Open for the future:
Envisioning chaplaincy in the midst of transition

Thursday May 29th, 2014
Session 1

Mrs Daniela Pöschl, representative of the Salzburger regional government

Welcoming speech

Mrs Pöschl presented an overview of the healthcare system in Austria. There are nine states and nine regional governments in Austria. Patients have free and unrestricted access to hospital care. 22 different social insurances are funded through divers types of contributions. State and local governments, social insurance and private households must pay a prescription fee. Some pay private insurance but it is not an obligation.

Among challenges met by the Austrian health system, Mme Pöschl mentioned geographical difficulties because of mountains, a high rate in-patient care and a shortage of health care professionals. Thanks to the 2103 Health care reform an agreement was made between central, local government and social insurance, for an extension of outpatient care and an increase in primary care.

Professor DDDR. Clemens Sedmak, Kings College London and Salzburg University
Clemens Sedmak is a social ethicist.

"Challenges for humane hospitals"

I. Decent institutions

Introduction
Decent institutions represent a minimal standard for humane hospitals. These are institutions, which do not humiliate human beings. Such institutions are careful of : Structural entry points (procedure), Interviewing of patients (nakedness), Intimate bodily noises (bathrooms which are not sound proof), Two-way humiliation (the presence of visitors in the room). The example of Susan Sontag was given as she writes about a patient traveling in a strange land and how minor details become of great importance for patients. *Tribulations d'une jeune cassière*, was quoted.

1. Humiliation
We (chaplains) should be sensitive to entry points by speaking with patients and staff members. Technology can be objectifying. A patient was horrified when the practitioners were fascinated by the high tech and showed no interested in her as a human being.

2. Decent institutions should not be hellish.
No eye contact can become hellish (Macarius' vision of hell). Active silence can be fearful (Evagre's vision of hell). The feeling of powerlessness is felt in front of doctors who are too knowledgeable. (An example of ancient times was given when professors couldn't be

asked directly). In his book, *The Palace of dreams*, an Albanian author described hell as being like a campus with huge buildings, busy people with dossiers. It's a place where you are not allowed to ask the question "Why" or where you do not get an answer. Quality improvement could turn the situation into a hellish situation. Auditing could become dangerous when thought as a value in itself. There should be leeway for individual thinking and expression.

II. Human vulnerability

"Poorness" is inflicted when a person can cause consequences to another. Something happens to me because of someone else. I am vulnerable because someone can do something to me. A person is vulnerable to the extent that she is not in a position to undermine occurrences. (Paul Formosa)

Three kinds of vulnerability (P Maconcy):

- Inherent Vulnerability: This comes with our human condition
- Situation Vulnerability: The context determines vulnerability. Vulnerability of a patient is higher.
- Pathogenic Vulnerability: Vulnerability caused by unnecessary situations

The experience of vulnerability triggers sensitivity. (R Goody)

To care means responding to the other persons needs by making the other person's ends our own.

III. Two examples

- H. Carel 2008, 2013: *Cry of the Flesh* (lung cancer) writes about her experience with illness despite a healthy life style. "I had no script to play my roll as a sick person. I had no time to be off stage. I didn't respect the roll because I cried. Empathy would have been so important. No one said to me "I'm sorry that you are ill."" She had to learn about epistemic injustice (the humiliation that a stranger would know important things about her health because she walked around with an oxygen bottle.) She stresses the importance of eye level and brings up the idea of language impoverishment: "How are you?" is no longer common language for relating between a patient and a healthy person. Chaplains can offer a language.

- Ben Watt, a musician writes about his experience in hospital in 1994, *Patient*, 2014. He was 29 years old but regressed to the age of a child. He wanted to be treated like a child. Doctors could not produce a proper diagnostic but why? "Are you not my dad and mom?" he asks. Patients' rights claim can be brought to an extreme reminding a person that he is an adult and has responsibilities. The need for care and physical contact is contrasted by social discontinuity of care; there are always different interlocutors. There is need of companionship.

IV. Regulative idea of the soul

By talking about the regulative idea of soul, reference was made to E. Kant. The human soul constitutes a regulative idea in that we do not need proof to know that it is

desirable to believe. Chaplains treat patients as if they are souls despite their condition (Alzheimer's disease, coma …)

Three examples of this idea:

- Dietrich Bonheoffer's polyphony describes different dimensions of life. There is so much more to a person than the role he is playing. A patient is so much more than a sick person; a prisoner is so much more than a prisoner. Inner life and outer life are correlated. Nourishment can be found in silence and rest, friendship, beauty (prayer). A soul can grow even under divers circumstances.
- Liminal situations are not always negative. Being on a threshold does not mean you cannot grow. (Jeremiah 29 and 30)
- For Aristotle, the soul gives the body its identity.

"We cry for bread and we cry for roses". There are two languages: one is for healthcare and the other concerns empathy and the soul.

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Session 2

Reverend Georges Hanzo, Director of Health Services Research & Quality, HealthCare Chaplaincy New York. G. Hanzo is a pediatric chaplain and more recently involved in research.

"The door is wide open"

The door is wide open for professional HealthCare chaplaincy

- The language of healthcare is important.
- Issues and mandates for chaplains from the US, Canada, Australia, New Zealand and the UK are not different.

Quality improvement is not the same as "Quality check".
Its primary purpose is to serve health care providers, patients and family.

I. US context:
- Going from in-patient care to out patient
- Bending the cost curve means costs won't go down but they will go up less.
- Improving outcome and reducing waste.
- Eliminate waiting rooms would be going from a doctor-centered hospital to a patient centered hospital.
- Integrating spiritual care
- All treatment is Evidence informed (as opposed to evidence-based). It means using the evidence that science can produce

Care is trans-disciplinary when the skill borders become pores. That means communication is possible. In an interdisciplinary care context, the professionals don't have to talk to each other.

II. Continuous Quality Improvement verses Quality Control

Accommodation of different cultures/religions:
- Delivery of Health Care in the World is changing very rapidly.
- The Demand to include Spirituality is on the Rise. All Health care providers including Spiritual Care Providers will be held accountable.
- Return on investment (ROI) in terms of patient satisfaction…
- Quality = effectiveness and efficiency. It's patient centered care
- Value = what the customer will pay for. Why count how many visits?
- What use is volume in Europe?
    - ° It's costly, not clinically helpful
    - ° Not valued by patients
    - ° Patients want value
- What is value in Europe?
    - ° The patient says what he values

The questionnaire is a value measure. It measures satisfaction

EPIC is used in Holland. "Please make an order" is asked to the doctor or the nurse.
A product list is asked for.

These are ways of asking us (chaplains) to describe what we do by using hospital language.

Reporting more referrals than visits turns to our advantage.

Triple aims of US care:
- Clinical Outcomes
- Cost
- Patient satisfaction

Patients are satisfied with standardized care because they know what to expect.
Research proves Patient satisfaction concerning chaplains.

Spiritual care can mean that people die less in intensive care.

We can proactively define and implement the spiritual /religious Outcomes that are consistent with our values and fully integrate them.
Or
We can continue to refuse to embrace outcomes and have outcomes that the System will choose imposed upon us.

CPT conveys a myth that we all go in with an intention: to help people.

The patient defines outcome value: feeling more peaceful, talking to the staff, feeling more hopeful. They define what is important to the patient, not the doctor…

Chaplains use process language.
Patients and doctors use outcome language.

What are we trying to do? We need to put it into language that people will understand
Different languages: nurses talk about patient choice and administrators talk about cost saving.

Charting can be about process so it's a misunderstanding.
Explain what you are doing or what might impact their treatment.
In the US, 60 -70 % of the doctors are looking for values.

Improving Care as a dimension of Palliative Care
Making Care Whole, (spirituality is the missing piece) Christina M Puchalski, MD, Betty Ferrell, RN PHD

Spiritual Care generalist vs Spiritual Care Specialist "Spiritual Care: Whose Job is it Anyway?", Southern Medical Journal, 97 12), 1242- 1244

Statements such as "Chaplains are harmless" mean that chaplains have no value.
Evidence is not just numbers in Science based research.

The idea that there is no evidence for chaplaincy work is wrong.

Getting trained chaplains is difficult.
Using hospital language for describing what we do does not mean changing our basic practice: relationships with patients. Outcome oriented chaplaincy is important.

Potential partners and collaboration in different areas should be sought:
- Teamwork and collaboration
- Ethical practice
- Training of nurses
- Linking with communities

Education in spiritual care:
- Patients feel more comfortable with self-management
- We will keep people out of hospitals

We need cross culture research

Definition of Spirituality:
Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence and experience of relationship to self, family, others, community, society, nature, and to the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.

Defining our role:
What is the value proposition?
What outcomes do we need to demonstrate?
What training do we have?

A call for research is made.