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FALL 2016/WINTER 2017

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A HEALTHCARE CHAPLAINCY NETWORK™ PUBLICATION

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HealthCare Chaplaincy Network™ is a global health care nonprofit organization that offers spiritual-related information and resources, and professional chaplaincy services in hospitals, other health care settings, and online. Our mission is to advance the integration of spiritual care in health care through clinical practice, research and education in order to improve the patient experience and satisfaction, and to help people faced with illness and grief find comfort and meaning—*whoever they are, whatever they believe, wherever they are*. We have been caring for the human spirit since 1961.

Inside

*Cover painting by **Rita Loyd***

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A LETTER FROM REV. ERIC J. HALL

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From corporations to sports to families, getting back to basics is a much-used strategy for education, revitalization, and other forward-thinking purposes. It also holds great promise in the field of spiritual care.

Professional chaplains learn and build upon the fundamentals as they go through clinical pastoral education, which includes clinical residency. Gaps exist, though, for other members of the interdisciplinary health care team and administrators.

Although all health care professionals—doctors, nurses, social workers, etc.—should provide some spiritual care, and studies show that a high percentage of patients wish their providers would ask about or discuss spirituality and/or religion, we repeatedly hear that training in spiritual care is minimal, even nil for some disciplines. How can these health care professionals, even with the best of intentions, provide high-quality spiritual care if they aren't taught the basics?

There's enormous value in a common knowledge and understanding of definitions, terminology, roles and objectives related to spiritual care. The more staff and administrators know, the better whole-person care can be. And only through this foundation can we achieve further integration of spiritual care into the interdisciplinary team and the overall health care landscape.

An increasing number of health care settings, educational institutions, organizations, and even policymakers are starting to realize that adjustments must be made. It will take more and more champions of spiritual care to further grow this movement—champions like those featured in this issue of Caring for the Human Spirit® magazine (see pages 5-8) who are seeing the positive impact of education and integration efforts at their hospitals. The University of Iowa Hospitals and Clinics, for one, hit a home run after its spiritual care team pioneered a hospital-wide integration project that began with this very premise: "It was necessary to start with the very basics."

Among HealthCare Chaplaincy Network's own efforts recently to expand knowledge about spiritual care to other disciplines: This fall, we released a white paper, "Spiritual Care: What It Means, Why It Matters in Health Care," that takes a linear, research-backed approach to this topic (www.healthcarechaplaincy.org/spiritualcare); we've added specialty tracks and the opportunity to earn a Certificate as a Spiritual Care Generalist for nurses and social workers at our fourth annual Caring for the Human Spirit® Conference that will take place this March; and as you'll see from the current and future issues of this magazine, we're directing articles to an interdisciplinary readership.

In a complex health care environment, teaching the basics is a simple approach that can result in a very meaningful objective: improving quality of life for all those in our care.

Thank you for caring for the human spirit,

CHAMPIONING SPIRITUAL CARE-PART I

Why a Hospital CEO Invests in Chaplaincy

By **Louis A. Shapiro**

There are many different aspects that patients need to consider when receiving care at a hospital, from choosing the physician best suited to their needs to understanding different treatment options. While Hospital for Special Surgery (HSS), New York City, is best known for helping people get back to what they need and love to do through excellent orthopedic and rheumatic care, a less obvious but essential element is addressing other patient needs, including spiritual care.

HSS is committed to caring for the whole person, an approach that has proven to produce better results from both clinical and patient satisfaction perspectives. As president and CEO, my continued investment in spiritual care services is vital to the hospital's patient population and to the medical and administrative staff who make up the HSS family.

Through spiritual care at HSS, patients have access to board certified chaplains who help them with their spiritual and emotional needs. Offering this service positively impacts a patient's stay and makes patients and their family members feel at ease while undergoing a major life event, like a hip replacement or a diagnosis of a chronic autoimmune disease.

Spiritual and religious needs are every bit as important as a patient's physical ones, and chaplaincy is fundamental to the hospital's pursuit of health care excellence. The multi-faith chaplaincy service includes handling a patient's specific religious needs for prayer and ritual, assisting patients in accessing religious resources during their stay, attending to the spiritual and coping needs of patients and their loved ones, and helping patients move toward renewed hope and peace following surgery or a recent diagnosis. All of this contributes to healing and wellness.

Spiritual care at HSS is a dynamic service that matches HSS' vibrant environment. For instance, the spiritual care team's quality assurance indicators are invariably high, which ensure that along with quality health care, patients receive leading spiritual care during their stay at HSS.

The department has grown significantly to include three full-time and one part-time chaplain to accommodate the increasing needs of patients and their families. The department has also moved to unit-based chaplain assignments so that the chaplains can establish relationships with personnel on their assigned units and work more closely with staff and patients through a collaborative care team approach. Similarly, the department now utilizes Business Intelligence Recording Tool (BIRT) standards to document and report quarterly on quality of compassionate care.

The dedication of spiritual care staff and their colleagues has directly resulted in better patient experience and lower readmission rates at HSS—another testament to why hospitals should invest in services such as these. For instance, during the intake process and prior to pre-operative care, many patients express a wish to be visited by a chaplain. A chaplain also completes rounds in pre-operative and post-operative care venues, and is well received by patients and their families before and after surgery. Religious holidays of all major faiths are also recognized in the hospital's nondenominational chapel to ensure that patients can observe and practice their faith during their stay.

The hospital's Press Ganey® survey results indicate that spiritual care positively contributes to a patient's experience and satisfaction. From a leadership perspective, these findings are invaluable as they validate the benefit of providing services that appropriately and successfully meet the spiritual needs of patients. In addition, the services provided by chaplains and the integration of chaplains into the hospital's care team directly support the hospital's strategic plan to institute best practices and deliver the best care possible.

Chaplaincy services extend to HSS employees as well, particularly at times of need such as a death in the family. Support includes organizing individual memorial services and an annual HSS memorial service for all members of the HSS family and their loved ones.

The mission of HSS is to help people get back to their own "game of life" more reliably than any other medical center in the world. To do this means vowing to also care for the human spirit and provide comfort to those who have put faith in the hospital's medical and other staff to care for their overall health needs.

The hospital's chaplains are deeply committed to prayer, learning, and professional development in order to serve as true advocates for patients of all faiths. It is with this mission and intent that the hospital's chaplains follow HSS' pathway to sustain leadership in health and wellness. This is the foundation for current and future success of spiritual care in a hospital setting.

Louis A. Shapiro, *of New York City, is president and CEO at Hospital for Special Surgery, New York City. The hospital has received the No. 1 and No. 2 ranking in orthopedics and rheumatology, respectively, according to the U.S. News & World Report Best Hospitals National Ranking by Specialty (2016-17).*

Out of the Mystery: Education Pulls Nurses Into Spiritual Screening

By **Jeremy Hudson, MA, BCC**

In health care, spirituality and spiritual care have the perception of being cloaked in the mysterious. Patients, family members, and health care professionals don't always have a solid grasp of what spiritual care is and what chaplains can offer. The confusion and lack of understanding are challenges for spiritual care providers who are trying to further integrate the discipline of spiritual care into the fabric of their institutions.

The Department of Spiritual Care at the University of Iowa Hospitals and Clinics (UIHC), Iowa City, Iowa, tackled this scenario—and, having done so, is now experiencing greater visibility and integration than previously, and is serving more people in need.

UIHC recently introduced a hospital-wide spiritual screening as a part of the nursing assessment to identify patients and family members who desire spiritual support while in the hospital. The initiative is an outgrowth of a collaboration with other disciplines and education about spirituality and spiritual care to all levels of the organization.

The multiple definitions of spirituality, religion, spiritual care, and religious care often add to the mystery and confusion surrounding chaplaincy. Even when chaplains themselves are asked how they define these terms, varied responses emerge. If spiritual care providers struggle to have consistent explanations and definitions of these concepts, then how do we expect other health care providers and administrators to know, understand and explain them to patients and their families?

Yet, the hands-on patient care staff are among spiritual care's strongest advocates if they are equipped with and give a consistent and concise message.

Chaplains need to be the champions, promoters and educators for spiritual care in their institutions. They must be open to and engage in opportune situations that present themselves and actively seek out other chances to collaborate at their organizations if chaplaincy is to continue to gain visibility and greater integration.

At UIHC, this process began when a nurse manager and social worker asked, "How do we identify patients and family members who might benefit from spiritual care?" This was an opportunity ripe for cultivation.

To move this forward, educating colleagues about spirituality and spiritual care was a key building block. And it was necessary to start with the very basics. We began with using the definition of spirituality drawn from the Greek, *pneuma*; the Hebrew, *ruach*; and the Latin, *spiritus*. All three words are defined as breath or spirit. Therefore, spirituality is that which gives breath to life. A person's spirituality can consist of such things as relationships, art, music, vocation, and even, but not always, religion. Spiritual distress is looking at how the present challenges impact the things that give breath to the life of a patient or family member.

This education created a better understanding of what spirituality is, how illness impacts spirituality, and why it is an important component of holistic care.

With the foundation set, UIHC undertook an initial pilot project for spiritual screening in which the unit social workers administered the screening. During a three-month period in 2015, 62 percent of patients screened requested spiritual care.

The goal was to implement the spiritual screening hospital-wide in

the social work assessment. However, understanding that a social worker does not visit every patient during a hospital stay, it was evident that this would only be a start, although certainly more than spiritual care providers can screen on their own.

From the social work screenings, the hope was to generate enough data to make the case for adding a spiritual component to the nursing assessment. Social work and chaplaincy aren't able to see every patient, but nursing does. If nursing did the initial screening as a part of their assessment, it would mean 100 percent of patients are screened for spiritual distress in the first 24 hours of admission and offered spiritual care.

The screening includes a scale for the patient/family to rate their level of distress from one (no distress) to 10 (extremely distressed). Chaplains use this scale to determine acuity and which patients should be visited first.

Through collaboration with and education of key leaders in administration, nursing, information technology, and social work, the project gained overwhelming support. As other disciplines heard about the screening or got involved, momentum and buy-in grew, along with the scope of the project. It went from a small pilot to implementation on four units to being incorporated in the nursing assessment hospital-wide within months of the initial pilot.

Now, at UIHC, every patient is

screened and offered spiritual care upon admission to the hospital.

Once the screening was added to the nursing assessment, it was taken out of the social work assessment. There have been discussions about the possibility of adding it back into the social work protocol. Having it in both offers different perspectives: since the social work assessment typically takes place later in a patient's hospital stay, circumstances may look much changed from the nurse's initial evaluation within the first 24 hours of admission.

The project was not without bumps in the road. For one, its scale was challenging. As a spiritual care department, we were walking into an unknown, and we wrestled with many questions. Among them: How many referrals would be generated? Do we have the staff to meet the potential needs? If we don't take the opportunity to have the screening in the nursing assessment, will the window ever present itself again? We chose not to look at the challenges as barriers, but, instead, view them as further opportunities for education and collaboration.

It has been a year since the spiritual screening went live in the nursing assessment. During that time, the initiative has produced an average of 264 additional requests for spiritual services per month, and a total of 3,100 additional requests for the year.

Many of the requests have come from units that do not have dedicated chaplains. The project provided data to ask for—and obtain—more staff for the Department of Spiritual Care in order to meet all of the requests received through the screening. Moreover, the data demonstrates that patients and their families, and health care team members desire and value spiritual care.

In addition, the screening has allowed for a greater presence and collaboration with hospital units where chaplains weren't as visible before. There have been requests from staff at outpatient clinics to add the screening tools to their assessments so those settings can offer spiritual services as well.

This endeavor has allowed UIHC's spiritual services a pathway to increase the presence and integration of spiritual care into the overall institution. As chaplains, there are opportunities throughout health care to educate and collaborate with colleagues to make our institutions better, further our craft, and, most of all, improve the care of those we serve.

Jeremy Hudson, MA, BCC, *of Anamosa, Iowa, is a clinical interfaith chaplain in the Department of Spiritual Care at the University of Iowa Hospitals and Clinics, Iowa City, Iowa.*

WATCH INTERVIEW
with Chaplain Jeremy Hudson
www.healthcarechaplaincy.org/magazine

Two-Way Street: Chaplaincy Interns Get Educated—and Educate Others About Role

By **The Rev. Jill M. Bowden, MDiv, MPA, BCC**

Three times a year a new "crop" of four or five clinical pastoral education (CPE) interns comes through the doors at Memorial Sloan Kettering Cancer Center (MSK), New York City. They are tasked to act in the role of chaplain, of spiritual care specialist, even as they begin their education.

In this sense, they are very much like physician interns: They have some background, and they have an idea of what they are to do and a set of guidelines to follow. Now, they need to build a framework on which to hang those guidelines as they model the professional chaplain they wish to become. The staff chaplains mentor each intern, and a supervisor provides oversight and feedback.

At the same time, these CPE interns are charged with the responsibility of educating others. Since chaplaincy is an integrated service within a multidisciplinary health care team, the students function from the first day of their internship as involved care providers. During the interns' orientation we talk about chaplains as educators, empowering the students to build relationships with other members of the interdisciplinary care team.

The time-honored method for chaplains to meet patients is to simply make rounds—going room to room and offering an introduction to chaplaincy and the hospital's spiritual and religious services. At MSK, we prefer to receive a referral based on spiritually defined needs rather than merely on request, so that chaplains see patients who are the most likely to have spiritual or religious needs, spiritual distress, or spiritual suffering.

These referrals come from anyone who interacts with a patient and who identifies the potential for spiritual distress based on their own perceptions: physicians, nurses, building services staff, lab technicians, physical therapists, and others. Anyone in the hospital can make a referral for spiritual support in much the same way that anyone

in the hospital can ask a patient, "Are you in pain?" and then follow up appropriately according to their own scope of service. That said, this structure for referrals to chaplains best holds true for spiritual distress when the staff person knows what that looks like.

First, CPE interns learn to educate colleagues by asking for referrals. A chaplain might say to a nurse, "Would any of your patients benefit from chaplain care today?" And then, if the nurse gives a searching look as to what that might mean, the student may expand upon the request: "Did anyone have a bad night? Did anyone get bad news or a new diagnosis? Is anyone going for a procedure today or is anyone going home?" These reminders and others like them serve as memory triggers involving situations that may cause spiritual distress and alert the nurse to the chaplain's areas of intervention.

Over time and with repetition and additional education about other visible signs that patients or their family members may be experiencing spiritual distress (e.g., tears, feelings of anxiety, or feelings of isolation from their religious community), these interns have a set of circumstances for which they will refer patients for spiritual care. Often, nurses or doctors see CPE interns or staff chaplains around the hospital and stop them to make a referral based on a new diagnosis, test results, or another development in the patient's care and treatment. The chaplain's presence reminds medical colleagues of the patient's need and the chaplain's ability to help. It's a win-win-win situation!

Chaplain care is relational; it functions within the affiliation created between a patient, the family, and the treatment team. Chaplains listen; we often say that we "listen people into hearing themselves." This is a big part of the CPE interns' training: to listen for what is said and what is unsaid, to be totally present, and to offer companionship for the journey with the trained mind and heart of a professional spiritual caregiver.

Throughout their development as spiritual care specialists, these new hearts and minds are called to the work of spiritual care in a health care setting. The chaplain interns get educated and they educate; and, in the process, our patients and their families benefit from their service to whole-person focus on the care of body, mind and spirit.

The Rev. Jill M. Bowden, MDiv, MPA, BCC, *of New York City, is director of chaplaincy services at Memorial Sloan Kettering Cancer Center, New York City, the world's oldest and largest private cancer center.*

Making the Case for Palliative Care

By **Rev. Eric J. Hall**

When a study last year by researchers at Mount Sinai Hospital, New York City, revealed that patients seen by chaplains are more satisfied with their hospital stay, I wasn't at all surprised. This groundbreaking study and mounting other research reinforce, with evidence, what we continually hear on the street about the value of chaplaincy care.

Likewise, also mirroring anecdotal comments, studies indicate that palliative care significantly improves clinical outcomes, including better quality of life for patients and their families, and better survival rates among people with cancer and others. No surprise there either.

But here is what does surprise me: Despite impressive growth in the number of palliative care programs at U.S. hospitals in the last decade, there remains a huge shortfall in the staffing of palliative care teams, including chaplains—resulting in a broken supply-demand chain for patients in need of this care.

A report by the Center to Advance Palliative Care and the National Palliative Care Research Center entitled "America's Care of Serious Illness: 2015 State-by-State Report Card on Access to Palliative Care in our Nation's Hospitals," concluded that "access to palliative care remains inadequate for millions of Americans living with serious illness despite continuing growth in the number of U.S. hospitals reporting palliative care programs."

Further, it said, "Hospital palliative care teams are often overstretched … between 1 million and 1.8 million patients admitted to U.S hospitals each year could benefit from palliative care, but are not receiving it."

A study, published in September 2016 in Health Affairs, found that of 410 hospital palliative care programs, nearly two-thirds had no paid chaplain, half had no paid registered nurse or social worker, and one-third had no paid medical doctor or osteopath. The lead author, Joanne Spetz, told Reuters, "A lot of these programs are running on a shoestring."

Something is very wrong here. Since these statistics represent data mined from 2012 and 2013, my hope is that the gap has narrowed somewhat since then. Sheer volume alone supports further integration of palliative care. The Center to Advance Palliative Care estimates that by 2020 there will be 157 million people living with at least one chronic illness.

Given the expected rise in cases of serious and chronic illness, and more studies showing the benefits of palliative care, it only follows that health care settings should bolster palliative care teams—and include professional chaplains on these teams. The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines call for a board certified chaplain to be a member of the health care team, especially in palliative care.

Source: National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care, 3rd edition 2013

This could be a chicken and egg situation. Among the various views on why palliative care teams fall short, many point to the fact that palliative care is a relatively young field. As such, there are not enough trained practitioners; this specialty is absent from administrators' budget radar; and there are limited government funds available for palliative care.

My feeling is lack of visibility has much to do with it. Advocacy can change all that.

Just look at the recent historic development in California. In September 2016, the California Department of Health Care Services (DHCS) released its final policy for the delivery of palliative care services for Medi-Cal beneficiaries. After considering stakeholder and expert feedback, it became the first state to recognize the valuable contribution of chaplains and the provision of spiritual care by requiring that managed care plans "must provide access to chaplain services as needed as part of the palliative care team." It recommends that the team include, but is not limited to, a doctor of medicine or osteopathy, a registered nurse and/or nurse practitioner, a social worker, and a chaplain.

In its comment letter to DHCS, HealthCare Chaplaincy Network (HCCN) wrote, in part, "As an organization that continues to witness the centrality of spiritual support to the coping and welfare of those who are sick and their loved ones, we urge DHCS to insure that spiritual care support is appropriately defined and the intent of SB1004 to include spiritual support in this new benefit is quickly and fully implemented."

The resulting inclusion of chaplaincy in the final policy speaks volumes for the profession and hopefully serves as a model for other states to follow. The provisions will help beneficiaries make more informed choices and improve quality of life for patients and their families.

Elsewhere, there are other advances afoot. Recently, for example, on the East Coast, one major medical

center pushed for and secured its first full-time palliative care chaplain. It's a victory that can have a big impact.

But, while palliative care is now viewed as a fast-growing medical specialty, we lack mandatory training in this field. Pending in Congress is H.R. 3119, the Palliative Care and Hospice Education and Training Act; introduced by Rep. Eliot Engel (D-N.Y.) and supported by 200 bipartisan cosponsors, it supports training for health care professionals and would promote expanded research and an awareness campaign about team-based palliative care, including spiritual care. If passed, this could be a game changer.

Meanwhile, more institutions need to follow the lead of prestigious institutions like the Harvard Medical School, which integrates palliative care principles into various required and elective courses, according to Harvard Magazine.

For chaplains, HCCN offers fundamentals and advanced online certificate courses in spiritual care in palliative care. Its affiliate, the Spiritual Care Association, recently announced a spiritual care fellowship in palliative care to give board certified chaplains working in hospice or palliative care the clinical competencies, skills and confidence to fully integrate into the interdisciplinary team.

It's time for health care professionals to highlight the value of palliative care and all its components—body, mind and spirit—so that this vital specialty gains more ground. Empowered chaplains and others committed to the key role of spiritual care in health care can be a driving force of change—change like requiring chaplains to be part of palliative care teams, reimbursing chaplaincy services that are a palliative care service, and providing training that narrows the shortfall of all disciplines on palliative care teams.

"The timing, demand and opportunity to expand access to palliative care are unprecedented," according to the 2015 report card. "Patients and families coping with serious illness want and need access to the quality of life that palliative care provides."

Over and over again, we've seen in all aspects of health care how powerful advocacy can be. And how rewarding it can be. Actor Michael J. Fox, whose diagnosis with Parkinson's disease led him into the advocacy space, once put it this way: "I mean I enjoy my work as an actor. But to make a difference in people's lives through advocacy and through supporting research—that's the kind of privilege that few people will get, and it's certainly bigger than being on TV every Thursday for half an hour."

Stay tuned. If we all make our voices heard, we can effect change in the delivery of quality palliative care, including spiritual care.

Rev. Eric J. Hall *is president and CEO of HealthCare Chaplaincy Network and the Spiritual Care Association.*

So few hours in the day, and so much to do—both personally and professionally. Rising tragedies around us, including horrific terrorist attacks and devastating natural disasters, weigh on our minds. Most of us and especially health care professionals who incessantly face the pain and suffering of others are feeling the squeeze. As a result, who gets lost in the shuffle? YOU.

This special section on self-care offers some suggestions on how you can take care of yourself and, in the process, help you best take care of others.

A Reminder to Professional and Family Caregivers:

Put on Your Oxygen Mask First

By **Rev. Gregory Johnson, SMM, MDiv**

"In the unlikely event of a loss of cabin pressure, please put on your oxygen mask first before assisting others."

How often has each of us heard this message? Really heard this message? In truth, this is the key to successful caregiving—both for professional and family caregivers.

It is not selfish to take care of oneself first; in fact, it is mandatory if we truly wish to be effective caregivers. We cannot give away what we do not have. If we are collapsing in any manner—physically, emotionally, spiritually—we are unable to help others.

In Scripture, we hear the directive: "Love your neighbor as yourself"—not more than, less than, or instead of, but as yourself. That implies that until we have cared for ourselves, we truly are not equipped or ready to care for another.

Of course, each of us knows this, and have likely shared this information with many of the people we have been working with and ministering to over the years. But do we really practice this in our daily efforts of caring?

Think of health care like a three-legged stool.

The first leg is the care recipient: someone ill in body, mind and/or spirit.

The second leg is the professional caregiver: doctors, nurses, chaplains, psychologists, clergy, home health care aides, or other paid health care workers.

And the third leg is the family caregiver: unpaid persons who provide care to both families of origin and families of choice.

Many of us know only too well that at times we may be playing more than one of these roles or even all three roles at once. And the latter can indeed cause unimaginable stress, burden, burnout, and even further sickness. As physical, emotional and spiritual beings, each area of our life greatly impacts the other.

We need to focus on this huge task of caring—and we need to begin with ourselves. A well can hold only so much water before it needs to be emptied, cleaned and refreshed to resume its purpose. Whether professional health care providers or family caregivers, we need to acknowledge our humanity, our limitations, and our needs.

While a trip to Bali for a total

spiritual pilgrimage may sound enticing, few of us can do this readily. However, there are many small, incremental steps that we can do:

• **Breathe.** Ten deep breaths just for me! This may seem very, very basic. Yet, it is the most often forgotten. Deep breaths connect us to the origin of our lives, the Divine Breath, and we are renewed.

• **Be present.** Take advantage of waiting for elevators or sitting in nonmoving traffic. Each is an opportunity to "go within" and to connect with your spiritual center, to relax even if for a few moments, and then to return refreshed and ready for the task ahead.

• **Begin and end each day with prayer time.** Whatever your tradition or beliefs, do not overlook this quiet time to connect with the Divine as you understand that to be. It is equally important to begin these periods of prayer, reflection and meditation by focused preparation. In other words, avoid the mindset of, "Oh yes, I got to pray—and boom." Bookend your times of prayer with silence, quiet and peace.

• **Lean on the team.** Your professional colleagues may have very real perspectives on this topic. They, too, need self-care, and often by you asking for help for yourself—especially if you are a chaplain, you are reminding them and giving them permission to do the same in their lives.

• **Seek therapy.** A therapist can help you use the tools of surrender and gratitude in caregiving situations. Remember, surrender does not mean giving up or losing. It is really letting go gently to receive abundantly.

• **Participate in support groups.** As we all know professionally, what we cannot do alone, we can do together. Yet, when faced with our own challenges we tend not to take this gift to heart. Many types of support groups exist, both on-site and online. Consider participating in one; if you are feeling resistant, perhaps just pray for the willingness to allow it to happen in your life.

• **Safeguard your own health and well-being.** Visit the doctor, take prescribed medications, get a flu shot, watch your diet, and exercise.

As caregivers, whether professional, family or both, we tend to push self-care to a back seat. But, for the benefit of the persons we care for and for ourselves, we must heed this reminder: You matter. You count. And only you can truly care for you.

Rev. Gregory Johnson, SMM, MDiv, *of New York City, is the senior advisor for family caregiving, Office of the CEO, at EmblemHealth, New York City. For 15 years, he has devoted his ministry to family caregivers as the creator and director of EmblemHealth's CARE for the Family Caregiver Initiative. He is also a caregiving advisor to HealthCare Chaplaincy Network.*

Decreasing Burnout in Palliative Care Clinicians

By **Madeline Leong, M.D.**

In October 2014, a group of palliative care physicians at The Johns Hopkins Hospital, Baltimore, Md., decided to ask for help. Day in and day out, the doctors listened to the heartbreaking stories of seriously ill patients. They faced a busy consult service and had little time for self-care.

According to research studies, caring for others can lead to physical and emotional exhaustion. Burnout is characterized by exhaustion, cynicism and inefficiency. Burned-out clinicians display less empathy, have riskier prescribing practices, and make more medical errors. Specialty hospice and palliative care clinicians have one of the highest burnout rates compared to other specialties (see page 14).

At Johns Hopkins, Sage Olnick, MDiv, RN, then a second-year clinical pastoral education resident specializing in palliative care, and I, then a hospice and palliative medicine fellow, searched for an intervention that would decrease burnout and promote resilience among the palliative care team. The result was an interdisciplinary, chaplain-led group called Care for the Caregiver.

The small group meets weekly for one hour in a quiet conference room in the hospital, and each session adheres to a specific format. There is a core group of members, but newcomers are always welcome.

The goal of Care for the Caregiver is not "pure education" or psychotherapy; rather, it is to create a healing environment that leads to better patient care.

For Rab Razzak, MBBS, M.D., a member of the group and the director of Outpatient Palliative Medicine, Care for the Caregiver is "the highlight of my week."

It "helps build cohesion and trust," he said. "It's a safe space to communicate and a setting to heal."

Joseph O'Neill, M.D., MPA, MS, who attended every session during his fellowship in hospice and palliative medicine at the hospital, agreed: "To do good palliative care, we must be fully present. This is much easier said than done. [Care for the Caregiver] goes beyond psychological support to create a spiritual space to reflect on the week's challenges."

"The group acts like a 'control-alt-delete' mechanism," O'Neill added. "The programs of defensiveness, callousness and fatigue can be stopped, and the palliative care doc software rebooted."

THE TEMPLATE

1. **Opening**—The group participates in two minutes of silence or a mind-body meditation. (For ideas on mediation exercises, refer to "Five Good Minutes: 100 Morning Practices to Help You Stay Calm and Focused All Day Long" by Jeffrey Brantley, M.D., and Wendy Millstine.)
2. **Check-in**—The group leader asks participants to reflect on one "high" and one "low" in their week. Sharing is encouraged, but not required. In one session, one member said the "high" of his week was taking his 4-year-old daughter to the grocery store. Another member said her "low" was feeling physically exhausted due to work and family responsibilities.
3. **Clinical cases**—The group leader asks members to share challenging clinical cases. Again, the emphasis is on spiritual or emotional concerns. The facilitator may ask open-ended follow-up questions, such as: "What went right?" or "Who can support you in this?"
4. **Resilience building**—Today, the theme is "courage." Some of the questions for reflection and discussion are:
   - What does courage mean to you?
   - Give an example of a time when you witnessed courage (e.g., in a patient).
   - What makes you brave?
   - How can we support patients who are facing the most difficult time of their lives?
5. **Closing**—The group leader reads a short, inspirational poem (e.g., "Tiger Face" by Stephen Dunn).

— Leong

Care for the Caregiver was designed with three core principles: trust and confidentiality; an interdisciplinary approach; and a clearly defined structure.

First, as in any small group, trust is key. In Care for the Caregiver, all members agree to keep discussions confidential. A chaplain-leader guides and facilitates the conversation. Olnick believes chaplains are uniquely qualified to do this.

"As a chaplain, I'm equipped to develop and design meaningful group sessions that attend to different preferences for expression," she said. "Chaplains are educated and trained to facilitate healthy and effective group dynamics. Above all, I try to reinfuse humanity back into the caregiver role."

Since Olnick was a member of the palliative care team, she was able to identify topics for the group based on the team's shared experiences. (Olnick relocated in August 2015, and the group is now led by Rev. Susan Donham, a board certified chaplain and the first palliative care chaplain fellow at Johns Hopkins.)

Second, the group is strongly interdisciplinary, built on the concept that all members can learn from each other. Care for the Caregiver is open to all clinicians in palliative care at the health system. Participants include physicians, medical students, residents, nurses, nurse practitioners, pharmacists, chaplains, and other trainees and health professionals.

Third, the group has a defined structure—necessary because it helps the group remain focused and positive. Sessions begin with a brief centering meditation; for example, two minutes of silence or five minutes of guided imagery. Next, the group leader facilitates a mindful "check-in": a creative process that invites participants to take inventory of current feelings and emotions.

After the opening activities, participants are invited to discuss clinical cases with an emphasis on spiritual or emotional challenges and shared experiences. Then, the chaplain leads a reflective exercise on a theme that has been selected for that specific meeting. This is personal and interactive: no PowerPoint allowed! The group ends with an inspirational reading or another brief mediation.

For the past two years, Care for the Caregiver has been a success at Johns Hopkins. It has become an integral part of the Johns Hopkins Hospice and Palliative Medicine Fellowship. In addition, the Department of Oncology is starting a similar program.

The group's template is ripe for duplication. Olnick, who now works as a staff chaplain at Lancaster General Health Penn Medicine in Lancaster, Pa., plans to start a caregiver group there soon.

For chaplains or clinicians looking to start their own group, it's important to recognize that dynamics can vary, so tweaking the format may be necessary. The bottom line is to be flexible and patient—and to listen.

Madeline Leong, M.D., *of Baltimore, Md., is an assistant professor of medicine at The Johns Hopkins University School of Medicine, Baltimore, Md. She is also a playwright; her most recent play, "Life Support," addresses end-of-life issues. Leong and Sage Olnick, the originators of Care for the Caregiver, continue to collaborate and explore their joint interest in wellness and resilience.*

WATCH INTERVIEW
with Dr. Madeline Leong
www.healthcarechaplaincy.org/magazine

AN INSIDE LOOK AT BURNOUT

62 percent is the overall burnout rate among specialty hospice and palliative care clinicians—one of the highest published rates compared to physicians from other specialties, according to a recent study based on a national survey of American Academy of Hospice and Palliative Medicine clinician members.[1]

The clinicians experienced at least one symptom of burnout: high emotional exhaustion (loss of enthusiasm for work) or high depersonalization (feelings of cynicism).

Nonphysician clinicians, including chaplains, nurses and social workers, reported significantly higher rates than their physician colleagues. Those at greatest risk: younger nonphysicians who worked more than 50 hours, weekends, and with fewer colleagues.

To manage burnout, at least 50 percent of respondents considered it essential to talk with family, friends, or significant others for support; participate in recreation, hobbies and exercise; and take vacations. Also rated highly were reading and "nurturing spiritual/religious aspects of myself."

The findings "emphasize the need for local and discipline-wide strategies to manage clinician burnout," the authors said.

[1] *Kamal AH, Bull JH, Wolf SP, Swetz KM, Shanafelt TD, Ast K, Kavalieratos D, Sinclair CT, Abernethy AP. Prevalence and Predictors of Burnout Among Hospice and Palliative Care Clinicians in the U.S. J Pain Symptom Manage. 2016 Apr;51(4):690-6. doi: 10.1016/j.jpainsymman.2015.10.020. Epub 2015 Nov 24. PubMed PMID: 26620234; PubMed Central PMCID: PMC4846384.*

SPIRITUAL MATURITY: How Achieving This Core Aspect of Personal Development Is Essential to Self-Care

By **Rev. Melissa Stewart, LCSW-R**

This conversation revolves around the ultimate question for all of us—health care professionals and patients alike: What is it that we need to learn and understand before we die?

This question carries others along with it: What does it mean to become spiritually mature? Why do some people make strides while others do not? Under what circumstances do we evolve spiritually—will this be the inevitable result of living or does something need to happen to us in order to become mature, psychologically, emotionally and spiritually?

And, most of all, why is reaching spiritual maturity important in terms of our well-being?

Many of us think of personal happiness as the true measure of a life lived well. However, it has been suggested that what is most important for our health is that our lives are meaningful, and not necessarily happy. Whereas "being happy is about feeling good, meaning is derived from contributing to others in a bigger way."[1] To be of service in the world is, by definition, meaningful work, but it may leave us feeling other than happy. Personal qualities of spiritual maturity may lead to experiences of well-being that are more reliable measures of spiritual health than happiness.

For those of us in the health care field, we may find ourselves simultaneously coping not only with our own private challenges, but also carrying the burden of others' struggles and sadness as we pursue the goal of living a meaningful life. This can be overwhelming and depleting; and it requires that we take every opportunity to engage in self-nurturance, in order to keep ourselves physically and emotionally strong and spiritually fit so that we can continue to help others without causing harm to ourselves.

A core component of healthy personal growth and developing a sustained capacity for our work is achieving spiritual maturity.

Those approaching elderhood and adults with terminal illness at any age seem to have an opportunity to accelerate the spiritual maturation process. It has been suggested that "the developmental task of advanced age can be viewed as a spiritual one. The core struggle during this late stage of life is between personal integrity and despair. Coping with a life-limiting illness can be compared to the normal aging process. Advanced illness may serve as a catalyst for spiritual growth, as the person's life and time left to achieve development is truncated by the disease process. Patients with a life-threatening illness and the elderly will benefit from engaging consciously in the aging/dying process and by embracing the occasion for learning and spiritual development."[2]

But it behooves all of us—elders, the terminally ill, and even the young and healthy—to strive toward spiritual maturity, no matter what our current circumstances. And for all, the key to the process of spiritual development is the acceptance of mortality.

When we recognize our physical impermanence, we have the potential to live fuller, more courageous lives. The conscious awareness of our own mortality will enable us to grapple with areas in our life that are troubling, even terrifying, and often exhausting. The wisdom that arises out of the deep working through of these experiences may serve as a protective factor against compassion fatigue.

It has been suggested that "accepting personal mortality … is,

in fact, the highest or most perfect way of living, far superior to living a life of constant and unconscious denial of mortality … The spiritually and psychologically mature person must be prepared to shoulder a considerable load of anxiety as the layers of repression against mortality anxiety are peeled away."[3]

Awareness of our mortality triggers intense death anxiety; however, the good news is that when we experience such anxiety, we are "primed to make significant changes. (We) are prompted to grapple with (our) fundamental human responsibility to construct an authentic life of engagement, connectivity, meaning, and self-fulfillment."[4]

Unfortunately, we live in a culture in which most people do not think or speak about illness, aging and death unless they must. Because of this, most of us feel utterly unprepared for these very natural experiences. It has been said that "without envisioning old age" or terminal illness during younger years, "as the culminating stage of spiritual development, we short-circuit this process and put brakes on the evolutionary imperative for growth."[5]

Spiritual maturity allows us to achieve completion by enhancing our ability to engage with the ending of one's life with equanimity and grace as well as the grief that accompanies life's end. If one possesses spiritual maturity in the face of death, as potentially brought to conscious awareness when the body is threatened by severe illness or old age, it will enable each of us to review our accomplishments and failures, to reconsider, reconnect and revise plans where needed, to forgive and be forgiven, to say goodbye to this life and the people and things we have loved, and perhaps to embrace whatever, if anything, might come next.

Although undeniably useful, this process is by no means easy, and we must be reminded to be gentle with ourselves as we face our biggest fear. "Achieving a state of emotional balance between that which causes us terror and that which enlivens and inspires us to live fully requires a continuous and intentional negotiation. Periods of 'denial' allow for a momentary reprieve, or neutral space, in which to regain psycho-spiritual equilibrium."[6]

So, how does a spiritually mature person get there? I have identified two broad-strokes pathways for spiritual growth. One is the path of "deepening into" a prescribed tradition, such as when one works with a particular religious law or practice and observes how the experience changes and evolves as the person ages and brings it to various life circumstances. The other path is giving oneself permission to explore and "try on" various practices and beliefs from one or more traditions, listening for a personal resonance or sense of alignment with them.

These pathways provide some context in which a medical crisis or "crisis of the body" occurs. In other words, we may use (or not) our spiritual framework to support how we might come to understand and approach the experience of a changing (aging, injured or ill) body. An individual's prior experience with religious or spiritual practice will likely affect how he or she manages the event/process.

For example, a person who is deeply engaged in intentional spiritual practice may immediately draw upon comforting belief systems or rituals, or may quickly place the experience into the category of "Things God/The Universe Places Before Me" to learn from or perhaps to burn off some bad karma. From a humanistic perspective, in the absence of a belief in a Divine figure or process, one may simply trust that it is a person's responsibility to find the good in every circumstance in an effort to become a better person.

Confronting death anxiety, as much as with any other troubling emotion, with awareness, instead of fleeing from it, and viewing it as a fundamental part of one's spiritual practice or discipline will naturally allow this core existential fear to be entertained as an ally.[7]

Simply living a long time does not necessarily guarantee that a person will become mature emotionally or spiritually, although the likelihood of being confronted by life-altering challenges that would inspire such growth increases over time. For those older people who tend to become more inflexible as they age, this rigidity can conflict with spiritual maturity.

Maturity has been defined as ripeness, which relies only on time. It has also been defined as full development, which relies on intention, brought to

circumstance. According to Richard Rohr, a well-published Franciscan priest, "There must be a direction to ripening—one that moves us beyond any exclusive concern with physical aging, because our concerns are much broader than that."[8]

"In a narrowed physical context," as brought on by illness or old age, "life can be lived more deeply. This is the process of growth that underlies the unfolding nature of spirituality."[9] Importantly, "the experience of aging," and, I assert, life-limiting illness at a younger age, "is itself a doorway to spiritual practice, one that transcends any particular religion or faith."[10]

The following reflects qualities that I have found to be present in those who appear to have achieved spiritual maturity: acceptance, courage, curiosity, discernment, flexibility, forgiveness, generosity, gratitude, honesty, hope, humility, humor, joyfulness, kindness, patience, transcendence and vulnerability.

Lastly, they possess a sense of freedom. As Victor Frankl wrote in his best-selling book "Man's Search for Meaning," "Everything can be taken from (someone) but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, to choose one's own way … It is this spiritual freedom—which cannot be taken away—that makes life meaningful and purposeful."[11]

Rev. Melissa Stewart, LCSW-R, *of New York City, has been a clinical social worker specializing in oncology for nearly 25 years and currently practices at Memorial Sloan Kettering Cancer Center, New York City. She was ordained as an interfaith minister through One Spirit Learning Alliance in 2010.*

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A Personal Note

Through professional experiences for nearly 25 years with patients with cancer and their loved ones, I have been profoundly changed by witnessing their process of coping with a life-threatening illness. During this time, I have also been challenged by my own personal losses and tragedies.

And something else happened, too. I have gotten older. In some ways, as a middle-aged woman, I've retained many of the personality traits of my younger years, but as my body has aged, my mind and my spiritual perspective have also matured. My spirituality has been shaped significantly by being so close to illness and death. I do recognize this as a gift, although it can be a heavy one to bear.

I approach this subject of spiritual maturity with a great deal of humility, knowing that I can only share my observations and contemplations on this most essential human process that is experienced by all mortal beings. I have certainly relied heavily on the wisdom of others, and I offer these ideas as a point for your own reflection.

It is a blessing to be aware of the concepts that I believe are necessary for spiritual maturity without the immediate threat, as far as I know, of my own death. I hope that I have enough time to learn how to live with them.

—Stewart

Mantram Repetition Matters

By **Jill E. Bormann, Ph.D., RN, FAAN**

As health care providers, most of us can recite the top 10 list of good self-care habits: (1) get enough sleep, (2) exercise regularly, (3) eat more fruits and vegetables, (4) drink plenty of water, (5) balance work and play, (6) carve out "alone" time, (7) engage in some type of relaxation, prayer, reflection or meditation, (8) get some sunshine, but use sunscreen, (9) don't smoke, and (10) drink alcohol in moderation.

Isn't there more—something else, something new, the next best practice, or latest research tip for improving life and becoming a better caregiver as a result?

Mantram repetition is a simple, easy-to-learn, evidence-based, and spiritually integrated practice for quickly calming the mind and relaxing the body. And, yes, we mean mantram, not mantra.

Both *mantram* and *mantra* are Sanskrit words meaning to "cross over the mind" or to "liberate and protect." However, the popular use of *mantra* refers to any secular words or phrases such as a motto, slogan, affirmation or self-talk. A true *mantram*, on the other hand, has been defined by Eknath Easwaran, a spiritual teacher at the Blue Mountain Center of Meditation, Tomales, Calif., as "the living symbol of the profoundest reality that the human being can conceive of, the highest power that we can respond to and love."[1]

Historically, nearly every spiritual or wisdom tradition has taught the value of repeating certain holy, sacred words that contain a "divine charge" that serves to calm the mind and body, and refreshes the spirit.[2]

There is growing evidence for the efficacy of mantram repetition to manage symptoms and behaviors in a variety of circumstances. Among health care providers, nurses have reported its benefits in the workplace when dealing with stressful situations;[3] and health care providers have reported its usage to reduce exhaustion.[4]

In addition, research has shown that mantram repetition can help veterans manage symptoms of post-traumatic stress disorder (PTSD), including nightmares, flashbacks, and road rage;[5] and help family caregivers of loved ones with dementia to reduce depression, anxiety, and caregiver burden.[6]

How to Choose a Mantram

Tips for choosing a mantram include the following

- Select a traditional spiritual word or phrase from one of the great wisdom traditions—something that has lasted and been hallowed by repetition over time (see page 19). In other words, refrain from making up your own.
- Allow several days and weeks to "try one on for size." Give it a test drive. If you like it, keep it. If not, try another.
- If you have difficulty choosing one, try Mahatma Gandhi's mantram: Rama—an invitation for eternal joy within.
- Stick with it. Once you select your mantram, keep it for the rest of your life. The longer you repeat it, the stronger and more effective it becomes.

How to Use a Mantram

To begin with, practice repeating a mantram when it is not needed in order to develop the potential to use it for stress management. Repeat it to

yourself during every spare moment throughout the day. Use it while walking, or waiting for an elevator, an appointment, or stop light. Repeat it every night before falling asleep. With this, you can create a powerful, lasting mind-body-spiritual connection.

This skill is incredibly practical because you can silently repeat your mantram at any time or any place. Practice does not require any set length of time, any particular environment, or any certain posture. The value of the mantram grows from the repetition of sending it deeper into your consciousness.

Don't be discouraged if you don't notice immediate effects. At first, the process of repeating a mantram may seem mechanical, artificial, or even silly. You might find that your mind resists the practice because it seems too simplistic or illogical.

However, with sustained commitment and intentional practice daily throughout the day and every night as you fall asleep, you will notice and experience a change in your reactions to stressful events. You will become more aware of your thoughts and realize that you have a choice when faced with a stressor. This is the beginning of "re-wiring" your thoughts and intentionally choosing to pause. Veterans call mantram repetition a "pause button for the mind" or "portable stress buster."

The final goal is making your mantram repetition practice a habit. Over time, your mantram will come to you automatically in moments of relaxation as well as moments of stress. It becomes your "staff of life," as Gandhi called it.

Ways to Use a Mantram

As a health care professional, there are multiple ways to use the mantram when working with patients and their loved ones. For example, repeat a mantram

- Before meeting a new patient, to focus and be present
- When you notice you are getting anxious, stressed or overwhelmed
- When you are struggling about what to say or do next
- When your thoughts start drifting to the past or future
- In anticipation of a difficult situation or conflict
- To redirect attention or interrupt unwanted recurring thoughts and/or feelings
- When you have flashbacks of a disturbing memory
- When experiencing the suffering of others (i.e., vicarious trauma)

Recommended mantrams include

- Rama (an invitation for eternal joy used by Mahatma Gandhi)
- Come, Lord Jesus or Lord, Have Mercy (short prayers)
- My God and My All (from Saint Francis of Assisi)
- Om Mani Padme Hum (Buddhist— a union of love and compassion with wisdom transforms into pure exalted body, speech and mind)
- So Hum (Hindu—I am That)
- Ribono Shel Olam (Hebrew—Lord of the Universe)
- Bismallah ir-Rahman ir-Rahim (Arabic—In the name of God, the most gracious, the merciful)
- Wakan Tanka (Lakota people—The Great Spirit)

Why a Mantram Works

Theoretically, we all have the capability to take a time-out and turn our attention to that calm, inner space within us—a place of respite, peace, and inner wholeness. But practically, few of us really know how to train our attention like a laser beam that enables us to tune out distractions and tune into our inner spiritual resources such as love, compassion, peace, hope, goodness, well-being, altruism and kindness.

As human beings, we are made up of more than our bodies and minds; we also have a spirit with unlimited resources that are available to us all the time. Like the sun that shines continuously, our spiritual resources are always present, but like the clouds that block the sunlight, our thoughts block our ability to remember and access our inner resources and light. Our attention is scattered outward, our thoughts are whirling out of control, and we forget the calm that resides within us.

There are several explanations for why mantram repetition works. On one level, repeating a mantram is merely redirecting attention away from any troubling thoughts, worries, or negative feelings. In this case, the mantram serves as an "eraser for the mind" by replacing negative thoughts with positive, sacred ones. You can also use it to interrupt unwanted, recurring thoughts; halt angry or upsetting reactions; or

reduce irritability and annoyance.

On another level, repeating a mantram over and over creates new neurological pathways in the brain, or neuroplasticity. Finally, mental repetition on a greater power (the mantram) allows all other thoughts to subside and provides greater access to our inner reservoir of spiritual resources.

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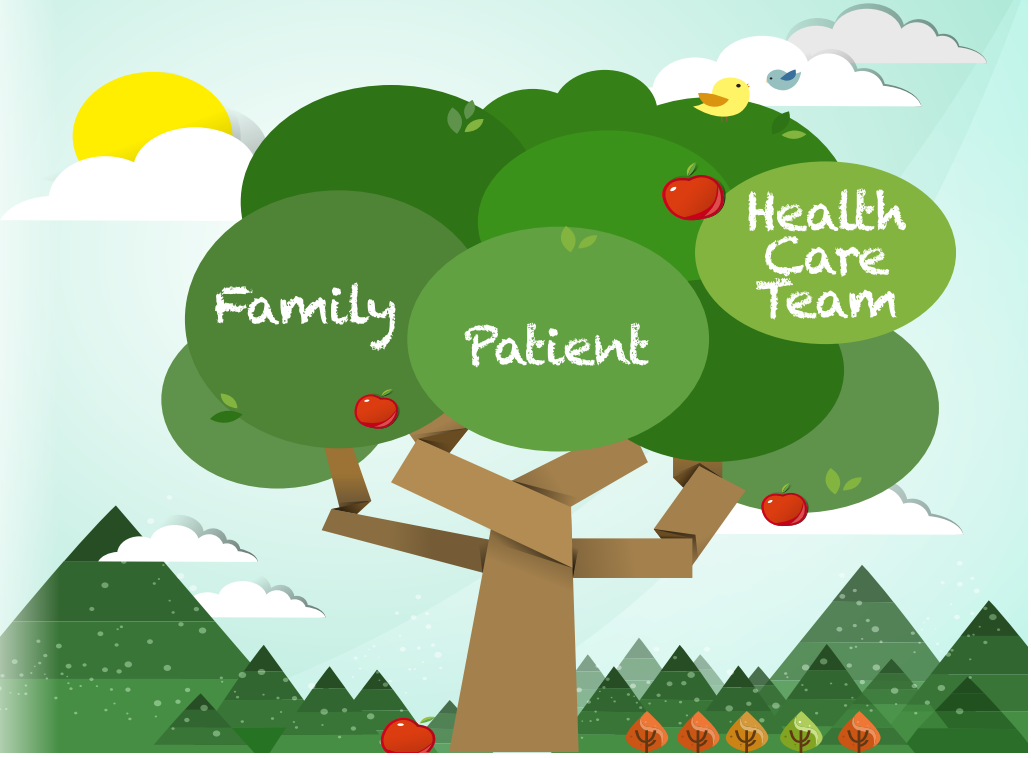

Bridging the Communication Gap: A Framework for Facilitating Family Meetings

By **Kathy Manske, RN, MSN, CCRN, CHPN**

As a hospital chaplain, you were about to visit 59-year-old Joseph who was diagnosed two years ago with lung cancer. Despite surgery and chemotherapy, he had now been diagnosed with brain metastasis and had required admission to the intensive care unit (ICU). He was receiving support in the form of a ventilator, hemodialysis, and a number of continuous IV medications to keep his heart rate and blood pressure within acceptable parameters.

The patient's nurse informed you that Joseph was critically ill and not expected to live through this admission, and that a request for life-saving measures was on record (full code). "The family is in denial and they just don't get it," she said.

When you entered the room, Joseph's wife, Sara, and two young adult sons who flew in from another state were at the bedside. Sara was tearful, and told you she "just can't understand how he got this sick. He was just working last week."

The sons were angry and expressed irritation with hospital staff. They reported, "The ICU doctor wants to unplug Dad, but his oncologist says he can get more chemotherapy if he gets better." The entire family voiced concern and frustration about their perception of mixed messages and physician requests for decisions about a plan of care.

What's a chaplain to do? How can you best support and assist this family? An interdisciplinary family meeting may be the answer.

Health care chaplains as well as other health care providers frequently encounter patients and families overwhelmed by the complexity of information received and the magnitude of decisions needed to be made during a hospitalization. The quality of communication received from the health care team can have a profound effect on patient and family outcomes from both a financial and emotional standpoint. For example, adequate communication can empower patients and families, increase patient/family satisfaction, decrease patient suffering/distress, and reduce moral distress for staff.

Research demonstrates that patients and families in the acute care setting consistently rate communication with the health care team as one of their most important needs. However, the simple act of communicating does not necessarily mean the communication is adequate.

In many cases, communication does not take place on a timely or regular basis. In other cases, even though communication is timely, its quality or content is inadequate. Interactions with physicians may be very brief and decision makers can be left with an incomplete or inaccurate grasp of clinical status, prognosis, or treatment options. The health care team can be left without knowing the identity of the legal decision maker or a clear understanding of the goals of care, treatment preferences, and end-of-life wishes.

A family meeting repeatedly surfaces in research literature as a means for improving the quality of communication. Facilitated by chaplains or other health care professionals, this effective evidence-based intervention can be a catalyst for identifying needs and expediting solutions. Moreover, it can cultivate mutual understanding and support, and confidence in the health care team.

The very triggers that might initiate a family meeting, and follow-up meetings, are the subjects that will most likely be discussed at them. The conference is a vehicle to provide information on disease trajectory, prognosis, and goals of care; to clarify code status; and to mediate disagreement among family members. It is also appropriate whenever there is a marked change in a patient's functional status or when major decision-making points are reached, such as a pending tracheostomy or feeding tube, or consideration of comfort care or transfer to hospice.

Any qualified member of the team—including chaplains—can arrange and facilitate this conference. The lead role often reflects the circumstances, such as a relationship

with the patient or family, or the culture of the health care setting. In the case of Joseph, the chaplain was the logical choice.

For these meetings, "family" is broadly defined. The patient and family determine their invited attendees, which can include anyone they wish—the patient when able, spouse, significant other, children, parents, siblings, close friends, or others.

The other participants represent members of the interdisciplinary health care team. Depending on the individual circumstances and goals of the meeting, these professionals may include the attending physician, consulting physicians, case management nurse and/or social worker, palliative care team members, spiritual care team members, and bedside nurse. In addition, a medical interpreter or telephone answering line may be required.

Prior to the family meeting, the health care team should hold a separate conversation so that they go into the conference on the same page and present a united message. This pre-meeting—formal or informal—should confirm the facilitator, set goals, and discuss the available treatment options and prognosis.

The actual family meeting is held in a conference room or another private area with enough seating for all attendees. If necessary, it can be held in the patient's hospital room if the person is able to participate but is confined to the room. Be sure to have tissues available and a speakerphone for those who need to join via telephone. Skype or Facetime is another option.

Introductions and agenda setting are important steps as they set the expectations for the meeting. At the onset, it is helpful for the facilitator to ask the patient or one person from the family to briefly summarize the situation. This allows the health care team to determine the extent of the knowledge gaps, misunderstandings or misperceptions about the patient's clinical status, prognosis, and treatment options.

If family members are acting as surrogate decision makers, it is important to encourage them to focus on what choices the patient would make—not what the family would choose. It can be useful to ask the family to imagine the patient sitting at the table and listening to the conversation or standing in the hospital room doorway and observing what was happening. What would the person tell the health care team he or she wanted?

Oftentimes, family will feel emotionally burdened by the thought of having to make life-altering or life-limiting decisions for their loved one. It helps to reframe the situation for them. Advise the family that they are not actually making the decision; they are simply telling the team what the patient would if he or she were able. It is also important to spend time identifying any cultural or spiritual beliefs that may impact the decision making. The facilitator should also clarify at the onset whether or not decisions are necessary at this time.

Throughout the meeting, emotions can run high, and health care professionals should be prepared to respond to the patient and family. This is where chaplains have an especially important role. It is critical to provide the family with early and frequent opportunities to ask questions, and to ask the team to explain and clarify any medical terminology or acronyms. Allow for periods of silence so the patient and family can absorb and process what they've just heard and have a chance to formulate questions.

The goal is to keep the meeting to under one hour. Any longer than this, and the family gets overwhelmed and the discussion begins to get circular and unproductive. To wrap up, summarize any decisions that have been made and schedule a follow-up meeting if necessary. The same factors that prompted the initial meeting may generate the need for additional ones.

Afterward, the health care team should hold a debriefing. This enables them to evaluate the meeting and possibly explore ways to change future ones. Moreover, it allows the team to vent and deal with their own emotions since these meetings can be as emotional for providers as they are for patients and their families.

FAMILY MEETING PROTOCOL

Provide for Appropriate Setting
- Private
- Seating for all attendees
- Speakerphone

Providers' Pre-Meeting
- Who will facilitate meeting
- Goals of meeting (information giving, code status, treatment decisions, etc.)
- Recommended plan of care
- Prognosis

Introduction/Agenda Setting
- Introduce health care team and family
- Identify goal of meeting
- Clarify whether or not decisions are needed now
- Establish ground rules

Information Giving
- Determine what is understood
- Provide update on current status, treatment options, prognosis
- Provide opportunities to ask questions
- Respond to emotional reactions

Decision Making
- Advance directives
- Patient's wishes

Wrap Up
- Summarize decisions
- Schedule follow-up meeting
- Health care team debriefing

Kathy Manske, RN, MSN, CCRN, CHPN, *Scottsdale, Ariz., is a palliative care nurse clinician at HonorHealth Scottsdale Osborn Medical Center, Scottsdale. She has spoken at various national conferences on topics related to palliative care and team dynamics. Manske, along with HonorHealth Scottsdale Osborn Medical Center colleagues Randall Olson, DMin, MDiv, a staff chaplain, and Carol Wangeman, RN, MSN, CHPN, a nurse clinician, presented on family meetings at HealthCare Chaplaincy Network's national conference last April.*

WATCH INTERVIEW
with Chaplain Randall Olson
www.healthcarechaplaincy.org/magazine

Inside a Canadian Hospital

Social Workers and Chaplains Work Hand-in-Hand on Team

By **Donna Bottomley, RSW, MSW,** and **Karen Grant, MA, RP, CASC**

While playing team sports in our youth, we've all learned the value of working together. Every member of the team plays an essential role that contributes to a desired outcome. Working within an interprofessional care team in a health care setting is no less important; in fact, it can be lifesaving and life-giving.

In Canada, the Canadian Interprofessional Health Care Collaborative and the Ontario Ministry of Health and Long-Term Care have been encouraging health care settings to utilize interprofessional collaboration (IPC) as a way of engaging in interprofessional education and effectively managing increasing workloads, reducing wait times, and increasing safety in their organizations. All disciplines, including spiritual care and social work, have professional requirements to work with the IPC team as part of their professional scope of practice.

The Ottawa Hospital, Ottawa, Ontario, introduced IPC in 2009, in what was believed to be the first hospital-based model in Canada. Today, it is among a growing number of hospitals in Canada and the rest of North America that has embraced this approach. Its InterProfessional Model of Care© promotes and improves staff cooperation within the organization to enhance quality of patient care. The model has grown over time and continually evolves.

At The Ottawa Hospital, social workers and chaplains are integral parts of the interdisciplinary team. They especially tend to closely work as a team within the team—perhaps more so than other health care providers—because of their similarities in scope of practice and focus on the psychological, spiritual and social dimensions of patients and their families. In addition, they, as well as other allied health members, tend to be the constant participants on a unit while physicians rotate in and out of the team.

Like other health care settings that successfully utilize IPC, The Ottawa Hospital's model defines collaboration as a "complex process requiring skills of competence, autonomy, mutual respect, self-confidence and commitment to all those involved." It relies on interpersonal understanding: beliefs, biases, strengths and limitations. It incorporates how one interprets and integrates knowledge, skills, and scope of practice within the team milieu.

Each member of the IPC team sees through the lens of his or her own experiences and knowledge. In working together, each begins to experience one another's expertise and boundaries through the process of communication and role demonstration.

To effectively execute IPC, health care providers must be willing to participate in a team and to feel there is a need and a reason to work in partnership toward a common goal. It is essential that all members communicate and demonstrate their roles to their colleagues. Collaborating and using the applicable referral indicators for each member's scope of practice are the cornerstones of the team.

It takes time to integrate skills and build collegial trust among all team members. To move this process along, it is important to get to know team members personally and professionally, to be open to support each other when needed, and to work together through the process of communication, role awareness, humility, team commitment, shared decision making, flexibility and openness to learn in a nonjudgmental and humble manner. In any role within a health care team, these core competencies are key skills in building effective collaboration through working safely and efficiently, and with client care at the center.

Perhaps ranking highest among the attributes fundamental to an IPC's success is ongoing and open communication. This involves providing clear and concise direction to all colleagues about interventions and desired outcomes.

Beyond collaborating among health care providers, this also means collaborating with patients and their families since any decision and outcome for management of care will ultimately affect them. Engaging them whenever possible in the conversation(s) during rounds and/or family meetings ultimately contributes to involvement and investment in their care, adherence to treatment regimen, and development of a sense of autonomy that can result in meaningful outcomes.

For social workers and chaplains, advocating for a person's quality of life frequently means providing perspective to the rest of the team regarding a person's cultural/spiritual beliefs that might affect care. It means asking for clarification of goals—humbly inserting one's own thoughts and feelings into the team's care plan and at times humbly accepting the answers as an individual's hopes, concerns and goals are discussed.

Especially evident during critical times, it also means assisting both the patient and/or family and team to bridge the gap between each of their wishes for therapeutic interventions and outcomes. For example, this may occur when a patient wishes to stop cancer treatments and prefers that the team provide quality rather than quantity of life, which may or may not reflect the team's current goals of care.

Charting clear, precise and important conversations is a very effective communication tool for all IPC members since not all of them are present during discussions or aware of certain situations or conversations. By documenting withdrawal of active treatment and/or important conversations and decisions regarding end-of-life care, the IPC team can work together to adapt their intervention in line with the change in the goals of care and to respect the person's wishes.

Effective communication by the IPC team provides a patient with autonomy, control over his or her health care, and a sense of dignity. These types of conversations can help cut hospital costs as well by reducing or eliminating unnecessary treatments and/or longer hospital stays.

As part of their team commitment, social workers and chaplains also work in tandem at times when they recognize that their colleagues would benefit from a side conversation and support due to a crisis or critical incident. Working together, communicating and accompanying staff through difficult times can reduce sick time and/or burnout and can also help save the institution money and time lost from workplace stress.

Role awareness/understanding is the other fundamental competency of any IPC group. No one team member can meet all the needs of those in their care. Participating in rounds and listening and watching other providers communicate their roles, they become familiar with who to consult with and what that team member can offer toward the person's care. (HealthCare Chaplaincy Network's evidence-based Scope of Practice document, released earlier this year, can help chaplains and other team members describe the framework in which to provide quality spiritual care in health care settings.)

> "Each team member sees through the lens of his or her own experiences and knowledge ..."

At The Ottawa Hospital, chaplaincy and social work have joined together to promote and educate the team on their respective roles as well as advocate for the other as appropriate. There are situations when both disciplines combine interventions—believing that dual involvement provides best care practices for overall holistic care and support. At other times, however, it may be more beneficial to "divide and conquer."

With this approach, social workers and chaplains convene regularly to discuss how to best meet the needs of care recipients and the IPC team. They distribute cases based on assessment of needs, team input, and scope of practice; and they continue to communicate and participate however and whenever necessary on the team.

Being aware of each other's referral indicators and one another's personal preferences and strengths with patients and their families, they can advocate for each other within the IPC team—suggesting who is more suitable to meet a certain person's needs based on knowledge of each other's skills, workload, and scope of practice. In this way, they can work more efficiently by reducing service duplication and covering more ground.

For example, both a social worker and chaplain attend family meetings at the hospital. If it is found that the family incorporates spiritual or religious coping strategies, the chaplain provides the support and follows up with the family either during and/or after the meeting. Should the person refuse spiritual intervention, social work gets involved.

Over the years, the IPC team has become more confident in understanding the roles of chaplains, social workers, and other colleagues, and referring to the appropriate provider. It takes commitment to continue to work at becoming a team as members come and go. We can all be advocates for IPC—knowing that a good team can contribute to safer practices, less staff burnout, lower hospital costs, improved team engagement and morale, more compassionate care, and the overall patient experience.

Donna Bottomley, RSW, MSW, *and* ***Karen Grant, MA, RP, CASC,*** *both of Ottawa, Ontario, work in the intensive care unit at The Ottawa Hospital-General Campus, a 1,117-bed acute care hospital. Bottomley is a registered social worker. Grant is a registered psychotherapist and a certified spiritual care practitioner by the Canadian Association for Spiritual Care (CASC). During their five years of working together, they have gotten to know one another both personally and professionally.*

Research Highlights Unique Impact of Chaplaincy

By **Rev. Brian P. Hughes, MDiv, MS, BCC**

Chaplains can and should look to research-generated, evidence-based best practices to help determine which patients we see, what specific spiritual care interventions we provide, how we both evaluate and communicate to team members the effectiveness of that care, and where we can be further utilized. The more familiar chaplains are with the published research, and the more we conduct research ourselves, the more we will be able to articulate the unique positive contributions chaplaincy care provides to patients, families and staff within health care settings.

Among the nearly 100 chaplaincy-related research articles published in 2015, here are six that showcase the impact of chaplaincy care.

1) *Marin, Deborah B., et al. Relationship Between Chaplain Visits and Patient Satisfaction. Journal of Health Care Chaplaincy 21.1 (2015): 14-24.* – looks at the impact of chaplaincy care on patients and families as measured by both Press Ganey® and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), the two most commonly used surveys to assess patient satisfaction.

Conducted at Mount Sinai Hospital, a 1,171-bed hospital in New York City, the study reviewed 67,592 hospitalizations, of which only 5.6 percent of total survey respondents had a chaplain visit.

Once adjusted for patient characteristics, the coefficient for the variable of chaplain visits was significant for all questions. This means that this study is "the first study demonstrating that patients who are seen by chaplains are more satisfied with their hospital stay, as measured by [both] surveys," the authors concluded. The bottom line: if a patient saw a chaplain, he or she scored the institution higher on these significant patient satisfaction measures.

2) *Cramer, Emily M., Kelly E. Tenzek, and Mike Allen. Recognizing Success in the Chaplain Profession: Connecting Perceptions with Practice. Journal of Health Care Chaplaincy 21.4 (2015): 131-150.* - discusses how chaplains know whether or not the spiritual care they provide at the end of life has been successful. This qualitative study looked at the experiences of 32 chaplains through rather open-ended interviews. Specifically, the participants were asked, "How do you feel you have successfully completed your job as a hospice

chaplain?" and "In hospice care, death is a certainty. How do you measure a successful interaction with a patient, family or interdisciplinary team?"

The authors analyzed the responses according to two distinct categories: nonverbal and verbal hallmarks of success. Respondents included personal sense of accomplishment, progress in fulfilling patient needs, and meaningful connection with patients as nonverbal hallmarks. The verbal hallmarks included patient affirmation, family affirmation, and an invitation to participate in religious rituals or rites.

This is a strong study that confirms what appears at first glance to be self-evident: chaplains look to themselves, their patients, and families to assess if their interactions have been successful. It highlights that most chaplains are unsure of how to measure the relative effectiveness of their interventions, and even think about whether what they do helps people. This is a question upon which every chaplain should reflect and have a ready response.

3) *Massey, Kevin, et al. What Do I Do? Developing a Taxonomy of Chaplaincy Activities and Interventions for Spiritual Care in Intensive Care Unit Palliative Care. BMC Palliative Care 14.1 (2015): 1.* - sought to tease out the actual spiritual care interventions chaplains use in a "normative inventory" to help communication between chaplains and interdisciplinary palliative care teams.

Much of this article details the authors' process of developing this standard terminology inventory of chaplaincy activities and outcomes, to be called the chaplaincy taxonomy.

Through a literature review, retrospective chat review, and other methods, they reduced a list of more than 450 potential interventions to 100 activities, broken down into intended effects, methods and interventions.

A table (Table 3) that lays out the taxonomy is rich with potential application. Chaplains seeking to improve their clinical communication both in charting and verbally with staff can benefit from using this resource.

4) *Choi, Philip J., et al. "The Patient Is Dying, Please Call the Chaplain": The Activities of Chaplains in One Medical Center's Intensive Care Units. Journal of Pain and Symptom Management 50.4 (2015): 501-506.* – describes the process and metrics of one large hospital's chaplaincy interactions with adults in the intensive care unit (ICU), and finds a scarcity of chaplaincy interactions.

The researchers found that of the 4,169 ICU admissions over the six-month study period, chaplains saw only 248 patients (5.9 percent), which, interestingly, is similar in number to the first study above; and they visited 80 percent of those who died in the ICU. Chaplains communicated with nurses after 141 patient encounters (56.9 percent) but with physicians after only 14 visits (5.6 percent); there was no documented

communication in 55 cases (22 percent). On average, chaplains were called two days into an ICU admission, and one day from their referral to the patient's unit discharge or death.

This is one of the first articles to give hard metrics for the chaplaincy process. It demonstrates a potential need for more proactive integration of chaplains into the critical care team.

5) *King, Stephen Duane, et al. Spiritual or Religious Struggle in Hematopoietic Cell Transplant Survivors. Psycho-Oncology (2015).* – looks at long-term survivors of hematopoietic cell transplantation (HCT) to find the incidence of religious or spiritual (R/S) struggle and its correlation to medical or demographic variables, as well as depression and quality of life.

The authors found that of the 1,449 respondents, 27 percent had experienced R/S struggle, and that this struggle was associated with both greater depression and decreased quality of life. It occurred more often for nonwhite, younger survivors, and survivors who identified as either "spiritual but not religious," or "religious but not spiritual." R/S struggle was not linked to any specific medical variables.

> A good resource for research articles is Google Scholar (https://scholar.google.com).

With this high prevalence of R/S struggle, HCT survivors should be screened for R/S struggle and referred appropriately, the authors said.

6) *Ernecoff, Natalie C., et al. Health Care Professionals' Responses to Religious or Spiritual Statements by Surrogate Decision Makers During Goals-of-care Discussions. JAMA Internal Medicine 175.10 (2015): 1662-1669.* – reviews how frequently families and health care professionals discuss religious or spiritual concerns (R/S) during goals-of-care discussions in intensive care, as well as how professionals respond to such concerns.

The authors evaluated 249 audio-recorded goals-of-care discussions between 651 surrogate decision makers and 441 health care professionals in 13 different ICUs. Strikingly, only two of these family meetings had a chaplain.

While the vast majority (77.6 percent) of 451 surrogates stated that R/S were fairly or very important in their life, only 40 family meetings (16.1 percent) discussed R/S concepts. Surrogates raised the R/S issues first in most cases (65 percent), and the health care provider responses were varied: they redirected the conversation to the medical concerns (38 percent); offered to involve chaplaincy care or the patient's faith leader (35 percent); made an explicit expression of empathy (33 percent); verbally acknowledged the statements (28 percent); or explained their own R/S beliefs (8 percent).

This mirrors existing research between patient/physician and R/S communication. It indicates a need for proactive integration of the exploration of R/S concerns into the goals-of-care discussions within critical care.

Rev. Brian P. Hughes, MDiv, MS, BCC, *of Garland, Texas, works with HealthCare Chaplaincy Network's programs and services team.*

Inspiration ... Pass it on!

Editor's note: This column is all about inspiration—to pass along to your patients and colleagues.

"I do not at all understand the mystery of grace—only that it meets us where we are but does not leave us where it found us."

— AUTHOR ANNE LAMOTT

Healing Grief Through Grace

By **The Rev. Sue Wintz, MDiv, BCC**

The thought of describing one's journey of grief as "grace" seems unsettling, if not impossible. Grace, after all, is typically defined as elegance or beauty of form, manner, motion or action—or in many religious traditions as mercy, clemency or pardon. How can either of these definitions apply when we feel as though we are in a deep, dark hole whether our grief is new or we're experiencing a "grief burst" at a later place in our journey? And if our grief was caused by another person, are we really expected to offer mercy or forgiveness?

There are those who would say yes to those traditional definitions of grace, but in my experience they are typically persons who have not faced grief that tears their world apart. Most importantly, they haven't lived through your grief. Everyone's experience of grief is individual, unique, and deserves to be honored and respected.

Grief asks so much of us; it changes our world from the way we once knew it, and it changes us from the person we were "before." We have to learn a new way of living in the world, choosing how we are going to take those first and then continuing steps that will last for the rest of our lives. We also need to reimagine our relationship with the person we loved who has died. The relationship doesn't end; it changes. We no longer see and hold that person in our lives, but we always hold him or her in our hearts, our memories, and our spirits.

I can say this from experience, as our beautiful daughter was killed by an adult speeding red light runner in 2003 during her senior year in high school. Our lives were shattered, and our beliefs about the world and the Divine were tested beyond words.

But whether we are religious, spiritual, have existential beliefs, or no formal belief system at all, the challenges are the same because we are all connected wherever and however we search to find meaning. How do we make sense of our grief? How do we move through it? Will we ever find happiness, purpose and joy again? Can we regain our balance?

As we know, grief is not a quick process: it can be one step forward and then a slide, not just a couple of steps, backwards. We can find joy in a moment, and in the next feel the overwhelming sadness knowing that we can't share that joy with the person who we long to have beside us. Yet one thing I have learned in the years since our daughter's death is that the journey does become softer. The painful moments—the grief bursts—still come, but they are clothed in loving remembrance and, yes, even grace.

You see, there is another meaning for grace—one that can become not just a lifeline for us when we are grieving, but a tool for hope and healing in our journey. Grace also means to favor or to honor. What better thing for us to do than to carve out space in our grief to honor the person we loved?

I long for our daughter every day. I wonder what she would be like; she was planning to be a teacher of developmentally delayed preschoolers and looked forward to being a mother someday. She loved life and was one of the kindest people I've ever known in how she cared for the people, animals and world around her.

I've chosen to include grace in my grief journey, which admittedly wasn't easy at first. I honor the lessons my daughter taught me from the time she was born (yes, even during those difficult adolescent years). Memories come back to me, and there is laughter amidst the tears. Random acts of kindness I do for others in her honor bring moments of joy. I am grateful that I was her mother; that she was, continues as, and will always be a part of our family. Most of all, I am grateful for her love and the grace she has encouraged me to embrace.

In your grief, as you redefine yourself and your world, invite your sadness to lead you forward one moment, one minute, one step at a time. And along the way, invite and practice grace as a way to honor and continue your relationship with the one you hold and love in your heart.

The Rev. Sue Wintz, MDiv, BCC, *of Mesa, Ariz., is HealthCare Chaplaincy Network's director of professional and community education, and the managing editor of its professional journal, PlainViews®.*

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