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Chaplains and spiritual caregivers in American healthcare organizations

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Introduction

Chaplains—increasingly called ‘spiritual caregivers’—have long histories in healthcare organizations. Many early hospitals were started by religious groups to provide moral as well as physical healing (Rosenberg 1987; Kauffman 1995; Kraut and Kraut 2007; Risse 1999). Religious workers—rabbis, ministers, priests, and nuns—were present in many of them providing religious alongside medical care. As a profession in the United States, healthcare chaplaincy began to emerge in the 1920s and to organize in the 1940s (Cadge 2012). Today about two-thirds of American hospitals have chaplains—a number that varies with policy and demographic factors in the United Kingdom, Europe, and Australia. Chaplains are also present in many hospice and palliative care organizations in the United States, as well as in some retirement and nursing facilities cross-nationally (Cadge et al. 2008; Flannelly et al. 2004; Swift 2015). In the last fifteen years, many chaplains have started to describe their work in terms of ‘spiritual care,’ a broader frame that includes people who are not traditionally religious, thereby increasing the potential professional jurisdiction of chaplains (Cadge 2012; Sullivan 2014; Idler et al. 2015).

Numerous studies describe who healthcare chaplains are, what they do, and how they interface with others in healthcare. Many argue that their unique positions on the edge of religious and of healthcare organizations make marginality or organizational ‘in-between-ness’ a defining and consistent characteristic of their work (Hansen 2012; Sullivan 2014; Cadge 2012; Paget and McCormack 2006). In his classic Hospital Ministry: The Role of the Chaplain Today, Lawrence Holst devoted a whole chapter to how hospital chaplains work ‘between worlds.’ What he calls the ‘tension’ or ‘enigma’ of this organizational position shapes the work: ‘Each world, or structure, has its own domain and demands, its assumptions and mission’ (Holst 1985: 12). A more recent and growing body of literature focuses on the effects of chaplains’ work and begins to connect, in a public health frame, chaplaincy interventions to their effects on patients, family members, and staff (Fitchett 2017).

This chapter briefly outlines the history of healthcare chaplaincy as a profession before describing who healthcare chaplains are, how they are trained, what they do, the authority by which they work, and what effects recent studies suggest their work has on patients, family
members, and staff. We focus primarily on chaplains in the United States, asking how religious diversity—including growing numbers of people with no religious affiliation—informs their work (Cooperman 2015). We conclude with brief reflections on what the work of chaplains in the United States suggests, as a case, about contemporary intersections between religion, medicine, and health, and with suggestions for future research.

**Brief history**

Sharing an etymology with the words *hostel* and *hotel*, hospitals in the early American colonies developed from precursors that provided lodging for the homeless, the poor, and travelers. Like the Jewish, Christian, and Muslim hospitals of previous centuries, early American hospitals provided more shelter than specialized medical care. They were charity institutions for the poor, the gravely ill, and desperate; everyone else was cared for in their homes (Meier and Tabak 2007; Miller 1997; Mollat 1986; Risse 1999; Swift 2009). Demographic and economic growth led to the founding of increasing numbers of hospitals after the Civil War, including many Catholic and Jewish ones. Catholic and Jewish hospitals—like all hospitals after the Civil War—were open to everyone and primarily housed poor and working class people (McCauley 2005; Rosenberg 1987; Starr 1982).

By 1920, changes in medical care and education had brought hospitals closer to how we think about them today. They became, as Charles Rosenberg argues, a national institution and not just a refuge for the urban poor (Rosenberg 1987). Chaplains became the formal carriers of religion and spirituality in American hospitals in the 1920s, if not before. In secular American hospitals at this time, chaplains were retired or volunteer clergy with no special training who visited patients in their own religious traditions alongside other volunteers frequently organized through women’s auxiliaries (Cadge 2012).

Hospitals moved from the periphery to the centre of American healthcare in the twentieth century and physicians had growing authority over care for the sick. Many Catholic and Jewish hospitals opened during this period and, as a distinct profession, healthcare chaplaincy in the United States emerged, not out of an impulse to provide religious and spiritual care in healthcare organizations, but out of reforms to Protestant theological education that started in the 1920s. Afraid of losing jurisdiction to psychological and psychiatric ideas gaining sway in the culture, Protestant theological schools developed hospital-based training programmes to get students out of their books and classrooms and into contact with people: what early leader Anton Boisen (1876–1965) called ‘living breathing documents’ (Holifield 2005; Johnson 1968). Clinical pastoral education (CPE), as a training process for clergy and—later—chaplains, emerged out of this effort as an experiential supplement to theological training that would enrich students’ educations. Boisen often taught through case studies and, as CPE developed, students wrote what they called ‘verbatims’: reports of conversations between themselves and patients that were discussed with other students and the instructor. In the 1930s and 1940s, several programmes were created that institutionalized CPE. An organization called ACPE—‘The Standard for Spiritual Care and Education’—remains today the central training programme for this work accredited by the US Department of Education.

Some of the people who completed CPE in the early years—all white Protestant men—went on to become chaplains and organized themselves through the American Protestant Hospital Association in the mid-1940s. Russell Dicks described how CPE trained chaplains differed from local clergy who visited hospitals in a now famous 1939 lecture, ‘The Work of the Chaplain in a General Hospital,’ delivered to the American Protestant Hospital Association.
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Chaplains must be in touch with other staff caring for patients; they must have a plan based on the severity of the patient’s illness, referrals, or information shared at admission about which patients to see; they must be responsible to someone in the hospital even if they are paid by someone outside the hospital; and they should keep written reports of their visits. Trained chaplains, Dicks argued, do more than perform rituals, they ‘know that in suffering and stress, people are either thrown back or else they gain confidence in the fundamental nature of things, and it is the chaplain’s hope to steady them in any way he can during such stress’ (Dicks 1940). Professional organizations of hospital chaplains multiplied and merged over the years continuing to emphasize the centrality of CPE for professional training.

Policy guidelines and training

Despite the history of chaplains in healthcare, few healthcare organizations required chaplains historically or mandated that they be trained in certain ways. The Joint Commission, which sets the policies healthcare organizations have to follow to receive federal funds, has called on hospitals since 1969 to address what they today call the ‘religious and spiritual beliefs, values and preferences’ of patients, but has never specified how hospitals should do so. Some hospitals hire chaplains, while others have nurses or social workers with specific training or meet this standard in another way. When hospitals do hire chaplains, they have never been required to hire those who completed CPE or are what is today referred to as ‘board-certified,’ though many do. While training programmes have varied over the years, today’s board-certified chaplains have a graduate theological degree, are endorsed by their religious organizations, completed four units of CPE, and have 2,000 hours of work experience (Cadge 2012).

Unlike other healthcare professionals who must be licenced to practise, healthcare chaplains are not licenced, which allows hospitals to legally hire a broad range of people into chaplaincy positions. Those they do hire are usually paid directly by the healthcare organization, rather than through reimbursements that the organization receives from health insurance companies (Cadge 2019). Veterans hospitals are an exception, as they have been required to have chaplains since 1945 (Monfalcone 2005; Sullivan 2010).

Since the healthcare chaplain first emerged, it has feminized and diversified. Most of these individuals are referred to as ‘chaplains’ or as ‘spiritual care givers’ in American healthcare organizations today, regardless of their religious backgrounds. Some are volunteers, though most are paid by the institutions where they work. Increasingly they are staffed by units rather than by religious tradition and so function as inter- or multi-faith chaplains, meeting with people from a range of backgrounds similar to and different from their own. The exceptions are Catholic priests and imams in some settings (Cadge 2012).

The demographics of healthcare chaplains

Reliable data about healthcare chaplains as a workforce is limited. About 6,000 chaplains belong to the main professional chaplaincy organizations (the Association for Professional Chaplains, the National Association of Catholic Chaplains, and the Neshama: National Association of Jewish Chaplains). Many fewer belong to the Association of Muslim Chaplains (Laird and Abdul Majid, this volume). Recent analyses show that about half of chaplains are women, the mean age is fifty-seven and the majority (64 per cent) are white. The largest fraction of chaplains remains mainline Protestant (30 per cent) though the number of chaplains from other religious backgrounds has grown. Evangelical Protestants tend to be under-represented in healthcare chaplaincy, perhaps because they commonly drop out during training,
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which emphasizes the centrality of interfaith work. About half of the 6,000 work in hospitals, and the other half work in hospices, the Veterans Administration, faith community settings, and other organizations (White et al. 2020).

Those working as healthcare chaplains come to the work along multiple paths. Some are ordained as clergy while others, particularly Catholics, are laypeople. Some come directly to chaplaincy out of a sense of vocation or call, while others enter after other work inside and outside of religious organizations. In interviews with the directors of chaplaincy and spiritual care departments and staff chaplains across the country in the mid-2000s, Cadge found that most directors intended to become chaplains and a few staff chaplains did. Most staff chaplains worked first as congregational clergy, teachers, campus ministers, or in fields as diverse as banking and entertainment. They saw in chaplaincy an opportunity to be with people in crisis—minus the bureaucracy of congregational work—as well as ways to enact commitments to social justice, and/or do personally fulfilling work. Many came to religious work as a second career. The training, preparation, and certification of these chaplains was varied, with the exception of Catholic priests, who were ordained and typically had only limited additional training in chaplaincy (Cadge 2012).

While many people come to chaplaincy after completing a unit of CPE or otherwise being exposed to it, growing numbers of theological schools are starting degree programmes in chaplaincy or spiritual care. This is one of few areas of growth in theological education, which is otherwise struggling with declining enrolment (Tanner 2017). Among the 270 Association of Theological Schools’ (ATS) member schools, candidates, and affiliates, about seventy offer some type of specialized chaplaincy program. Over a dozen schools in the United States that offer accredited master’s degrees but are not affiliated with the ATS also have chaplaincy programmes including Jewish, Muslim, Buddhist, and interfaith institutions. In a study of twenty such programmes, colleagues and I identified five patterns in how they developed: a military chaplaincy pattern, a pastoral counselling pattern, a minority religion pattern, a CPE pattern, and an interfaith pattern. While a few started in the 1990s, most developed since 2000 and new programmes continue to appear (Cadge et al. 2020).

Growth of chaplaincy programmes in theological schools

In the development of such programmes, the pastoral counselling approach, for example, is most common in mainline Protestant schools with a robust tradition of pastoral theology, such as Brite Divinity School (Fort Worth, Texas) and Iliff School of Theology (Denver). It is also present at Nazarene Theological Seminary (Kansas City, Missouri), which is more evangelical in character. In this pattern, a chaplaincy programme develops under the guidance of a senior faculty member in the field of pastoral counselling or pastoral theology, often as a gradual shift in emphasis from counselling to chaplaincy.

The minority religious groups approach is more common in schools that serve students from religious groups with small but growing numbers in the US population and limited institutional presence. Islamic programmes like at Hartford Seminary (Hartford, Connecticut) and Bayan Claremont (Claremont, California), and Buddhist programmes like at Naropa University (Boulder, Colorado) and University of the West (Rosemead, California) fall into this group. What is unique about these programmes is that a primary reason they offer a master’s degree in the first place is to open up pathways into professional chaplaincy for their constituents. In Islam, for example, the role of the congregational leader or imam requires specific training and knowledge, but not the academic master’s degree that would qualify a clergyperson for service as a chaplain in, for example, the armed forces (Fawcett 2014;
Buddhism has highly developed monastic traditions and a system of passing down wisdom through teaching lineages, but not the kind of ordained or licenced leadership historically required to work in the military or federal prisons as a chaplain (Seager 1999). What effect these new programmes will have on the training and work of healthcare chaplains is an open question, as is how their graduates are being placed in chaplaincy positions in healthcare in comparison to those who complete theological degrees absent this chaplaincy emphasis (Cadge et al. 2019).

In addition to the growth of these programmes, some other indicators—like growing numbers of clergy working outside of congregations—suggest that interest in chaplaincy may be on the rise (Schleifer and Cadge 2019). More people are completing units of clinical education; between 2005 and 2015, the number of student units of ACPE completed increased by twenty-five per cent. There also may be more clergy working as chaplains because the number of jobs in congregations may be declining as the number of congregations decline. Some studies and media accounts describe clergy stitching together multiple part-time positions working as chaplains and for multiple congregations and/or in multiple occupations, including outside of religious organizations, to make ends meet (Chang 2004; Francis et al. 2013; Wheeler 2014; Vaters 2017; Perry and Schleifer 2019).

The work of chaplains: institutional contexts

As the training for healthcare chaplaincy develops, the work and profession itself shifts. Some observers have described healthcare chaplaincy as a ‘profession in process’ or one with various segments in transition (De Vries et al. 2008). As healthcare organizations have become more evidence-based and the American population becomes less religious overall, the work chaplains do and how they connect with the organizations within which they work has changed. These changes themselves also vary by institution and by chaplain. At some healthcare organizations, chaplains are a part of formal protocols attending to all situations when a patient’s heart stops (called a code), all deaths, and/or all trauma situations. At other institutions, the chaplains are more peripheral: available if needed, but rarely called as part of routine hospital business. Cadge describes three ideal types to describe organizational approaches to the work of chaplains in hospitals. In professional departments, chaplains are highly trained, a part of protocol, and integrated into healthcare teams and the hospital at large. Transitional departments aspire to be professional and are moving in that direction. And traditional departments have chaplains who, in their own words, ‘fly below the radar’ or work as ‘lone rangers.’ There are few to no situations in traditional institutions when chaplains are always called; departments rely more on volunteers than well-trained chaplains and chaplains are much less integrated across the hospital (Cadge 2012).

The orientation of departments is important because it organizationally shapes the work the chaplains (can) do and how they do it. Historically, chaplains were staffed by religious traditions and cared for people with whom they shared a religious background. Today, growing numbers of chaplains—especially in large healthcare organizations—are staffed by units, meaning the person in the medical intensive care unit or the paediatrics unit sees and is responsible for the care of everyone on the unit, regardless of how their personal spiritual and religious backgrounds compare to those of the patients, families, and staff. If a chaplain from a particular religious background is needed for ritual support, like a Catholic priest at the end of life, that person is paged after the chaplain who covers the unit provides an initial assessment. In professional departments, chaplains are considered part of healthcare teams rather than a separate service provided by the hospital. They sometimes make rounds with the healthcare
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Chaplains and spiritual caregivers team and can provide support institutionally across a range of issues. In traditional departments, this is less often the case.

Nurses are the healthcare professionals with whom chaplains work most consistently, as nurses are most frequently at the bedside. Despite growing attention to spirituality and religion in their training, however, many nurses as well as physicians and other healthcare providers are not immediately comfortable with these topics (Cadge 2012). In recent years, a few healthcare organizations have initiated ‘spiritual generalist trainings’ to help healthcare staff learn about spirituality and religion and know when to call a chaplain. The premise of this approach is that all members of the healthcare team can learn to screen for spiritual struggle and spiritual distress and integrate basic spiritual resources into care plans for patients (Robinson et al. 2016, 2007). Trainings, taught by chaplains, prepare non-chaplain members of healthcare teams to do basic ‘spiritual assessments,’ which begin to determine whether patients and family members are struggling with spiritual and existential questions (Fitchett 2017; Cadge and Bandini 2015). If so, participants are taught to call the chaplain who is the spiritual expert on the team. Beyond these trainings, additional research is needed about how chaplains can best work with healthcare teams and most effectively utilize their skills and their small numbers (in relation to other healthcare professionals).

Chaplains in the context of end of life issues

Chaplains work in a range of settings in healthcare organizations and are seen most consistently around end of life issues, particularly in palliative care and hospice settings (Cadge 2012; Berlinger 2008; Puchalski et al. 2009; Balboni et al. 2017; Ferrell et al. 2018). They help patients, family members, and staff talk about death, support people through end of life decisions, and accompany people as they die. They also, at some hospitals, work with the morgue and with funeral homes as corpses are moved and hold memorial services for individuals and institutions to honour those who have died. While medical professionals tend to see working around death as low status or ‘dirty’ work, chaplains often describe working with dying people as a privilege, part of their calling to the work, and the sacred in their midst (Cadge 2012). That said, according to a recent survey, less than half of US palliative care programmes had funded chaplaincy positions (Spetz et al. 2016). The work of chaplains around end of life issues is also very different in hospitals than in community hospices where they frequently do bereavement work as well.

Work of chaplains: interpersonal contexts

Most chaplains in healthcare work negotiate with their institutions and a range of people in them—custodial staff, paramedical staff, nurses, doctors, and so on—in the course of their daily work. In that work, chaplains support patients, families, and staff through conversation, formal and informal rituals, and connections to resources beyond the hospital. In interviews, chaplains in academic medical centres emphasize the importance of being present for people, supporting their healing beyond the biomedical, and helping people cultivate hope. They serve to remind people that healing is not only of the body and to help people put their experiences in broader contexts (Cadge 2012). Numerous studies describe what chaplains do in conversation, supportive decision-making, prayer, and religious and spiritual rituals (summarized in Fitchett 2017). In one recent study, Ellen Idler and colleagues used episode-based diaries to enable chaplains to record their work in a large urban hospital on handheld devices. Average visits lasted just over twenty minutes. Active listening was the most common activity in visits.
followed by being present, conducting a spiritual assessment, prayer, engagement around an advanced directive, and other activities. Existential questions were the most common topics of conversation followed by spiritual and religious concerns and family matters (Idler et al. 2015).

Several taxonomies, including one with 100 items developed by Kevin Massey, further help to specify what chaplains do and what effect their work has on patients, family members, and staff (Massey et al. 2015). Additional studies explore what patients want from chaplains and how they experience chaplains’ interventions. A comprehensive study conducted at the Mayo Clinic found that chaplains remind patients of ‘God’s care and presence,’ and that they provide support, accompany patients during times of anxiety and uncertainty, and/or provide counselling around moral and ethical issues. Seventy per cent of 1,500 respondents in this study wanted a chaplain to visit during their stay, with about a third requesting daily visits (Piderman et al. 2010). A large study at the University of Chicago found that about 40 per cent of inpatients wanted to talk about religion and spirituality during their stay, and only half had the opportunity to do so, suggesting that demand for the services of chaplains may be greater than their availability (Williams et al. 2011). This evidence of unmet demand for spiritual and religious care is also evident among oncology patients in several studies (Astrow et al. 2007; Balboni et al. 2012, 2013, 2007).

Ethnographic studies of chaplains provide a more fine-grained sense of the negotiations they engage in daily. In her anthropological study of the ‘ambivalent chaplain,’ Frances Norwood focuses on how healthcare chaplains move between discourses of religion, spirituality, and medicine. ‘The position of the modern-day hospital chaplain within a world of medicine is a difficult one,’ she argues, ‘that is situated between structural differences that revere medical forms of power, hierarchy, and practice over religious ones. The result is an ambivalent chaplain who must alternately embrace one or the other paradigm in order to survive’ (Norwood 2006: 4). At times, Norwood sees chaplains embracing their connection to medicine and de-emphasizing their religious connections, and at other times, she sees the opposite. Embracing takes place as chaplains listen to patients (what Norwood calls a special kind of witnessing), through touch, and as they support patients with issues that the medical system deems outside their purview. Distancing occurs as chaplains learn to speak the language of medicine (particularly with gatekeepers), to not lead with explicitly spiritual and religious questions, and to downplay the ways their approaches are different from other healthcare professionals. Norwood describes all of this as she watches chaplains in training try to adjust to the bureaucracy of modern hospitals, the medicalization of bodies, and the hierarchy and rigidity of the social organization of medicine. Ultimately, she argues, ‘the margins are active, dynamic, and contested ground where agents [chaplains] negotiate for power and for place’ in modern-day healthcare organizations (Norwood 2006: 24).

In addition to moving across institutional registers, chaplains negotiate a wide range of spiritual and religious differences in their daily work. In some cases, they neutralize religious differences by emphasizing commonalities, at times through the language of presence (Sullivan 2014). In other situations, chaplains code-switch, moving between different religious languages, symbols, and practices as they work with different people. This is most commonly evident in the form and content of prayers and in the way a single chaplain prays differently with different patients depending on each patient’s background and concerns. In a descriptive study of such interactions, Cadge and Sigalow show how neutralizing and code-switching are shaped by the ways chaplains are trained and the time they spend with patients and families in one-on-one conversation (Cadge and Sigalow 2013). Language around end of life situations, for example, may differ greatly between devout Christian families and that of patients
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and families who are agnostic or atheist. In the American setting, the ability to code-switch between these settings is becoming more and more a standard competency in the profession.

**Professional mandate and evidence-based spiritual care**

From the start, the basis or mandate for chaplains’ work and the sources of their authority in healthcare organizations have been questions for chaplains and for the people with whom they work. Like professionals in a range of industries, chaplains have long sought to articulate their professional mandate and advocate for their work (Kronus 1976; Freidson 1984; Abbott 1988). Some of the ways they articulated their professional mandates reflect approaches in other fields while others are new, such as adopting the language of healthcare (including the highly formalized process of obtaining standardized accreditation) and trying to prove their expertise using the methods of healthcare. In recent years, for example, the Association for Professional Chaplains had drawn on the language of ‘standards of practice’ from medical discourse to develop Standards of Practice for Professional Chaplains in Acute Care and other areas including hospice and palliative care. The APC also encouraged chaplains to submit ‘best practices’ to the national office, reflecting emphases on best practices among other healthcare professionals (Cadge 2019).

Empirical research has become more central to how chaplains make the case for their work. Some of this attention parallels growing research about religion as a social determinant of health (Idler 2014). Larry VandeCreek, a chaplain and research advocate, encouraged chaplaincy colleagues to pay more attention to the empirical research relevant to their work in the 1990s, writing that research was ‘becoming so relevant that chaplains who ignore [it] will increasingly be thought of by these professionals as uninformed. Continued neglect of these results will imply that the knowledge base of pastoral care is out of date and other professionals will begin to regard chaplains as incompetent. Thus, we must find ways to integrate the research results of others into their clinical practice’ (Cadge 2019). Evidence-based practice had become the norm in healthcare, requiring that if chaplains wanted to be taken seriously as healthcare professionals, they would need to engage with research and use it as an advocacy tool for the profession (Timmermans and Kolker 2004). Such research includes the development of spiritual screening tools to help non-chaplain healthcare professionals refer to chaplains those patients who would most benefit.

The current body of outcomes-based chaplaincy research is best described in *Evidence-Based Healthcare Chaplaincy: A Research Reader* (Fitchett et al. 2018). George Fitchett, a chaplain and epidemiologist, led much of this research and education. Chaplaincy training is now integrating outcomes-based research, with the APC requiring chaplains to have research literacy.

There are two reasons for this shift, Fitchett and colleagues argue. First, that ‘healthcare is in an evidence-based activity and unless chaplains working in healthcare can provide evidence for the benefits associated with their work, they will be marginalized’ (Handzo et al. 2014 cited in Fitchett et al. 2018). Second, and more importantly, chaplains need to know if the care they are providing is having effects, which, Fitchett argues, necessitates empirical research. Chaplains have not always valued having empirical evidence that their work is effective with some arguing that it undermines the soul of the work.

The most robust studies about the effects of chaplains’ work focus on patient and family satisfaction and coping, both generally and for patients with specific concerns. Studies suggest that patients who are visited by a chaplain while hospitalized are more satisfied with their experience in the hospital than those who are not (Marin et al. 2015; Johnson et al. 2014;
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VandeCreek 2004; Sharma et al. 2016). Patient satisfaction measures took on renewed importance in healthcare after the passage of the Patient Protection and Affordable Care Act in 2010 because of linkages between them and hospitals’ reimbursements. Additional studies focus on specific outcomes—like reduced anxiety and improved coping—for groups of patients receiving chaplaincy care (Iler et al. 2001: 281). Bay and colleagues, for example, worked with patients undergoing coronary artery bypass grafts, finding that those who received five visits from chaplains over a six-month period displayed more positive and fewer negative religious coping behaviours (Bay et al. 2008). Chaplains describe religious and spiritual struggle and coping as the ways in which people’s experiences with religion and spirituality shape their experiences, for example feeling abandoned or punished by God or supported by one’s faith community. A much smaller body of research considers the effects chaplains have on healthcare staff mostly through relationships and morale building (Fitchett 2017).

Healthcare chaplains in outpatient settings

A few studies have also begun to focus on the work of healthcare chaplains in outpatient settings, including in primary care. In the UK, a Community Chaplaincy Listening service was introduced by the Healthcare Chaplaincy Training and Development Unit of NHS Education for Scotland in 2010. Primary care providers viewed listening as central to quality healthcare and embedded chaplains in their clinics to listen. These ‘chaplain listeners’ met with patients as many times as needed to hear their stories. Sessions lasted fifty minutes and patients were free to discharge themselves from the service at any time without explanation. General practitioners and patients reported overwhelmingly positive experiences with this service. Managers saw it as a way to enable all patients to be heard and to enable physicians to focus on those who were most ill. The most common topics of conversation were bereavement, relationship issues, stress, and depression (Mowat et al. 2012; Bunniss et al. 2013). A similar study was conducted in Sandwell, an economically deprived urban area of England’s West Midlands, with similar results (Kevern and Hill 2015). While the aforementioned researchers did not survey providers, making chaplains available to staff may create further opportunities to influence staff morale and promote meaning making and to reduce staff burnout rates (Keogh et al. 2017; Shanafelt 2009; West et al. 2016).

It is not clear where chaplains get the authority to do their work in healthcare organizations. Some chaplains point to evidence of the effectiveness of their work, cite their credentials as spiritual or religious professional, and others refer to some combination of the two. This authority does not challenge other healthcare professionals’ work, as Andrew Abbott’s (1988) classic approach to the professions would suggest. Rather, chaplains uniquely name their work as those tasks that other healthcare professionals do not. They have built their professional mandate by reframing this labour as a companion profession, one that comes alongside others without seeking to challenge their jurisdiction (Cadge 2019).

Summary and looking forward

Healthcare chaplains, increasingly called ‘spiritual care providers,’ work in hospitals, hospice and palliative care settings, retirement and nursing homes, and even outpatient settings in the United States. With the exception of the Veterans Administration, few of these settings are mandated to hire chaplains though they are required to attend to patients’ spiritual and religious values, beliefs, and perspectives. As a group, healthcare chaplaincy has professionalized
over time, transitioning from local religious leaders to individuals trained through clinical pastoral education to board-certified chaplains by their colleagues in the profession. The people doing chaplaincy work have become more religiously-diverse, though mainline Protestants remain overrepresented (White et al. 2020). Most chaplains today serve people from a range of spiritual and religious backgrounds, including none, and this ability to move among people is central to their training.

Over time, chaplains have made different arguments about the authority with which they do their work and how they relate to the healthcare organizations. Increasingly, the profession is making empirical arguments for their work as an evidence base develops for healthcare chaplaincy and more chaplains are research-informed and research-literate. Chaplains are increasingly part of multidisciplinary teams, especially in large academic medical centres, and are more integrated into the care of patients. Although they remain at the bottom of many hierarchies in healthcare organizations, many chaplains use this marginal position to their advantage for the freedom it gives to move among different types of staff, patients, and families. This positioning leads chaplains to move along multiple axes as they shift among discourses of health, medicine, and various religious, spiritual, and existential registers.

Looking forward, chaplains will likely serve growing numbers of people with no background in institutional forms of religion as American religious demographics continue to trend in that direction. These and others find meaning in many places that chaplains may be called to support. A recent survey by the Pew Forum showed more Americans finding meaning in family, career, and money than in spiritual and religious traditions, which raises questions about how chaplaincy will adapt or, perhaps, decline (van Kessel et al. 2018). Chaplains will also likely serve more people in outpatient settings, which points to the need for clinical research as well as greater attention to the business case for chaplaincy as it informs patient outcomes, costs, and staffing models. Questions about how chaplains can best be trained—in theological as well as clinical settings—are also on the table with growing numbers of theological schools starting chaplaincy training programmes and declining jobs in congregational settings. We have hypothesized elsewhere that chaplains—in healthcare as well as the military, workplaces, prisons, and other settings—may become the theologically-educated people with whom Americans have the most contact as religious demographics, including membership and attendance rates, continue to shift (Cadge and Skaggs 2018).

As a case, healthcare chaplaincy raises questions about how religion and medicine are entangled within biomedical institutions. As people with non-biomedical sources of authority that have been integrated into healthcare systems in different ways over time, the work of chaplains and the way chaplaincy has changed shows shifts in these entanglements over time. Chaplaincy further illustrates the movement across discourses both individually and organizationally with people from a broad range of backgrounds. In the future, more intentionally cross-national research will expand these questions enabling the development of theory about how national policies, state positions, demographics, and other factors influence the supply and reception of healthcare chaplains. We hope this future research will also more fully take into account the diversity of chaplains, patients, and families to more fully understand questions of power and authority therein.

Note

Bibliography


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