

## The Human Touch: A Phenomenological Study of Spiritual Care Workers in the Hospital Setting

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### Abstract

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This qualitative phenomenological study investigated the perceptions of medical personnel working in mid-sized acute-care hospitals of the effectiveness of spiritual care workers (chaplains) in providing care for hospitalized patients and their families. Participants were asked to relate their experiences and impressions of the work done by spiritual care workers and the effects on the physical, emotional and mental well-being of the patients these individuals serve. From the research the following themes emerged: 1) No Ordinary Day, 2) Things That Give Comfort, 3) A Silent Presence, and 4) Healing of the Soul. Findings showed that medical providers view spiritual care workers as a positive influence on patient and family healing, and as specialists in spiritual and emotional patient care. In addition, medical personnel reported having respect and high regard for spiritual care workers and their contributions to care of the "whole person". Interviewees also were shown to value the spiritual support they themselves received which participants credit with allowing them to continue to work in an emotionally demanding patient care role.

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**Keywords:** hospital chaplains, holistic care, grief, comfort, family support, hospice

### 1. Introduction

Spiritual care providers have long been part of the patient care team in the acute care hospital setting although opinions about their value to patient care vary. Under the Sustainable Growth Rate Formula, in which Medicare reimburses medical facilities for services provided based on CPT codes, reimbursements have declined while costs have risen (Van de Water, 2010; Guterman, Zezza, & Schoen, 2013).

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Private insurers, long counted upon to make up the difference between costs of care and Medicare payments, are now matching the reduced reimbursement rates (McIntosh, 2011; Potter, 2012). As hospitals cut costs to adjust for declining reimbursements, nonessential services are often at risk for reduction (Rolfes, 2013). Given this fiscal challenge, there is a need to document the value of certain services such as spiritual care work for patients to support hospitals continuing to offer these kinds of features.

## **2. Previous Research**

Research on chaplain effectiveness has been limited and generally falls within two categories: patient satisfaction studies and outcome studies of specific chaplain-patient interactions and chaplain interventions (Gleason, 2012a; Jankowski, Handzo & Flannelly, 2011; Galek, Flannelly, Jankowski, & Handzo, 2011). Gleason (2013) states that the best assessor of spiritual care value is the patient (Gleason, personal communication, 6 April 2013), yet patient surveys after care frequently share the issue of being nonspecific as to what exactly provided the satisfaction. Intervention studies share a similar lack, as it is difficult to specify the outcomes directly resulting from the specific work of spiritual care workers as separate from other caregivers' work. As an example, Jankowski et al. (2011) found no patient-outcome studies that documented chaplaincy care in particular rather than spiritual care provided by the multidisciplinary team.

Ethical considerations also exist around data collection. Patients and their families are by definition in a vulnerable state at the time they use hospital and chaplain services. Data collection is difficult without intruding upon patients and their families at a time when their resources are needed for healing and recovery or obtaining information after they have left the hospital.

One outcome-related approach has been to measure spiritual care efficacy from other members of the patient care team, specifically their impressions of the value of spiritual care to patient treatment. Cadge, Calle, and Dillinger (2011) compared how pediatricians and chaplains working together at the same medical center viewed the work of a chaplain. This method, while not capturing the opinions of the customer (patients and their families), avoids the risk of potentially invading individuals when they are vulnerable.

## 2.1 Significance of Study

The study of the value of spiritual care can add critical information to the health care equation and patient experience. Hospitals are more likely to allocate funding to continue to support their spiritual care staff if further evidence and knowledge is generated to support the continuance of spiritual care. A study focused on spiritual care is of interest to health care administrators and practitioners seeking to provide the best medical care possible with limited budgets. This kind of study is also of value to spiritual care professionals as it measures effectiveness by querying a skilled and discriminating pool of informants (medical doctors and nurses working full time in the acute care hospital setting). In this study, the terms "chaplain" and "spiritual care worker" are used interchangeably. In much of the literature reviewed for this study, the term "spiritual care worker" was used as an illustration for the more holistic work that these individuals provide for the spiritual care of patients and their families, while "chaplain" typically had a narrower focus with religious connotations ("What does it," "A simple explanation").

## 3. Literature Review

To better explore this phenomenon, previous literature and research that explored the role of a spiritual care worker in the acute-care hospital setting were reviewed. Specifically, literature that discussed the understanding of spiritual care worker roles in patient healing, participation in team-based patient care, and the value of the spiritual care worker in holistic patient care was examined. This review sought to digest some of the literature surrounding the contribution of hospital chaplains to patient care and to look into future trends for chaplaincy and spiritual care.

### 3.1 Defining Spiritual Care Worker Roles

Spiritual care varies in definition, role, and responsibility between patients and other health care providers and among health care delivery systems (Cadge, et al., 2011; Piderman, Marek, Jenkins, Johnson, Buryska, & Mueller, 2008). In the US and Canada, hospital chaplains are required to be certified by one of five agencies which have common requirements that include: (a) a graduate theological education, (b) endorsement in a particular faith tradition, (c) clinical pastoral education equivalent to a year of post-graduate education, and (d) demonstrated clinical competencies (Sakurai, 2003).

In Great Britain, the National Health Service has no comparable or single standard for chaplains (McManus, 2006). However, a 2006 study recommended standards to provide a common framework of training, reflection, and skills development (McManus, 2006).

Spiritual care workers have defined their role as aiming to “offer a sense of God’s attentiveness and compassion in the midst of suffering and struggle” (Piderman et al., 2008, p. 58) and see a primary function as responding to crisis (Sakurai, 2003). Spiritual care workers value the attention they can pay to healing and the spiritual and emotional support they provide, and speak of healing in the healthcare setting as an outgrowth of relationships (Cadge et al., 2011).

From a patient perspective, a Mayo Clinic study asked hospital patients to rate the importance of listed reasons for requesting a chaplain visit. The top rated reason was “to be reminded of God’s care and presence” (Piderman et al., 2008, p. 61). Patients have been found to value spiritual care workers’ listening skills, their presence in times of anxiety, and the care they provide to the patients’ families (Piderman et al., 2008, p. 64).

From the physician perspective, the Cadge, Calle and Dillinger (2011) study revealed chaplains had a broad view of their place in patient care, providing perspectives of “wholeness, presence, and healing” for the families (p. 302). The researchers also found some pediatricians saw the chaplains as part of the interdisciplinary team and as providing support to patients and families, particularly around deaths (Cadge, et al., 2011).

Some pediatric oncologists in the study viewed chaplains similarly to social workers, as an additional resource on whom to call rather than as integral to the care team. Some physicians expressed concerns about accommodation of the wide variety of faiths represented among patients and their families and the need for complementary and alternative medicine (Cadge et al., 2011).

From the hospital administrator perspective, Flannelly et al. (2005) queried hospital department directors on their perceptions of spiritual care workers’ roles and functions. Healthcare professionals in this study rated spiritual care workers highly on their contributions with grief work, as patients and families who are unable to progress through the grief process use disproportionate amounts of hospital resources, in addition to increasing their own suffering (Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005).

The same study found that prayer was perceived as a principle function of a chaplain; physicians rated prayer lower than other hospital professionals, which the study authors suggest may be due to physician training in the scientific method and their view of spiritual matters as unscientific (Flannelly et al., 2005). The study suggests some healthcare providers may be unaware of the extensive training in patient care that certified chaplains must complete, and the authors recommend in-service education to hospital staff to increase chaplain utilization.

### 3.2 Changing Roles

The Joint Commission for the Accreditation of Healthcare Organizations (now simply the Joint Commission) has changed its recommendations regarding provision of religious and spiritual care to hospital patients (Cadge, Freese, & Christakis, 2008). After 1997, The Joint Commission added recommendations that each patient have, at the very least, a spiritual assessment that looks at how his or her spirituality may affect the care received (Sakurai, 2003). The content of this spiritual assessment is not specified, though the Joint Commission offers a list of potential survey areas ("Standards FAQ details," 2008). The US Federal Centers for Medicare and Medicaid Services (CMS) to date reimburses for spiritual care only for hospice patients, and requires that spiritual care be provided to this patient segment in order for facilities to be reimbursed as hospice care providers ("Medicare and Medicaid Programs," 2008).

Hospitals pay for patient spiritual care out of overhead, and as Jacobs (2008), believes that hospitals must make an investment in their spiritual care teams.

Spiritual care workers' work around the process of dying and grief continues to develop as they add the rituals of various faith traditions, create formal bereavement programs, and serve as spiritual figures who provide the transition of the loved one from life to death (Cadge et al., 2011; Barletta & Witteveen, 2007). Thus, the role of a chaplain has expanded from providing prayer and faith rituals, to support the patient and the family (Sakurai, 2003). Mulder and Carey listed seven key roles of spiritual care providers: 1) a quiet attentive presence and a listening ear, 2) bedside visitation, 3) counseling for issues associated with bereavement, personal crisis, grief, and loss, 4) organization of funerals, 5) prayer, 6) sacraments and rituals, and 7) encouragement and support of patients by respecting their dignity and bringing peace and hope (as cited in Barletta & Witteveen, 2007).

Carey's list from 1972 uses more religious language: 1) witness role – telling of God's love and life's meaning, 2) thanatonic role – helping patients and families cope with terminal illness and death, 3) sacramental role – using ritual to comfort and strengthen patients, 4) prayer role – chapel services and praying with and for patients and families, 5) teacher role – discussing ethical questions, 6) counselor role – skills to help patients with anxiety, guilt and family problems, 7) team-worker role – acting as part of the hospital healing team (as cited in Barletta & Witteveen, 2007).

Researchers from the Department of Sociology at Brandeis University studied whether the Joint Commission's recommendations have had measurable effect on how hospital systems provide spiritual care up through 2008 (Cadge, et al., 2008). One hypothesis was that not-for-profit hospitals and teaching hospitals would be more likely to have spiritual care services than would investor-owned systems, as chaplains do not directly contribute positively to the hospital bottom line. The study found a positive correlation between hospital size and presence of spiritual care staff, and between church-operated hospitals and presence of spiritual care staff (p. 628). The study suggests that the Joint Commission's guideline changes are mostly symbolic, "reflecting changes already being made in hospitals" (p. 630).

Smaller hospitals and rural area hospitals were found to be less likely to offer spiritual care than were urban hospitals (Cadge et al., 2008).

The authors suggest this could be attributed to the presumed availability of local religious leaders, combined with lack of resources to fund and operate a spiritual care department (Cadge et al., 2008). Sakurai (2003), herself a Catholic chaplain, states replacement of hospital chaplain services with local clergy visits is ineffective, as "the chaplain's role is radically different from that of community clergy" (p. 28). Sakurai (2003) describes a medical facility as a "foreign land" to parish clergy members, who are accustomed to the homogeneity of the members of their own churches (p. 28). In contrast, hospital chaplains are trained first to investigate each patient's belief system and honor what has meaning for the patient (Sakurai, 2003; Handzo, 2006). Chaplains are trained to distinguish between religion and spirituality (Wintz, 2013), and to be a resource for healing and wellbeing rather than evangelists for a particular faith (Wintz, n.d.) Differences between the duties of a chaplain and of community clergy are also defined by the Health Insurance Portability and Accountability Act's instructions regarding patient privacy (Health Insurance Portability and Accountability Act, 1996).

Community clergy may be welcome guests in the health care setting, but because they are not on staff, their access to patient information is limited, while hospital chaplains, as members of staff, have more extensive access (Sakurai, 2003).

### 3.3 Next Steps

Spiritual care workers face heavier workloads as the number of such staff employed by US hospitals decreases, with a spiritual-care-worker-to-patient ratio estimated at 1.8 to 2.6 full-time-equivalent spiritual care workers per 100 patients, the higher number being found in religiously affiliated hospitals (Piderman et al., 2008). Spiritual care workers employed in the United Kingdom's National Health Service reported feeling stress as they became aware that spiritual care was an area being reviewed for budget cuts, resulting from the National Secular Society of Britain recommendation that the over-32-million-pound annual cost of chaplain care should not be funded out of NHS budgets (Kendall-Raynor, 2009).

To continue to grow the role of the spiritual care worker in order to meet changing needs and changing budgets, the Standards of Practice Acute Care Work Group of the Association of Professional Chaplains, and the Association for Clinical Pastoral Education and National Association of Catholic Chaplains released the second draft of its Consensus Document for Standards of Practice for Professional Chaplains in Acute Care (2009). This document is considered to be under constant review as needs and conditions in the industry change (Standards of Practice Acute Care Work Group, 2009). The document applies best practice principles used elsewhere in health care, such as developing a plan of care, adhering to a common code of ethics, providing timely and sensitive care, adopting continuous quality improvement, and practicing evidence-based care and contributing to research when appropriate. Derrickson (2012) expressed concern about the research component, cautioning against research priorities detracting from the theological base of chaplain work.

Gleason (2012b) attempted to address this concern, and constructed a knowledgebase of 395 chaplain care case samples, suggesting it be used, among other things, as a source of second opinions. Users are instructed to categorize a current case based on given guidelines, search the knowledgebase for similar cases, and compare those cases with the care plans they have chosen to analyze the effectiveness of outcomes (Gleason, 2012b).

Often spiritual care professionals lack hard evidence of the effectiveness of their patient care and the benefit they provide to health care systems (Gleason, 2012a). Hennepin County Medical Center, located in Minneapolis, Minnesota, sought ways to “work with a management paradigm that demands tangible proof that any service offered provides measurable benefits” (Richardson, Owens-Pike, & Bauck, 2011, p. 22). Utilizing a process improvement tool called Plan-Do-Study-Act, or PDSA (Institute for Healthcare Improvement, 2012), spiritual care workers at Hennepin County Medical Center invited patients and families to report on what they found valuable about spiritual care. The study involved contacting family members of hospitalized patients and interviewing them about their experiences. This approach demonstrated to hospital administration that spiritual care was contributing to the system’s improved patient satisfaction scores, leading to increased budgeting for grief support hours and improved alignment of the chaplains with organizational mission, vision, and values (Richardson et al., 2011, p. 26).

Jacobs (2008) pointed out another difficulty with patient satisfaction scores, that the patients with whom spiritual care people spend the most time are dying and therefore do not fill out patient satisfaction surveys (Jacobs, 2008).

Flannelly, Weaver, and Handzo (2003) looked at the source of oncology patient referrals to spiritual care at Memorial Sloan-Kettering Cancer Center in New York City. This study found that nurses produced the highest percentage of referrals, theorizing that nurses may be more religious themselves and citing also the formal orientation of nurses to pastoral care. A 10-year comparison of chaplaincy in the New York City area studied the time chaplains spent with patients and with their families (Vanderwerker, Handzo, Fogg, & Overvold, 2008). As hypothesized by the study authors, time spent with patients increased at the expense of time with families (p. 20). Like in the Memorial Sloan-Kettering study finding (Flannelly et al., 2003), nurses in the Vanderwerker et al. (2008) study were found to play a substantial role in referring patients to spiritual care (2008). These two studies are rich sources of data about referrals which may be useful in recommending changes that will increase effective use of chaplain services. Flannelly et al. (2012) sought to evaluate chaplain contributions toward assisting patients at end of life and found a positive correlation between chaplaincy services and both lower rates of hospital deaths and higher rates of hospice enrollment (Flannelly, Emanuel, Handzo, Galek, Siltan, & Carlson, 2012). The authors suggest this may demonstrate chaplain skill at helping patients and their families align their values with treatment plans.



Finally, Fair (2010) notes a role in which chaplains may add value in any workplace, including health care: as that of a subject matter expert in ethics, stress management, critical incident counseling, and employee morale. He advises careful clarification of state law so that chaplains do not step outside the parameters within which they may legally operate (Fair, 2010).

### 3.4 Summary

As determined through literature, the position of the hospital spiritual care worker is defined from the perspective of licensure and in the perceptions of other health caregivers, patients and their families, and spiritual care workers themselves. Hospital spiritual care is not defined by specific religious traditions.

The role of the hospital spiritual care worker has changed over past decades and continues to transform as financial pressures require every member of the health care team to add measurably to the value equation. A common theme in the literature is that the part spiritual care workers play in patient healing and experience is still not clearly defined and understood.

## 4. Methods

Due to these current limitations in understanding the aim of this study was to explore the value of hospital spiritual care to patient care from the perspective of the medical staff most responsible for the patient's care. This qualitative, phenomenological study collected impressions and opinions from respected experts in patient care through semi-structured interviews with the doctors and nurse leaders caring for the very ill in the hospital.

A qualitative approach was selected because data were sought from participants in their work setting and sought to understand the meaning these participants ascribe to the work of spiritual care workers (Creswell, 2009, p. 4). A phenomenological study was elected to seek the essence of the lived experiences of this group of participants to further explore the value of this role in healthcare (p. 13).

## 4.1 Sample

The population of interest in this study is the medical personnel, specifically nurse leaders and other hospitalists who provide the acute care of patients in inpatient settings where full-time spiritual care workers also work. Hospitals were selected using data collected by the WHA Information Center, LLC (2012), based on two criteria: size in number of staffed beds and presence of full-time spiritual care staff. Medium to large hospitals are more likely to staff with full-time spiritual care workers than are small or critical-access hospitals (Cadge, et al., 2008). Thus, only hospitals of 100 beds or more were considered. Selected hospitals had a spiritual care department with full-time staffing. From these facilities, eight hospitals were selected based on geography, to include hospitals in the eastern, central, southern, and western parts of Wisconsin. A final selection of two hospitals (hereafter referred to as "Hospital A" and "Hospital B") was made.

Request for organizational approval was obtained from the institutional review boards at each. The sample, then, consists of hospitalists/internists and nurse leaders from each of the two hospitals.

**Table 1: Participant Demographics**

Identifying letter	Role	Sex	Hospital	Self-description of faith
A	Hospitalist (MD)	M	A	LDS
B	Hospitalist (MD)	M	B	Hindu
C	Hospitalist (PA-C)	F	B	spiritual/no religion
D	Hospitalist (MD)	F	A	Raised Catholic, no religion
E	Hospitalist (MD)	F	B	Atheist
F	Nurse leader	F	B	Catholic
G	Nurse leader	F	B	Catholic
H	Nurse leader	F	A	Lutheran/ELCA
I	Nurse leader	F	A	Raised Catholic, no religion

### 4.1.1 Data Collection and Analysis

Interviews were digitally recorded and later transcribed by the researcher. Interview questions were adapted from tools developed by Cadge's (2011) research and modified for this research setting. Interviews ranged in length from 20 to 70 minutes and averaged 40 minutes.

There were seven females and two males interviewed; this is proportionate to the general population of doctors and nurses in the US. ("Minority nursing statistics"; Young et al., 2013). Interviewees were all employed full time in the respective hospitals. Several had worked at no other facility during their career. Years of experience ranged from about eight to over 30. All nurses held leadership positions in addition to direct patient care duties. Two of the participants were educated abroad. One of the participants mentioned having done mission work before choosing a medical career. There was also a range of spiritual backgrounds in the participants, including Christian (Catholic, Protestant), Hindu, Church of Jesus Christ of Latter-Day Saints, and atheist. Some stated that they were "spiritual" when asked about their personal faith, stating that they had been raised in church-going households but no longer actively practice the faith of their childhood. Each has witnessed spiritual care workers' interactions with patients and their families on the inpatient units where each works (See Table 1 for demographic information).

After the interviews were transcribed, the data were interpreted using the phenomenological steps described by Giorgi (2012) and Creswell (2009). Giorgi (2012) and Creswell (2009) recommend that the interview transcripts are read through in their entirety several times. This was done to gain a holistic view of the data. Then the transcripts were reread and meaning units were identified (Creswell, 2009). From the meaning units, code words were established, using axial coding methods (Creswell, 2009). At this point code words and phrases from the interviews were reviewed with a peer reviewer, and a 94% code reliability was found (Creswell, 2009). Code words and phrases were extracted into a separate list and duplicates removed. Code words were then grouped into similar categories based on the participant's meanings. From there, four themes emerged, and a phenomenological essence statement determined from the data.

## 5. Results

Four main themes emerged from the data and were named using interviewee in vivo statements. The themes that were found were: 1) *No Ordinary Day*, 2) *Things That Give Comfort*, 3) *A Silent Presence*, and 4) *Healing of the Soul*. In addition, a phenomenological essence statement emerged from the findings: *It is in the complementary treatment methods of medical caregivers and spiritual care workers that patients were able to heal the whole person.*

This study looked at how very ill patients are cared for in an extremely stressful time of their lives, when they face personal crisis and life disruption. No matter how serious their illness is as viewed by others, it has an impact on their lives. Intervening conditions relate to how the various care teams approach patient care: health care workers trained to be physical healers, spiritual care workers trained to be emotional and spiritual healers. They meet in the demanding environment of the hospital to care for the same patients, and it is this complementary medicine strategy that leads to the phenomenon of a holistic health focus in which patients are able to find peace and meaning. Sometimes that peace also means recovery from the physical ailment that brought patients to the hospital, but even when it does not, the complementary care may allow them to find a resolution in keeping with their personal beliefs and values.

### 5. 1 No Ordinary Day

Respondents indicated a critical point in a patient's course when physical distress becomes spiritual anguish. Medical personnel learn to recognize these moments as cues to call on spiritual care. Nurses in particular described taking cues from expressions of anger and fear, from tearfulness, from intense family interactions, and from denial as indications to call a spiritual care consultation. Respondent G described "a weight and heaviness" and that patients appear "anxious" and "distracted". Respondent E described "nervous" patients as needing a consult. Respondents noted that these critical points usually involve a transition or turning point, and that they considered spiritual care workers to be experts in transitioning through those points and helping patients find meaning.

What constitutes a critical point differed from case to case, and depended upon the significance of the event to the patient or family. Examples of critical moments ranged from a relatively straightforward surgery, to receiving a terminal diagnosis, to the death of a patient in the presence of family members. Respondent B noted the critical point is not always a negative change and commented that he also finds spiritual care helpful to patients processing good news. Another, Respondent F, noted value in the simple recognition that today is not an ordinary day for the patient or family, that the occurrence of the day requires processing. She recounted spiritual care workers acknowledge this significance by saying, "We recognize that, to you, this is different than your normal everyday flow. You might be nervous and you might be scared, and we're here to support you."

In elaborating on what cues are telling as to when Spiritual Care needs to become involved, Respondent F described thinking, "Oofda, this family is intense"

(6). Another, Respondent I, described patients attempting to leave the hospital prematurely as a cue. These critical moments for patients are seen as a causal condition.

## 5.2 Things That Give Comfort

Interviewees described spiritual care workers as experts at providing comfort and being trained in providing a comforting presence. This contribution is seen as an intervening condition in Figure 1.

Comfort took the shape of a listening ear, supportive listening, silent listening, life review (where spiritual care workers assisted patients to review the events of their lives and find meaning), handholding, taking on a friend role and acting in the place of family members who cannot be at bedside.

"We all do supportive listening, but they are the experts in it," commented Respondent H. She described the spiritual care workers at her hospital as "instrumental in patient and family care". Another interviewee, Respondent D, described how, when some spiritual care workers enter a room, she can feel the emotion in the room ease. Her hospital is a teaching hospital for spiritual care workers, and she commented that this calming presence required training and practice, as she saw it developing in individual spiritual care interns over time.

Interviewees identified spiritual care workers as persons with whom patients and families could discuss a disease not in terms of tests and prognoses, but in what the disease will mean to patients' independence and sense of self. "Behind that can be much more fear of losing control, fear of losing identity," related Respondent E. She also noted the value for some patients of a listener who is not a family member, rather a stranger. Respondent D noted that, rather than a provider coming in to talk about specifics of symptoms and medical issues, the spiritual care worker asks, "How are you doing as a person?" Respondent B, a hospitalist, commented that he specifically offers patients the care of "somebody else besides a physician" to sit down and talk out issues.

Interviewees described the comfort spiritual care workers offered to family members of the sick. In one case shared by Respondent H, a man was dying, and his wife wished not to have a crowd present. The spiritual care worker supported this decision and quietly attended the bedside with her, offering small gestures of physical comfort to her as she waited. In another case also related by Respondent H, a patient with a severe brain injury was unconscious and unresponsive; in his case, the patient himself did not need the care, according to my interviewee, rather the family needed the support as they processed the idea of him never getting his life back the way it was. This interviewee commented specifically on how the spiritual care worker anticipated the needs of the patient's children effectively.

Spiritual care workers were described as being skilled at getting to the bottom of what concerned patients and their families. Respondents described getting a "vibe" from a patient (Respondent G) or sensing "something wasn't right" (Respondent H), and relying on the expertise of a spiritual care worker to discover what was wrong. Respondent H described how offering comfort aligns with patient-centered care as it helps patients come to peace with the things that cannot be cured.

She also told of a patient who, unknown to the medical staff, was processing the very recent death of her husband in addition to her own illness, but only the spiritual care worker was able to tease this out.

Comfort could take the form of assisting patients to accept their diagnosis. In one case, a patient became gravely and rapidly ill with an aggressive cancer, and Spiritual Care worked with this patient. Over the six weeks of her acute illness, Respondent H noted that the patient progressed from speaking about being afraid of dying, to a place of focusing more on the time that she had left. Respondent B described spiritual care workers as helping patients and families in "finding peace as much as possible".

### 5.3 A Silent Presence

Several respondents related that spiritual care workers have different time constraints and different agendas than other medical care providers and are able to provide a continuity of care across unit and facility boundaries that constrain medical providers. This is seen as a strategy from an axial coding perspective. Repeatedly I heard from interviewees that spiritual care workers could take the time to care for people that the medical staff could not spare.

"I'd love to sit and hold hands, but I can't," commented Respondent B. Respondent I stated, "We nurses want to sit with them all the time, but we can't. We can get the chaplain in there and turn that around.... They can just sit there for the longest time." Interviewees seemed to admire not just the scheduling which allowed for this presence, but the spiritual care workers' patience and ability to be still with a patient for long periods of time.

The word "consistent" arose frequently. Spiritual care workers were a consistent face in the lives of the sick and their families. Several stories surrounded spiritual care workers who connected with patients, maintaining support through the hospitalization and after discharge. "This chaplain was there the whole time. He was the continuity," commented Respondent I. "Patients see all kinds of nurses coming and going. But the chaplains, they follow those patients. And the patients know they will see that chaplain again."

Respondent H explained that it would be inappropriate for a physical caregiver such as a nurse to maintain a relationship with a patient once the patient was no longer a patient on that unit, but the spiritual care workers did not have these constraints. Some stories involved spiritual care workers who followed patients to nursing homes and eventually to home, maintaining the relationship.

Respondent F noted the Spiritual Care Department staff already know patients before the patients arrive on her floor, and she found this beneficial as she assumed care. "It's nice to chat with the person from Spiritual Care, because they can fill you in on the background and family dynamics and where the patient is in processing and coping with the diagnosis." Respondent I used the phrase "guide and guard" to describe spiritual care workers sitting with patients "for the longest time," being quietly present and guarding them from hurting themselves. More than one interviewee observed that spiritual care workers lack the perceived agenda that other providers (physicians, nurses and social workers) may have. Social workers in particular were distinguished from spiritual care workers in that social workers are interacting with patients to accomplish something specific, such as to devise a discharge plan or arrange financial support. Spiritual care workers "work very hard to come in without any agenda," related Respondent C.

#### 5.4 Healing of the Soul

According to interviewees, spiritual care workers bring a holistic view to medical care, viewing patients as “not just a diagnosis” (Respondent F) and as a body, mind and soul, and thus this is the phenomenon revealed by axial coding. Respondents repeatedly stated that holism was not part of their formal training, that they became familiar with it after they began their patient care careers.

Respondent B, a physician educated abroad, stated that he only learned of a relationship between physical and spiritual care in his residency in the United States.

Nearly every respondent spoke of spiritual healing in relationship to physical healing. “Allopathic medicine deals with physical ailments,” stated Respondent B. “We don’t do a good job with spiritual aspects or the emotional aspects of being sick. What about the sickness that pneumonia brings to the soul or the mind?” He commented that there was a “background and expertise” in the spiritual aspects of patient care and that those skills complemented his own.

Another physician, Respondent E, was specific about why distress of the mind slows healing of the body: the action of suprarenal corticosteroids such as adrenaline. “Any time you have someone who is calm and at peace, you can expect a better outcome.”

Several respondents spoke of the spiritual care workers as the “appropriate people for the job” or as the experts with the training in seeing “the whole person”. Respondent C admitted she could not tell many stories of how spiritual care workers interacted with her patients because she trusted the spiritual care people to do their work and did not follow up on them. “It’s like calling the surgeon. I don’t go and check that the surgeon is doing the surgery. If I call the chaplain to come and help support somebody, that’s what they do without me needing to go and make sure.” Respondent I gave the example of a patient who had reached maximum physical healing, but whose illness had left her with physical limitations which she considered so grievous that she wanted to die. A spiritual care worker offered spiritual support throughout her course of treatment. The physical caregiver attributed the patient’s improvement in coping and self-care skills to the spiritual care worker’s intervention.



Respondent G noted that while patients may come into a hospital for one specific reason, their actual need may be for something else. She saw the spiritual care staff as the providers of that other type of care, asking "What else do you need?" Respondent B stated he believed "people should get that kind of treatment to address needs which I cannot personally address, because I don't understand as much as I would like to".

Two separate interviewees used analogies about medicines to state their belief that patients should have spiritual care available to them. "Just because one antibiotic doesn't treat everything doesn't mean we withhold antibiotics," said Respondent B. Respondent E said, "If we provide Tylenol and Dilaudid for patients who have pain, I think we should take care of the soul". This interviewee, who self-identified as atheist, was adamant that spiritual care workers provided an expertise she could not. She admitted that spiritual matters were completely unfamiliar to her, and she appreciated having an expert for referral, saying, "I would definitely not want to see the chaplain going out of the hospital."

## 5.5 Unexpected Findings

In addition to the themes that emerged from the participants, there were a couple of unexpected findings. The first was the acceptance by these medical professionals of death as a potentially natural (although also difficult) outcome, and the appreciation they had for spiritual care workers who helped patients and their families come to a similar acceptance. These are individuals who deal with dying patients frequently. "Life is okay, but death is not bad either," commented Respondent B. "The outcomes that happen that are the right ones are not always what one would call 'good,' because I don't think that death is necessarily a bad outcome for a lot of people," added Respondent C. "It is the natural outcome. Mortality is one hundred percent." The work that spiritual care workers do helping people process a tough diagnosis was seen as a value by many of those interviewed. Respondent G told of how Spiritual Care is paged to the bedside with any death, and how she sees a "change in the family" after the spiritual care worker spends some time with them. "You know, the patient has already passed away, they've already said their goodbyes, and it feels like they're almost a little bit more at peace. That's usually when we see families go. They stay with their loved one until they have that last little bit of peace."

The other surprising finding was the depth of support that spiritual care workers offer to the caregivers in addition to the patients and their families. Most of the respondents related at least one memory of being personally supported and comforted by a spiritual care worker. Respondent F told of a patient her own mother's age with widely metastatic breast cancer. The patient's daughters were the nurse's age, and as she cared for the woman and her daughters, this nurse became close to them all. When the woman died, the nurse was present.

A spiritual care worker was called, as per routine, and that person and the nurse worked to take care of all the end-of-life details. It was not until the nurse left the room and was alone in the unit's kitchenette that she realized how deeply this occurrence had affected her and how close to home it had hit. The spiritual care worker who had helped the family found her there and asked about her needs. "Her checking on me was kind of that release valve, and I just bawled like a baby on her shoulder," this nurse remembered. "I needed to do that to cope and continue my day. It's not like I could just go home. That doesn't work.

Having that outlet and that comfort, that it's okay, it's time to cry, that's why I'm here – that was something that I won't ever forget." Respondent C said, "People die around here, and sometimes it's not pretty. Staff need to have a way to process that."

One finding was that the opinion that spiritual care supports staff was not universal among interviewees. Two providers, both physicians, stated that they did not look to Spiritual Care for support. One, Respondent A, did not elaborate other than to say he would prefer to consult his own church clergy. The other, Respondent E, stated she felt it was common for medical people to want to project a facade of invulnerability, and if she were feeling overwhelmed, she would just call in sick and stay home rather than seeking help from Spiritual Care. Last, Respondent I commented that she would like to see Spiritual Care offer more support to the medical staff, and felt it as lacking in her hospital.

Supporting the staff with ethical counsel was noted as helpful. Respondent G told of a case in which a gravely ill patient was placed on a terminal drip for palliative sedation:

That brought up a lot of ethical issues, not only with patient and family but with our staff as well, and the spiritual care person that was on for the weekend would approach me every day. Not only would he ask about how the patient was doing, he also asked how the staff was doing. Were there any questions, were there any concerns, was there anybody who wanted to talk to him? It was really nice knowing that he was involved with us, knowing that we might have some ethical dilemmas.

One interviewee, Respondent A, had very little to say of the value of spiritual care workers. He said that he had few associations with the hospital's spiritual care staff and had never utilized "what they specialize in." His opinion was that spiritual care only helps "select patients" who "come from faith". Thus,

## **6. Implications**

In general, the findings of these interviews support related studies on the value and role of spiritual care providers as experts in comfort (Cadge et al., 2011), ethics (De Vries, Berlinger, & Cadge, 2008), and holism (Cadge et al., 2011). Respondents confirmed the findings of Vanderwerker et al. (2008) that nurses are a strong source of referrals to spiritual care. Respondent I alone noted that physical therapists are also a source of recommendations, stating that she believed physical therapists tend to see patient care more holistically, and this opinion is also consistent with Vanderwerker et al.'s (2008) findings (p. 21).

The respondents who spoke of spiritual care workers spending as much time as needed with patients and their families corroborate other research. For instance, Jacobs(2008) wrote, "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"

One gap noted is the possibility that medical providers are not sufficiently informed about the qualifications of a professional spiritual care worker and do not distinguish between a local religious leader and a specialist in spiritual care. The sample in this study was likely too small to generalize, but in this limited group, nurses demonstrated a more accurate understanding of spiritual care workers as seeking to understand patients' own beliefs rather than imposing their own.

Respondent I described the chaplains at her hospital as “chameleons” who “don’t tell someone what to believe,” rather “find out what the patient needs and then be that”. Respondent E expressed reservations about whether spiritual care workers were “willing to accept” the beliefs of others. Cadge, Calle and Dillinger (2011) reported similar physician concerns (p. 307, 310).

## **7. Limitations and Future Research**

There are several limitations to this study, which could be explored through further research. One limitation is that two Upper Midwest hospitals in locales with largely Catholic-Christian populations were sampled.

It may be revealing to query hospitals in other metropolitan areas of the United States, such as on the coasts and in the large inland industrial cities, where there are larger populations of people with more diverse backgrounds.

Another limitation is the potential bias of the respondents. Several respondents expressed eagerness to participate. One consideration is that those who participated may be biased in favor of spiritual care workers, and those who had negative or negligible positive experience with spiritual care did not volunteer to participate. An effort should be made to seek out a variety of respondents to mitigate this.

One last consideration is the need to explore not only the perception of spiritual workers influence on the patient healing, but also on the family and medical staff as well. Given the nature of funding and hospital prioritization of finances, further research on the total impact of these individuals can make would also strengthen the argument for their on-going services.

## **8. Conclusion**

As hospitals wrestle with rising costs and declining reimbursements, they find it more and more important that every dollar spent add value to patient care. Currently, spiritual care is paid out of hospital overhead (Cardona, 2011). Yet, the Centers for Medicare and Medicaid Services (CMS) direct that hospice patients’ spiritual health be addressed (“A simple explanation”), and the Joint Commission calls for a spiritual assessment of inpatients (Cadge et al., 2008).

If spiritual care adds substantial value for patients and their families, and if it contributes significantly to patient-centered care and to positive patient outcomes, hospital leaders may be more likely to continue to support it.

This study showed that medical personnel value spiritual care workers their expertise in the care of the mind and spirit. Their stories show how spiritual care workers care holistically for patients and their families through comfort and presence, how they are of aid at critical turning points in patients' lives, and how they provide continuity and calm at a chaotic time. These hospitalists and highly skilled nurses expressed the need to support the spiritual needs of patients and caregivers alike as part of providing good patient care.

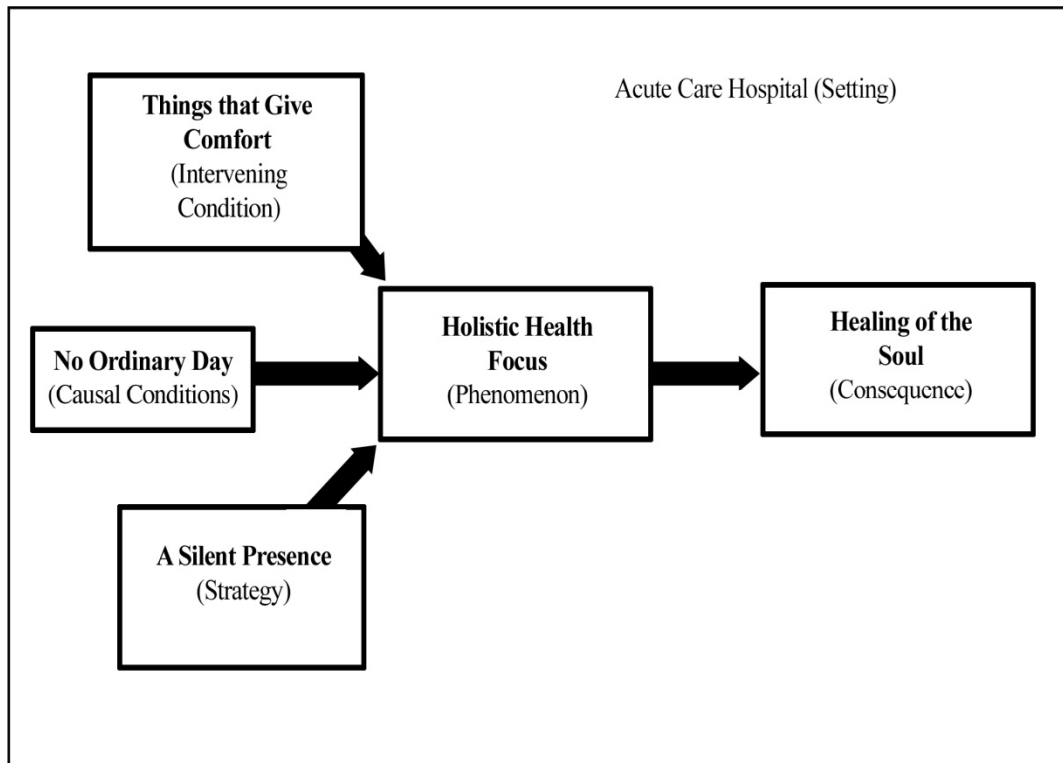
In addition, it was found that the spiritual care workers also provide emotional and mental support for the doctors, nurses and family members who are caring for patients.

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**Appendix A:** Table 1**Appendix B:** Figure 1**Figure 1: Axial Coding Analysis**