Health Care Debate Begins with the Patient

I have been caring for people for quite a while – as a missionary in Pakistan and as a chaplain in New York,” says Sister Margaret Oettinger, OP, director of pastoral care at Hospital for Special Surgery.

“For each person I seek to help, I need to help them answer these questions: What are your spiritual needs? What are your spiritual resources? What are your hopes? How can I help you?”

This initial step with the patient pinpoints how the fields of chaplaincy care and palliative care intersect.

Most Americans would ask: what is palliative care?

And the Winner is… “Chaplaincy Care”

Professional chaplains have been debating for some time how best to describe the work they do. Is it “Pastoral care?” “Spiritual care?” Or something else?

The Association of Professional Chaplains has concluded that the answer is “chaplaincy care.”

Why? It's because neither “pastoral care” nor “spiritual care” fully convey the breadth of expertise that a board certified chaplain – who serves people of all faiths or none – brings to the professional health care team.

According to the association's president, The Rev. Sue Wintz, “The role of the professional chaplain has expanded beyond simply addressing religious needs to encompassing issues of patient or client and family communication, beliefs and values, cultural needs, education and quality. The APC board recognized that the historical words ‘pastoral’ and
A message from the Rev. Dr. Walter J. Smith, S.J., President & CEO

Two books written by University of California, San Francisco medical sociologists Barney G. Glaser and Anselm L. Strauss had a formative impact on my intellectual and professional development: Awareness of Dying (1965) and Time for Dying (1968). Applying the methodologies of what they later termed “grounded theory,” Glaser & Strauss began to study the unstudied. They observed the way people with serious, progressive illness and their families interact with each other over what can be a long and stressful period of time. They observed that people seem to die on their own discrete timetables, often on trajectories quite different from those that their loved ones or physicians might predict.

Glaser & Strauss's original theories and work influenced my own doctoral research in the 1970s and have continued to stimulate my thinking some forty years later. Their research has helped me to understand the wisdom of the old adage that “timing is everything.” We tend to organize our life and work in real time, and much of it is dependent on the timing of other people and things. Sometimes projects develop as planned; more often, there are twists and turns along the way. How we recalibrate and manage amid these “course changes” frequently influences outcomes and makes us quintessentially the people we are.

How often have we heard folks speak about their lives in terms of timing and the serendipitous coming together of a host of other factors? We talk about “being in the right place, with the right people, and at the right time.”

This brings me to the heart of what I wish to share with you as I reflect on the ways the social worlds of professional chaplaincy and palliative care are coming together at this critically important moment in our country’s history. The timing of this national debate on health care reform has brought together two groups who have knowledge and practical experience about the issues, because they spend every day on the front lines providing direct care to patients and families. I believe that palliative care and chaplaincy can provide informed answers to the foundational questions about how to provide access, maintain affordability, and insure quality for patients and their loved ones.

Our loyal readers and supporters already have some understanding about what professional health care chaplains do. Caring for sick, disabled, aging or dying people has always...

A Chaplain’s Healing Story

At about 6 pm, my cell phone rang just before I was preparing to leave work at the hospital. It was my mother. Her speech was solemn and direct. “Please call your friend Shirley right away.” I knew that Shirley's dog Dusty, a constant companion of eleven years, had been suffering from cancer.

When I phoned Shirley, she was at the animal hospital. Between her sobbing, she told me that Dusty’s kidneys were failing and that she and the vet had agreed that it was time to euthanize Dusty. She asked if I could be there with her during his final moments of life.

I had spent the day ministering to patients and their families; now my friend was asking for pastoral support as she faced a difficult transition with a beloved pet. I realized that Shirley and the staff at the veterinary hospital needed my support. Dogs don’t need chaplains. People do.

I joined Shirley, the medical staff and a few friends in a private room at the veterinary hospital. We all gathered around Dusty, holding hands and joined in a contemplative moment of silent prayer as the veterinarian administered the injection. I read a short...
been the special privilege of people of every faith tradition. Judaism encourages its followers to take care of those in need, to be a mensch—a decent human being who goes out of his or her way to assist another. Moved by well-established Islamic principles of compassion and caring for the welfare of their neighbors (zakat), Muslims use their human and material resources to make the world a better place for people who are facing hardships through illness and poverty. And Christians, acknowledging that they are children of God, also recognize that they are sisters and brothers who freely accept an obligation to care for each other.

Not motivated by any particular religious faith, palliative care, nonetheless, accepts these same human obligations. The World Health Organization (2002) defined palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” Our Mt. Sinai colleague, Dr. Diane Meier, speaks of the primary goal of palliative care even more succinctly: “matching treatments to informed patient and family preferences and goals.”

Our national mandate to provide quality care for all Americans has brought leaders in professional chaplaincy and palliative care into a natural convergence because the issue that matters most—insuring access to humane, competent and affordable health care—touches on areas where we and our palliative care colleagues have theoretical and empirical knowledge rooted in significant clinical experience. In naturally synergistic ways, chaplaincy and palliative care share a common social world in which we exercise a visionary vocation and mission to care for individuals and families.

In the months and years ahead, you can expect to see HealthCare Chaplaincy assuming increased leadership with its colleagues in the field of palliative medicine as we add our own humble and informed voice to public policy conversation on how best to care compassionately for our sisters and brothers in their times of need.

We happen to be in the right place, at the right time, and with exactly the right people. ◆

The Rev. Dr. Walter J. Smith, S.J.
President & CEO

Providing Chaplaincy Care in an Unexpected Place

passage of scripture and spoke about the unconditional love of God. We laughed and cried as we celebrated the gift that Dusty had been to Shirley.

The doctor thanked me profusely for coming and lending support in what had been a difficult moment for him and his staff.

That night, Shirley phoned me. With grateful tears she said, “Thank you. Thank you. I told everyone that Dusty was special. I don’t know of anyone else whose dog had a chaplain assisting his loved ones during the final moments of his life.” ◆

Shirley’s dog Dusty.
‘spiritual’ didn’t fully reflect the role that the chaplain has on the multidisciplinary team.”

The limitation of the term “pastoral care” is that it only describes the direct care of patients, loved ones and staff, which is only part of what a professional chaplain does.

“Spiritual care” refers to “interventions, individual or communal, that facilitate the ability to express the integration of the body, mind and spirit to achieve wholeness, health and a sense of connection to self, others and/or a higher power.” “Spiritual care,” like “pastoral care” is only part of what a chaplain does.

The Rev. Dr. Martha Jacobs, a member of the association’s board and managing editor of HealthCare Chaplaincy’s e-newsletter PlainViews® for chaplains and other spiritual care providers says, “Spiritual care is done by all members of the health care team. If you look at all the articles that have come out in recent years about spirituality, many are written by doctors, nurses and social workers. So we needed a name that describes what we do uniquely.”

Sue Wintz sums up the Association of Professional Chaplains’ position: “As chaplaincy has become more professional in both its qualifications and contributions, the board chose to adopt the words ‘chaplaincy care’ to reflect the actual daily work that the chaplain does. This shift in language provides greater opportunities for chaplains and their professional care to be fully utilized by the organizations that employ them.”

“‘Chaplaincy care’ speaks to the wider function of the chaplain in health care,” agrees the Rev. Jon Overvold, also an association board member and director of pastoral care and education at North Shore University Hospital for HealthCare Chaplaincy. “We realized there were limitations to the words ‘pastoral care’ and ‘spiritual care,’ and the term ‘chaplaincy care’ is what we think best describes what we do. Chaplains have a larger role in institutions that serve the community as a whole.”

HealthCare Chaplaincy as well has adopted “chaplaincy care” to describe our work, but we recognize that since the terms “pastoral care” and “spiritual care” are better known, we will not yet jettison them completely.

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John S. Dyson, Government and Business Leader, Joins Board of Trustees

At its February 23rd winter meeting, HealthCare Chaplaincy’s board elected John S. Dyson to trusteeship, effective immediately.

Mr. Dyson is chairman of Millbrook Capital Management Inc., an investment firm that manages approximately $500 million in total assets. He also is chairman and chief executive officer of Pebble Ridge Vineyards & Wine Estates, which owns and manages three wineries and five vineyards located in California’s Sonoma Valley, New York’s Hudson Valley, and the Tuscan hills in Italy.

Formerly, John Dyson was chairman of New York City’s Council of Economic Advisors, deputy mayor for economic development and finance in the Giuliani administration, chairman of the New York Power Authority in the Carey and Cuomo administrations, and New York State commissioner of commerce and also of agriculture in the Carey administration.

He is a trustee emeritus of Cornell University and the Middlesex School in Concord, Massachusetts, and former chairman of the board of Historic Hudson Valley in New York.

“I firmly believe in HealthCare Chaplaincy’s mission,” says Mr. Dyson, “and I will dedicate my time and energies as trustee to help the Chaplaincy realize its critically important commitment to create a visionary new model of residential end-of-life care. I believe the Chaplaincy will continue to play an increasingly important leadership role in health care reform, and its iconic project will serve as a national health care demonstration model for the integration of palliative care and chaplaincy care.”
Palliative care relieves the pain, symptoms, and suffering of serious illness at any age to improve quality of life.

Diane. E. Meier, MD, director of the Center to Advance Palliative Care, defines palliative care as “matching treatment to informed patient and family goals.”

“Palliative care is the integration of quality care for the whole person... spirit, mind, body,” explains the Rev. Dr. Walter J. Smith, S.J., HealthCare Chaplaincy president and CEO. “It’s a team approach to care where physicians, nurses, chaplains, and social workers all work together for the common purpose of developing a comprehensive plan of care for this individual and for that person’s loved ones.”

Father Smith points out that “the health care debate, however it ultimately plays out, has disposed an unparalleled opportunity for palliative care. Popular attention is now focused on the need to achieve a high-performance health care system. Quality definitely is a very big concern for health care reform; cost effectiveness is also a key issue. Palliative care offers both.”

Palliative care is a growing trend in the United States: 1,455 hospitals report having a program, a 130% increase from the year 2000.

Unfortunately many people think palliative care is limited to end of life care and is synonymous with hospice care.

That is false, asserts the American Academy of Hospice and Palliative Medicine: “Palliative care is whole-person care that relieves symptoms of a disease or disorder whether or not it can be cured. You can receive palliative care at any stage of a serious illness, whether that illness is potentially curable, chronic or life-threatening. Hospice is a specific type of palliative care for people who likely have six months or less to live. In other words, hospice care is always palliative, but not all palliative care is hospice care.”

In an important development, a 2009 consensus conference of more than 50 physicians, nurses, professional chaplains, social workers, professors, and university level researchers sponsored by the Archstone Foundation concluded that spirituality plays a crucial role in palliative care, and that a board certified professional chaplain should be the spiritual care professional on the palliative care team.

The Rev. George Handzo, HealthCare Chaplaincy’s vice president, Pastoral Care Leadership & Practice, describes the chaplain’s role: “It is not to reduce cost or to impose a choice. Instead the chaplain helps the patient and family understand their care options and helps them match up those options with the patient’s values and beliefs. Many patients don’t know the options available to them.”

R. Sean Morrison, MD, president-elect of the American Academy of Hospice and Palliative Medicine and director of the National Palliative Care Research Center, is concerned that since “palliative care is linked to ‘end-of-life’ care in the minds of the public, professionals, and policy makers, this is a major barrier to ensuring access to high quality medical care for persons with serious and advanced illness.”

Dr. Morrison urges “a public/private social marketing campaign to rebrand palliative care, increase public demand, and promote effective bi-partisan legislation.”

HealthCare Chaplaincy has joined with Doctors Meier and Morrison and other palliative care proponents to begin to spread the message. Father Smith was a panelist at the recent conference on palliative care hosted by the New York City Health & Hospitals Corporation and participated with four physicians in a recent national roundtable discussion “Palliative Medicine: Politics and Policy” published in the Journal of Palliative Medicine. Further, a recent edition of the public television program The Open Mind focused on palliative care with a half hour interview with Father Smith.

In early March the Rev. George Handzo co-presented a workshop at the Annual Assembly of American Academy of Hospice and Palliative Medicine in Boston, entitled “Improving Spiritual Care as a Domain of Palliative Care.”

Future issues of The Beacon will tell you more about HealthCare Chaplaincy’s ongoing work as a thought leader for accessible, affordable, and quality palliative care.

That’s because palliative care, just like chaplaincy care, begins with the patient.

Sr. Margaret Oettinger, OP, is a board certified chaplain and a member of the Dominican Sisters of Sparkhill. Originally a New York City elementary school teacher, she spent eight years as a teacher and hospital chaplain in Pakistan. Sr. Margaret is a graduate of HealthCare Chaplaincy’s clinical pastoral education program at NYU Langone Medical Center. Since 1990 she has been the Director of Pastoral Care at Hospital for Special Surgery, steadily building a vibrant and integrated chaplaincy care service.
Chronic problems require structural change,” insisted the famous management consultant W. Edwards Deming. “Our health care system is full of chronic problems,” says Kevin Dahill, former president and CEO of New York United Hospital and now president and CEO of the Nassau-Suffolk Hospital Council. He has also been chairman for the National Conference of Metropolitan Hospital Associations.

Mr. Dahill asserts, “The reform of the health care system must begin with a change of the delivery system. Hospitals must tell the government how it must work before somebody goes bankrupt. We must change the business model and must pursue an evidence-based medicine agenda.”

He spoke at HealthCare Chaplaincy’s January grand rounds session for staff.

Dr. David Sackett, Professor Emeritus, Clinical Epidemiology & Biostatistics at McMaster University in Ontario and an authority on evidence-based medicine describes it as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

As with palliative care, evidence-based medicine starts with the patient.

According to a tutorial developed by the Duke University Medical Center Library and the University of North Carolina at Chapel Hill Health Science Library: “Evidence-based medicine is the integration of clinical expertise, patient values, and the best evidence into the decision-making process for patient care.”

“I said to other hospital CEO’s that we must find a way to do more with less. Today we need to do less. Hospitals are not going to get paid more.”

Mr. Dahill says that while hospitals do a good job of tracking performance through data, many hospitals and physicians tend not to ask in advance if it’s a good idea to perform that procedure. They are hospital-centered, not patient-centered. The reason lies with the current business model of fee-for-service medicine. “The more we do, the more we get paid. There’s no incentive not to do so. Doctors and hospitals are not bad people. They’re caught up in the system,” explained Mr. Dahill.

He urges moving to a patient-centered business model where the government or insurance company pays a bundled payment to a single entity which coordinates care and pays for service to each provider. One example would be where a patient is served by the hospital, physicians, rehabilitation facility, and then home care. “In today’s model,” he says, “if home care doesn’t serve the patient well, the hospital gets the patient back, and the hospital gets paid again. That needs to change. We must increase integration and lower the walls of the silos that exist today.”

He is not alone in his recommendation; many other experts in the health care policy debate agree.

Mr. Dahill predicts that the American health care system will over the next ten years move to a more integrated system where payment is bundled and evidence-based medicine establishes the standards for better patient-centered care.

In this transformation what is the place of board certified chaplains? Chaplains will continue to be a vitally important component, says Mr. Dahill, through their unique role serving patients, families, and medical staff. 

To support HealthCare Chaplaincy online; to arrange “In honor of” and “In memory of” gifts; and for information about other types of support, please visit our Website: www.healthcarechaplaincy.org. For personal assistance, please contact Miel Medley at 212.644.1111, ext. 132, or at mmedley@healthcarechaplaincy.org. Advancement Office: 315 East 62nd Street; New York, NY 10065; 212.644.1111, ext. 132.
The National Association of Jewish Chaplains has elected Rabbi Daniel Coleman to its Board of Directors and Rabbi Bonita Taylor to the position of vice president. Of the NAJC’s eight member Executive Board, half are HealthCare Chaplaincy alumni: Rabbi Bonita Taylor, Rabbi Naomi Kalish, Rabbi Lowell Kronick and Rabbi Ephraim Karp.

Dr. Sarah L. Weinberger-Littman recently presented a portion of her research on the role of religious orientation in the development of disordered eating, at the Renfrew Center Foundation Annual Conference on the prevention and treatment of eating disorders. Prominent researchers and clinicians in the field have begun to recognize that for many women, at the core of their eating disorder lies a spiritual dimension or void that needs to be addressed.

Life Trustee Edee Bjomson conceived and led the creation of the video oral history now online at healthcarechaplaincy.org.

PlainViews® Begins its Seventh Year of Serving the Chaplaincy Profession

="It is hard to believe that we are beginning our seventh year of e-publishing PlainViews,” reflects the Rev. Dr. Martha R. Jacobs, Managing Editor.

Since its founding in 2004, PlainViews has published over 700 articles and 81 book reviews.

“From the responses that I receive to PlainViews from around the world,” continues Dr. Jacobs, “it has been clear that we have brought the world of pastoral care to a new level of awareness of how and where professional chaplaincy is provided. It has also brought chaplains who work by themselves a sense of community: PlainViews has helped them to feel like they are part of something greater.”

“In establishing PlainViews,” explains the Rev. Dr. Walter J. Smith, S.J., “HealthCare Chaplaincy recognized a need to provide the profession of chaplaincy with an accessible and reliable forum through which it might discover its voice and regularly share its experience. Through more than 150 issues during the past six years, chaplains and students have authored 99% of the articles that have been published. For chaplains. By chaplains.”

Among the members of the Advisory Board who reflected on PlainViews’ last six years, Chaplain Rozann Shakleton notes: “PlainViews is a trendsetter with respect to electronic delivery. It has provided a vehicle for cross pollination between the North American chaplaincy associations and over the years has become international in scope. I see this interconnection as vital to furthering the profession of chaplaincy.”

“For all the creative work that has gone into PlainViews, we pause and give grateful thanks,” adds Father Smith.
Healthcare Chaplaincy is a national leader in the research, education, and practice of multifaith patient-centered care. It helps people find meaning and comfort—regardless of religion or beliefs—in stressful health care situations. For nearly 50 years it has collaborated with major academic medical centers and other professional organizations to integrate spiritual care within health care. It is a thought leader for accessible, affordable, and quality palliative care.

View Fr. Smith on Public TV

Through the video now on our website homepage healthcarechaplaincy.org, you can view the Rev. Dr. Walter J. Smith, S.J., speaking with host Professor Richard D. Heffner, on *The Open Mind*, public television’s longest-running interview program.

Topics include the national health care policy debate, the role of professional multifaith chaplaincy in palliative care, defining spirituality, the culture of dying in America, and plans for HealthCare Chaplaincy’s enhanced assisted living residence.

Save the Date

Come join us for our annual Commissioning of Chaplains as we celebrate the inherent value and purpose of professional chaplaincy and the religious diversity of our staff.

**Monday, May 10, 2010**

5:30 pm  Reception

6:30 pm  Ceremony

Christ Church United Methodist
Park Avenue at 60th Street, New York City