate by serving as a paradigm for improved balance between science and art in health care.

What counts cannot always be counted; what can be counted does not always count.

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Notes

[ii] Id.
[iii] Id.
[iv] Id.
[xi] Though I am not entirely convinced there is such a thing as completely objective testing, and I am dubious about its efficacy—my passing score on the bar exam after graduating from law school almost certainly measured and verified my cramming and test-taking abilities more than my competency and readiness to practice law.
[xii] Even within the medical profession itself, there is concern with a modern tendency to “medicalize” human emotions. See, e.g., Allan V. Horwitz, Jerome C. Wakefield, The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder (Oxford University Press 2007).
[xv] Rachel Naomi Remen, “Helping, Fixing or Serving?” Shambhala Sun (September 1999).
[xvi] www.rachelremen.com/

To cite this article: Lieberman, Karen. Protecting the Soul of Spiritual Care PlainViews. Vol 13 No. 5. 5/18/16. HealthCare Chaplaincy Network. Web: http://www.plainviews.org.