The Future Is Now: Revisiting Lawrence Holst’s 1985 Predictions for Hospital Chaplaincy

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In the closing years of the twentieth century, Hospital Ministry: The Role of the Chaplain Today, edited by Lawrence Holst, stood as the definitive assessment of hospital chaplaincy. The closing chapter, authored by Holst, looks at threats and opportunities facing “the chaplain in the future.” Now, thirty years into that future, Russell Myers, a board certified chaplain serving a major midwestern hospital, examines those predictions in light of present day health care realities. Following his review, several members of CT’s editorial board respond with comments from their individual experiences. You are invited to add your voice to the conversation via e-mail to cteditor@professionalchaplains.org. Additional reflections will be included in the next issue of CT.

In 1985, Lawrence Holst edited Hospital Ministry: The Role of the Chaplain Today.1 Lutheran General Hospital, Park Ridge, IL, where Holst chaired the Division of Pastoral Care, had just completed its twenty-fifth year. He writes in the Preface, “In that quarter century our Division of Pastoral Care has received broad institutional support. ... Over the years, much has changed and grown.” Reflecting on an effort to publish a text on chaplaincy in 1973, Holst comments that “changing times and personnel, as well as new perspectives” had stimulated the 1985 effort.

Hospital Ministry made a significant contribution to the literature of professional chaplaincy and has continued to be relevant over the years. Part I addresses “Context and Identity” with attention to the unique role of the chaplain in the midst of a high-tech medical environment as well as the role and functions of the hospital chaplain. Part II, “Listening to the Voices of Suffering,” focuses on specific areas of hospital ministry. Part III examines “Many Other Functions” of the hospital chaplain, including administration, ethics and teaching. Hospital Ministry was reissued in 2006 by a different publisher, though with no updates or changes; thus, its words are now offered unedited to a new generation.

Given the opportunity to co-teach an elective course on chaplaincy at United Theological Seminary of the Twin Cities in 2010, I instinctively chose Hospital Ministry as one of the recommended readings. It was during that time that I was particularly drawn to the book’s closing chapter, “The Chaplain in the Future: Threats and Opportunities,” written by Lawrence Holst. From the vantage point of the late twentieth century, Holst recaps the evolution of the American hospital in the previous decades and then “undertakes the hazardous task of prognosticating the impact of the hospital’s changing delivery patterns upon chaplaincy.”

It has now been more than twenty-five years since the original publication of Hospital Ministry. The future that Holst wondered about is home to us. He writes, “We have some broad hints as to what will happen to hospitals in the future.” His vision of the “threats and opportunities” of our time provides an interesting and thought-provoking topic for reflection and discussion. Holst raises two broad questions:
• Where does that leave hospitals?
• Where does that leave chaplains?

Under each heading he lists his predictions for the future. Following Holst’s format, I list his predictions and my observations, using arrow symbols to mean that ↑ yes, I think Holst was right; ↓ no, I think he missed this one; and ↔ the accuracy of a prediction is unclear.

“Where does that leave hospitals?”

They will be much more cost conscious. ↑
This may have been the low-hanging fruit in 1985. Hospitals already were paying more attention to cost, and history has borne that out.

They will be more competitive and entrepreneurial. ↑
Competition has led to the consolidation of hospitals into networks and health care systems, and also has contributed to increased advertising and attention to market share. One element of competition has come from the emergence of specialty health care centers, an example of what Clayton Christensen, Harvard Business professor and author, describes as “disruptive technologies.” In The Innovator’s Dilemma, Christensen writes about the challenge to businesses when competitors draw off profitable aspects of their industry, offering customers an alternative that tends to be cheaper, smaller and easier to use. Freestanding surgical centers, emergency care centers and birthing centers are examples of disruptive innovations in healthcare.

In his follow-up book, The Innovator’s Solution, Christensen states that disruptive innovations “don’t attempt to bring better products to established customers in existing markets. Rather, they disrupt and redefine that trajectory by introducing products or services that are not as good as currently available products. But disruptive technologies offer other benefits—typically, they are simpler, more convenient, and less expensive products that appeal to new or less-demanding customers.” Holst was correct in anticipating that healthcare entities would become more competitive and entrepreneurial and would seek lower-cost ways to deliver care. Specialty healthcare centers may be considered to be non-hospital competitors, although in the changing landscape of health care, they actually may be owned by the same health system that owns the neighboring hospital.

They will be narrower in scope of medical services. ↓
Holst predicted that each hospital “will determine what it can do best and most efficiently and do it.” This would suggest a collaborative understanding between hospitals, in which each one offers a narrower scope of services, leaving other specialty areas to the neighboring institution. Perhaps this is the case among hospitals that are part of the same larger network or health system; however, between competitors there is little evidence of that kind of cooperation.

Competition has led healthcare in almost the opposite direction, into a much-criticized and expensive duplication of services by rival hospitals. More than twenty years ago, the New York Times reported on efforts “to rein in what some have called a medical technology arms race. … A set of forces, indicative of basic traits of the nation’s health system that undermine efforts at cost-control, brought about the rapid spread of MRI machines and procedures. Manufacturers constantly pushed new machines on the market. The purchase of a machine by one hospital inspired others to want to keep up.” With regard to the scope of medical services provided by US hospitals, we are not living in the future Holst imagined.
They will be fewer in number. ↔
Consolidation and mergers have reduced the number of hospitals in urban areas. Holst was right in forecasting that “those that survive will become part of massive coalitions and networks, making it difficult for the local hospital to retain its unique identity and mission.”
Missing from his list of predictions is the impact of the expansion of healthcare systems into small- and medium-size cities. While many towns are not losing their hospitals, they are losing ownership, along with their unique identities. Operating under the banner of a network headquartered miles away has brought a change from local leadership and decision making. We may have to wait another twenty-five years to determine if this is a positive development.

They will care for fewer inpatients for briefer periods of time. ↑
This prediction has two parts: reduced inpatient census, and reduced length of stay. Reduced census has been impacted by the rise of outpatient surgical centers, expanded services offered by long-term care centers to include rehab and transitional care units and other non-hospital care. Related to that is the reduction in length of stay, driven in part by the availability of tertiary care in non-hospital settings. Technology has contributed to reduced length of stay with less invasive procedures requiring fewer days for recovery.

They will be physically focused. ↓
Holst defines “physically focused” as providing “no reward for doing a more humane job or for addressing quality-of-life issues.” Contrary to the dangers foreseen in the mid-1980s, U.S. society has become more consumer-driven, and healthcare organizations are listening to the public’s demands for more humane care. Patient satisfaction surveys have become an integral part of how hospitals do business, providing feedback that is taken very seriously by administrators. I believe most hospitals today are extremely sensitive to survey scores, and as a result are more attuned to quality-of-life issues. Patient satisfaction is directly tied to marketing, finances and hospitals’ desire to distinguish themselves from their competitors. Consultants and trainers teach physicians and hospital employees to improve their communications with each other and with patients. Hospice, palliative care, advance care planning, complementary therapies and integrative health and healing are modalities particularly centered on respectful, compassionate care.

They will house the acutely ill who only can be treated there. ↑
A smaller portion of health care is delivered in the hospital than was in the past; more services are offered outside the hospital. Observing this trend myself over the past two decades, I anticipate that the hospital of the twenty-second century might consist only of an ED and an ICU, with all other direct patient care being provided elsewhere.

They will take services into the home. ↑
We see this happening already, with home nursing care, home hospice/palliative care and the emergence of community-based paramedics making house calls. The cost of inpatient care, along with patients’ preference for being at home if at all possible, will continue to push more services out of the acute-care hospital.

Holst, writing in 1985, couldn’t predict that health care reform would be a defining issue of the 2012 presidential election. Nevertheless, he foresees a health care crisis as he concludes his predictions of the future of hospitals: “The hospital of tomorrow will be tested as never before. It will confront the contradictory demands of the public for ‘high tech’ and ‘high touch’ at low costs. Admittedly, it is a grim picture. Admittedly, it is a speculative picture. Admittedly, public moods and temperaments can and do shift, as do national priorities. But it is clear today that the public is opting for lower medical costs. To miss that is to be naïve. How much that will impact quality and comprehensiveness of care, no one knows. And if that impact is severe—as many predict—who knows what the public’s next mandate will be?”
“Where does that leave chaplains?”
Holst next turns his attention to the place of the chaplain in the new world of healthcare. He writes, “Hospital chaplaincy is not going out of business. But it will indeed change.” He expresses his belief that “chaplaincy in the future will need to broaden two bases: clinical and financial. Like any change, corporate or individual, this will pose threats and opportunities.”

Broadening the clinical base
“As hospitals need to broaden their base of services, so will the chaplain. Chaplains can be no less creative than hospitals. If fewer people are going to spend fewer days in tomorrow’s hospital (and there is no anticipated cutback in illness), then people are going to be treated somewhere. The chaplain will need to pursue that somewhere.”

That somewhere will be in outpatient facilities.
In the days when all surgeries, workups, testing and therapies were done in the hospital, the patients came to the chaplain. Holst is correct in his prediction that “in the future these patients will be a less captive audience. The chaplain will have to go looking for them.” Budget constraints, coupled with a narrow understanding of the role and function of the chaplain, have challenged chaplains’ abilities to follow the patients into some non-hospital settings. Yet there are encouraging signs, as chaplains have taken Holst’s counsel to be creative. A pilot project in our hospital has a CPE resident’s clinical assignment tied to patients from a nearby clinic. She makes an initial assessment visit to all clinic patients who are admitted to the hospital and continues to see those for whom ongoing spiritual care is indicated. Significantly, she also makes follow-up phone calls after discharge and is available to meet patients in the clinic for additional chaplaincy support.

That somewhere will also be in the home.
Community-based services such as hospice care have well-established practices of chaplains making home visits. Chaplains may have a role on other ambulatory care teams, but the practice of chaplains making home visits does not yet appear to be widespread.

One of Holst’s assumptions merits comment. With respect to home-based chaplaincy care, he writes, “Most chaplains come out of the parish ministry where home visits are routine.” While I generally agree that most chaplains have some experience in congregational ministry, my observation is that there is growing interest in chaplaincy among second-career people who either have not yet considered ministry in a congregation or who simply wish to bypass the parish and move directly into chaplaincy.

Whether they are successful at finding a job depends in part on who is doing the hiring, the credentials required by the employer, whether they are affiliated with a denomination that will endorse them for chaplaincy and whether the endorsing body requires parish service as a prerequisite for specialized ministry as chaplain. If current trends continue, i.e., people in mid-life explore chaplaincy as a vocation, and if formal affiliation with faith communities declines, we may see greater numbers of chaplain candidates whose experience does not include ministry in the congregational setting and/or affiliation with an endorsing body.

Implications for the Association of Professional Chaplains include education of employing organizations about the benefits of hiring board certified professional chaplains, advocating for certification as a necessary credential for applicants and reaffirming its commitment to ecclesiastical endorsement as an essential requirement for board certification.

That somewhere will be with employees.
Holst writes that “hospitals, and other corporations, have learned that it is in their self-interest to keep employees well, to help them effectively cope with stresses and crises in their lives.” This is
not new. But in answer to his question “where does that leave chaplains?” Holst asserts that “The time has come for the pastoral function to be formalized.”

I don’t have evidence of this beyond my own setting, but for me the change has been striking. Fourteen years ago an administrator at my hospital stated, “Let’s not muddy the water. Chaplains are here for patients and families, not for employees.” Today the current administration turns to chaplains for counsel in leading crucial conversations, facilitating critical incident debriefings, presenting on self-care and stress management and providing confidential one-on-one support of employees. Five years ago, I was asked by the president of our healthcare system’s ambulance service to be the chaplain—not for the patients but for staff support of the EMTs and paramedics. I suspect that these changes are not unusual and that chaplains around the country also are seeing an increase in their formal support of employees.

That somewhere will be in administration. ↔

I do not see a great deal of evidence to suggest that chaplains are being tapped for high-level administrative positions today any more than they were in decades past. Perhaps those in other parts of the country are having a different experience.

That somewhere will be with the elderly. ↑

Holst is correct in his belief that “the trend has already developed; it will continue.” With demographic shifts underway with the retiring of the baby boom generation, this area of ministry will continue to grow.

That somewhere will be in hospital image building. ↓

Holst recognizes that the hospitals of the future “will remain service organizations. Their major product will continue to be personalized care.” However, I do not think history has shown him to be correct in expecting that “To help call attention to that primary focus in the midst of cutbacks will be a primary task of the chaplain. To help see to it that ... a caring image is projected in the community, will be a much needed function of pastoral care in a hospital.” In my experience, that task has been given to the marketing and public relations experts.

Broadening the financial base

In this last section, Holst speculates that “It may be necessary in the future for chaplains to become direct revenue producers. Certainly, this will appear threatening to the vast majority of hospital chaplains whose budgets in the past have been provided by others’ revenue production.” He then makes three general comments.

An obvious market is the parish. Chaplains may need to partially subsidize their salaries through services rendered to parishes. ... It may become a necessity. ↑

In the changing environment of healthcare financing, we have colleagues whose hospital spiritual care departments have had major budget cuts. Responses to a sudden reduction in funding have varied. Some work groups have “shared the pain” with each chaplain absorbing a .1 - .5 FTE cut. Others have eliminated an entire position, reducing the size of the chaplaincy staff. It is unknown whether those individuals then seek employment in congregations, pick up part-time chaplaincy work at other institutions or draw on other personal skills and talents to earn incomes. The total numbers of chaplains may not have changed much in the past few years, but it does appear that the number of chaplains working in full-time positions has declined. For many, seeking other sources of income has indeed become a necessity.

The chaplain of tomorrow may have to raise funds for chaplaincy. ↔

The evidence of this is unclear. To a limited extent, some spiritual care departments receive nonbudgeted funding, but the amounts and sources vary considerably. Holst lists possible sources
as local congregations, foundations, individuals and corporations. Of those, I could more readily imagine foundations and individuals supporting the chaplaincy program at a hospital than local congregations, who face financial challenges of their own.

**Paying the freight for clinical pastoral education (CPE).**

Holst writes that “a blunt word needs to be spoken to the national and local church. ... The public has paid the freight [for chaplaincy and CPE]. This has been an involuntary contribution. Patients have not consented to it. Most of them probably did not know that a portion of their hospital bill went toward chaplaincy and pastoral education. In all of this the church has been a hitchhiker. Today, thousands of pastors, of all denominations, serving in institutions and parishes, have received clinical training in hospitals at the public's expense. Those sources of public reimbursement are shrinking. ... The church will need to invest more of its energies and funds in chaplaincy and CPE.”

It does not appear that much has changed since this was written. If anything, the practice has become more deeply embedded. Medicare passthrough dollars paid to hospitals continue to provide some of the funding for CPE residency and supervisory training programs.

There are at least two issues here. One is the inclusion of CPE as an integral part of preparation for congregational ministry. Some denominations require that all candidates for ordination complete a unit of CPE. Yet we hear little about seminaries hiring CPE supervisors and supporting their own programs. In the constantly changing world of health care financing, it is possible that hospital-based CPE programs will no longer be funded. All three of the Level 1 trauma hospitals in the Twin Cities once had CPE programs; today there are none. I doubt that denominations have considered the implications to theological education for congregational ministry candidates if students do not have the opportunity to participate in CPE internships. Here, I think Holst was correct. If/when the number of CPE sites declines to the point that seminarians are unable to meet the CPE requirement, I fear that denominations will simply drop the requirement, and future faith leaders will be less equipped for pastoral ministry.

A second issue is the requirement of four units of CPE for board certification as a professional chaplain. In that regard, I am not convinced that it is the denominations’ responsibility to provide the training for clergy who wish to pursue a specialized ministry in chaplaincy. One might argue that current attitudes toward spirituality, spiritual care and the chaplain’s role on the interdisciplinary care team would support public financing of some of the costs of chaplaincy education. Whether that is a gain or a loss is a topic for another conversation.

**Conclusion**

Holst concludes by affirming his belief that

[H]ospital chaplaincy will continue in the near and distant future... There is also no doubt in my mind that chaplaincy will need to be modified. ... Like patients, chaplains will face new boundaries and limits. ... Like patients, chaplains have resources. ... Like patients, chaplains must contend with a changing image. ... The chaplain’s place and role in the hospital has won broad acceptance. But that place has changed. Now chaplains face new struggles, new limits, and new challenges. ... Like so many patients, chaplains need new visions and the will to pursue them.

Like a wise mentor, Holst extends an invitation and a challenge to us. What threats and opportunities face us and the next generation of chaplains? What are our visions, and how will we pursue them.

