PATIENT-LED PASTORAL CARE:
A Model of Practice of Interfaith Chaplaincy in Hospital Settings

Chaplain John Ehman, Penn Presbyterian Medical Center (john.ehman@pennmedicine.upenn.edu), 12/2/19

"Follow the lead of the patient" has been a mantra in interfaith healthcare chaplaincy since the modern development of the field, over the past half-century. Patient-Led Pastoral Care is a disciplined art of accompanying and supporting -- with relational skill -- people in health crises as they make meaning and cope with their existential reality. It revolves around all that underlies and rests upon what is sacred for individuals, and its aim is to help others feel *cared for*. Chaplains help patients while they think and feel their own best way ahead through illness or injury, offering opportunity for them to bring together the cognitive and emotional parts of the experience. Chaplains hear people into voice, see them in ways that allow them to see themselves more deeply and more hopefully, and personally hold out the potential for greater connection and aliveness.

The model underscores the importance of patients' leading in the pastoral interaction, but Patient-Led Pastoral Care does not *require* patients to take the lead. The intent is to *maximize* the prospect for patients, with chaplains following and encouraging patients' own processes. The model applies not only to "patients" per se, but to anyone to whom chaplains offer pastoral care.

FOLLOW THE LEAD OF THE ONE IN NEED

Patient-Led Pastoral Care aligns with the principle of patient autonomy that is basic to the health care context. It builds upon patients' capacities to find their way toward healing, drawing upon their values, beliefs, worldviews, and spiritual/religious traditions. It accommodates the diversity of people who come for medical treatment to an institution not for religious purposes. And, it recognizes that interfaith chaplains work from outside of patients' own religious authority structures. The very fact that someone has been hospitalized suggests that they are contending with a level of disempowerment, so the model of Patient-Led Pastoral Care seeks to *empower* patients through an experience of pastoral caring.

THE DISCIPLINED ART OF HELPING PATIENTS TAKE A CONSTRUCTIVE LEAD

Chaplains almost always bring some momentum of leading into a patient encounter, if only by means of having walked into another's space. Much of the disciplined art of pastoral care is grounded in the ways that we return others' "space" to them and effectively enhance it with a caring presence. To this end, we seek to be non-anxious, to be personally open and responsive, and to give time for patients' initiative to emerge out of a sense of safety. To do this, we must be self-aware of our own needs -- like a desire to control, to problem-solve, or to be expedient during a busy day -- that incline us to take the lead ourselves. And, we must be sensitive to patients' general feelings of vulnerability and their reasonable caution in exposing closely held knowledge about themselves to relative strangers.

Monitoring how much we are taking the lead in an interaction at any one point is a way to check against our confounding patients' own processes of discovery and coping [--see Appendix 1]. By the same token, monitoring how much patients are *able* to take the lead and considering what factors may be aiding or hindering their processes, is a way for us to adjust to patients in real time. If patients are having difficulty taking the lead, how can we maximize opportunity for them presently and keep open opportunities for the near future? If for some reason patients are taking the lead in a manner that does not seem constructive (for example: they seem to be merely feeding a self-destructive fixation, or are attempting to triangulate a chaplain in a conflict with other staff), then how might we increase our lead carefully and intentionally? Even then, we would do so only to a level necessary for the immediate circumstance, in order to avoid wresting the overall lead away from those with whom we journey.

PRESERVING THE PATIENT-LED PASTORAL RELATIONSHIP

Since pastoral encounters usually begin quite practically by a chaplain's initiative, any additional instances of chaplains taking a strong lead risk establishing a *pattern* of leading that can be hard to overcome. Once chaplains are perceived as leaders in conversation, patients may come to think of themselves as in a *chaplain's* "space," with only the chance to lead themselves at a chaplain's discretion. Therefore, it is crucial to try consistently and proactively to preserve the patient-led quality of exchanges, for the sake of subsequent encounters with the same or a different chaplain. The autonomy that patients may feel in taking the lead can all too quickly and easily be diminished and narrowed. Even if patients want the chaplain to take the lead, such deference may limit the range of further chaplaincy interaction through the Patient-Led model.

<u>WE ARE PASTORAL CARE. CARE IS OUR NOUN.</u>

Care is our noun; care is the foundation of our name. *Pastoral* is our adjective, qualifying that our care revolves around what is spiritual or sacred to patients. For the relatively brief periods that patients come through acute care hospitals, their experience of any chaplain should be one of having what is spiritual or sacred to them heard and acknowledged. Patient-Led Pastoral Care provides the interactional "space" for patients to allow us to know what they wish would be heard, what thoughts or feelings in the moment they need appreciated. Meeting patients "where they are" and responding with reverence to what is most vital to them is a powerful and empowering form of caring. It is our professional intervention. For many religious patients, this caring experience with chaplains is an affirmation of who they are as children of a loving God; and for those who do not identify as religious or spiritual, it can be an eye-to-eye, heart-to-heart connection that is significantly helpful in the midst of challenging days. We are pastoral caregivers -- distinct from an identity of "caring pastors," even though some chaplains have that role outside of the hospital -- and our aim for every encounter should be to leave others feeling *cared for* in light of what is important and sacred to them.

<u>DIFFERENCES FROM CONGREGATIONAL CLERGY AND FROM SPIRITUAL COUNSELORS</u>

Many patients think of interfaith chaplains in terms of models of congregational clergy or of some form of spiritual counselors. Chaplains have limited chance to convey what we do without inadvertently driving the interaction by presenting a large amount of information, though the opening minute or so of a visit does give some window to describe our role before we begin turning the initiative over to the patient. Patient-Led Pastoral Care may benefit from some basic informational orientation being offered to a patient about interfaith chaplaincy, but it is a model that is largely clarified through patients' very experience of chaplains. We are present with patients and respond to them in a way that is experientially different from that of congregational clergy or spiritual counselors.

CONGREGATIONAL CLERGY work from a place of authority within religious traditions. If a patient says to a visiting congregational clergy person, "I don't know if I can ever forgive him for hurting me," then the clergy person might offer authoritative instruction out of their common religion, including reference to scripture, and could plausibly say something like, "Scripture guides us to forgive others and to remember that we are the recipients of forgiveness." Another example: a patient says, "I've been a good person, so why is God doing this to me, when so many bad people never have anything happen to them?" In response, a congregational clergy person might talk about theological teachings behind the question of theodicy or offer an inspirational word out of the religious tradition, to lift the patient's spirits based largely upon the clergy person's religious authority. Such responses would be appropriate for the role of congregational clergy, however, they would be quite leading and dependent upon a patient's respect for the religion-specific authority of the clergy person.

A COUNSELOR would work within a contracted and often extended relationship, and with specific counseling methodology, credentialing, and accountability. In response to a patient's expression of "I don't know if I can ever forgive him for hurting me," a counselor might direct the interaction according to an agreed upon counseling model, perhaps suggesting something like, "Let's focus on forgiveness," or maybe noting, "Research shows that forgiving others can actually be a relief to ourselves." And, in response to a patient's question of "Why is God doing this to me?" a counselor might answer back, "Why do you think this is the will of God?" Such responses again would tend to be leading, with even very patient-centered approaches operating from the authority based in the formal counseling context.

On the other hand, an INTERFAITH CHAPLAIN would tend to respond in a way that gives the lead to a patient, seeking to allow the opening up of the patient's thoughts and feelings in the immediacy of a pastoral interaction. To the statement of "I don't know if I can ever forgive him for hurting me," a chaplain might say, "You're hurting and have been thinking about forgiveness." To the statement of "I've been a good person, so why is God doing this to me, when so many bad people never have anything happen to them?" a chaplain would move to encourage the patient to further engage their sense of the question with something like, "It doesn't feel right." That would hopefully facilitate the patient's own exploration, with the help of a caring hearer. We sometimes call this "hearing the other into voice" or "hearing the other into hearing themselves." Once a patient has an experience of the role of a chaplain as being that of following the patient's lead, additional clarification of the role may not be necessary. If it does turn out to be called for, then questions like "What does a chaplain do?" can be handled as a *response*, in a manner that allows the patient to effectively stay in the lead.

STANDING IN FOR CONGREGATIONAL/COMMUNITY CLERGY AT SPECIFIC TIMES

Chaplains are often asked to stand in the place of congregational clergy usually for the purpose of basic prayer and rituals, for which we bring a knowledge of appropriate action for a variety of spiritual/religious traditions and interfaith contexts. In practice, this is seldom problematic because patients or families self-select in making such requests according to traditions open to interfaith interaction, and chaplains can otherwise help facilitate contact with patients' own clergy. However, in cases where chaplains are asked to take a lead in a fashion of congregational clergy, care must be exercised to ensure that any action does not exceed the immediate need for a stand-in, so as not to cause confusion about the role of an interfaith chaplain. Corporate prayer is necessarily a highly leading act, as the person offering the prayer is in the position of speaking for the others present. Rituals like baptisms or marriages assume some special authority of those officiating. Presenting liturgical or scriptural readings can easily move into the realm of instruction and authoritative interpretation. Time-sensitive requests warrant chaplains' action, but whenever feasible we steer patients and families toward their own religious authorities for needs best met in an ongoing relationship that transcends hospitalization and may continue afterward.

Sometimes a chaplain is of the same religious tradition as a patient and may be able to meet tradition-specific needs as a result of that happenstance, but the lengths to which one might go must be weighed against how working out of a tradition-specific authority can compromise the flexibility of a chaplain in providing Patient-Led Pastoral Care after the fact. If a patient is personally connected to a chaplain through an outside congregational or another relationship, then the chaplain involved should ideally bring into the case an additional chaplain who is unconnected, so that the patient can receive the same scope of service of interfaith chaplaincy offered to other patients. Then a patient could have access both to someone inside and to someone outside of their network. One of the advantages to patients of working with an unconnected chaplain is the relative freedom of sharing with someone beyond one's regular social circle. In this regard, a chaplain can be a most "welcome stranger."[1]

PATIENT-LED PASTORAL CARE AS A FULL MODEL FOR THE PATIENT ENCOUNTER

Patient-Led Pastoral Care should set the tone for the entirety of a patient encounter. It is not simply a strategy for drawing out a patient's story as a prelude to giving instruction. It *is* our intervention; it is our caring service to patients and families. It operates through such skills as empathic listening and accompaniment, Reverent Acknowledgement [--see Appendix 2] of what is important and sacred, sensitivity to diversity and inclusion dynamics, and the encouragement of patients' *strengths* for spiritual coping. The model aims to ensure consistency of service across chaplaincy staff, supportive of the multidisciplinary

[1] A chaplain in the acute care setting is often a "welcome stranger," disconnected from patients' lives outside of the hospital. As such, chaplains may offer patients a rare chance to share their thoughts and feelings outside of any perceived *constraints* of their social networks. While there might be some awkwardness in talking about private issues with a "stranger," patients can also feel an exceptional sense of freedom and safety in knowing that the chaplain is otherwise unconnected and may never be seen again, and that whatever confidential knowledge the chaplain holds will be separated in a very practical way from the patient's family and friends. It is not unusual for chaplains to hear: "No one else knows this," or "I've never told anyone this before."

team, and provides patients with experiences of care in being heard and helped along in their own spiritual journeys of healing. Chaplains' skills are expressed through individual personality and style, but patients should receive the same general approach of care no matter which staff chaplain visits.

A TYPICAL COURSE FOR PATIENT-LED PASTORAL CARE

1) The chaplain makes an introduction as a member of the care team and presents in a manner that is relationally caring.
2) The chaplain provides a non-anxious presence and works to create an inviting and safe space for the patient to begin taking the lead.
3) The chaplain shows a consistent interest in what the patient offers and acts to *maintain* the space for the patient's own process, maximizing the patient's opportunity for meaning-making, coping, and relating.
4) The chaplain may be tested by the patient (for example: by burying an important point in other material, saying everything is fine but doing so with emotional cues, speaking unusually softly or loudly, or using shocking language) and should demonstrate by "low-leading" responses [--see Appendix 1] that the patient is being heard carefully and respectfully in the sense of burdens and strengths.
5) The chaplain follows the lead of the patient and uses methods like Reverent Acknowledgment [--see Appendix 2] to respond to emotional content as well as to the narrative of the patient's story.
6) The chaplain attends to any specific requests by the patient in ways that affirm the Patient-Led model. Sometimes patients interrupt their sharing to ask for advice, perhaps because they are used to clergy being more directive. In such instances, the chaplain would lean toward encouraging the continuation of the patient's constructive coping process by reflecting back elements of what the patient has said, or the chaplain would affirm by other means the value of the patient's lead. The chaplain would typically refer to a patient's own congregational clergy or ongoing spiritual support and resources for specific advice.
7) The chaplain may offer to hallow what is important and sacred to the patient in prayer or a time of shared silence, being mindful of the intricacies of leading during prayer.

WHAT ARE THE RISKS WHEN THE CHAPLAIN TAKES THE LEAD?

In addition to the risk of role confusion and that of confounding the chaplain-patient relationship for subsequent encounters by the same or a different chaplain, the potential consequences of chaplains taking the lead include:

- We may never know what the patient needed heard --how the patient needed to feel cared for.
- By providing an "external" answer to a patient's concerns, we can undercut the patient's investment in a course of action. Patient buy-in is usually strongest in the long run when a solution emerges organically from the person's problem-solving.
- By speaking from a place of authority, we may ultimately have the effect of disempowering patients, essentially asking them to submit to our direction.
- We arrogate to ourselves authority across lines of religious/cultural diversity.
- Given our limited exposure to -- and understanding of -- a patient, we risk providing guidance that does not take into account all relevant factors, including the subtle pressures of their unique context.
- We may implicitly or explicitly offer guidance in tension with a patient's tradition, authorities, and community, potentially perforating their needed support structure in a time of personal crisis.
- We risk setting ourselves up as alternate authorities for the patient and cultivating a dependence upon us that we cannot support, since our relationship will be disrupted at the time of hospital discharge.
- Leading the patient may provoke a reaction of resistance that could add to the burden of the patient and extend beyond the capacity of the chaplain to manage. The higher the degree of leading [--see Appendix 2], the greater the risk of resistance.

—Acknowledgement: This document was developed with critical input from Chaplain Ralph Ciampa and Chaplain Suzanne Roose

APPENDIX 1

EXAMPLES OF LEVELS OF LEADING IN CHAPLAINCY INTERACTIONS *

One way of looking at a pastoral visit with a patient is with an eye to how much the chaplain may be leading or directing the course of the interaction. The more directive the chaplain, the less likely the conversation will be driven by a patient's expression of personal needs as well as the greater the risk of triggering a patient's resistance, which would then be a new issue requiring attention.

Least Leading

1. Attentive silence
2. A nod or “m-hum" (--simple indication of understanding)
3. Patient: "So this is all new to me, because I've never had surgery before"; chaplain: "This is all new to you" (--brief restatement or parroting of the patient's exact own words, implicitly affirming having heard the patient, but with some care not to selectively overemphasize a theme)
4. Chaplain: "I didn’t hear you clearly, did you say 'the nurse'?"; patient: "I said 'the worst'" (--simple clarification of a particular word or phrase that the patient has used)
5. "I hear you saying that this experience of surgery is all new to you" (--basic clarification of a theme the patient appears to have stated, confirming the patient's line of thought with minimal interpretation)
6. "You are frightened" (--Reverent Acknowledgement of the patient's sharing with special attention to emotional content) [--*see Appendix 1 regarding Reverent Acknowledgement*]

Moderately Leading

7. "The hospital can be a strange-feeling place" (--simple normalization of a feeling or experience without appeal to some special insider knowledge or expertise by the chaplain)
8. "Yes, I agree." (--explicit approval of something that has been said)
9. "You seem to be very good at problem-solving" (--affirmation of expressed capacity/strengths)
10. "You’ve always been healthy and very independent, able to solve any problem that has come your way, but now you suddenly find yourself in the hospital with a lot beyond your control" (--summary recounting of major points and themes of what has been expressed)

Strongly Leading

11. "This sudden injury has made the world seem very unpredictable and scary, and that does bring up questions about God's providence" (--analysis/interpretation of what's been expressed)
12. "Have you thought about...?"† *or* "It might be helpful to…” (--suggesting/advising a course of action)
13. "Things will work out" (--reassurance against worries)
14. "No, you are not worthless; you are a child of God!" (--explicit rejection/contradiction of expressed ideas or feelings, even in the service of affirmation)
15. Changing the subject

---

* John Ehman, 12/2/19, based in part upon lectures by Allan W. Reed, ACPE Supervisor, St. Luke's Hospital, New York, NY

† Any question, even one intended to be inviting, may be experienced as significantly leading.

APPENDIX 2

REVERENT ACKNOWLEDGEMENT: A DISCIPLINE OF PASTORAL CONVERSATION

Chaplain Ralph C. Ciampa, ACPE Educator (retired)
Director of Pastoral Care, Hospital of the University of Pennsylvania, 1988-2013

Reverent Acknowledgement is a method of Pastoral Care used to offer support to persons in some degree of crisis. Reverent Acknowledgement aims at a healing relationship extended by the chaplain through attentiveness to the story, concerns, and feelings, of the patient. The chaplain is therefore guided by the patient's "agenda" and offers an invitational rather than a probing or advising stance.

Reverent Acknowledgement is based upon the pastoral counseling style of Dr. William B. Oglesby (*Biblical Themes for Pastoral Care*) which in turn drew upon the theory of client-centered counseling developed by Carl Rogers. The underlying theory is that the experience of "being known" and accepted is in keeping with the essence of human purpose and fulfillment. Therefore, a relationship which embodies this experience has healing qualities which bring peace and comfort, and foster creative and adaptive responses to crisis.

The *acknowledgement* dynamic in relationship is primarily achieved through recognizing and naming the feelings expressed directly or indirectly by the patient, and by otherwise being attentive to the story and concerns of the patient. The quality of *reverence* is manifested in the overall attitude of the chaplain, in the formal role of the chaplain, and in the incorporation of the appropriate spiritual and religious practices such as prayer, sacred text, ritual and sacrament. The discipline of Reverent Acknowledgement is differentiated from approaches to pastoral care and counseling which are more prescriptive or problem solving in their emphasis.

This method of pastoral care intends to engage and enhance the spiritual resources of patients whether those resources are explicit or implicit. Patients without formal religious beliefs or practice are often responsive to this mode of pastoral care.

Reverent Acknowledgement is an effective supportive approach for persons experiencing loss, crisis, and coping with chronic challenges. It is a helpful perspective in providing care to persons with more defined emotional disorders, but it is not proposed as a complete therapeutic response to such emotional disorders. Reverent Acknowledgement helps to restore a sense of personal connection in the face of the many practical and emotional aspects of isolation which accompany the experience of illness. In this way it helps to restore an attitude of hope, even when prospects for physical cure are limited. In the context of such relationship, patients often draw upon their religious beliefs and values and traditions to surround their experiences within a framework of meaning and purpose. This further contributes to an attitude of hope and a capacity to cope with loss and challenge. In the face of inevitable loss, the experience of Reverent Acknowledgement often indicates that is not loss that destroys us, but loss plus isolation. Reverent Acknowledgement is a meaningful response to threatened isolation.

11/26/19