December 2015 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Hemming, P., Teague, P. J., Crowe, T. and Levine, R. "**Chaplains on the medical team: a qualitative analysis of an interprofessional curriculum for internal medicine residents and chaplain interns**." *Journal of Religion and Health* 55, no. 2 (April 2016): 560-571. [*This article was originally featured ahead-of-print.*]

SUMMARY and COMMENT: This month's article builds upon a theme broached in our November article: chaplains working alongside of physicians; though in this case through a program in place since 2011 at the Johns Hopkins Bayview Medical Center (Baltimore, MD) that has partnered CPE interns with an inpatient teaching service for medical residents. Focus groups of participating attending physicians, medical residents and chaplain students "suggest strong potential to jointly advance training in core competencies of each profession" [p. 567] and provide insights on curricular logistics. Also, co-author and ACPE Supervisor Paula J. Teague has added to this month's feature some thoughts for our Network.

The educational program in place works with a special ward service "with a lower patient census where the chief aim is to ensure that residents know their patients as individuals" [p. 562].

> During the 4 week rotation, chaplain interns spend 1 day per week rounding with the medical team. They are introduced to patients as a member of the team and participate in morning rounds at the bedside. During the afternoon, they partner with the team in supporting patient care by returning to see patients identified as having spiritual needs. Patients may decline to have a return chaplain visit. Chaplain interns are expected to teach the medical team briefly about their role as a chaplain and how to do an initial spiritual assessment. Chaplain interns are provided opportunities to role model discussions about spirituality with patients during bedside rounds. [p. 562]

Six focus groups, lasting 30 minutes to an hour, were conducted using open-ended prompts: 1) What did you learn? 2) How did you change? 3) What was the value of this experience? and 4) What could have been improved? [--see Table 1, p. 563]. Transcripts were coded by two of the authors for key themes, and the analysis was reviewed for accuracy by "two participating attending physicians, two internal medicine residents, and one chaplain intern" [p. 563].

Four themes emerged (and are illustrated with quotes from the transcripts):

Theme One: Both Attending Physicians and Residents Became Aware of Effective Communication Skills for Addressing Spirituality --

> Physicians noted that they were introduced to new ways of approaching patient interactions from observing chaplain interns speaking at the bedside with the patient on rounds. These new techniques included active listening, observing, and using appropriate language for discussing spirituality. Multiple residents described learning how effectively they could help patients by simply being present and using silence. ...One attending physician felt that watching chaplain interns model communication taught these skills more effectively than other potential teaching methods.... [pp. 563-564]

Theme Two: Chaplain Interns Enhanced the Delivery of Team-Based Patient-Centered Care --

> Both attending physicians and residents appreciated the ability of chaplain interns to invite patients to share their own experience, by asking about important aspects of their lives. ...Also, physicians perceived the chaplain interns as extremely helpful in addressing the care of patients who were viewed as being more difficult to work with.... ...One chaplain intern mentioned that at times she was able to refocus bedside discussion on rounds from a biomedical focus back to the patient's psychosocial experience.... [p. 564]

Theme Three: Chaplains May be a Source of Emotional Support to the Medical Team --

> Multiple physician participants noted instances when, in the event of a challenging patient event (such as a death or the need to deliver bad news), the chaplain intern took the opportunity to lead a brief reflection on the experience. ...For chaplain interns, they learned from these interactions that they could lend meaningful support to their physician colleagues. ...Medical residents saw chaplain interns as individuals who had expertise in handling some of the negative emotions that arise during patient care. [pp. 565-566]

Theme Four: This Interprofessional Partnership has Three Keys to Success: Adequate Introductions for Team Members, Clear Expectations, and Opportunities for Feedback --

> Chaplain interns felt more integrated when physicians introduced the chaplains to patients as a part of the team. Medical residents noted that they appreciated knowing a little bit more about the CPE trainee, and that this fostered collaboration. ...Attending physicians, unused to incorporating a chaplain on the team found it difficult to bring them into rounds. In other cases, CPE trainees were eager to participate and contributed to rounds in ways that were seen as distracting or inappropriate by the attending. It became apparent that each participant needed up-front expectations of how to interact across professional disciplines in rounds. ...Chaplain interns early in the curriculum noted a lack of feedback on their contributions. [pp. 566-567]

The authors note that in light of anecdotes prior to this research, they "hypothesized that participants would learn more about communication skills and interprofessional work" and "anticipated that participants would have challenges related to defining the role of a chaplain on the medical team [p. 563]. However,

> We did not initially envision that chaplain interns and medical teams would engage in mutual emotional support. Without prompting, they took the opportunity to reflect on loss and grief in a way that was therapeutic to members of the team. Residents described these experiences as a form of support group. ...Focus group residents felt strongly that chaplain interns' interventions provided coping strategies, and in some cases closure, to difficult experiences. [pp. 567-568]

In relation to practical points in Theme Four (above), the program has subsequently been adjusted to better clarify role expectations of the interns (e.g., "[W]e have modified chaplain interns' orientation to include instruction on the structure of the medical team, and the function of rounds" [p. 568]) and to provide opportunity for feedback (e.g., [W]e developed a structured feedback form that chaplain interns would use to elicit feedback from the attending physician...[p. 568]).

While this article reports an investigation of a multi-year program, the qualitative study itself is limited [--see p. 568 for limitations]. Still, it indicates the viability of a model of interprofessional education for CPE programs, and it lays groundwork for future research involving direct patient perspectives and patient satisfaction, as well as the effect of such a model on team members' skills and behaviors. The program is said to have been designed to help fill the "gaps in...training" [p. 561] for physicians and chaplains that have implications for collaboration in patient care. The authors comment at one point: "Chaplains may not be accustomed to or be comfortable approaching physicians in connection with a patient's care" [p. 561], and so perhaps one specific area for future research could be the effect of such a program on chaplains' abilities to engage physicians as team professionals --which is a classic issue in CPE.

The authors' bibliography of 48 references gives a number of good leads for further reading (but see also Related Items of Interest, below).

Special Note to the Network from Article Co-Author Paula J. Teague, DMin, MBA, Senior Director, Spiritual Care and Chaplaincy for Johns Hopkins Health System:

> As you read the article "Chaplains on the Healthcare Team," my hope is that you are thinking about how you could replicate all or parts of the curriculum. There were special circumstances that allowed us to launch the curriculum in the ways that we did: a medical service called "Aliki"* (named for its benefactor) which focused specifically on the whole person, a grant from the Foundation for Spirituality and Medicine, and a curriculum development course through the School of Medicine where we had mentorship and physician partners. Having said this and with great appreciation for this support, I do believe that our work is replicable. Here is how.
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> 1. Whether there is a formal medical education program or not, there are educational programs in hospitals and medical centers. Examples are grand rounds, mortality conferences, staff meetings, department meetings, etc. This is a place to find partners.
> 2. Clinical Pastoral Education programs focus on experiential educational models which are certainly viable without a formal CPE program in place. The research we did and the outcome of the curriculum we developed supported the notion that experience is a great teacher. Having chaplains or chaplain trainees shoulder to shoulder with physicians or physician trainees was a key. So find ways for chaplains to see patients/clients together with the medical team or individual physicians, e.g. rounds.
> 3. Engage physicians about their perceptions of spiritual care and chaplaincy. This can individually or in group settings. It is important to hear where physicians have concerns and questions. It was truly surprised at the mystery surrounding what a chaplain does from physician colleagues. We were told that "you chaplains go in the patient's room and do something mysterious and we know it somehow improves what happens." Physicians seemed curious and a little wary about our patient encounters though their support for spiritual care services was solid.
> 4. Look for opportunities to reflect with physicians about their work. We found that relationships developed through the shoulder to shoulder work that then allowed for joint reflective activities that were sometimes personally supportive of physicians *and* allowed for learning about the provision of spiritual care and the chaplains' role.
> 5. The curriculum development plan that we followed is available in book form, *Curriculum Development for Medical Education: A Six Step Approach*. CPE depends on sound curriculum development and this methodology is a must for Supervisory Education students and for CPE programs. It includes the important steps of looking at the work of others through literature searches, asking what consumers want through a focused analysis and developing evaluation measures for the program itself. In CPE we

assess the learners thoroughly and perhaps are not as complete in the program evaluation.

6. Finally, this work depended on recording of chaplain trainees and physician experiences. This is certainly possible in audio recorded interviews or written stories. Hearing the heart of the matter in these stories pointed us toward further opportunities to partner with physicians to improve patient experiences and also gave us insight into our chaplain trainees' gaps in knowledge. Qualitative analysis has a rigor which is needed. As we engaged in this process, we were doing the work of a chaplain; listening well to the story and responding relationally to what had been said.

If you want to discuss this project, we would be excited to talk with you.

--Paula J. Teague (pteague1@jhmi.edu)

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* Perroti Aliki is the benefactor. A description of the Aliki program can be found on YouTube by the title of The Aliki Initiative-Innovative Patient Care.

Suggestions for the Use of the Article for Student Discussion:

This article should spark creative discussion in a Supervisory Education peer group, regarding educational strategy. The practical lessons found in Theme Four [p. 566-567] alone should be of interest to for supervisors in training. In terms of use with CPE residency and internship groups, the article paints a picture of chaplain-physician interaction that may allow students to envision greater integration into the medical team. How do students currently feel about their role in the medical team? Do they understand the roles of others on medical rounds, and how do they believe they are perceived? What might be ways to clarify roles and expectations in the students' multidisciplinary/interprofessional work? What patient care skills might chaplains help to teach physicians, and what might chaplains learn *from* physicians? Have students experienced being an emotional support to physicians? If not, then what is the practical potential there? What are students' reactions to the report of Theme Three [pp. 565-566]? Finally, students might like to discuss the structured feedback form that was developed as part of the project.

Related Items of Interest:

I. For more on the dynamics of the chaplain-physician relationship, see our July 2011 Articles-of-the-Month plus also the following:

> Carey L. B. and Cohen, J. "**Chaplain-physician consultancy: when chaplains and doctors meet in the clinical context**." *Journal of Religion and Health* 48, no. 3 (September 2009): 353-367. [(Abstract:) This paper summarizes the perspectives of 327 Australian health care chaplains concerning their interaction with physicians within the clinical context. In general terms the findings indicated that nearly 90% of chaplains believed that it was part of their professional role to consult with physicians regarding patient/family issues. Differences of involvement between volunteer and staff chaplains, Catholic and Protestant, male and female chaplains and the type of chaplaincy training are noted, as are the perspectives of chaplaincy informants regarding their role in relation to physicians. Some implications of this study with respect to chaplaincy utility and training are noted.]

Thiel, M. M. and Robinson, M. R. "**Physicians' collaboration with chaplains: difficulties and benefits**." *Journal of Clinical Ethics* 8, no. 1 (1997): 94-103. [While this is an older article and not a report of research, its two chaplain authors name important dynamics in the chaplain-physician relationship that remain relevant. See especially the section on Difficulties in the Relationships Between Chaplains and Physicians (pp 96-97).]

Winiger, D. "**Physicians' Perceptions of the Chaplain's Role in Critical Care**." Dissertation, 2007. [This is a doctoral dissertation by Daniel Winiger (who is now Chaplain at the Wellmont Health System's Holston Valley Medical Center in Kingsport, TN) and is available online from Asbury Theological Seminary. (Abstract:) The purpose of this study was to investigate physicians' perceptions of the role of chaplains in the common goal of health care delivery in a critical care setting. Chaplains practice their ministry as a minority in a biologically and technologically driven environment. Some chaplains have found that their relationships with physicians are strained. In order for chaplains to function with more confidence, they need to understand their role in critical care better. Because physicians are the primary decision makers in hospitals and decide how closely they want to work with others, this project investigated how physicians perceive the chaplain's role. The critical care setting was chosen because patients express a higher need and desire for spiritual care as acuity of their illness increases. During times of serious illness and end of life, the domains of medicine and faith start to overlap. Patients and, more often, families have to integrate medical facts with their faith. In those times physicians' perceptions of the chaplain's role become particularly relevant. Due to the particularity and newness of research into the domain of the physician chaplain relationship, I chose the qualitative research methodology, conducting semistructured interviews. The qualitative format and semi-structured interviews proved valuable as physicians expressed their personal experience and opinion about the very chaplains with whom they rub shoulders during their daily work. A surprising finding of the study was that critical care physicians perceive chaplains are most important for providing ministry to patients' families, who are experiencing acute grief as their loved ones face critical illness and possible death. Congruent with previous research was that physicians appraise faith in psychological and not religious terms. In keeping with already reported studies, critical care physicians also did not attribute curative properties to faith activities, such as prayer or sacrament. Physicians clearly delineated between the domains of medicine and faith in keeping with a well-established distinction between science and religion. Nevertheless, physicians in this study recognized the importance of faith as a means of coping with illness, dying and death, and appropriately recognized chaplains as trained professionals who are able to provide spiritual care. Physicians also expressed appreciation for chaplains' immediate availability and expertise in dealing with emotional and spiritual issues and verbalized a high level of trust toward them.]

II. Howard Clinebell, the noted professor or pastoral counseling at the Claremont School of Theology (Claremont, CA), suggested five essential elements for good clergy-physician relationships in an introduction to a somewhat obscure book: Montgomery, D. W., ed., ***Healing and Wholeness*** [Richmond, VA: John Knox Press, 1971] --see pp. 13-16. These are enumerated in two relatively accessible articles, however: on p. 57 of Underwood, R. D., Underwood, B. B. and Mosley, D., "**The chaplain/pastoral counselor as a behavioral medicine consultant in cardiac rehabilitation: a team approach**," *Journal of Health Care Chaplaincy* 3, no. 2 (1991): 55-75; and on pp. 353-354 of Carey L. B. and Cohen, J., "**Chaplain-physician consultancy: when chaplains and doctors meet in the clinical context**," *Journal of Religion and Health* 48, no. 3 (September 2009): 353-367. The elements, which are as follows, would seem to have application to the *chaplain*-physician relationship:

- Mutual understanding and appreciation of each other's unique competencies, views, insights and contributions to the helping-healing enterprise
- Willingness and the opportunity to communicate
- Openness to learn from each other

- A robust sense of professional self esteem
- More frequent opportunities to work together in helping the same patient/parishioner

III. For a small study of medical students *shadowing* chaplains, and about shadowing as an educational strategy, see our February 2014 Article-of-the-Month:

> Perechocky, A., DeLisser, H., Ciampa, R., Browning, J., Shea, J. A. and Corcoran, A. M. "**Piloting a medical student observational experience with hospital-based trauma chaplains**." *Journal of Surgical Education* 71, no. 1 (January-February 2014): 91-95. [(Abstract:) INTRODUCTION: Medical students have typically received relatively modest training in approaches for engaging the concerns of patients and families facing life-threatening situations and terminal illnesses. We propose that medical students would perceive benefits to their communication skills, understanding of the role of the chaplain, and knowledge of emotional and spiritual needs of grieving patients and families after shadowing hospital-based trauma chaplains whose work focuses on emergency department traumas and intensive care units. METHODS: The authors developed a pilot program in which medical students shadowed a trauma chaplain during an on-call shift in an urban level 1 trauma center. Students subsequently completed an evaluative survey of their experience. RESULTS: Of 21 participants, 14 (67%) completed the questionnaire. Students observed an average of 1.50 traumas and 3.57 interactions with patients or families. One-third of the students witnessed a death. More than 90% of respondents agreed or strongly agreed that (1) the program provided them with a greater understanding of how to engage patients and families in difficult conversations; (2) they learned about the chaplain's role in the hospital; and (3) the experience was useful for their medical education, careers, and personal development. About two-thirds (9/14) perceived that they learned how to discuss spirituality with patients and families. All recommended the experience be part of the medical school curriculum. DISCUSSION: Observational experiences with hospital-based trauma chaplains might be an effective nondidactic approach for teaching medical students effective communication with patients and families, collaboration with chaplains, and spirituality in patient care.]

IV. The following are four first-hand reflections on CPE and chaplaincy from a physician perspective, plus one (Todres, et al.) description of a CPE program for physicians.

> Allbrook, D. B. "**A metamorphosis: doctor to chaplain**." *Medical Journal of Australia* 172, no. 8 (April 17, 2000): 390-391. [This is a personal reflection by an Australian retired palliative care physician and academic after a year in a hospital pastoral care (chaplaincy training) program. The author treats implications for his understanding of the practice of medicine and offers a description of the role of the chaplain.]

> Faris, I. B. "**Perspectives from a surgeon turned hospital chaplain**." *Medical Journal of Australia* 172, no. 8 (April 17, 2000): 389-90. [An Australian retired surgeon reflects upon his experience in a hospital chaplaincy program and the perspective he has gained, in the process, on the practice of medicine.]

> Feldstein, C. B. "**Bridging with the sacred: reflections of an MD chaplain**." *Journal of Pain & Symptom Management* 42, no. 1 (July 2011): 155-161. [This is the author's personal story of becoming part of the Jewish Chaplaincy at Stanford University Medical Center, including CPE.]

> Tarumi, Y., Taube, A. and Watanabe, S. "**Clinical Pastoral Education: a physician's experience and reflection on the meaning of spiritual care in palliative care**." *Journal of Pastoral Care & Counselin*g 57, no. 1 (Spring 2003): 27-31. [A Canadian physician "reflects on her experience as a

chaplain intern and how this Clinical Pastoral Education experience led to a deeper understanding of spiritual care in the palliative setting" (--from the abstract).]

Todres, I. D., Catlin, E. A. and Thiel, M. M. "**The intensivist in a spiritual care training program adapted for clinicians**." *Critical Care Medicine* 33, no. 12 (December 2005): 2733-2736. [This is a report of how a special Clinical Pastoral Education program for physicians at Massachusetts General Hospital affected those physicians. Integration papers revealed that "clinical practice became infused with new awareness, sensitivity, and language; graduates learned to relate more meaningfully to patients/families of patients and discover a richer relationship with them; spiritual distress was (newly) recognizable in patients, caregivers, and self" (--from the abstract, but see also, p. 2735).]

V. The research reported in this month's article was also presented as a poster to the American Geriatrics Society Annual Scientific Meeting, May 15-17, 2014, in Orlando, FL, and an abstract was published in a supplement of the organization's journal:

Sandoval, M. M. "**Chaplains on the medical team: an interprofessional partnership for patient care: A80**." *Journal of the American Geriatrics Society* 62, Suppl. 1 (March 2014): S47. [(Abstract:) Background: The Joint Commission (JCAHO) and the Institute of medicine (IOM) have acknowledged the importance of creating systems of care that address patients psychosocial, spiritual, and cultural values since it influence medical care. We developed a shared educational experience for internal medicine (IM) ward teams and chaplain interns in clinical pastoral education (CPE). The objectives for the participants are to teach providers to incorporate patient spiritual assessments into their care and to encourage collaborative practice with chaplains. Methods: At Johns Hopkins Bayview Medical Center (JHBMC), select CPE interns participate longitudinally with one of the IM resident inpatient teams. The team includes one attending physician, a resident, two interns, and two medical students. Description: A pilot of the curriculum is ongoing wherein CPE interns round with the team, advising and teaching them about the spiritual needs of patients. Each CPE trainee spends approximately 4 weeks with the medical team. The research team directed group interviews of participants from each group that is participating in the curriculum; medical residents, CPE students, and faculty who function as the attending physicians on the inpatient medical service. We surveyed Internal Medicine Residents at Johns Hopkins Bayview Medical Center (JHBMC). Data were collected via a group interview. 33 of 57 residents responded to the survey, a response rate of 57.9%. 25 of the 33 respondents had participated with CPE trainees as part of the pilot curriculum. The majority of residents felt that understanding patients' spirituality was important. Less than onethird of residents felt very comfortable in conversations with patients about spirituality. Residents reported low knowledge about and use of spiritual assessment tools. But more than 90% reported that they had requested at least one referral to the chaplain during their last month. Discussion: Our approach is pioneering in that it brings an integrated education to the patient's bedside integrating the education of chaplains and physicians to improve treatment, decision making, creates multi-disciplinary communication and positively impacting patient satisfaction.]
