Beyond Hospital Walls: Gwinnett Health System Takes Chaplaincy into the Community

Charles Christie

Early on a Monday morning our chaplaincy staff responded to a call to attend to the family of a cardiac arrest victim. This is not unusual; it is what chaplains do in most settings. However, what happened next was somewhat unusual although it is becoming a model for our chaplaincy department as we continue to look for ways to reach out to our community.

Our hospital system is a not-for-profit health system with a strong sense of community. Hospital leadership has fostered a sense of promoting health in the community. In fact, one of the five corporate values is “service to the community.” The chaplaincy staff has been part of this initiative, making ourselves available to churches, schools, and other groups. We lead grief groups in local schools, speak to church and community groups on end-of-life issues, provide supervised ministry settings for local seminary students, cross-train and help with the police and fire critical incident stress management teams, and provide critical incident stress management services to schools and businesses when asked. We have always seen outreach to the community within our mission as a health system as well as our calling as chaplains. Chaplains have unique gifts, training, and expertise which may be helpful beyond hospital and institutional walls.

Chaplains have unique gifts, training, and experience which may be of benefit beyond institutional walls. In an effort to add value to their institutions, chaplains can look for opportunities to provide “community chaplaincy.” One such opportunity for community chaplaincy is in the area of critical incident response. This article outlines the response of chaplains in one institution to a local business which experienced a workplace death. This intervention may serve as a model and inspiration for future opportunities as chaplains make themselves available to the community on behalf of their institutions.

Charles (Chuck) Christie is an APC Board Certified Chaplain currently serving as Staff Chaplain at Gwinnett Health System, Lawrenceville, GA. He also holds an M.Div. With Chaplain Bob Duvall, he developed “Working With the Grain: A Man’s Work Experience in Grief” in which men who have suffered loss gather to build a small pavilion to “work out” their grief in an active, physical, and ritualistic way. The two presented their thoughts and discoveries related to the masculine style of grief at the 1999 APC meeting in Kansas City. Correspondence may be addressed to him at Gwinnett Health System, P.O. Box 348, Lawrenceville, GA 30046; CChristi@promina.org
A death in the workplace

This particular Monday began like any other at the office/warehouse of a local business with workers arriving, catching up, and starting the business day. In a large room with office cubicles, they were just starting work when one of their coworkers fell in the aisle next to her desk. As coworkers rushed to lend aid, they thought she had fainted but found her to be pulseless and not breathing. According to plans in place, first responders from the work force quickly began CPR. Others lent what aid they could: someone called 911; someone else ran to the parking lot to flag down the paramedics and direct them into the building; the others looked on in horror, watching their friend and coworker of fifteen years dying despite everyone’s best efforts. After what seemed like an eternity, the paramedics took over and transported her to the ambulance. The associates who had not heard what was going on now saw the stretcher go out with their coworker, CPR in progress.

The human resources (HR) director followed her associate to the hospital to assist with information and render aid to the family. When she returned to work, the HR director looked for ways to help her associates. This horrific scene and subsequent death had left palpable effects among the work force. Those witnesses were obviously suffering the effects of traumatic stress, and shock waves had reverberated throughout this building of more than one hundred associates.

The community relations arm of our health system’s psychiatric unit had recently provided a Drug Free Workplace Program, and the HR director had the name of our community relations representative. When the HR director asked for assistance for her associates, our community relations representative thought of the health system’s Critical Incident Stress Management Team.

Chaplains respond with critical incident stress debriefing

In addition to being a staff chaplain, I serve as the clinical director of this team. I was put in touch with the HR director to act as consultant and coordinate assistance for her associates. There was no question that we would help in whatever way we could.

Our team uses a debriefing model developed by Dr. Jeffery Mitchell. While the critical incident stress debriefing (CISD) is the centerpiece of a critical incident stress management program, it is not a stand-alone response to critical incident stress. A critical incident stress management team uses many tools to mitigate the effects of critical incident stress. In fact, the response presented here is an example of how a critical incident team can use several tools, including the CISD.

A critical incident is any incident which might overwhelm persons’ normal ability to cope and function in their normal activities and roles. While the CISD model is usually reserved for use with emergency workers, it can be adapted for use with the public. Cardiac arrests may be nearly daily occurrences for paramedics and emergency room staff, however they are highly unusual for persons outside emergency services. Certainly the stress of witnessing and experiencing the death of their coworker constituted a “critical incident.” Early on we were cognizant, not only of the critical incident stress, but also of the grief which many coworkers would experience. In our consultations with the HR director, we were sensitive to the deep sense of loss experienced with the death of this well-liked, long-time associate.

While this was a very significant loss, the business was part of an international company and could not close during debriefings. Also, there were potentially 60-100 associates who might wish to participate in debriefings, far too many for one or two meetings. With the HR director’s approval, we decided to hold three debriefings the morning after the death of the associate.

The first debriefing was for the associate’s closest friends and coworkers as well as the first responders and caregivers, who attempted to resuscitate their friend. The second debriefing was for those who worked near the associate or who interacted with her in their duties. The third debriefing was for anyone else who wanted to come. All of these meetings were voluntary, and while most in the first meeting were specifically invited, it was understood that one could attend any one of the debriefings, depending on time and comfort level.
The debriefings were very well attended. The depth of feeling expressed was remarkable. CISD follows a seven-stage process in which the participants are guided from facts, to thoughts, to feelings, back to thoughts, and then facts again. The hope is to guide people into the affective dimension and return them to “solid footing,” all the while normalizing their feelings. Many persons who experience strong affective reactions after trauma feel isolated. Often they also feel they should be able to manage anything and may feel “crazy” if their thoughts and feelings are uncontrolled. It is incredibly affirming to meet with others who feel much like oneself. A constant reminder to participants in debriefings is, “you are a normal person having normal reactions to an abnormal event.”

Our response team consisted of two chaplains and a former psychiatric nurse who is now in community relations. All are part of our CISD team and familiar with the process. We all had worked together in hospital and community debriefings. Our team served as consultants to the HR director, offering suggestions in addition to the debriefings. In the education phase of the debriefings we provided significant information on grief and loss, including what to expect and suggestions for coping. The team provided contact numbers for individual follow-up if needed.

The education phase of the debriefing can be a place where participants explore ways of self care. The leaders offer some standard stress management skills and information which are important; however, the participants may have excellent ideas for their particular situation. As we worked with the debriefing groups, some themes began to develop. Certainly issues of critical incident stress were evident. However, as chaplains we were especially sensitive to issues of grief and loss.

**CISD program is tailored to specific needs**

One of the ideas which sprang from the group and HR director was the idea of a “time out” room. For a week or so, the company agreed to provide a space where associates could go for brief periods if they felt overwhelmed. It was understood that associates would be able to go there without being asked if they were O.K. or explain why they were there.

Another issue explored by the groups was how to reorganize the work space. We discussed how the family could retrieve personal effects and how to leave the work space. Included in this discussion was the inevitable issue of replacing the associate.

The group setting provided a safe forum to express otherwise inexpressible issues. The group was able to ask questions which many had but were afraid to address individually. This also provided a service to HR and management as associates were allowed to participate in some of the discussion. They already felt disempowered by the fragility of life. Having management make arbitrary decisions about such basic questions as what to do with their friend’s personal items would have added to this feeling.

The theme which seemed to be most striking was the “broken-off” nature of this loss. CISD validates and normalizes one’s loss of control in the face of horrific experiences. However, we also were aware the sense of disenfranchised grief and loss. Normal rituals around death and loss pay attention to the family and home and often do not give voice to friends and coworkers when the reality is that many of us spend more time with our coworkers than our families. At funeral services, a place of honor is given to a third cousin from another state while the coworker of the deceased must stand in the back of the chapel. What we heard from the associates was their keen sense of loss. Some of these people had worked with the deceased eight hours a day, five days a week, for over fifteen years. They knew about her family, her loves, her likes and dislikes. Yet there was little opportunity to have their loss validated or to say as a group what this loss meant.

CISD is an effective vehicle for managing traumatic stress, and group work is also a vital tool in working through grief and loss. However, an equally vital aid in healing is ritual. As chaplains and ministers we have an ear and sense for ritual and community, and this situation seemed to cry out for such an avenue of expression.

Most forms of crisis intervention and grief work are “talking cures.” While expressing one’s feelings and gaining cognitive understanding is important, an
act or task can make a direct connection with the unconscious. The ritual act thus becomes an avenue to connect themes which may never be expressed in words.

This sudden loss of a co-worker had broken into the workplace community and raised far too many issues to be dealt with solely by talking. Group ritual offered a way to acknowledge the loss and begin to incorporate it into the life of the community.

**Providing a memorial service**

About two weeks after the debriefings the HR director contacted our department about planning a memorial tree planting. We planned a nonsectarian service of dedication with attention to the lost associate, corporate loss, and sense of spirituality which joins all who feel loss. We invited the associate’s family to attend the service, which allowed coworkers to participate by sharing stories, memories, or words about their co-worker.

As chaplains, we represent “the community of faith”; however, we do not have to represent any particular brand of faith. In this way, we were able to go to a place of business in which a diverse group of persons felt a strong sense of community and to celebrate their shared sense of spirituality without endorsing any particular religion or spirituality.

We asked that the tree be placed in its hole prior to the service with its roots left uncovered. We planned to have the associates and family finish planting the tree at the close of the service. Upon our arrival, we learned that the shovel had been forgotten.

A ritual is a very conscious act which pays special attention to the needs of its participants. The intention is to provide a vehicle for unconscious connections and expression, and a well-planned ritual provides the setting for serendipitous moments.

As the service began, each person was given a twig, and every third or fourth person was given a piece of rough string. The homily or lesson was a story in which participants were asked to tie their twigs together in bundles of three or four and asked to try and break the bundles. Of course, a bundle of twigs is much stronger than a single twig. During the benediction, the groups held the bundles of twigs high with hands joined as the blessing was spoken. Afterward they were invited to come and lay their bundles at the foot of the tree. As we had no shovel, we ended the invitation here.

As participants brought their bundles of twigs to the tree, instead of just laying the bundles down, they carefully placed them in the hole around the root-ball. Then, as if on cue, several coworkers got down on their knees and began to rake dirt over the bundles with their bare hands. Everyone gathered around as the bundles of twigs were tenderly planted by hand along with the tree.

**Conclusion**

Certainly, even in this case a group of mental health professionals could have conducted the debriefings, and local clergy could have provided a memorial service. However, as chaplains who live and work with crisis, death, and spirituality every day, we offer unique perspectives. Very few mental health professionals have the exposure and experience of health care chaplains to crisis situations and death and dying. As chaplains, we also see and experience much more in the way of critical incidents than local clergy do. We also were able to bring a nonsectarianism to this situation which local clergy from a particular congregation could not. Critical incidents such as the cardiac arrest and death of this associate bring many issues and questions which chaplains are uniquely equipped to address. Attending not just to religious questions, but to the broader spiritual questions and issues which crisis situations raise is what chaplains do every day. In this case we were able to validate the kinship of loss, sense of vulnerability, fragility and sacredness of life and also to facilitate a corporate expression of these very spiritual issues.

This case is just one example of how chaplains can make themselves available to the communities in which their institutions are located. In fact, chaplains may be an important untapped resource for both their institutions as well as their communities. All of us feel the need to see as many patients as possible and may even be pressured by our institutions to do so. However, we see ourselves short if we limit our vision to those within our hospital walls. Health care chaplains are experts
in crisis care, death and dying, grief issues, conflict resolution, and spirituality.

This particular business would never have been able to have its own institutional chaplain, but we were able to provide that service in the name of our health system. By being who we are and doing what we do best, chaplains can add tremendous value both to the institutions and to the communities in which they serve.

References


2 Ibid., 2.

