

Engaging Medical Culture: Suggestions for the Education of Healthcare Chaplains

Dagmar Grefe
Cheryl D. Lew

Summary

In order to function in an interpretive role about the meaning of illness, chaplains need to be able to understand its culture and move into the frame of reference of the medical world.

“We were included as part of the team, never disregarded.”

“It’s hot and cold. There are some staff members who know what we are doing and others don’t.”

“It’s different in end-of-life situations. When you’re paged and on-call, your presence is noticed more. The doctors would step away once the family started to cry and would turn to us then.”

“Some staff sees chaplains primarily as Christian and don’t have yet fully incorporated that we are interfaith.”

These statements are from Clinical Pastoral Education (CPE) interns and residents and express their impressions of their integration with hospital staff at the completion of a training program in a large medical institution. Even after several years of the CPE program’s existence in the hospital, trainees experience their integration in the healthcare teams as mixed. On the one hand, they feel welcome and included by other healthcare professionals, es-

Rev. Dagmar Grefe, PhD, is clinical assistant professor of pediatrics at the Keck School of Medicine, University of Southern California and manager of the Department of Spiritual Care and Clinical Pastoral Education at Children’s Hospital Los Angeles, 4650 Sunset Blvd., Mailstop 80, Los Angeles, CA 90027 (Email: dgrefe@chla.usc.edu).

Cheryl D. Lew, MD, MSBioethics, Associate Professor of Clinical Pediatrics, Bioethicist, Children’s Hospital Los Angeles, University of Southern California, Keck School of Medicine, 4650 Sunset Blvd., Los Angeles, CA 90027 (Email: clew@chla.usc.edu).

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pecially when they are needed in crisis situations. At the same time, they feel that many healthcare team members do not clearly understand their role as a chaplain. As Wendy Cadge in her study of the role of religion in hospital settings indicates, these inconsistencies in perceptions are not uncommon.¹ They may indicate a structural problem inherent in the role of the chaplain: Chaplains do not integrate in the medical culture as easily as other professional groups. In this article, we suggest steps that will assist those who prepare students for professional chaplaincy with this integration. Dagmar Grefe provides reflections from the perspective of an ACPE supervisor and manager of spiritual care. Cheryl Lew responds from her perspective as a physician and medical educator.

Culture, commonly understood, includes the patterns in which groups of people experience and understand life: values, language, ideas, structures of social relationships, behavioral patterns, and customs.² On hearing the word "culture," we initially may think of different ethnic groups. But professional groups also develop a unique culture with particular patterns of behavior and communication. The vast majority of Clinical Pastoral Education is done in the field of healthcare which has its own culture in hospitals and hospice programs.

In order to effectively care for patients, CPE interns and residents need to develop competency in engaging the medical culture in which they work and function. I understand medical culture here broadly as the prevalent culture in healthcare settings shared by members of the interdisciplinary healthcare teams comprised of physicians, nurses, allied health professionals, and administrators. I offer five suggestions for educators assisting chaplain interns and residents in integrating into the culture of healthcare: 1) reflect on spiritual care in a secular context; 2) develop tools of communication; 3) develop specific curricula; 4) become conversant in outcome-based research; and 5) build on common ground.

REFLECT ON SPIRITUAL CARE IN A SECULAR CONTEXT

Institutional medical care has undergone a paradigm shift from pre-Renaissance hospitals as religious charitable organizations to contemporary medical institutions with a focus on cure and treatment of acute illness through primarily rational-technical means.³ Today's healthcare chaplains are challenged to articulate their role in the world of medical science. The medical anthropologist Francis Norwood has shed light on this situation with her

12-month ethnography observing chaplain interns at a university teaching hospital. In her assessment, the tension between religion and medicine is inherent in the role of the chaplain. Chaplains, she concludes are “ambivalent.” In order to survive, they must alternatively embrace the religious world and the medical world. They are marginalized in the hospital setting, but not without agency.⁴ Chaplains do not initiate religion unless it is desired by patients or their families. They primarily focus on developing interpersonal connections in order to attend to patients’ spiritual needs, thus downplaying their religious role and being more congruent with the medical world.⁵ At the same time, they are distinct from the dominant medical culture by taking time to listen to patients, providing non-invasive presence and support, and stepping into areas where some other healthcare disciplines are marginal—when cure is not possible and patients face death. Since Norwood’s study is limited to the experience of chaplain interns, the experience of marginalization may be amplified and not representative for all chaplains. However, Cadge’s study of the role of spirituality in healthcare underscores that the professional legitimacy of chaplains is not always self-evident and their role remains unclear for many staff members.⁶

The physicians Carla Boutin-Foster, Jordan C. Foster, and Lyuba Kopasek propose that medical students become more sensitive toward the diverse cultures of patients when they develop self-awareness about their own medical culture.⁷ Medical students learn their culture often through role modeling and a “hidden curriculum.” As medical students become intentionally reflective of the customs, language, and belief systems of their professional culture, they can also appreciate the culture of diverse patients rather than seeing the patient simply as an “other.”⁸ In a similar fashion, we can better assist chaplain trainees by reflecting in formal discussion on their religious culture, how it differentiates from the medical culture and how they can constructively relate to the latter.

Our society has become increasingly secularized and, at the same time, religiously pluralistic. Patient populations and staff in healthcare organizations reflect these cultural shifts. Spiritual care providers in public institutions are challenged more than religious community leaders to engage not only religious pluralism, but also a scientific and secular environment. When they first encounter this context, they may experience a “culture shock.” Chaplain interns and residents must learn an abundance of information when they enter the hospital. As part of orientation they receive a crash course in patient safety, infection control, the roles of different healthcare

professions, as well as basics about spiritual care and crisis management. They have to cope with a heightened level of anxiety about being with persons in crisis. Once they begin visiting patients, they also quickly encounter stereotypes of patients and staff who often do not know much about the role of the chaplain and may mistake them as providers of end-of-life rituals ("angel of death"), or possible proselytizers.⁹ Chaplain interns and residents have to show initiative in reaching out to medical staff in order to raise spiritual concerns of patients in interdisciplinary meetings.

Chaplain interns and residents have spent several years in theological education where their main orientation toward religion has been shared by their peers and professors. The primary dialogue partners of theological disciplines are philosophy and the humanities, which in the medical world are often considered as "soft science." The majority of professional chaplains and clinical educators have not been educated in empirical sciences. Theological students are being prepared to become religious leaders. When entering the hospital they learn that their status is low in the staff hierarchy and that their role is not clear to many healthcare team members. These experiences can be intimidating and create diffuse feelings of inferiority, particularly when the underlying cultural differences are not addressed. In order to relate to the medical context constructively, spiritual care providers need to first become aware of their own religious culture and appreciate how different it is from the scientific medical culture they encounter in the hospital setting.

DEVELOP TOOLS OF COMMUNICATION

Boutin-Foster, et al, point out that "the lexicon of physicians is characterized by statistical facts, presented in terms of probability, gradations of severity, and the use acronyms and medical terminology that are often unfamiliar to the patient."¹⁰ At times they speak in impersonal language, referring to the patient rarely by name.¹¹ Physicians' explanatory models of illness are based on "their perceptions of the etiology, onset, pathophysiology, course, and treatment of a disease process."¹² Patients often interpret the meaning of an illness differently. Their understanding is shaped by their culture and they reflect on it in terms of what it means for their daily life, their future, and those close to them.¹³

Many patients and families, especially those for whom a health crisis has raised spiritual questions, embrace the chaplain's support. For them spiritual care can become an important element of coping during their hospital-

ization. Even patients and families who do not see themselves as formally religious often benefit from the care of interfaith chaplains. Chaplains seek interpersonal engagement with patients and assist them in processing what the illness means to them and their loved ones. They can be cultural brokers in raising these patient voices to the medical team. Their closeness to the experience of patients, their understanding of patients' spiritual questions, and coping mechanism contribute to the work of the whole healthcare team.

In order to function in this interpretive role, chaplains need to be able to move into the frame of reference of the medical world. Wendy Cadge observes that many chaplains are hesitant to chart in the medical record and often provide little detail about their interactions with patients, leaving medical staff members "uncertain about the care chaplains provide."¹⁴ Without the proper communication of this care, in interdisciplinary team meetings or in the medical record, the chaplain's patient care remains invisible. Their work may be of great benefit to the patient, but the healthcare team may not know about it because it happens in a parallel world. Over the years, I have seen chaplains' chart notes with statements such as "this chaplain assured the patient that God loves her." The use of theological language in the medical record seems to indicate that the author of such a note is unaware that their religious language is not understandable in a medical record where religious framework is not shared.

In addition to a consultation note that includes a spiritual assessment, our hospital encourages chaplains to contribute to the multidisciplinary plan of care, which all members of the healthcare team review and sign before patient encounters. Chaplains are encouraged to contribute care issues that the whole team can address and to formulate treatment goals for concerns such as "spiritual distress," "grief," or "anxiety," for example. I have found that chaplaincy students have difficulty communicating their work with patients with concrete outcomes in mind or how their patient interactions benefit the patient, or how they relate to the approach of the medical team. I have increasingly devoted time with students in skills laboratories, reviewing their documentation and assisting them in developing a language that is understandable in a non-religious context, focused on observable data, assessments, articulating goals for their care plan and reflective of the care plan of the multidisciplinary team.

DEVELOP SPECIFIC CURRICULA

Over the years, when writing final evaluations for level 1 CPE interns, I have found that the ACPE outcomes insufficiently address what and how students learn about patient care.¹⁵ Only one outcome addresses patient care directly: "311.7 Initiate helping relationships within and across diverse populations." Other outcomes speak to self awareness about one's personal and religious history, functioning in individual and group supervision, integration of theory and practice, and engagement of the learning process. When reading the outcomes of level 1 CPE, I imagine the student primarily in the spiritual care office in interaction with the supervisor and peers, rather than in the patient room or on the hospital unit. The trademarks of Clinical Pastoral Education have been the interaction of interpersonal experience and reflection, and the nurturing of self-awareness. These are indeed important elements in patient care, but our focus needs to become much broader.

The outcomes for level 2 CPE are more directly related to patient care. However, the standards are so vague that there is little guidance on what and how to teach, which contributes to inconsistencies among training programs. Standards would be enriched if they focused specifically on therapeutic communication skills, basic understanding of grief, crisis management, coping, death and dying, medical ethics, clinical documentation, just to name a few examples. Many of my colleagues in CPE include these topics in the curriculum, but our standards do not reflect this practice.¹⁶ I also hear from colleagues that they wish basics in healthcare administration would have been part of their curriculum in supervisory education.¹⁷ Our low emphasis on skill development may contribute to the cultural differences to other professional training programs in healthcare. Clearer standards and definition of core competencies will help us in integrating our work with those of other professionals in the interdisciplinary healthcare team.

BECOME CONVERSANT IN OUTCOME-BASED RESEARCH

Concluding her study of the role of religion and spirituality in healthcare, Wendy Cadge gives recommendations for health-care providers, administrators, and chaplains, providing constructive contributions to the professionalization of spiritual care. In her assessment, chaplains "need to ask themselves what their patients need and what outcomes are central to their work."¹⁸ Some chaplains may be skeptical about engaging in evidence-based

research as a legitimization of their work for fear of losing their identity. After all, spiritual care providers are guided by their spiritual values of attending to the sick and vulnerable, providing compassionate support for persons in crisis, for the dying and their families. But communicating these values and the service to patients in the language that is spoken in the healthcare setting does not mean giving up our professional identity. Thinking about our work in terms of outcomes for patients and families can make us more effective in what we do. We can become better advocates for compassionate care when we learn and teach our trainees to actively engage the medical culture.

In addition, many of us do not feel adequately prepared for outcome-oriented research. Cadge takes stock of traditional chaplaincy education and concludes: "Many learn little about what an outcome is or about the standards that administrators refer to when they speak of evidence-based medicine."¹⁹ As educators we are challenged to become familiar with research methods that are new to us, but necessary if we want to be able to critically evaluate empirical studies, and to conduct studies investigating how spiritual care may contribute to the quality of life and coping of patients and families. Theological graduate programs specializing in Master degrees in chaplaincy could take on an important role in teaching outcome-based research.

BUILD ON COMMON GROUND

Cultures are fluid, and so far, I have painted a rather static picture pointing out the differences between religious and medical culture. Many chaplains are intentional about the integration in the medical team, through participation in interdisciplinary team meetings and through appropriate documentation of spiritual assessments and care plans. While physicians are primarily concerned with the physical well-being of their patients, I have seen many physicians provide emotional support and speak compassionately with their patients and families. Chaplains are the experts in addressing the spiritual needs of patients. However, nurses, social workers, and increasingly physicians are being trained to screen for and address spiritual needs. The field of integrative medicine is evolving, and physician leaders such as Christina Puchalski and Harold Koenig have advocated for stronger inclusion of spirituality in healthcare.²⁰ As providers of and educators for spiritual care, we can only benefit by strengthening our efforts in joining these discussions about the role of spirituality in healthcare and by contributing our perspectives.

Chaplains offer an important service to patients, families, and the institutions in which they work. They are close to the experience of patients and their communities. They facilitate patients', families, and often staffs' spiritual coping with crisis, providing a service that is relevant to patients but not widely addressed by others. We can strengthen this service if we assure that we provide it, not parallel to, but integrated into the work of healthcare.

Commentary and Response from a Clinician-Educator Bioethicist:

I appreciate Rev. Grefe's proposal for improving chaplaincy education within the hospital setting. Therefore, rather than comment on each of her points, I thought to add a few remarks in supplement to her views.

From the time when the Children's Hospital Los Angeles (CHLA) institution recognized the need and value of developing a Spiritual Care service until the present, there has been a sea change in the understanding of professional culture. In particular, we're concerned with the culture of "biomedicine" as described by Arthur Kleinman—to include an "extreme insistence on materialism as the grounds of knowledge" and the requirement that "single causal chains must be used to specify pathogenesis in a language of structural flaws and mechanisms as the rationale for therapeutic efficacy."²¹ This uber-technologic stance regarding disease understanding and therapy has not given way to the previous holistic "family and patient centered care" but has grown beyond its silo to include a more holistic, integrated view that admits its own limitations, engages in self-reflection, and whose principal goal is the alleviation of suffering. Kleinman and others also acknowledge the many subcultures within biomedicine—physicians, nurses, developmental specialists and psychosocial professionals (social work and psychology)—are increasingly active in their places at the table.²² Further, in an academically intense teaching and research institution like CHLA, virtually all subspecialty services, including the very large General Pediatrics Division, have adopted an interdisciplinary model of clinical delivery, i.e., healthcare teams which attempt to provide a form of "family-centered medical home-like" care, even on an inpatient basis.

An examination of the history of interdisciplinary team-building at CHLA will provide some guidance for better integration of CPE trainees into present day teams.

Some 40 years ago at CHLA, both the Divisions of Neonatology & Pediatric Pulmonology and Hematology-Oncology, under enlightened medical division leadership, saw the value of involving other healthcare and

psychosocial professionals as part of their healthcare teams. The specific motivations included: 1) improvement in continuity of care through case management, principally by advance practice nurses specialized in the particular expertise of each medical division; and 2) family-centered and holistic care through attention to psychosocial needs. These team approaches were so successful that government and public insurance programs began to make both hospital and physician payment contingent upon having such teams and documenting accountability from each team member. Expectations for each team member were consistent involvement in patient care, participation on a regular basis of either or both interdisciplinary bedside rounds and care, and conferences with and without patient/family.

It is important to acknowledge that there are already healthcare professionals on the team who function as intermediaries in maintaining communication with patients and their families. Further, these healthcare professionals may also function as advocates for patients in the larger community. In this context of interdisciplinary care, what role for chaplaincy should there be? Clearly, chaplains provide an additional and probably different viewpoint in addition to simply being an additional observer of patient behavior or interaction not seen by other members of the team.

What may be necessary to more fully integrate chaplaincy into the healthcare team is to consider the following: 1) Expectations of chaplains should include consistent and regular involvement in patient care as a part of the team, as opposed to solely as individual, private interaction including participation in team rounds and conferences on a regular, scheduled basis; 2) In order for chaplaincy trainees to become acculturated to the acute care environment through role-modeling, staff chaplains must also meet the expectations under 1) as well. The only way to have both a seat and voice at the table as other allied health professionals do is not to inhabit the same technical language as physicians and nurses, but to be visible and vocal from the perspective and expertise of spiritual care; 3) Be part of team building efforts encompassing what Margaret UrbanWalker has described as a process of iterative discussion among group members, face to face and together, in order to understand and build common ground and common language.²³ In such a process, chaplaincy interns may learn an appropriate degree of self-assertiveness in explaining and advocating for their viewpoints; and, 4) just as all the other allied health professionals have asserted their professional roles and voices in ongoing dialogue with medical teams, chaplains must do the same.

Finally, it should be noted that medical residents may not have the same degree of competence in small group or team work as their attending faculty members. By the same token, perhaps it is not a realistic or practical expectation that chaplaincy interns feel any more integrated into the team process than their staff chaplaincy faculty do. Perhaps a necessary part of the learning process is to feel a bit lost. Only in acknowledging one's limitations can one actually identify which skills must be acquired in order to achieve the next level of mastery.

NOTES

1. Wendy Cadge, *Paging God. Religion in the Halls of Medicine* (Chicago: Chicago University Press, 2012), 122.
2. Emmanuel Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed. (London and Philadelphia: Jessica Kingsley Publishers, 2003), 31.
3. Francis Norwood, "The Ambivalent Chaplain: Negotiating Structural and Ideological Difference on the Margins of Modern-Day Hospital Medicine." *Medical Anthropology* 25, no. 1 (2006): 3–4.
4. *Ibid.*, 1; 4.
5. *Ibid.*, 20.
6. Cadge, 121ff.
7. Carla Boutin-Foster, Jordan C. Foster, and Lybua Konopasek, "Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence." *Academic Medicine* 83, no. 1 (2008): 106.
8. *Ibid.*, 109; 106.
9. See also Norwood, 18–19.
10. Boutin-Foster, et al, 108.
11. *Ibid.*
12. *Ibid.*, 109.
13. *Ibid.*
14. Cadge, 124.
15. Association of Clinical Pastoral Education, "311.7 Initiate Helping Relationships within and across Diverse Populations," *ACPE Standards & Manuals*, 2010, 14f, accessed February 16, 2014, http://www.eneacpe.org/Home/Accreditation_files/ACPE%20Accreditation%20Manual.pdf.
16. The Education Committee of the Pacific Region of the ACPE currently is developing a common core for level 1 and 2 CPE. A taskforce of the national ACPE has worked on

a curriculum for supervisory education. These efforts are a welcome first step in the direction of more specificity in curricula for the training of chaplains.

17. See also Cadge's recommendations, 205.
18. *Ibid.*, 204.
19. *Ibid.*, 205.
20. To name just two publications: Christina M. Puchalski and Betty Ferrell, *Making Healthcare Whole: Integrating Spirituality into Patient Care* (West Conshohocken, PA: Templeton Press, 2010) and Harold Koenig, *Medicine, Religion and Health: Where Science and Spirituality Meet* (West Conshohocken, PA: Templeton Press, 2008).
21. Arthur Kleinman, *Writing at the Margin: Discourse between Anthropology and Medicine* (Berkeley, CA: University of California Press, 1995), 21–40.
22. Renée C. Fox, "Cultural Competence and the Culture of Medicine," *The New England Journal of Medicine* 353, no. 13 (2005): 1316–1319.
23. Margaret Urban Walker, "Keeping Moral Space Open," *Hastings Center Report* 23, no. 2 (1993): 33–40.