Responses to “The Future Is Now”

AS A CHAPLAIN WHO WAS BOARD CERTIFIED IN 1984, I have seen much of what this writer is reflecting upon. I was a bit concerned by the discussion of chaplaincy as a second career—bypassing the parish—and some of the endorsing issues this raises for denominations. I am aware this is a point of tension.

How are hospital administrators to be assured of well-trained, professionally qualified chaplains unless APC and other chaplain advocacy groups step up to the plate and do the necessary education?

The writer commented on Holst’s statement that hospitals will be narrower in the scope of medical services. Paralleling this are chaplaincy services that are becoming specialized as well. APC President David Johnson wrote about this in a recent issue of APC e-News (14:1 [February 2012]) as an area that certification is beginning to explore. The standards of practice in acute and long-term care also speak to this issue.

Margaret A. Muncie MDiv BCC
Executive Director
Canterbury Counseling Center
Greenville, SC

THE AUTHOR’S ASSESSMENTS OF HOLST’S PROGNOSTICATION are based considerably on personal observation. Overall this reflection could benefit from documentation to support the observations and conclusions about the current health care environment. That would be a major enterprise in itself and perhaps beyond the scope of the author’s intent. Nonetheless, for someone with the interest to investigate today’s environment in more detail this would be something worth pursuing through a detailed research project.

Having made the comments about personal observations, here are a few of my thoughts regarding the author’s conclusions.

I tend to agree with most of the assessments. Here are a few that stand out in my mind.

- Hospitals have not narrowed their scope of medical services. The competition to capture market share has led to a proliferation of duplication of services and “keeping up with the Jones.”

- Consolidation has become the norm. Urban networks have been created and small community based facilities have been absorbed by large national health systems.

- Hospitals have continued to become places for the more physically ill while outpatient services have increased. For academic teaching hospitals in particular, while the number of beds may have decreased, the number of acute and ICU beds seems to have increased.

- More services are delivered at home through growth in outpatient hospice and home care organizations. I’d like to see statistics to support this trend.

- There does seem to be an increased focus on employees as attention is given to retention. It would be helpful to cite examples of programming by chaplains that address issues such as compassion fatigue or participation in employee assistance programs (EAP). Chaplains also are more active in development of bereavement programming for staff.
Focus on the elderly continues to increase. I’ve observed a growth in chaplain positions in continuing care communities. Again, I’d love to see a way of capturing that trend with more statistics.

There are a few conclusions for which I do not see evidence and would be interested in further exploration and documentation. Again, here are a few that stand out in my mind.

- I would like to see some evidence that we really have moved to the outpatient setting and that this venue has grown more than inpatient chaplaincy. That has not been my observation.
- I would like to see evidence that chaplains are expected to broaden their financial base. My observation is that chaplaincy has become more professional and is recognized as such by health care organizations. Chaplain salaries appear to generally be supported by hospitals at a more professional rate and hospitals in return have proportionate expectations of chaplains. If anything, the proliferation of part-time positions appears more to be the function of hospitals supplementing one person pastoral care staffs with paid PRN chaplains rather than volunteers. This transition seems to be made possible by the number of clergy with clinical training who, due to geographical restrictions, are unable to secure full-time employment as chaplains.

Finally, the reflection and assessment of Holst’s prognostications could have been strengthened by identification of changes in chaplaincy that were not on the radar in 1985. These include the following.

- There is considerable attention to the need for evidence based practice.
- There is now considerable attention to the need for chaplains to be research literate and to increase research participation and competence.
- There is increased focus on chaplains functioning within cross disciplinary context and for chaplains being included in institutional protocols related to organ donation, transplantation and trauma teams, to name just a few.
- There is increased focus on pastoral care specialization, including services such as palliative care, burn and rehabilitation.

Alexander Tartaglia DMin BCC
Associate Dean
School of Allied Health Professions
Virginia Commonwealth University
Richmond, VA

I ADMIT TO BEING A CONTRARIAN. There are substantial changes in the offing, which will impact health care and chaplaincy, about which the writer seems oblivious. For example, in commenting on the Holst assertion, “They will be narrower in scope of medical services,” he adjudges this as wrong. I think that the changes afoot in health care will necessitate this kind of movement. As hospitals have merged, there already have been shifts in consolidating services (at least, in the two hospital system in which I work).

With respect to the comment about chaplains moving to outpatient facilities, perhaps I am myopic, but I have not seen evidence of this. The CPE pilot project notwithstanding, the primary focus of chaplains in my experience remains inpatient care.
Lastly, I really believe that the writer is wrong about “broadening the financial base” in suggesting that the number of chaplains working full-time has declined. Certainly there have been cut backs in the wake of the economic downtown, but I have not observed this trend as described by the writer. I wonder if APC statistics support this assertion.

Rabbi Jeffery M. Silberman DMin BCC
Director of Spiritual Care
Danbury Hospital – Western Connecticut Health Network
Danbury, CT

JEFFERY IS NOT A CONTRARIAN BUT RATHER A CLOSE READER. Narrowing the scope of hospital services is a direction that leads to improvements in patient care quality. Building specific centers of excellence can lower costs and improve care because facilities are more tightly designed and the training and knowledge of the staff is more focused.

I don’t see chaplains moving into outpatient centers. Many hospitals have seen a decline in outpatient services as many of these services, e.g., surgery, imaging, endoscopy, have moved into free standing centers or to physicians’ offices. The current economy has challenged hospitals to the core. Financial decisions are now being made according to the demanding bottom line. It is about the green dollars saved only and not necessarily refining practices or gaining efficiencies.

I finished my residency in CPE in 1977 and subsequently served as an “externally funded” chaplain supported by the General Baptist Convention of Texas and the Baptist Home Mission Board working with the hospitals affiliated with the Mayo Clinic, Rochester, MN. My 4-month-old son, diagnosed with hemophilia, was a frequent flyer at St. Mary’s, and I became intimately acquainted with the ins and outs of health care (seventeen infusions over three years—fourteen in the ED). As a father, I have battled the nonsensical decisions of reimbursement.

I remember Lutheran General (Park Ridge, IL – now part of Advocate Health Care) being held up for all to see as the shining example. The story was that at LG you could not open fifty beds without a full-time chaplain. Holst was living and working in the catbird seat with strong institutional support for chaplaincy and CPE. He was in a faith-related health care system that deeply believed in high touch.

Even then, there were significant storm clouds on the horizon in health care and faith communities. Diagnosis related groups (DRG) were instituted in the eighties, and the rise of fundamentalism in faith communities and politics began to tighten the mission and budgets of faith related hospitals. Contracting services was the rage in the Veterans Administration, and only the Bishop’s ring slamming the desk prevented its extension to the VA chaplains.

Today I live and work in the “somewhere.”

Robert W. Duvall MDiv BCC
Director of Chaplaincy
Gwinnett Medical Center
Lawrenceville, GA

HOLST’S PREMISE ABOUT HOSPITALS DECIDING WHAT THEY DO BEST, and limiting their services accordingly, need not suggest that hospitals will collaborate to divide the
labor. They may well reach this conclusion via independent analysis. There is some evidence that hospitals have done what Holst predicted, i.e., consolidate their efforts into services they do best (or that make the most money). A recent article in Modern Healthcare details how hospitals have reduced/terminated nonprofitable services—mental health in particular—and ramped up revenue-generating services in the aftermath of the recent Great Recession. (See “Juggling the Lineup,” January 16, 2012.)

With respect to the home as one of the “somewheres,” the author references Holst’s comment that most chaplains come out of the parish “where home visits are routine.” He appears not to question the assumption that home visitation by pastors is still frequent. Is it?

With respect to the comment that chaplains still are rare in senior management positions. I don’t know if that is the only avenue into “administration” that Holst has in mind. Some chaplains pursue ministry by finding ways to make their voices heard even if they are not members of executive leadership.

In the same vein, I see chaplains collectively engaged in “image-building” efforts via professional organizations, such as the resources that APC has invested in the institutional “advocacy” realm. I believe Healing Spirit was published largely to promote chaplaincy to administrators and hospitals’ communities.

In the area of broadening the financial base, I would be interested in the author’s take on the rise of a large service provider like HealthCare Chaplaincy as a means of alternative funding.

As to paying the freight for CPE, both Holst and the author focus the analysis on the church. What strikes me, though, is the underlying still-Christian assumption, which seems to ignore two elephants in the room:

- Chaplains today are rooted in multiple religious and spiritual traditions.
- Hospital chaplaincy’s clientele reflects an interfaith/“spiritual” reality.

The author’s comment that “not much has changed since this was written [in 1985]” overlooks this continuing evolution. The passing remark about the changing nature of the relationship between chaplains and their faith communities could be expanded in terms of these changes.

The author claims that “it is clear today that the public is opting for lower medical costs.” That’s not what I see. People without means seek less care, or no care at all: no cost is low enough. Those who do seek treatment seem to do so without regard to cost.

Finally, is the focus on hospital chaplains the right one in 2012? Numerically, they do predominate. Maybe it’s good to be reminded of that in a field that has embraced the global term “health care chaplaincy.”

David B. McCurdy DMin BCC
Senior Ethics Consultant and Director of Organizational Ethics
Advocate Health Care
Park Ridge, IL