A paper:
Access to Hospital Chaplain Care

Robert Baral
REGR 6385 – Education for Peace & Justice
Fordham University, The Bronx
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PREFACE

The purpose of this paper is to examine the nature and course of modern hospital Chaplaincy and grapple with the question of where today's hospital Chaplain's first allegiance should rest. Is today's hospital Chaplain first an agent of The Church that anoints and sends him/her? Or first the agent of the secular healthcare institution that trains and pays him/her? In wrestling with these questions, I hope to offer a prescription for facilitating the right to access to hospital Chaplain care.

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ABSTRACT
At the satellite hospital that I primarily work at as a Chaplain, 24/7 in-house Chaplain care has only been in place for about a year. Many hospital staff have questions and issues about if and when they should make referrals to the on-duty Chaplain for pastoral care of patients, families and staff. I therefore propose to consider the nature of hospital Chaplain care today; the interfacing of hospital Chaplaincy with Medicine and Nursing; the right to access to Chaplain care in the hospital setting; the benefits of hospital Chaplain care; the emergence of the modern hospital Chaplain; addressing obstacles to accessing hospital Chaplain care; Catholic Social Teaching for teaching access to Chaplain care; a teaching model for staff to facilitate Chaplain care.

The greatest obstacle to staff making referrals to the hospital Chaplain is when those same staff sees the Chaplain as unprofessional, uncaring and insensitive. Beyond disseminating basic how to information throughout the hospital in an ongoing manner and having a visible presence, the best thing the hospital Chaplain can do to facilitate staff making referrals for Chaplaincy care is to prove himself/herself to staff as one who is professional, caring and sensitive towards them. This requires being present, building up relationships and being a Chaplain with as much empathy for caregivers as for patients and families.

I conclude that it is not so much the right policy answers, academic journal references or assessment tools used for in-services with staff that will facilitate caregivers calling for the Chaplain when distress in spiritual struggles are apparent. Rather, it is more the serving in an effective, professional, caring manner and developing empathetic one-on-one pastoral and human relationships with staff that will enable caregivers to be more open to making referrals to the hospital Chaplain.

DEDICATION
This paper is dedicated to the vision of Christian ministry of giving the gift of self to GOD and others that inspired Mrs. Abigail Ann Geisinger to erect and dedicate "The George F. Geisinger Memorial Hospital" to the loving memory of her husband, George Francis Geisinger, in the year of our Lord, A.D. 1915.

EPIGRAPH
JESUS CHRIST says, "…The Son of Man came not to be served but to serve and to give His life as a ransom for many." [MATTHEW 20:28, NAB]

I. INTRODUCTION

As a lay Catholic working in a secular healthcare system [1] [2] as a hospital Chaplain, [3] or more correctly a Catholic "Lay Ecclesial Health Care Minister," [4] the social justice concern that is important to me is access to Chaplain care in the hospital setting. On a forgotten wall of a less used front entrance of the main hospital of the healthcare system that employs me is a forgotten plaque with an inscription by the founder of the hospital:

> "The George F. Geisinger Memorial Hospital, erected and endowed in loving memory of George Francis Geisinger, 1821 – 1883, by his wife, Abigail Ann Geisinger, *A.D.* 1915. '*Not to be ministered unto, but to minister*.'" [*emphasis added*][5]

The date is marked by "A.D.," - "Anno Domini" – meaning "The Year of our Lord." [6] This is the once common Christian notation of the year that denotes after the birth of CHRIST, a reflection of the society and the personhood of Mrs. Geisinger that dedicated this hospital at its founding. [7] The last phrase of the dedication plaque is a Bible Text from the first half of The Words of JESUS CHRIST in MATTHEW 20:28, which in The NAB reads, "…The Son of Man came not to be served but to serve and to give His life as a ransom for many." [8] If this plaque is any indicator, Mrs. Geisinger was a Christian lady of compassion who believed in the spirit and work of Christian ministry.

At the satellite hospital that I primarily work at – Geisinger Wyoming Valley Medical Center (GWVMC) - 24/7 in-house Chaplain care has only been in place since about 4/2010. One year later, many hospital staff have questions and issues about if and when they should make referrals to the on-duty Chaplain for pastoral care of patients, families and staff. I therefore propose to consider the nature of hospital Chaplain care today; interfacing of hospital Chaplaincy with Medicine and Nursing; the right to access to Chaplain care in the hospital setting; the

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[1] 1, Geisinger Health System, "Geisinger Medical Center – Danville, PA." http://www.geisinger.org/locations/gmc/index.html.
[2] 1, Geisinger Health System, "Geisinger Wyoming Valley Medical Center – Wilkes-Barre, PA." http://www.geisinger.org/locations/gwv/index.html
[3] 2, Catholic Canon Law, # 564. Only Priests may use the title "Chaplain" in The Catholic Church.
[4] 3, Melczek, "Use of Title 'Chaplain' in Pastoral Care Ministry," para 4. "Lay Ecclesial Health Care Minister" is a Catholic Church title that recognizes the increasing numbers of Lay Catholics serving in institutions as "Chaplains," but preserves the Church title "Chaplain" for Priests alone.
[5] 4, KJV, MATTHEW 20:28a.
[6] 5, Webster, "Desk Dictionary of The English Language, entry for "A.D.," p 10.
[7] 1, Geisinger Health System, "Geisinger History." http://www.geisinger.org/about/history.html
[8] 6, NAB, MATTHEW 20:28.

benefits of hospital Chaplain care; the emergence of the modern hospital Chaplain; addressing obstacles to accessing hospital Chaplain care; Catholic Social Teaching for teaching access to Chaplain care; a teaching model for staff to facilitate Chaplain care.

II. THE NATURE OF HOSPITAL CHAPLAIN CARE TODAY

The modern hospital Chaplain straddles both worlds of the local Faith congregation and the local health care system. Tovino (2005) sees the hospital Chaplain today as "both Pastor and Clinician, theologically educated and clinically trained, endorsed by both Church and hospital. …of The Church but not in the parish. …nobody's Pastor but everybody's Pastor. His salary is from the hospital, [but] his mandate is from The Church… by history and Tradition he is closer to his colleagues in the parish ministry, but his daily interactions are with physicians and nurses…" [9] Is the hospital Chaplain the agent The Church that sends him/her? Or an agent of the health care system that employs him/her? If the priorities are correct, I believe he/she can be both, but only with constant vigilance and struggle. This requires reconnecting with the Biblical compassion of Christian ministry, of which Hessel (1992) says:

> "Christian ministry is the function of faithful communities in response to GOD's Grace. Functioning ministry has the character of costly service and the purpose of empowering witness. As people in mission/ministry join the struggle of Faith with the powers of this age in ways that express radically mutual Love, they 'complete what remains of CHRIST's afflictions' (COLOSSIANS 1:24) and share 'the joy that was set before Him' (HEBREWS 12:2). Thus The Body of CHRIST in the world continues the ministry of JESUS CHRIST." [10]

Modern hospital Chaplain work is called to be widely "spiritual," often "religious" and always a radical Love in response to GOD's preceding, sanctifying and sustaining Grace, that unearned "help GOD gives us" to pour upon us "the righteousness of GOD" that unites us "by Faith and Baptism to The Passion and Resurrection of CHRIST" by The HOLY SPIRIT that "makes us sharers in His Life." [11] For the hospital Chaplain to retain his primary allegiance to The Church in the world to bring to his/her work the ministry of JESUS CHRIST in costly service as an empowering witness, he/she must make a profoundly paradoxical adjustment in

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[9] 7, Tovino, "Hospital Chaplaincy under the HIPAA Privacy Rule," p 72, para 2. "Hospital Chaplains: In-Between the Worlds of Religion and Medicine."
[10] 8, Hessel, "Social Ministry," Chapter 2, "Every Congregation's Dilemma," p 34, para 2 – p 35, "What is Ministry?"
[11] 9, CCC, # 2017-2029, p 544-545, "In Brief" summary of Grace.

his/her secondary allegiance to the healthcare institution that employs him/her. In an increasingly pluralistic society and the secular healthcare industry, the hospital Chaplain today must be prepared to offer a universal "spiritual care" to everyone, but a selective "religious care" only to some.

This distinction is vital to making the Chaplain relevant in secular institutions and pluralistic populations, allowing him/her to retain a presence on the field of battle. Zucker et al (2007) distinguishes between spiritual versus religious needs. "Spiritual" is defined as "…the experience of our souls as they engage the issues to which contemporary life exposes us." [12] The Chaplain's spiritual care invites people to share the experiences of their souls, to give those burdens, feelings and joys and experiences expression in a safe space. "Religious" is defined as "…how persons understand themselves in relation to a religious or 'Faith group' …[observing] specific, primarily fixed, rituals to engage their belief systems." [13]

Taylor (2006) sees "spirituality" as the soul's "need for purpose and meaning, forgiveness, love and relatedness, hope, creativity," that "unifying force of a person, the essence of being that permeates all of life and is manifested in one's being, knowing and doing; the interconnectedness with self, others, nature and [ultimately] GOD…" For many spirituality is expressed in "religious faith and its expression." [14] Taylor sees "religion" as "the organized, codified and often institutionalized beliefs and practices that express one's spirituality." [15]

Timmins and Kelly (2008) agree that "spirituality" is for many inseparable from the "religious." Spirituality is universal and can even be non-theistic, a striving "for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any GOD…" For Timmins and Kelly, spirituality "…suggests broadly a person's belief in a power apart from their own existence that transcends the present," while religion is "an outward practice of a spiritual understanding through the use of frameworks for a system of beliefs, values, codes of conduct

[12] 10, Zucker et al, "The Chaplain as an Authentic and Ethical Presence," p 15, para 2, "Introduction."
[13] 10, Ibid., p 16, paragraph 1. "Contrasting Religious and Spiritual."
[14] 11, Taylor, "Spiritual Care," Section 2, "What Is Spirituality?" para 1.
[15] 11, Taylor, "Spiritual Care," Section 2, "What Is Spirituality?" para 2.

and rituals." [16] For those who see themselves as neither "spiritual" nor "religious," hospital Chaplains can offer "spiritual" care through the healthcare experience. What is needed by the Chaplain is permission, empathy and for someone to call for his/her services.

III. INTERFACING OF HOSPITAL CHAPLAINCY WITH MEDICINE AND NURSING

The hospital Chaplain, as with all pastoral caregivers, "legitimately enters upon the sacred ground of another's spiritual life only with that person's invitation or permission…" Hospitals are places of crisis of body, mind and soul. The Geisinger Chaplain manual (2011) recognizes that, "In crisis, persons tend to struggle with what they value highly and believe most deeply. Crisis… moves people to trust and reach out to strangers; [hospital] ministry, therefore, calls for a value system that precludes exploitation or manipulation of others." [17] The hospital Chaplain's professional ministry must always entail self-evaluation, self-supervision, self-awareness – coupled with interdisciplinary collaboration - to be at once authentic to his/her own Faith convictions while respecting the dignity and personhood of all those placed in his/her hands in need of effective and empathetic pastoral care. It is an awesome privilege and sacred duty that, when actually or perceived to be broken, is the primary barrier to hospital staff calling for Chaplaincy care for those in need.

GWVMC Chaplains interfacing with hospital Medicine and Nursing staff is imbedded in the Vision and Mission of the "Division of Spiritual Care." The Vision, "To reflect The Presence of The Divine." The Mission, "…to promote spiritual well being for the diverse populations we serve. We are committed to engage patients, families, staff, as well as the broader community by supporting and enhancing their process of healing and the renewal of body, mind and spirit. Through our interfaith identity, we reflect The Love of The Divine for all persons." GWVMC Spiritual Care Department policy is that "services are available to all patients, families and staff" 24/7 since about 4/2010. [18]

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[16] 12, Timmins and Kelly, "Spiritual Assessment in Intensive and Cardiac Care Nursing," p 125.
[17] 13, Geisinger Spiritual Care Manual, "Policy 01.102, Section 1.0 Administrative, Title – Assumptions," para 1&3. http://infoweb.geisinger.edu/ghs_manuals/spiritual_care/system/owner/sw_scm_01.102.html
[18] 13, GWVMC Spiritual Care Manual, "Vision, Mission and Values for the Division of Spiritual Care." http://infoweb.geisinger.edu/ghs_manuals/spiritual_care/system/owner/gmc_scm_01_102.html

Prior to this, the hospital had one fulltime Chaplain in-house during weekday hours, supplemented by a Catholic Priest, who serves first as Pastor at a local Parish. So there is no institutional memory of Chaplain presence 24/7 at GWVMC. Patients and families in need of spiritual care are urged to call for the on-duty Chaplain by calling the Chaplain's office or the hospital operator. Chaplains are paged as part of hospital response teams to all serious or potentially serious traumas and in-house emergencies. Chaplains respond to other emergency situations on requests, which can include end-of-life and withdrawal of life support situations, as soon as possible. Hospital staff is encouraged to be sensitive and alert for spiritual struggles that should result in a call for the on-duty Chaplain, including:

> "Patients or families having difficulty coping with the medical situation. The lonely patient or one with few visitors. The apprehensive or fearful person. The patient unsettled about scheduled surgery. The discovery of a serious or potentially terminal diagnosis. The one whose Pastor is unable to visit. The appearance that additional religious resources would benefit a patient or family." [19]

IV. THE RIGHT TO ACCESS TO CHAPLAIN CARE IN THE HOSPITAL SETTING

Hospital Chaplain care is not mandated in the USA. The Joint Commission on Accreditation of Hospital Organizations (JCAHO) does not mandate who is to provide spiritual care in hospitals, but it does mandate that it be provided. VandeCreek and Burton (2001) report that JCAHO states, "Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and *spiritual* values." [20] [*emphasis added*] Chaplains are a widely used means of meeting this standard. Clark et al (2003) report that JCAHO acknowledges patients' "psychosocial, *spiritual* and cultural values affect how they respond to their care" and that "*spirituality* and emotional well-being as aspects of patient care." Clark et al note JCAHO Standard RI.1.3.5 "refers to *pastoral care and other spiritual services*." And JCAHO Standard RI.1.2.8, "The hospital addresses care at the end of life" by "responding to the psychological, social, emotional, *spiritual* and cultural concerns of the patient and family." [21] [*emphasis added*]

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[19] 13, Geisinger, "GWVMC Policy 02.201b, Section 1.0 Administrative, Title - Spiritual Care Services." http://infoweb.geisinger.edu/ghs_manuals/spiritual_care/system/owner/sw_scm_02.201b.html

[20] 14, VandeCreek and Burton, "Professional Chaplaincy: Its Role and Importance in Healthcare," p 82, para 1. "Source: JCAHO (1998), CAMH Refreshed Core, January, RI.1."

[21] 15, Clark, et al, "Addressing Patients' Emotional and Spiritual Needs," p 659, para 1.

Spiritual and religious care during a healthcare crisis often provides hope, the root of both that often has such remarkably positive effects on health outcomes. Puchalski (2000) observes that "Spirituality and Religion offer people hope and help give meaning to people's suffering:" [22]

> "Hope is an aspect of spiritual wellbeing that looks with confidence to future outcomes. Hope can change during the course of an illness. Early on, the person may hope for a cure. Later, … [if] a cure seems unlikely, the person may hope for time to finish old projects, travel, make peace with loved ones, and have a peaceful death. In times of severe and disabling injury, hope – 'the passion for the possible' – may be mediated through ritual, meditation, prayer, traditional sacred narratives, or other inspirational readings…" [23]

This should not surprise the Churchman. As HEBREWS 11:1 reads, "Faith is the realization of what is hoped for and evidence of things not seen." [24] Puchalski concludes that hope is directly connected to healing: "Medications and surgery can treat the illness and often bring cure, but by focusing only on the physical aspects of the patient, one ignores the disease[s] of the spirit. Healing involves more than just technical fixes." [25] To care for people as mere machines to be repaired, as one would drop off a disabled car for an engine repair, denies the emerging large body of academic research that documents to impressive contributions that spirituality and religion can have on a better healthcare outcome.

V. THE BENEFITS OF HOSPITAL CHAPLAIN CARE

Mueller et al (2001) find that "a majority of the nearly 850 studies of mental health and 350 studies of physical health have found a direct relationship between religious involvement and spirituality and better health outcomes." [26] They note this association "has been found regardless of the study design… and the population studied. In addition, religious and spiritual variable were not the primary ones or the only ones used in most studies. These study design features limit bias. Further, recent well-designed studies have shown a direct relationship between religious involvement and spirituality and better health

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[22] 16, Puchalski, "Touching The Spirit: The Essence of Healing," p 1, "Scientific Studies," para 3.
[23] 16, Ibid., para 4.
[24] 6, NAB, HEBREWS 11:1.
[25] 16, Puchalski, "Touching The Spirit: The Essence of Healing," p 1, "Medicine and Spirituality," para 1.
[26] 17, Mueller, "Religious Involvement, Spirituality and Medicine," p 1230, "What Conclusions Can be Drawn from the Research?" para 1.

outcomes even after adjusting for potential confounding variables." [27]

Koenig (2004) notes, "Systematic studies of religious coping in medical settings document the high proportion of patients who depend on religious beliefs and practices to cope with health problems. In a study of 337 patients who were consecutively admitted to the general medicine, cardiology, and neurology services of Duke University Medical Center in North Carolina, nearly 90% reported using religion to some degree to cope, and more than 40% indicated that it was the most important factor that kept them going." As of 2004, "More than 60 studies have now examined the role that religion plays in helping patients cope with such diverse medical conditions as arthritis, diabetes, kidney disease, cancer, heart disease, lung disease, HIV/AIDS, cystic fibrosis, cystic fibrosis, sickle cell anemia, amyotrophic lateral sclerosis, chronic pain, and severe or terminal illness as an adolescent." [28]

Koenig (2004) adds, "Patients in these studies commonly report that religious beliefs and practices are powerful sources of comfort, hope and meaning, particularly in coping with medical illness… This is particularly true for patients with certain disorders that are characterized by their chronic nature, extent of disability, or poor prognosis. There were also special populations for whom religion appears particularly relevant, including the elderly, women and ethnic minorities…" [29]

Koenig (2004) states, "religious beliefs and practices help patients to cope better with their illnesses, enhance their social support and help them to avoid self-destructive behaviors such as substance abuse." Faith "influences physical health through psychological, social and behavioral pathways… If increased religiosity reduces stress levels and enhances social support, then it ought to also affect physical health" in a positive way. "…there is growing evidence that religiosity may benefit patients' physical health through its positive effects on the mental health." [30] "Since religiousness is associated with greater marital stability and more social support in general, the religious person has more persons around who are

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[27] 17, Ibid., para 2
[28] 18, Koenig, "Religion, Spirituality and Medicine," p 1194, para 4 – p 1195.
[29] 18, Ibid., p 1195, para 1.
[30] 18, Koenig, "Religion, Spirituality and Medicine," p 1195, "Religion and Physical Health," para 1.

concerned about him or her…, [which leads to] increased treatment compliance." [31] Further, "because religiousness is associated with greater hope, optimism and meaning and purpose in life, religiously active persons are more likely to have a reason for living and getting better." [32]

Koenig (2004) reports that even before 2000, nearly 700 studies looked at the relationship between religion, well-being and mental health. Almost 500 of these studies "demonstrated a significant positive association with better mental health, greater well-being or lower substance abuse." [33] Of these nearly 500 studies, "religious beliefs and practices [were] associated with less depression and faster recovery from depression (60 of 93 studies), lower suicide rates (57 of 68), less anxiety (35 of 69), and less substance abuse (98 of 120), [and] they were also associated with greater wellbeing-hope, and optimism (91 of 114), more purpose and meaning in life (15 of 16), greater marital satisfaction and stability (35 of 38) and higher social support (19 of 20)…" The scientific community has taken notice. The number of articles, studies and reviews of religion, spirituality and mental health in psychological literature in 2000 to 2002 versus 1980 to 1982 increased 1,100%. A summary on reports done prior to 2000 shows that "religious beliefs and practices have been associated with better immune function (5 of 5 studies); lower death rates from cancer (5 of 7); less heart disease or better cardiac outcomes (7 of 11); and better health behaviors (23 of 25, less cigarette smoking; 3 of 5, more exercise; 2 of 2 better sleep). Further, in studies of mortality, 39 of 52 (75%) found that religious persons live significantly longer… adding an additional 7 years of lifespan (14 years for Blacks)." [34]

Clark et al (2002) conducted a comprehensive, systematic academic literature search and review of Press Ganey patient surveys to examine if patients' emotional and spiritual needs are important, if hospitals are effectively meeting these needs and how these can be improved. They examined data on 1,732,562 U.S. patients. [35] They note regarding patient satisfaction, "The hospital staff's ability to address patients' emotional and spiritual needs factors in to patients' perceptions of the overall experience of care, the provider and the

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[31] 18, Ibid., p 1197, "Disease Detection and Treatment Compliance," para 1.
[32] 18, Ibid., para 2.
[33] 18, Ibid., p 1195, "Religion, Well-being & Mental Health," para 1.
[34] 18, Ibid, para 2.
[35] 15, Clark, et al, "Addressing Patients' Emotional & Spiritual Needs," p 659, "At-a-Glance," para 1-3.

organization." [36] Clark et al conclude, "Spirituality has been shown to be associated with decreased anxiety and depression. Increased use of Spiritual practices among persons with AIDS has been associated with a decrease in psychological distress and depression and an increase in emotional coping ability… The notion that caring for emotional and spiritual needs employs behaviors and interventions of a similar nature [to psychological ones] – support, sensitivity, empathy, comfort, affirmation, and attentiveness to patients' unique needs – is supported by the literature and in the data analysis of the survey results." [37]

Clark et al (2002) state that meeting spiritual and religious needs of patients and families in the hospital setting directly improves emotional wellbeing because "those needs directly involve… a range of emotions experienced during hospitalization, including a search for meaning, transcendence, desire to maintain formal Religious practices, alleviating fear and loneliness, and The Presence of GOD." [38] Areas for improvement are "the immediate availability of [emotional/spiritual support] resources, appropriate referrals to Chaplains or leaders in the [local] religious community, a team dedicated to evaluating and improving the emotional and spiritual care experience, and standardized… [identification] and meeting of emotional and spiritual needs." [39]

VI. EMERGENCE OF THE MODERN HOSPITAL CHAPLAIN

The hospital Chaplain is educated theologically, trained clinically and credentialed professionally to function as part of the patient health care team. US Federal Medicare legislation considers "Clinical Pastoral Education" (CPE) – the engine that trains Clergy to function as hospital Chaplains - "a form of graduate medical education," which make medical facilities with certified CPE programs eligible for financial reimbursements from Medicare, placing Chaplains pursuing certification through national Chaplaincy associations on par with Nursing and other Allied Health professionals. [40]

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[36] 15, Ibid., p 659, para 3.
[37] 15, Clark, et al, "Addressing Patients' Emotional & Spiritual Needs," p 660, "Results," para 2
[38] 15, Ibid., para 1.
[39] 15, Ibid., p 659, "Article-at-a-Glance," para 1-4.
[40] 19, Lee, "In a Secular Spirit: Strategies of CPE," p 342, para 2.

The US Federal Health and Human Services [HHS], in the preamble to its "Privacy Rule" imbedded in the Health Insurance Portability and Accountability Act of 1996 [HIPAA], states that health care "does not include methods of healing that are solely spiritual." [41] The visiting Clergyman paying a sick call to a hospitalized parishioner is thus viewed in this language as not part of the official healthcare team and not entitled to PHI [42] of patients. By definition, this is because his practice includes "methods of healing that are solely spiritual." The hospital Chaplain's "methods of healing" are in part spiritual, but must also be significantly non-spiritual as a matter of survival. Tovino (2005) observes:

> "Some health care attorneys interpret the preamble as prohibiting hospitals and physicians from sharing individually identifiable health information with hospital-employed Chaplains. On the other hand, many hospital Chaplains argue that the preamble fails to distinguish between hospital Chaplains (who, as members of the health care team, should be entitled to full access to patients' health information), and community Clergypersons (who are entitled to receive limited directory information about those patients who have agreed to disclosures of their directory information)." [43]

VandeCreek (2010) comments on the professionalization and shift of hospital Chaplaincy from a theological to a psychosocial model of care: First, "The attention is provided by those who receive specialized education and credentialing by peers; such education and recognition constitutes the foundation for providing 'professional attention.'" Second, "the purpose of spiritual care is to help patients with the relationship between The Sacred (i.e., including their perceptions, assumptions, feelings, beliefs) and their illness, hospitalization, and recovery or possible death." Hospital Chaplains are increasingly first agents of the healthcare system that trains and employs them, rather than The Church that calls and anoints them. This "requires that Chaplains help patients link their concerns to what they perceive as sacred and its positive or negative influences" of coping and decision making around the total hospital experience, rather than using objective Religious Truths of traditional Faith to chart their course for them. [44]

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[41] 7, Tovino, "Hospital Chaplaincy Under The HIPAA Rule," p 51-52, "Introduction."
[42] Protected Health Information [PHI] under HIPAA is any information in any form that identifies an individual patient as receiving – past, present or future – any form of care within a covered health entity.
[43] 7, Tovino, "Hospital Chaplaincy Under The HIPAA Rule," p 52, para 1. "Introduction."
[44] 20, VandeCreek, "Defining and Advocating for Spiritual Care in the Hospital," p 4, "A Definition of Spiritual Care," para 2-3.

Hospital Chaplains are uniquely and professionally trained to help people find positive outcomes of these spiritual struggles in the health care setting. Lee (2002) evaluates the modern hospital-based "Clinical Pastoral Education" (CPE) movement, of which the hospital Chaplain is increasingly a product. Lee rightly observes that CPE "represents the emergence of a secularized professional practice from a more religiously-based theological practice of Chaplaincy." Expanding the Chaplain's pastoral care from primarily religious care to spiritual care is a means of adaptation and survival, "one means by which religious health care ministry negotiates the secular realm of biomedicine and the pluralism of the contemporary United States health care marketplace" and society. The label of "spiritual care," one part of which may be religious care, makes it possible for the hospital Chaplain to remain relevant and marketable to populations of increasingly diverse populations of "any patient's 'belief system,' regardless of his or her religious affiliation (or lack thereof)." [45]

Englehardt (2003) observes that hospital Chaplain ministry, through the engine of CPE, is "in the midst of a radical transformation from a traditional Christian ministry grounded in and guided by particular denominational understandings of Christian right worship and right belief to a profession comprising persons of various religions united in norms articulated in an ecumenism located within a public space defined by non-religious terms." [46] This causes a separation of the hospital Chaplain from Traditional Faith norms and practice, a severing from the local Faith congregation and a remolding into an agent of the healthcare system instead of The Church. This process is exacerbated by the need of Chaplains to prove themselves as members of the healthcare team by engaging in as many non-spiritual/religious services as possible to justify their continued existence in an increasingly financially stressed healthcare environment.

In this transformation, I wonder if Mrs. Geisinger would recognize the Chaplains that serve in the hospital community she founded as Ministers of The Church. Has the sense of Christian ministry in which people are called individually and corporately to follow CHRIST, and enter Christian ministry to serve The Lord by serving others, been displaced? Has the

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[45] 19, Lee, "In a Secular Spirit: Strategies of Clinical Pastoral Education," p 339, para 1. "Introduction."
[46] 21, Englehardt, "The Dechristianization of Christian Hospital Chaplaincy, p 139, para 1 to p 140. "Hospital Chaplaincy Dechristianized."

Christian giving of self in love of GOD and neighbor [47] - as JESUS gave Himself for us [48] - been sold for the sake of mammon? [49] The danger is ever present.

VII. ADDRESSING OBSTACLES TO ACCESSING HOSPITAL CHAPLAIN CARE

Holland and Henriot (1983) talk of "The Pastoral Circle" of social action, rooted in the "Experience" of the social unit in which the issue takes place. The authors picture this as a circle, or more exactly an expanding spiral: "Insertion; Social Analysis; Theological Reflection; Pastoral Planning" and so forth. [50] While many social action models call for an analysis of a problem by stepping back to have an overall but distant perspective, Holland and Henriot call for one to step in to view the situation from among those living within the social unit. This is the model I have intuitively used in studying and addressing this issue by inserting myself as an active team member with my Nurses, particularly in the ER and ICU at GWVMC. I do Chaplain rounds on units every shift to be visibly present and to get to know the staff.

This invites questions and provides teaching opportunities when I am experienced as being open and concerned about the feelings, burdens and issues of caregivers, especially Doctors and Nurses. I listen and work with these and other staff, hearing their spoken – and often more importantly their unspoken questions. The most vital things I as a Chaplain can do to answer these questions, beyond simple facts of policy and procedure, is to accompany, listen empathetically, be willing and reliable when called, to serve effectively and to value each colleague as much as each patient and family.

It is not so much the right policy answers and academic journal references that give the hospital Chaplain greater access through and referrals from staff, as it is serving as in an effective, professional, caring manner and developing empathetic one-on-one pastoral and human relationships with staff. In my own experience as a Paramedic, Registered Nurse and now Chaplain, of all the questions that can be asked about access and referral to hospital Chaplain care, underneath is I believe always some form of the question that I recognize in

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[47] 6, NAB, LEVITICUS 19:18 & DEUTERONOMY 6:4-5; MATTHEW 22:36-40.
[48] 6, NAB, MATTHEW 20:28b; I TIMOTHY 2:4-6.
[49] 6, NAB, MATTHEW 6:24b.
[50] 22, Holland and Henriot, "Social Analysis," p 8. "Diagram 1 – The Pastoral Circle."

myself, "I have personal issues of insecurity with my own spirituality, religion and identity. Avoiding calling for a Chaplain in the face of clearly apparent spiritual struggle causing distress in others prevents me from having to address these same issues and fears in myself."

VIII. CATHOLIC SOCIAL TEACHING FOR TEACHING ACCESS TO CHAPLAIN CARE

The USCCB (2005) identifies seven key themes of "Catholic Social Teaching" (CST): "Life and Dignity of the Human Person; Call to Family, Community, and Participation; Rights and Responsibilities; Option for the Poor and Vulnerable; The Dignity of Work and the Rights of Workers; Solidarity; Care for God's Creation." [51] But how do we put these CST ideals into pragmatic Christian social action in our everyday spheres of influence? Pope John Paul XXIII (1961) answers with a 3-step plan:

> "There are three stages which should normally be followed in the reduction of social principles into practice. First, one reviews the concrete situation; secondly one forms a judgment on it in the light of these same principles; thirdly one decides what in the circumstances can and should be done to implement these principles. These are the three stages that are usually expressed in the three terms: look, judge, act. It is important for our young people to grasp this method and to practice it. Knowledge acquired in this way does not remain merely abstract, but is seen as something that must be translated into action." [52]

Saint Thomas Aquinas, in his "Summa Theologica" (written 1265-1274), asks what the relationship between reason, prudence and action are. He defines prudence as "right reason applied to action," which he sees as "the chief act of reason in regard to action," a 3-step process:

> Observe - "The first is 'to take counsel,' which belongs to discovery, for counsel is an act of inquiry..." 2. Judge - "The second act is 'to judge of what one has discovered,' and this is an act of the speculative reason." 3. Act - "But the practical reason, which is directed to action, goes further, and its third act is 'to command,' which act consists in applying to action the things counseled and judged..." [53]

The Belgian Priest, Father Joseph Cardijn (1882-1967) promoted a social justice model known as "See-Judge-Act," which he developed while serving as a Chaplain to groups of Christian factory workers to help them improve their working conditions. This model may be expanded to "See-Think-Judge-Act:"

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[51] 23, USCCB, "Seven Key Themes of Catholic Social Teaching."
[52] 24, Pope John Paul XXIII, "Mater et Magistra [Mother and Teacher]," # 236-237.
[53] 25, Saint Thomas Aquinas, Summa Theologica, Second Part of The Second Part, Question 47, Article 8, "Whether command is the chief act of prudence?"

> 1. "**See/Observe** the world around you. Explore and probe an experience or situation to discover its positive and negative values. What exactly is happening? What is this doing to people? (the consequences) Why is this happening? (the causes)" 2. "**Think** to make the process clearer. Express and clarify your ideas. Learn by listening to others and sharing your understandings with them. What do you think about all this?" 3. "**Judge** what you see in the light of Gospel values and the teachings of The Church. Explore and probe an experience or situation to discover its positive and negative values. What do you think should be happening? What does your Faith say?" 4. "**Act** to make your world a better place. Action can take many forms. It may be a persona or group action. What exactly is it that you want to change (long-term goal) What action are you going to take now (short-term goal) Who can you involve in your action?" [54]

IX. A TEACHING MODEL FOR HOSPITAL STAFF TO FACILITATE CHAPLAIN CARE

Initial education at GWVMC on Chaplaincy becoming available 24/7 was done globally across the institution. At that time, my Department did in fact have a pamphlet available to distribute throughout the hospital entitled "Spiritual Care Services…," [55] which continues to be placed throughout the hospital. Added to this was a letter, written by our staff Chaplains, distributed to hospital Department heads to share with staff, particularly Nursing units. It advised of the new 24/7 Chaplain coverage, explained the benefits of Chaplain care, gave examples of when to call and how to do so. [56]

The initial saturation with these tools, coupled with an active Chaplain presence, gave an institutional awareness of the expanded coverage. What is now needed is a way to invite and stir hospital staff to be more open to apparent spiritual distress that should prompt a referral to Chaplaincy. The model of spiritual assessment to teach staff is not so important as is the opening of discussion itself. Reasonable healthcare professionals can discern the degree of spiritual struggle in patients, families and staff intuitively. It is a natural gift made sharper in most caregivers by being constantly faced with suffering, pain, dying and death in the hospital world.

The key is facilitating a culture of empathy for others by helping caregivers feel and express empathy for themselves. This would be best done in short unit in-services and small group discussion groups throughout the hospital. My experience is this invites the logical

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[54] 26, Marist College, "Social Justice - A Model for Action: See, Think, Judge, Act," p 2-3.
[55] 1, Spiritual Care Services, "Spiritual Care Services at Geisinger Wyoming Valley." A pamphlet distributed throughout the hospital teaching about when and how to call for a hospital Chaplain.
[56] 1, GWVMC Chaplains, "Did you know that Geisinger Wyoming Valley has… full-time Chaplain[s]?" Letter distributed to hospital dept's in 2010 announcing expansion of in-house Chaplain coverage to 24/7.

question, “Okay, Chaplain. Now I’ve determined someone is in the midst of a spiritual struggle. What do I do with this?” The answer that I would hope to offer, “It is everyone’s duty in our hospital family to offer general support to those in their spiritual struggles and to make a referral to the Chaplain.”

I propose to teach the modified version of Cardijn’s social justice action model, "See - Think - Judge – Act" and a brief spiritual assessment model suitable for bedside use. One of many good choices is the “FICA” model, a simple acronym for a spiritual assessment developed by Puchalski et al (2000) which stands for “Faith or Beliefs; Importance and influence; Community; Address or Application:” [57] Pocket sized cards are available through the George Washington Institute for Spirituality and Health: [58]

F – Faith and Belief
Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds "No," the health care provider might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.
I – Importance
"What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"
C – Community
"Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples, and mosques, or a group of like-minded friends can serve as strong support systems for some patients.
A – Address in Care
"How would you like me, your healthcare provider, to address these issues in your healthcare?"

X. IN CONCLUSION

I began by citing the words of the memorial plaque in a forgotten hospital entrance that Mrs. Geisinger dedicated at the founding of the hospital that bears hers and her husband’s name, “in The year of our Lord,” A. D. 1915 and noted The Bible Text from MATTHEW 20:28a, “…Not to be ministered unto, but to minister.” At the satellite hospital that I primarily work at as a Chaplain, one year after our in-house Chaplain coverage went 24/7, I have found many

[57] 27, Puchalski and Romer, “Taking a Spiritual History Allows Clinicians to Understand Patients More Fully,” p 131, Table - “Spiritual Assessment Tool - FICA.”
[58] 28, GWish, “FICA Spiritual History Tool.”

hospital staff have questions and issues about if and when to make referrals to the Chaplain to provide pastoral care to patients, families and staff.

The nature of hospital Chaplain care today is that he/she has one foot in The Church and the foot in the healthcare system. Is the hospital Chaplain then first the agent The Church that sends him/her? Or an agent of the healthcare system that employs him/her? By GOD's Grace, he/she needs to be both, first keeping firmly rooted in The Body of CHRIST and secondly in the hospital community. But this requires a radical and paradoxical distinction in practice between universal "spiritual care" needs versus select "religious care" needs. In our ever increasingly pluralistic society and its ever increasingly secularized institutions, the hospital Chaplain – to keep a presence on the field of battle - must be prepared to offer some form of "spiritual care" that virtually everyone needs versus the "religious care" that some desire.

The Vision of "The Division of Spiritual Care" at GWVMC is "To reflect The Presence of The Divine." The Mission of promoting healing leads to a wide interfacing with hospital Medicine and Nursing staff. Unlike at the main Geisinger hospital, there is no institutional memory at the satellite hospital of a 24/7 in-house Chaplain presence. While hospital staff is encouraged in many ways to make referrals to the on-duty Chaplain, and while Chaplains respond to a wide range of emergencies and cases, the learning curve remains. JCAHO, the organization that accredits healthcare institutions, does not mandate who provides spiritual care, but does mandate that it be provided. Most hospitals find Chaplains to be the easiest way to meet this standard. Implicit in this recognition is that positive spiritual and religious care contributes markedly to positive healthcare outcomes. The emerging body of academic evidence that confirms this is impressive, contributing to an evolving standard of care that calls for healthcare professionals to make referrals to hospital Chaplains when the need is apparent.

The emerging professionalization and dechristianization of hospital Chaplaincy is driven to a great degree by U.S. Medicare reimbursement to qualified "Clinical Pastoral Education" institutions and by the U.S. Health and Human Service's preamble to the Privacy Rule of HIPAA, which states that practitioners who provide "methods of healing that are solely spiritual" are not entitled to patient Protected Health Information. Thus the pressure for Chaplains today to

provide as many non-spiritual/non-religious methods of healing and services as spiritual/religious ones. And while education and competency standards for Chaplain certification are marks of a professional healthcare field, the shift from theological to psychosocial care brings with it a distancing of the hospital Chaplain from The Church and the sense of Christian mission that sent him/her into healthcare ministry in the first place. The consequences of this inversion of allegiance raises questions around which master the hospital Chaplain serves first.

Obstacles that inhibit healthcare staff from making referrals to hospital Chaplains are varied. But the need for making such referrals for those suffering in spiritual struggles is often apparent enough to most caregivers. Underneath most questions and resistance to calling for the Chaplain for patients, families and fellow staff in obvious need of Chaplaincy care is usually some degree of an unspoken fear that says, "If I assess distressing spiritual struggle and call the Chaplain for others in my care, I will have to face the same issues in my own self."

I lastly reviewed a model for teaching social action promoted by Saint Thomas Aquinas, Pope John Paul XXIII and Father Joseph Cardijn to apply basic themes of Catholic Social Teaching: see/think-judge-act. I propose to use this model, coupled with teaching a brief spiritual assessment model such as Dr. Puchalski's "Faith-Importance-Community-Address in Care" (FICA) acronym to hospital staff in short unit in-services and small group discussions. Among others, the logical question of what to do when distress in spiritual struggle is identified – do what you can and call the on-duty Chaplain – would arise in due course.

The greatest obstacle to staff making referrals to the hospital Chaplain is when those same staff sees the Chaplain as unprofessional, uncaring and insensitive. Beyond disseminating basic how to information throughout the hospital in an ongoing manner and having a visible presence, the best thing the hospital Chaplain can do to facilitate staff making referrals for Chaplaincy care is to prove himself/herself to staff as one who is professional, caring and sensitive towards them. This requires being present, building up relationships and being a Chaplain with as much empathy for caregivers as for patients and families.

I conclude that it is not so much the right policy answers, academic journal references or assessment tools used for in-services with staff that will facilitate caregivers calling for the Chaplain when distress in spiritual struggles are apparent. Rather, it is more the serving in an effective, professional, caring manner and developing empathetic one-on-one pastoral and human relationships with staff that will enable caregivers to be more open to making referrals to the hospital Chaplain. As Mrs. Geisinger cited when she founded the hospital system that I work at, so I conclude by citing The same Source: MATTHEW 20:28, "…The Son of Man came not to be served but to serve and to give His life as a ransom for many." [59]

[59] 6, NAB, MATTHEW 20:28.

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