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Why Hospitals Must Be Hospitable; Why Health Care Must Be Healing--And Why Chaplains Must Lead the Way

The words "hospital" and "hospitable" and the words "health" and healing" are obviously derived from the same roots.[i] And yet, patient surveys repeatedly demonstrate that there is a significant disconnect between what goes on in a hospital and the idea of being hospitable, and between the modern health care system and any common sense notion of healing.[ii]

How did we stray so far from our roots?

Historic conceptions of health embraced an understanding of the interconnectedness of the mind, body and spirit. Classical Jewish texts, for instance, make a clear connection between the health of the body and the health of the soul. Medieval Jewish literature uses the term *"sheleimut"* for health, a word that derives from the word *"shalem,"* which means "whole." And the great medieval Jewish philosopher and physician, Maimonides, taught that "the physician should not treat the disease but the patient who is suffering from it."[iii]

Modernity pays lip service to this idea of holistic care, but generally does not practice what it preaches. Increased specialization has led to more rigid separation of these aspects of the person. A hospital patient today can look forward to being seen by innumerable practitioners; only rarely does anyone have panoramic vision of the overall impact of the various discrete interventions upon the patient as a whole.

The evaluation of health care outcomes in our time demands quantifiability. The medical model encourages us to focus on that which we can measure. Speed and efficiency are highly valued. Time guzzlers like education and meaningful dialogue with patients and families, for the most part, are not.[iv] The modern approach to medicine reduces the human being to an object even a kind of machine.[v] We label those we serve by their diagnosis, procedure, symptoms, body part, etc. We ignore their *humanity*. How can you measure that?

Alas, the human being is considerably more complex than this. Our failure to acknowledge and value those we serve in their totality is at least one reason that readmission rates are so high.[vi] We deal with the acute problems that bring patients into our hospitals, and then we send them out as quickly as possible. We need to hear and embrace our patients'

stories. Their stories are as important to their diagnosis as the latest piece of technology.[vii]

The Importance of Listening

Listening is much less expensive than tests and technology. But it can also be more time-consuming.[viii] And worse, it requires us to give more of ourselves in the care of our patients than many are willing or able to give.

Some reasons are external: productivity standards; ever-burgeoning paperwork demands; administrators who fail to grasp the real needs and under-hire in favor a bigger bottom line, placing additional strain on the system and on those who strive to do their best within it.

Some reasons are internal: some people are not good listeners. These folks miss much in their diagnosis of the patient. Some can hear but lack the empathy to do anything with what they've heard. And some would like to address the needs they've identified but have no idea how to do so, since these skills were not emphasized during their training.[ix]

When it comes to the patient's psychosocial needs, we order a psych consult or prescribe an antidepressant or a sedative, but we don't usually dig deeper for an answer to the real question—what is causing the depression, anxiety or agitation? What can we do about it besides hide it beneath a medication?

Many of my patients become deeply attached to me during their hospitalization. Often, they are demonstrably different in some way after we have met. Sometimes the patient can identify and articulate what is different. Sometimes the feedback instead comes from a surprised and often puzzled physician or nurse: "Wow, things got so much better after your visit!"

Why? It isn't because I possess some unique gift or ability. And it certainly isn't because I addressed their medical issues. I am, indeed, professionally trained as a board-certified chaplain—a far more rigorous and demanding path than the one I took in my first career to become a licensed attorney—but I often have no means of "fixing" their problems, and I virtually never have the miracle cure that so many come to the hospital hoping for or even expecting (thanks to modern-day marketing or overly-optimistic prognostications).

I believe what many patients feel after meeting with me is a profound sense of relief. Not necessarily relief from physical pain (though this may, in fact, sometimes be an incidental benefit), but rather relief from the spiritual and/or emotional suffering associated with the dehumanizing experience of hospitalization. They appreciate me because I am a *person* on the hospital staff who sees them, too, as *persons*. Not patients, not symptoms, not diagnoses and, God forbid, not a room number.

Returning a Sense of Wholeness

I give them a chance to return to their sense of wholeness. To their sense of empowerment. I reduce their feelings of isolation. I advocate for them (lawyer's genes) and I encourage them to advocate for themselves.

I can't offer drugs, tests or procedures. I offer empathy, warmth, connection, relationship. I diminish loneliness and fear and feelings of vulnerability with information and reassurance. I do not cure people (at least not directly), but I facilitate their *healing*. I believe people who heal have a much better chance of being restored to health (which may or may not mean being cured). Not only that, I believe they have a much better chance of restoring *themselves* to health.

What role, then, can chaplains play in enhancing the health care experience of patients and their families? Paradoxically, I believe we need to find our strength in our "limitations," and use the clarity that results from our limited ability to offer traditional medical interventions as a tool to meaningfully influence others and improve outcomes for patients and their families.

I am employed by a large health care system, but I am based primarily at a small community hospital where I actually know my colleagues and have the opportunity to work collaboratively with them. I meet individually with physicians and other clinicians on behalf of patients and families when I believe that will enhance the care being provided. I provide input at daily patient care rounds and participate in interdisciplinary care conferences. I offer orientation to new employees about the importance of spiritual and person-centered care, and I work with nursing, pharmacy and therapy students who are getting clinical experience in our hospital. I serve on my hospital's ethics committee and look forward to joining one or more of our newly-forming patient experience work teams. In all of these various venues, I am fortunate to have the chance to use my "limitations" to keep the connection between "hospital" and "hospitable" and between "health" and "healing" in the forefront of our collective consciousness and to influence the thinking, attitudes and behavior of a wide range of people and the overall culture of the organization.

How do I get others to "listen" to me? Certainly not by demanding that they do so. The "pastoral authority" we learn about in CPE is not conferred upon us by means of our certification. We earn our place on the interdisciplinary care team by establishing ourselves as safe, trustworthy and reliable colleagues. I endeavor to accomplish this (over time) by interacting with my colleagues the very same way I'm hoping they will treat our patients and families: with empathy, warmth, dignity and respect. By staying mindful of my word choices, tone and body language. By bringing appropriate humor into the discussion. And, perhaps most importantly, by actively listening myself in turn, i.e., by providing staff members with an authentic experience of being and *feeling* heard. That is the nature of healing dialogue. Once we have experienced something ourselves, we know better how to replicate it.

Chaplains have a unique opportunity to promote positive, constructive and caring relationship for the benefit of patients, families and staff. We are well-equipped to bring hospitality back into our hospitals and healing into health care, and to exhort others to join us. To be sure, there is still much work to be done, even at my small community hospital and certainly in the modern health care system generally. And it is not easy work. On the contrary, changing individual attitudes and institutional culture is a slow, tough slog, fraught with real frustrations and setbacks along the way.

Though our progress may not be linear, it can and must be forward progress nonetheless. The ***Mishna*** teaches, "You are not required to finish the work, but neither are you free to

desist from it."[x] Chaplains are not responsible for changing the entire system or even an entire workplace, but we are nevertheless obligated to do our part and to lead when and where we can.

References

[i] The words "hospital" and "hospitable" are derived from the Latin *hospes*, meaning "host," "guest," or "stranger." Charlton T. Lewis, *An Elementary Latin Dictionary* http://www.amazon.com/Elementary-Latin-Dictionary-Charlton-Thomas/dp/1174571098 (Oxford University Press, 2000), p. 371. The words "health" and "healing" are derived from the Old English *"hal,"* and the Old High German, *"heil,"* meaning "whole." *See* Byron L. Sherwin, *In Partnership with God: Contemporary Jewish Law and Ethics* http://www.amazon.com/In-Partnership-God-Contemporary-Jewish/dp/0815624905 (Syracuse University Press, 1990), p. 81.

[ii] *See, e.g.,* Peter Pronovost, "The Patient Wish List," *US News and World Report*, October 15, 2015 http://health.usnews.com/health-news/patient-advice/articles/2015/10/15/the-patient-wish-list ; Harvey Chochinov, MD, *Dignity in Care*, http://www.dignityincare.ca/en/

[iii] Sherwin, *supra*, p. 83 (quoting Moses Maimonides, *Treatise on Asthma*, p. 89).

[iv] *See, e.g.,* Roni Caryn Rabin, "You're on the Clock: Doctors Rush Patients Out the Door," *USA Today,* April 29, 2014 http://www.usatoday.com/story/news/nation/2014/04/20/doctor-visits-time-crunch-health-care/7822161/

[v] Sherwin, *supra*, pp. 192-93.

[vi] *See, e.g.,* Boulding W., Glickman SW, Manary MP, Schulman KA, Staelin R, "Relationship Between Patient Satisfaction with Inpatient Care and Hospital Readmission Within 30 Days," http://www.ncbi.nlm.nih.gov/pubmed/21348567 Am J Manag Care. 2011 Jan;17(1):41-8.

[vii] *See* Rachel Naomi Remen, *Kitchen Table Wisdom: Stories that Heal* http://www.amazon.com/Kitchen-Table-Wisdom-Stories-That/dp/1574530631 (Riverhead Books 1996); Chochinov, *supra*.

[viii] Through research studies, Dr. Chochinov rebuts the assumption that active listening absorbs more of a caregiver's time, arguing instead that offering a patient complete and undivided attention can actually reduce the amount of time needed to provide quality care. Chochinov, *supra*.

[ix] We are seeing notable improvement in this area, as medical training programs increasingly include time for self-reflection and coursework in effective and empathic communication. *See, e.g.,* Stacey Burling, "Medical Students Use Self-Reflection to Improve Patient Care," *The Philadelphia Inquirer,* September 27, 2015 http://articles.philly.com/2015-09-27/news/66932660_1_students-patients-homeless-man ; Jacqueline Fellows, "Add Empathy, Improve Patient Experience," *HealthLeaders Media,* October 1, 2015 http://healthleadersmedia.com/print/PHY-321254/Add-Empathy-Improve-Patient-Experience

[x] *Pirkei Avot* (2:21).

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This piece is dedicated to the memory of her teacher, Rabbi Dr. Byron L. Sherwin, ZT"L

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