June 2016 Article of the Month

This month's article selection is highlighted by John Ehman,
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The article was suggested by George Fitchett,
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Idler, E. L., Grant, G. H., Quest, T., Binney, Z. and Perkins, M. M. "**Practical matters and ultimate concerns, "doing," and "being": a diary study of the chaplain's role in the care of the seriously ill in an urban acute care hospital**." *Journal for the Scientific Study of Religion* 54, no. 4 (December 2015): 722-738.

SUMMARY and COMMENT: This month's study, out of Emory University and Healthcare, was conducted by two sociologists, a chaplain, a palliative care physician, and an epidemiologist; and the approach is markedly sociological. The authors note that "[q]uantitative, observational studies attempting to describe the social role of the health-care chaplain in the 21st-century hospital are rare" [p. 724], and so they developed an episode-based diary methodology using a digital tablet, "in order to maximize the chaplains' closeness to their lived experience in their work role" [p. 726]. The article presents both a proof-of-concept regarding use of the digital diary and an insightful picture of palliative care chaplains' activities and experiences in a large, diverse, secular, urban hospital.

The diary instrument, created with input from chaplains (not part of the final study), recorded information on referral sources, visit times and locations, participants, activities during the encounter, topics of conversation, the chaplain's feelings and summary evaluation of the encounter, and whether the visit could be characterized as "a surface conversation or extensive care response" [p. 728, and see the text for a listing of particulars]. It also logged whether chaplains had reviewed the medical record or were aware of the patient's diagnosis or prognosis, and whether this was a first or subsequent visit. The diary's core items were closed-ended (i.e., mostly yes/no or multiple choice), but there was "opportunity at the end...for the chaplain to provide additional open-ended information on the encounter that was not already captured by the instrument" [p. 728].

From January through October of 2013, "nine chaplains [--four staff chaplains and five chaplain residents] recorded 1,140 diaries of visits with 782 unique patients" [p. 729]. Visits lasted an average of 22.5 minutes, and "72.5 percent were initial visits of the recording chaplain with the patient (although the patient may have had a previous visit with a different chaplain)" [p. 729]. Also, "[t]he average number of persons present at a visit was 3.8 (including the chaplain); 43 percent of the time there were three or more persons (to a maximum of 10) present," and "one-quarter of the time the chaplain was visiting only with family or friends" [p. 730].

Among other results:

> In general, chaplains felt satisfied with the visits. In nearly 70 percent of visits the chaplain had reviewed the patient's chart prior to the visit, and in 82.7 percent of visits he or she was aware of the patient's specific diagnosis. Chaplains characterized more than two-thirds of visits as "extensive care response" rather than "surface conversation," and 57.4 percent of visits were rated as "excellent" overall. [p. 730]
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> [T]he most commonly reported activity is "active listening," reported in 92 percent of all visits. However, active listening was almost always a prelude to another activity --just 14 percent of visits had active listening as their sole activity. The next most frequent activity is ministry of presence, found in 48.1 percent of visits, and spiritual assessment is reported in 38.8 percent of visits. Explicitly religious practices (other than prayer) were performed in just 3.2 percent of visits. Prayers were requested and/or said in 28.3 percent of visits. Chaplains reported touching patients or family members in 21.4 percent of visits and providing some form of assistance with advance directives in 10.1 percent of visits. Thus, active listening was reported for almost every visit, and prayers and other explicitly religious activities were recorded for fewer than 30 percent of visits. [p. 730]
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> The single most frequent topic of conversation with patients concerned physical symptoms (30.6 percent of visits). For families, the most frequent topic was "existential matters," a term that our chaplains used to describe questions patients and families ponder, such as "Why me?" "Why now?" This was present in 30 percent of visits in which family members were present. Spiritual/religious matters were the second most frequent topic of conversation for patients (29.6 percent) and third most frequent for families (28.8 percent), but note that in both cases spiritual/religious matters were discussed in fewer than 3 in 10 visits. [p. 731]

The researchers then broke down the data on activities and topics of conversations using two-cluster solutions. Regarding activities, those categorized as "doing" consisted of actions like prayer, touch, and advance directives; and those categorized as "being" consisted of active listening, spiritual assessment, and ministry of presence. "[W]e found that 94.3 percent of visits contained 'being' activities, and 53.4 percent of visits had 'doing' activities" [p. 730]. Regarding topics of conversations, those categorized as "practical matters" consisted of things like family concerns, life review, medical care, and financial concerns; and those categorized as "ultimate concerns" consisted of things like spiritual/religious matters, physical symptoms, and emotions. Visits with patients involved practical matters 74.6% of the time and ultimate concerns 63.7% of the time. Visits with families showed slightly higher incidences of both kinds of topics.

The final phase of the analysis explored how the clustering of "practical matters" and "ultimate concerns" topics and of "doing" and "being" activities might be connected with chaplains' evaluations and lengths of visits. "Overall, chaplains gave their highest ratings to conversations that were comprehensive, including both practical matters and ultimate concerns...[which were] also the visits that have the longest average duration" [p. 732]. Furthermore, chaplains "are most satisfied with visits that include the "being" activities of active listening, spiritual assessment, and ministry of presence" [p. 732]. The researchers conclude that "[c]haplains appear to be significantly more rewarded by their work when they have more time to spend with patients and their families, and that allows them to engage in activities or conversations that encompass multiple clusters" [p. 735].

One of the key points in the authors' discussion of the findings is the observation that "ultimate concerns" signified a "level of intensity" reached in a full two-thirds of chaplains' encounters, and that "the frequency with which chaplains engage in conversations at this level says something quite profound about their work role in the context of people in crisis" [p. 736]. Moreover, "the chaplain has perhaps the best vantage point on the health-care team for seeing the patient's family and social context and appreciating the meaning of the current crisis in the context of the patient's life course" [p. 736]. They go on to say: "What our study contributes to this issue is evidence that the work of chaplains may be strengthened by their unique social position: chaplains have the time and mandate to maintain a view of the whole patient and his or her family including their lives both inside and outside of the hospital" [p. 737].

The authors additionally conclude that the diary method used here was feasible as a way for chaplains to record daily work and was not "unduly burdensome" [p. 732]. "After training and practice with the touch screen, chaplains reported that a visit diary took five minutes or less to complete" [p. 728]. "Our study also showed that the rapid recording of details about the visit allowed collection of data on a range of new topics for chaplaincy research" [p, 735]. This article offers many potential points of departure for research and fruitful questions for chaplains to consider (e.g., whether active listening, which was used in over 90% of encounters, "was simply a gateway to the rest of the encounter or if it was important in its own right" [p. 735]).

Limitations to the study are well acknowledged [--see p. 736], including the use of a non-random sample at a single hospital, a cross-sectional design that goes to correlational rather then causal relationships, and the fact that the one palliative care chaplain completed more diary entries than the other chaplains. What might be implicit in the latter limitation, but is not addressed explicitly, would seem to be that the practice and perspective of chaplaincy students (CPE residents) is not distinguished from that of presumably more experienced staff chaplains (--an issue previously raised by an anthropological study of chaplains that was featured as our April 2006 Article-of-the-Month). However, this "close-up view of chaplains' work" [p. 737] helps fill out a picture of chaplaincy as a profession: "We believe that these findings contribute to a framework for understanding the distinctiveness of the abstract knowledge and specialized skills that chaplains possess, and that mark them clearly as a professional group in the context of the modern health-care team" [p. 737].

Special comments to the Network from our article's lead author, Ellen L. Idler, PhD, Samuel Candler Dobbs Chair of Sociology, Director of the Religion and Public Health Collaborative, Department of Epidemiology, Rollins School of Public Health, Emory University; and co-author Chaplain George H. Grant, PhD, Executive Director of Spiritual Health at Emory Healthcare, Woodruff Health Sciences Center, Emory University:

> This study was undertaken with the explicit purpose of involving chaplains in research. George Grant was a key member of the team from the start, of course, and made major contributions to the project's conceptualization, data collection, development of instruments, and the interpretation of findings. But a real bonus for chaplain research training was the involvement of the "pilot chaplains" at Emory University Hospital, who test-drove the initial survey on iPads and shared their reactions and experiences of collecting data. They unquestionably helped us improve the quality and brevity of the instrument! --*ELI*
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> Hands on data collection empowered our chaplains and chaplain residents to critically engage in a funded investigation and help us to see our work as having an impact on care response through research outcomes. Our intent was to grow our embrace and comfortability with research overall and more particularly add to the discovery of who we are and what we do as spiritual health clinicians. We thoroughly enjoyed the work which continues! --*GHG*

Suggestions for the Use of the Article for Student Discussion:

This is a moderately long but very readable and engaging article that provides a range of options for discussion, though students beyond their first unit of CPE would be in a better position to contextualize the study. As a picture of chaplains' work, it is intriguing, and some specific findings (e.g., the "surprising finding...[of]...the rather low numbers for religious practice activities" [p. 735]) should draw specific attention. Do the findings generally seem to reflect students' own experience? Can students relate to the categories of doing/being and practical matters/ultimate concerns? What about the inclusion of spiritual assessment with "being" activities [--

see pp. 735-736], or physical symptoms with the "ultimate concerns" cluster of topics [--see p. 736]? What do students think of the idea of the diary and of its individual items? The *feelings* part of the diary was modified in light of chaplains' feedback during piloting [--see p. 727], so what do students think of the options in the final form [--see p. 728, and see also Items of Related Interest, §I, below]? The authors describe the role of the healthcare chaplain as "anomalous" [pp. 723 and 737] and "at the intersection of two complex social institutions" [p. 737, and see also p. 722]. Can students identify with this? What about the description of chaplains also as being "betwixt and between" [p. 737] the world of the patient and that of the healthcare institution? Do students agree that "[o]ne could argue that the linking of physical, emotional, religious, spiritual, and existential levels is evidence that chaplains have the special role on the health-care team of caring for the *whole person*" [p. 736]? The table of "Chaplain Activities or Interventions Identified in Earlier Observational Studies" [p. 725] provides a convenient summary for discussion of earlier research. This study focused on chaplains dealing with palliative care situations. How do students believe their pastoral practice may vary depending upon whether the patient is gravely ill or not?

Related Items of Interest:

I. The chaplains involved with the development of the digital diary used in the study suggested the incorporation of feeling items from the "Feeling Wheel" used in their CPE training [--see p. 727]. A copy of the wheel is available at a href="https://med.emory.edu/excel/documents/Feeling%20Wheel.pdf" target="_blank">https://med.emory.edu/excel/documents/Feeling%20Wheel.pdf. The design contains core emotions at the center and more specific feelings in the outer rings. The source given in our featured article is Gloria Wilcox's *Feelings: Converting Negatives to Positives* (Augusta, GA: Morris Publishing, 2001), but an earlier source would be:

> Willcox, G. "**The Feeling Wheel: A tool for expanding awareness of emotions and increasing spontaneity and intimacy**." *Transactional Analysis Journal* 12, no. 4 (October 1982): 274-276. [(Abstract:) The Feeling Wheel is designed to aid people in learning to recognize and communicate about their feelings. It consists of an inner circle with 5 sectors and two outer concentric circles. The sectors are each labeled with the name of a primary feeling, viz., mad, sad, scared, joyful, powerful, and peaceful. The outer rings contain names of secondary feelings related to the primary ones. The wheel has proven useful in assisting clients to learn how to identify, to express, to generate, and to change feelings. Suggestions for employment of the Feeling Wheel are provided.]

II. In light of chaplains' encounter activities in the diary used in this research [--see p. 728], readers may wish to review two other sources for chaplains' activities, developed by chaplains. These lists have been generated by research but stand apart from the various studies on "what chaplains actually do in their day-to-day work" [p. 723], cited in our article.

> Hilsman, G. "**Patient needs, chaplain functions, and outcomes for study**." Poster presentation, ACPE National Conference, October 25-29, 2005 (Honolulu, HI). Available from the ACPE Research Network at www.acperesearch.net/Hilsman2.pdf. [Note the Chaplain Function listing. The poster was noted in our Winter 2006 *Newsletter*.]

> Massey, K., Barnes, M. J., Villines, D., Goldstein, J. D., Pierson, A. L., Scherer, C., Vander Laan, B. and Summerfelt, W. T. "**What do I do? Developing a taxonomy of chaplaincy activities and interventions for spiritual care in intensive care unit palliative care**." *BMC Palliative Care* 14 (2015): 10 [electronic journal article designation]. [(Abstract:) BACKGROUND: Chaplains are increasingly seen as key members of interdisciplinary palliative care teams, yet the specific interventions and hoped for outcomes of their work are poorly understood. This project served to develop a standard terminology inventory for the chaplaincy field, to be called the chaplaincy

taxonomy. METHODS: The research team used a mixed methods approach to generate, evaluate and validate items for the taxonomy. We conducted a literature review, retrospective chart review, focus groups, self-observation, experience sampling, concept mapping, and reliability testing. Chaplaincy activities focused primarily on palliative care in an intensive care unit setting in order to capture a broad cross section of chaplaincy activities. RESULTS: Literature and chart review resulted in 438 taxonomy items for testing. Chaplain focus groups generated an additional 100 items and removed 421 items as duplications. Self-Observation, Experience Sampling and Concept Mapping provided validity that the taxonomy items were actual activities that chaplains perform in their spiritual care. Inter-rater reliability for chaplains to identify taxonomy items from vignettes was 0.903. CONCLUSIONS: The 100 item chaplaincy taxonomy provides a strong foundation for a normative inventory of chaplaincy activities and outcomes. A deliberative process is proposed to further expand and refine the taxonomy to create a standard terminological inventory for the field of chaplaincy. A standard terminology could improve the ways inter-disciplinary palliative care teams communicate about chaplaincy activities and outcomes.]

III. Our authors comment on "active listening" [--see pp. 735-736] and observe that it is "often discussed in the chaplaincy and counseling literature" [p. 735]. The following are recent articles on the subject. Note that active listening has been well considered in the literature from Great Britain in the past several years.

Bunniss, S., Mowat, H. and Snowden, A. "**Community Chaplaincy Listening: practical theology in action**." *Scottish Journal of Healthcare Chaplaincy* 16 (2013): 42-51. [(Abstract:) WHAT WE KNOW ALREADY: Patients, GPs and chaplains reported very positively overall on the first pilot of the Community Chaplaincy Listening (CCL) service. NHS Managers, GPs and patients would like to see CCL as part of the continuing provision of NHS listening therapies. WHAT THIS PAPER ADDS: Descriptive statistics of who uses the CCL service and why; patients and chaplains describe what happens in a CCL session; patients report the difference CCL makes to their lives; and an insight into what spiritual listening means in the context of CCL. WHY THIS IS IMPORTANT: CCL is a direct and practical application of the desire of Scottish healthcare policy to provide preventative care in the community. It has potential implications for GP consultations, prescribing patterns and patient medications compliance. HOW THIS IMPACTS ON CHAPLAINCY: Through CCL chaplains have established a new role as specialist spiritual care providers within primary care teams. Chaplains providing spiritual listening sessions can now evidence how listening directly enhances patient wellbeing and resilience.] [This article is available online from the journal.]

Manzano, A., Swift, C., Closs, S. J. and Briggs, M. "**Active listening by hospital chaplaincy volunteers: benefits, challenges and good practice**." *Health and Social Care Chaplaincy* 3, No 2 (2015): https://journals.equinoxpub.com/index.php/HSCC/article/view/26065 [online journal article access]. [(Abstract:) Active listening (AL) is a communication technique frequently used in counselling. This study explored the feasibility of implementing a ward based AL intervention for patients by chaplaincy volunteers in the UK National Health Service. Seven focus groups (n=47) included healthcare researchers, lecturers, nurses, patients, AL tutors, active listeners volunteers and chaplaincy volunteers. Acceptability and perceived effectiveness of a patient/volunteer listener intervention were explored. Analysis followed the framework approach. Four themes emerged: (a) Listening as a wellbeing generator; (b) Benefits of AL delivered by volunteers; (c) Spirituality and public perceptions of hospital chaplaincy; (d) Challenges of structured communication techniques in acute care. Participants reported positive attitudes towards the introduction of AL provided by volunteers in acute wards. They shared a common belief that when people are listened to, wellbeing improves through control, choice and empowerment. Patients' acceptability of the intervention increased if it was delivered by volunteers.]

Mowat, H., Bunniss, S. and Kelly, E."**Community Chaplaincy Listening: working with General Practitioners to support patient wellbeing**." *Scottish Journal of Healthcare Chaplaincy* 15, no. 1

(2012). [(Abstract:) This article reports the first stage of a national programme instigated by the Healthcare Chaplaincy Training and Development Unit of NHS Education for Scotland and supported by the Scottish Government. In the first stage Chaplains were invited to join an action research project with the purpose of designing listening services in GP surgeries. Some of the chaplains were already offering listening services. Chaplains and researchers worked together to co – create and design a spiritual listening intervention based on prior experience and research evidence which was then introduced into four Health Boards in Scotland. Qualitative data about the intervention was then gathered by the researchers from chaplains, patients and referrers, usually GPs. This data shows that the intervention, in its first incarnation, was well received. The findings are reported and the next two phases outlined.] [This article is available online from the journal.]

Mowat, H., Bunniss, S., Snowden, A. and Wright, L. "**Listening as health care**." *Scottish Journal of Healthcare Chaplaincy* 16 (2013): 35-41. [(Abstract:) WHAT WE KNOW ALREADY: Listening is an essential part of caring practice. Being listened to and telling our story is in itself therapeutic and life affirming. Listening is time consuming and whilst acknowledged as central to care in practice is hard to accomplish given the pressures on health and social care staff in terms of targets, paperwork and protocols. WHAT THIS PAPER ADDS: The sociological background to listening and its practice in contemporary health services. WHY THIS IS IMPORTANT: Community Chaplaincy listening is based on the assumption of careful, agenda free listening. HOW THIS IMPACTS ON CHAPLAINCY: Chaplains are primarily the bearers and witnesses of stories of suffering and triumph. Understanding the link between wellbeing and the act of listening gives theoretical substance to the core work of chaplaincy.] [This article is available online from the journal.]

Mundle, R. and Smith, B. "**Hospital chaplains and embodied listening: engaging with stories and the body in healthcare environments**." *Illness, Crisis and Loss* 21, no. 2 (2013): 95-108. [(Abstract:) This article illuminates how a largely overlooked group of healthcare professionals--hospital chaplains--engage in listening, along with what they perceive it means to listen well. The analysis of data generated reveals that engaging in listening, and doing this well, is for chaplains about inhabiting a relational body that includes: (a) being at eye level in relation to the other person; (b) making eye contact with the other; (c) understanding emotions as embodied narrative plots; (d) being still; and (e) distancing themselves from religion. The article closes with some critical reflections on listening and preparing our bodies to listen well.]
