Commentary from a Physician

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**Why Standards of Practice?** Health care professionals face a dilemma: they want to do what is “best” for their patients, but they often find it difficult to determine what practices are evidence based and/or meet their profession’s expectations. This challenge derives from the paucity of studies that provide unequivocal evidence for or against a specific practice as well as from the limitations to effective peer review.

Often the paucity of studies is amplified by the existing studies’ failure to differentiate the efficacy from the effectiveness of a practice. The effectiveness of a practice is how well it works in the real world with varying patients and families under varying circumstances. When chaplains and other health care professionals participate in continuing education, what they learn may be neither based on unequivocal evidence nor easily adaptable to their patients’ circumstances.

Thus, health care professionals often must rely on peer review to evaluate their practices: a group of professionals with similar training and experience reviews each others’ practices and reaches a consensus on whether each individual’s practices are considered acceptable in their profession. In the absence of an evidence-based practice as “the gold standard,” the criteria for this consensus judgment is implicit and subjective.

Patterns of practice (among physicians) show a high degree of similarity within a small geographic area but a high degree of variation between small geographic areas. Consequently, review by geographically nearby peers often reinforces a specific practice among those peers, even if that practice varies from the practice in other geographic areas. It is likely that this phenomenon of “small area variation” exists in the practices of other health care professionals, including chaplains. Other limitations to effective peer review include collegial or competitive relationships between reviewers and reviewees, and, especially in smaller settings, the absence of true “peers.”

So chaplaincy services and chaplains need evidence-based (when available) professional standards of practice that have been set through a national, rather than a “small area,” consensus process. Such standards may provide the following:

- Guidance to individual chaplains and chaplaincy services to achieve contemporary levels of good practice.
- A roadmap for continuous improvement in chaplaincy services.
- Criteria that may be used by other clinical and administrative institutional leaders to assess the performance of chaplaincy services.
- Goals to be achieved by enrollees in chaplaincy education and training programs.

The strengths of the *Standards of Practice for Professional Chaplains in Acute Care* include both the scope and the inclusion of measurement criteria and graduated examples. Important themes include the chaplain’s role in the microsystem of the treatment team, patient and patient’s family, and the needed sensitivity to cultural differences that is important for both safety and quality in patient care. The role of the chaplain in fostering sensitivity and responsiveness to racial, ethnic,
religious and cultural differences between patients and staff—as well as among staff—is growing in importance in our increasingly multicultural society.

However, these standards of practice raise two questions. First, in a multichaplain service, does each chaplain need to perform all the practices, or does the service collectively need to perform them? While it would be inappropriate for an individual to perform a practice that violates a standard, does the individual need to perform every practice, at least at the basic level? Clinical and administrative institutional leaders will be concerned primarily about the collective performance of the chaplaincy service, but each chaplain will also want to assess his/her individual performance.

The second question is whether there are standards of practice related to initiating services to a patient and/or patient’s family. Standard 4 addresses the need to respond to treatment team members’ referrals, and Standard 1 addresses the assessment process once patient contact is initiated. Under what circumstances should patient contact be initiated in the absence of a referral? Clinical and administrative institutional leaders will be interested in the answer as will individual chaplains.

Despite these unanswered questions, the new standards of practice should make a significant contribution to the quality of chaplaincy practice in acute care settings and serve as a useful resource for chaplains and chaplaincy services as well as clinical and administrative institutional leaders.