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Educating Oncology Nurses On When To Refer Patients For Chaplaincy Services At AnMed Health

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ABSTRACT

EDUCATING ONCOLOGY NURSES ON WHEN TO
REFER PATIENTS FOR CHAPLAINCY SERVICES
AT ANMED HEALTH

by

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Adviser: Daniel Forbes

ABSTRACT OF GRADUATE STUDENT RESEARCH

Project Document

Andrews University

Seventh-day Adventist Theological Seminary

Title: EDUCATING ONCOLOGY NURSES ON WHEN TO REFER PATIENTS
FOR CHAPLAINCY SERVICES AT ANMED HEALTH

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Problem

At AnMed Health, the chaplain is responsible for providing spiritual care to patients in spiritual distress. The chaplains depend upon nurses to help identify those patients and make the appropriate referral to the spiritual care department. Oncology patients have been increasingly overlooked by not receiving the care of a chaplain, particularly during times when bad news is given. The nurses on the oncology unit are either too busy or untrained to identify patients in spiritual distress.

Method

A pocket guide was developed and presented to the oncology nurses to help educate them on when to call a chaplain. Data was collected five months before the nurses were given in-service training on using the pocket guide. Data was also collected five months after the in-service to determine if the utilization of the chaplaincy service had increase. Thus, a qualitative method was used in order to make a comparison between the data before and after the pocket guide in-service training.

Results

Any chaplain providing spiritual care to a patient on the oncology unit was engaged in the collection of data for comparison. The data showed a very small increase in the utilization of chaplaincy services after the in-service training with the pocket guide. Two additional months were added in which I personally spent more time on the oncology unit interacting with the staff. The data showed a marked increase during those two months.

Conclusion

This study demonstrates that personal collaboration with the nursing staff increased their trust in the services provided by the chaplain. Nurses are more apt to utilize the services of the chaplain when they are aware of the study being conducted and they feel included in the outcome. Additionally, the pocket guide was useful in educating the nurses on when to refer patients for spiritual care by chaplaincy service.

Andrews University
Seventh-day Adventist Theological Seminary

EDUCATING ONCOLOGY NURSES ON WHEN TO
REFER PATIENTS FOR CHAPLAINCY SERVICES
AT ANMED HEALTH

A Project Document
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Ministry

by
Cheryl P. Simmons

August 2017

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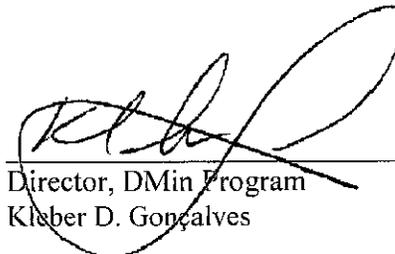
by

Cheryl P. Simmons

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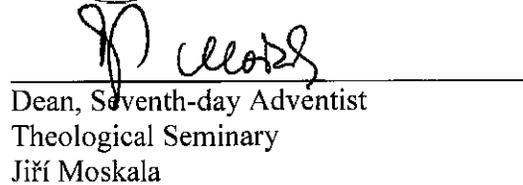
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CHAPTER 1

INTRODUCTION

Working as a hospital chaplain has its days of joy and sadness. From the birth of a new baby to the death of a family patriarch, a chaplain can be, and is often, called upon. Not many people can say that they like or love their job. I can! But, it is not enough to like or love my job; I want to make a difference in the lives of the patients I am called to serve.

The difference I make for these patients can be in the form of a touch or a smile sometimes it is the form of quiet presence. However, I or any other chaplain must be aware of the patient and his or her need(s) before the journey with that patient can begin. Relying on other staff members can be a problem if they are untrained in some form of spiritual awareness or distress. The research data I have reviewed reveals that a holistic approach towards patient care is optimum care. If we are to provide optimum care, the chaplain must be part of the medical team.

Description of the Ministry Context

I work as a full-time staff chaplain at AnMed Health Center in Anderson, South Carolina. AnMed is an independent, not-for-profit health system. It is located in the downtown Anderson area servicing a mixed cultural and socio-economic community. Housed on two campuses with 400 physicians, 3,600 employees, and 588 beds (AnMed Health, n.d.). AnMed (n.d.) says, “Our vision is to be recognized and celebrated as

According to our employee manual, two of the building blocks to the vision are, “Exercising a Passion for Serving Others” and “Fostering a Nurturing Culture.”

AnMed began in 1904, when Jennie Gilmer had a vision to help sick children in Anderson County. Since that time, it has grown to specialize in areas such as, Heart and Vascular Care, Women’s Care, Children’s Care, and Neurology Care. AnMed continues to grow and expand its services to meet the needs of the community.

I have chosen Four Center (4C) as my ministry context. Four Center, which is the oncology unit, has a 30-bed capacity and maintains a census of 95-100%. It operates with 44 staff members between two 12-hour shifts, one social worker, one clinical case manager, and one nurse manager. With three oncologists, patients with all forms of cancer are seen and treated.

Statement of the Problem

The chaplains’ department at AnMed Health consists of the department director and three staff chaplains, one of which focuses primarily on palliative care patients, those who have chronic illnesses requiring additional education and goal setting in order to decrease hospital admissions. With countless material and a well-educated staff, patients still fall through the crack and are not seen. From my two years of observation, not many of the staff, including doctors, nurses, and administration, are aware of the role of the chaplain, particularly on the oncology unit. The staff have not been trained to identify the needs of the patients as they relate to spiritual care in such pivotal moments.

Statement of the Task

The task of this project was to develop, implement, and evaluate an educational process to teach oncology nurses at AnMed Health when to refer patients to the Chaplaincy Services.

Delimitations

This study was delimited to one specific group on the oncology unit. Only the nurses on the unit apply specifically to my project.

Description of the Project Process

The basis for my theological reflection was to look at examples from the Bible and Ellen G. White dealing with suffering, and to show how they might be relevant to the oncology patient. This revelation not only helped me to know that sin is not always at the core of sickness and suffering, but also that God is present with us in our suffering. Patients are frequently torn about their illness and wonder why God would allow their suffering. In this theological reflection, I find that some suffering is so that God may be glorified.

The usage of the paralytic, Mark 2:1-12, and the woman with the issue of blood, Mark 5:25-34, demonstrates that there are different forms of suffering. For this project, I looked at spiritual suffering, emotional/psychological suffering, physical suffering, and social suffering as they relate to both the paralytic and the woman with the issue of blood. From this review, I am able to appreciate the multiplicity of suffering that oncology patients may potentially endure.

I reviewed current literature on chaplaincy and oncology nursing as it relates to the spirituality of oncology patients. I wanted to know if other hospitals with oncology

units experienced problems with nurses referring patients to the service of chaplains. Also, it was important to ascertain how those nurses recognized and possibly initiated some form of spiritual screening for their patients exhibiting spiritual distress.

If the nurses actually did their own spiritual screening, what was the next step? Did they refer to a chaplain for a spiritual assessment or did they attend to the needs of their patients themselves? Though there was not a vast amount of information available surrounding this topic, the information I did find proved to be helpful and enlightening.

A pocket-sized guide was developed describing spiritual need identifiers to trigger staff nurses when a chaplain referral is indicated. It includes such triggers as in the event of a death to sacraments and end-of-life issues. The backside of the pocket guide explained what is a chaplain. I felt this was necessary in educating the staff as to why chaplains do what they do.

I provided a one-time in-service training for the oncology nurses during their monthly staff meeting to ensure understanding and comfort in using the pocket guide. The staff meeting was helpful in that I was personally able to explain the use of the pocket guide and answer any questions that may be asked.

A follow-up evaluation was conducted to determine if an increase in referrals had occurred compared to the data collected before the initiation of the pocket-sized guide. I used the same forms to collect post data as I did for the pre-data. At the end of the 10-month period, I spent an additional two months on the unit collecting data. This was suggested by my context committee. The purpose of the additional two months was to see if an increase in my presence would make a difference in referrals. This time was well spent where trust and friendship was developed.

CHAPTER 2

THEOLOGICAL REFLECTION ON SUFFERING

Looking at a theology of suffering can help one to understand the need of care that is often offered by chaplains. I come in contact with varying forms of suffering while working with patients on the oncology unit at AnMed Health Hospital. These sufferings can be seen in the life of the paralytic, in Mark 2, and the woman with the issue of blood, in Mark 5 in at least four distinctive areas: Spiritual Suffering, Emotional and/or Psychological Suffering, Physical Suffering, and Social Suffering. Suffering, according to Elwell and Comfort (2001), is “Anything causing pain or distress; calamity...because of sin, misery is a common human experience, and our short life is full of trouble” (p. 1,221). “Suffering is our physical difficulties (pain, loss of function) combined with our emotional reaction to them” (Spirituality of suffering, 2005).

Morse (2001) suggests, “Suffering is perceived as comprising two major behavioral states: enduring (in which emotions are suppressed; it is manifested as an emotionless state) and emotional suffering (an overt state of distress in which emotions are released)” (p. 47). The phenomenon of spiritual suffering is commonly witnessed on the oncology unit at AnMed Health and thus it becomes the responsibility of a trained chaplain to spiritually assess and determine the best antidotal recourse; that is, how to

best help the patient and or family work through their suffering or, better yet, journey with them in their suffering.

This journeying requires empathetic listening, a non-anxious presence, a non-judgmental attitude, and often the ability to dig deep into the root of any problem of the sufferer. This type of work, in my opinion, can only be done by a well-trained chaplain, one who has not only theological training but clinical training as well.

It is helpful to understand, to a degree, the spiritual causation of sickness and disease; therefore, appreciating the need and services of chaplains. With a vast number of books, articles, and sermons on this seemingly simple, yet complicated subject, this quest of understanding could lead to a non-exhaustive study. Much has been filtered through in order to taper my references to avoid redundancy or material without relevancy.

When considering the theology of sickness and disease, as Christians, the first source of information should always be the Bible. The following texts have been chosen to demonstrate that sickness is not a new paradigm but is the result of a predisposition of sin which has flawed the human body. Using the King James Version of the Bible, Genesis chapter 3:17-19 sets the stage for what is to follow from that time until Jesus comes. The verse, I believe, to be the most poignant is 19, “for dust thou art, and unto dust shalt thou return.” At some point in time, man will die. This is part of the curse pronounced upon Adam by God in the previous texts.

It is evident from the daily obituary that man no longer live hundreds of years as did Adam, who lived 930 years (Gen 5:5). Or Methuselah, being the oldest man who ever lived at 969 years (Gen 5:27), and Noah, living 950 years (Gen 9:29). The Psalmist,

David, declared, “The days of our years are threescore years and ten; and if by reason of strength they be fourscore years, yet is their strength labour and sorrow; for it is soon cut off, and we fly away” (Ps 90:10). If David’s words are true, and I believe that they are, this would mean that during his life-time man’s life span had dwindled down from 969 years to 60 or perhaps 70 years.

This decline in years can be attributed to a number of factors, such as war, disobedience to God, plagues, famines, and disease; however, of those many factors sickness and disease is our primary focus. The works of Jesus, as declared by Matthew and John, demonstrate that He was aware of man’s fallen state and sought to alleviate his pain and suffering through healing. For example: “And his fame went throughout all Syria: and they brought unto him all sick people that were taken with divers diseases and torments, and those which were possessed with devils, and those which were lunatic, and those that had the palsy; and he healed them” (Matt 4:24). Those ailments required then and do now the touch of the Master Healer.

Another text offered by the disciple Matthew is found in chapter 10:1, “And when he had called unto him his twelve disciples, he gave them power against unclean spirits, to cast them out, and to heal all manner of sickness and all manner of disease.” Again, the disciple Matthew is offering evidence that Jesus is familiar with sickness and disease, and seeks to bring relief through his disciples. Jesus’ use of His disciples suggests that there is a work of healing that extends beyond Himself but not exclusive of Himself.

To further iterate the above thought, James provides the following counsel “Is any sick among you? Let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord” (Jas 5:14). Again, God uses mortal man

to come to the aide of his ailing brother. Things have not changed over two thousand years. Man continues this downward spiral of sickness and disease, and he continues to die.

The mortality of man would be too much to endure without the final chapter of the Bible. Revelation 21:4, “And God shall wipe away all tears from their eyes; and there shall be no more death, neither sorrow, nor crying, neither shall there be any more pain: for the former things are passed away.” I have used this text frequently at the bedside of a deceased patient or during a funeral service. For here solace is found in knowing that sickness and disease will finally come to an end along with death, the mortal enemy.

Mark Beuving (2012) seems to agree that sin was not a part of God’s original design for this world. He further alludes that sickness is a corruption of God’s good world. We can safely ascertain that before Genesis 3, there was no sickness or disease for sin had not invaded the Garden of Eden and Adam nor Eve suffered its bitter consequences. This, I believe, is precisely Beuving’s position.

According to Beuving, sickness can be the direct result of personal sin, but it is not always. And solid believers have been crushed by the mistaken notion—self-aggrandizing and often wielded like a sword—that if one just had enough faith or holiness one would be rich and healthy. Slick (n.d.) agrees with Beuving stating, “that sickness is part of the effect of sin in the world and upon the descendants of Adam.”

Larchet agrees with Beuving that illness is a direct result of sin. Larchet (2002, p. 27) suggests that it is because of sin that our sick bodies are clothed in garments of skin; mortal and overwhelmed with suffering, we pass through this temporary, impermanent world, and we have been condemned to live our lives at the mercy of countless evils and

multitudes of calamities. There was a cause of concern for me regarding the above statement due to its depressive undertone. However, further reading opened an opportunity of hope for the believer who chooses Christ as his Savior. Thus, concluding that sickness, though death may occur, does not have to be the finality.

Another writer, White (1932), suggests that not only are sickness, suffering, and death due to sin; they are the work of an antagonistic power. “Satan is the destroyer; God is the Restorer” (p. 11.2). It is compulsory that the chaplain remembers, as White puts it, “The desire of God for every human being is expressed in the words, ‘Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth’” (p. 11.4).

The awareness or presence of suffering did not begin with modern medicine or at AnMed Health. The Bible provides numerous accounts of suffering. However, there are two biblical accounts, which demonstrate the fullness of each of the above areas of suffering.

Spiritual Suffering

The first is the story of the paralytic, found in Mark 2:1-12.

¹ And again he entered into Capernaum after *some* days; and it was noised that he was in the house. ² And straightway many were gathered together, insomuch that there was no room to receive *them*, no, not so much as about the door: and he preached the word unto them. ³ And they come unto him, bringing one sick of the palsy, which was borne of four. ⁴ And when they could not come nigh unto him for the press, they uncovered the roof where he was: and when they had broken *it* up, they let down the bed wherein the sick of the palsy lay. ⁵ When Jesus saw their faith, he said unto the sick of the palsy, Son, thy sins be forgiven thee. ⁶ But there were certain of the scribes sitting there, and reasoning in their hearts, ⁷ Why doth this *man* thus speak blasphemies? who can forgive sins but God only? ⁸ And immediately when Jesus perceived in his spirit that they so reasoned within themselves, he said unto them, Why reason ye these things in your hearts? ⁹ Whether is it easier to say to the sick of the palsy, *Thy* sins be forgiven thee; or to say, Arise, and take up thy bed, and walk?

¹⁰ But that ye may know that the Son of man hath power on earth to forgive sins, (he saith to the sick of the palsy,) ¹¹ I say unto thee, Arise, and take up thy bed, and go thy way into thine house. ¹² And immediately he arose, took up the bed, and went forth before them all; insomuch that they were all amazed, and glorified God, saying, We never saw it on this fashion. (KJV)

According to The National Association of Catholic Chaplains, “Spiritual pain is defined here as emotional distress due to spiritual and religious issues” (“Spiritual suffering scale,” n.d.). Verse five proves that the paralytic in this story has a sin problem, “Your *sins* are forgiven you” (emphasis supplied). Jesus here correlates sin and sickness. In John 9:1-3 He denies that sin and sickness had any correlation in the case of the man who was blind from birth. These two passages suggest that some illnesses are due to personal sins, but not all are. Some are simply due to evil in the world” (Dybdahl, 2010, p. 1298). Despite Jesus’ teaching, it was a common belief of that day that any form of sickness or disease was due to a direct relation of one’s sin. For example, Job’s friends associated his illness with some unconfessed sin(s) (Job 8:4-22).

As already alluded to above in John 9, Jesus’ disciples asked Him about a man born blind: “His disciples asked him, ‘Rabbi, who sinned, this man or his parents, that he was born blind?’” (NIV)? Again, the thought was that sickness or any deformity was the result of sin. “While not all physical infirmity is the result of personal sin (John 9:3), it seems in this case that it was. Jesus looked past the physical disability and saw the man’s deeper need” (Cooper, 2000, p. 32). I have found that this thought of relating sin to one’s illness is no different today. Many patients also attribute their cancer to punishment from God for some unconfessed sin or evil done in their lives.

In the case of the paralytic, his spiritual condition was at the root of his debilitation. Spiritually, this man was paralyzed more than he was physically. In the

Preacher's outline and sermon Bible commentary, the writer notes, "Jesus proclaimed forgiveness of the man's sins. Forgiving the man's sins was far more important than healing him (Mark 2:10). A sound body assures life for only a few years at most; a sound soul assures life forever" (Leadership ministries worldwide, 1996). Thus, Jesus addresses his sin problem and in turn heals his physical malady.

White (1905), referring to the paralytic, notes, "The burden of guilt rolls from the sick man's soul. He cannot doubt. Christ's words reveal His power to read the heart. Who can deny His power to forgive sins?" She continues, "Hope takes the place of despair, and joy of oppressive gloom. The man's physical pain is gone, and his whole being is transformed. Making no further request, he lay in peaceful silence, too happy for words" (p. 35). When sins are forgiven, one can continue to live in peace or die with the assurance that all is well with the soul. The role of the chaplain becomes crucial to the patient dealing with spiritual suffering. Handzo (2015) states,

I would propose that the goal of spiritual care is to eliminate spiritual suffering. We will never get there of course, but why wouldn't we want to try? When I started in cancer care 35 years ago, the common wisdom was that many people with cancer were naturally going to be depressed because they had cancer. The implication was that nothing could be done about that. We have since learned very differently and depression in cancer patients is considered a highly treatable condition. Why not treat spiritual suffering the same way? We know very little about how to do this, but if we don't resolve that a lot can be done, we will never learn how (p. 12).

Journeying with patients in their spiritual suffering may not relieve pain or heal their diseases, but can and often does provide a means of coping, and alleviates the sense of aloneness that often accompanies spiritual suffering. A number of studies have been conducted in order to develop a tool to measure spiritual distress. One in particular is called a Spiritual Distress Assessment Tool (SDAT). The results of such a study was published online by BioMed Geriatric.

According to the authors, there were three dimensions considered to determine spiritual distress: meaning, transcendence, and values. Meaning is “the need for life balance,” transcendence is “the need for connection,” and values is “the need for values acknowledgement and the need to maintain control” (Monod, Martin, Spencer, Rochat, & Bula, 2012, p. 22).

Though background history is not given about the lifestyle prior to this encounter with Jesus, our paralytic in Mark 2, based upon the SDAT, must have suffered some degree of spiritual distress. Though their study was conducted amongst an elderly population, others have duplicated similar results in younger patients, making the SDAT a valuable tool to measure spiritual distress.

I see a dichotomy in this story with the paralytic, which can also affect the hope or expectation of healing today. In verse 7, the scribes were filled with indignation towards Jesus: “Why doth this *man* thus speak blasphemies? Who can forgive sins but God only?” (KJV). The scribes are correct, only God can forgive sins. The paralytic came to Jesus for healing, not salvation. However, he left with both. Often, patients who seek healing from God may be in denial of their physical condition and its prognosis. It was the faith in Jesus exhibited by the paralytic that brought healing. Are we saying today that this same kind of faith is either non-existent or is no longer effective? Are we saying that patients cannot receive healing and salvation today?

I have experienced, as a chaplain, calls from staff members wanting me to convince a patient and sometimes their family that care or healing is futile. Some cases this may be true; however, I cannot exclude the prerogative of God to heal whom He chooses and when. As a Christian, I must and do believe that God still responds to the

call of His faithful children and will supply their needs. The word *forgiven* is mentioned approximately forty-two times in the Bible. It is the forgiveness of sin that makes true healing possible. Healing and salvation are still available today.

Emotional/Psychological Suffering

According to Wasieleski (2008), “Emotional suffering causes a great (*sic*) of pain to the mind as well as the body. It can cause us to be ill or even worse, experience a nervous breakdown, self-pity, depression, anger, stress and so on.” This form of suffering cuts deep into psyche and can be worse than physical pain. Physical pain can often last for a short period of time, while emotional or psychological pain, if not properly dealt with, can last for years or even a lifetime. Such is the case with the paralytic.

Emotionally and psychologically, he needed healing to relieve him of his own prison.

This man was desperate to get to Jesus. His desperation is noted by the means to which he and his friends would go to get an audience with Jesus Christ, The Savior. One can only imagine the stress he suffered as a result of his limitations. For years, this man had to endure the lack of autonomy. There could be no independence or self-sufficiency for him. He would have to depend upon others just for simple activities of daily living. This man realized that he had a Jesus problem. A Jesus problem is a problem that only Jesus can solve. And only Jesus could forgive him of his sin or enable him to walk again.

Oncology patients encounter the same emotional and psychological suffering as did the paralytic. “I can’t work anymore.” “Who is going to take care of my children should I die?” “I can’t afford to be sick.” These are real existential/emotional/psychological questions that stress men and women alike. However, men, who see themselves as the head of their homes, the bread winner, and the person who makes sure

things function correctly, often suffer the greatest from emotional and psychological suffering. I have not found any evidence to substantiate this statement; although, I have observed it time and time again on my oncology unit.

Many staff members overlook or are not properly trained to identify the signs of emotional or psychological suffering. As a result, patients may not get the proper care they need. Without that care, the patient is forced to remain in their state of suffering.

Given the high prevalence rates of psychosocial and emotional distress in a rapidly expanding cancer population—cancer prevalence is expected to double within the next 15 years in developed countries (27)—and the demonstrated benefit to patients and families, it is no wonder that on compassionate grounds alone, the Canadian Strategy for Cancer Control supported the proposition that Emotional Distress be considered the sixth vital sign—implying that monitoring of emotional distress should be undertaken as routinely as monitoring of the other vital signs. (Bultz & Carlson, 2005)

It is safe to say that more staff, especially oncology nurses, should be trained to assess for emotional suffering. When identified by physicians, emotional and psychological suffering are often treated with medications and/or counseling. Conversely, trained chaplains, much like other counselors, are often able to get at the root of such issues, alleviating the need for medicines.

Zaza and Baines (2002) seem to be agreeing with Bultz and Carlson when they say, “Fourteen of the 19 reviewed studies on psychological distress found a significant association between increased pain and increased distress” (p. 526). Additionally, they add, “comprehensive chronic pain assessment should include routine screening for psychological distress” (Zaza & Baines). This would mean that some form of emotional and psychological screening or assessment should be conducted on all chronically ill patients by trained staff members.

Also, according to Bultz and Carlson (2005),

You can look at suffering in a positive way or a negative way. One produces hope, compassion, kindness and love, and the other just flat out produces darkness and that darkness can go deep. Fear, worries and lack of faith will cause a great deal of emotional suffering.

The paralytic man must have chosen to take the positive approach since his hope and desire was to get to Jesus.

White (2006) agrees, “This unusual method of reaching Jesus was the desperate suggestion of the paralytic himself, who feared that, though now so close to Jesus, he might yet lose his opportunity” (p. 268). What an opportunity for this paralytic. Face-to-face with Jesus, his sins are forgiven and he is made whole. “Who forgiveth all thine iniquities; who healeth all thy diseases” (Ps 103:3, KJV).

Then, there is the element of faith mentioned by Bultz and Carlson in the healing of emotional and psychological suffering. The paralytic demonstrated saving faith in Jesus. Faith is key to any type of healing. Without faith, we have nothing. It is the stuff that is needed to make lame legs walk again. The paralytic knew this and cancer patients are asked to believe it. And though the cancer patient may not be cured of cancer, his/her faith will bring healing to his soul and the assurance that Jesus is near.

Physical Suffering

Physical suffering comes as a result of some form of injury to the body. This injury results in pain. When this pain extends for a prolonged period of time it is generally referred to as suffering. Baines and Norlander (2000) suggest that physical suffering is directly related to the degree of pain an individual has. It is difficult to determine if the paralytic in Mark 2 suffered any pain or not, as none of the synoptic writers allude to pain of any kind. However, we do know that he could not walk. We are

left to speculate if pain was involved. “The Greek word used to describe the malady of the man in Mark 2 is *paralutikos*, ‘a paralytic’” (Baines & Norlander, 2000). For the paralytics of today, “the only treatment for paralysis is to treat its underlying cause. The loss of function caused by long-term paralysis can be treated through a comprehensive rehabilitation program” (*The Free dictionary*, n.d.). Even with rehab the prognosis is very slim. “The likelihood of recovery from paralysis depends on what is causing it and how much damage has been done to the nervous system” (*The Free dictionary*, n.d.). We are not told how long the paralytic was paralyzed. Nevertheless, we can assume some form of suffering from his paralysis.

Lethborg, Aranda, Cox, and Kissane (2007) conducted a study on the relationship between physical suffering, meaning in life, and connection to others in adjustment to cancer. They concluded,

This study speaks to the clinical complexity of the dynamic experience of suffering and meaning in cancer. We need to better understand the impact of physical suffering and meaning in the lives of this population and to actively work toward the enhancement of social support and connection with others for this group. Optimal palliative and family-centered care blended with therapies that promote a sense of meaning of life lived appear crucial to ameliorate suffering. (p. 377)

Families are encouraged to be present and participate in the care and support of the cancer patient. They play an integral role in the emotional and psychological well-being of the patient. In a position of security, they are able to encourage the patient’s trust in providers and alleviate the loneliness that often accompanies lengthy hospital stays.

Palliative care (Lo, Quill, & Tulsky, 1999, p. 744) “focuses on relief of suffering, psychosocial support, and, as much as possible, closure near the end of life. As disease progresses, many patients choose palliation as the paramount goal of care.” However, palliative care providers at AnMed Health are, for the most part, viewed by physicians

and nurses alike as “social workers for hospice.” They are called when all efforts have failed and hospice and comfort measure only is the only resort. If their services are sought early, they can help a lot of the unnecessary pain and suffering patients often endure. Some cancers can be cured with modern medicines and some cannot. The paralytic did not need the services of palliative care; he needed Jesus. With Jesus, all ailments are abated even for the cancer patient. Emotional and psychological pain is arrested and suffering eases and sometimes vanishes.

Social Suffering

Social suffering usually results from not being able to have some form of community. It is a sense of isolation by the sufferer. Usually, the suffering of cancer patients affects family and friends. Such was the case with this paralytic. Cooper (2000) in his commentary on Mark suggests, “He had friends whose faith matched his and were determined to get him to Jesus. The four men had to drag the cot up the stairs, tear up the tiles, and dig through the thatch. The hole would have to be large enough to get the cot through” (p. 32). The fact that he was “borne of four,” as noted in verse 3, according to Nichol (1980), is “a detail given by Mark only. This and other details not only reflect the factual nature of the account but also mark it as the account of an eyewitness, in this case probably Peter” (p. 579). This paralytic was fortunate to have friends who were concerned enough about his suffering that they would expend themselves to get him to Jesus. They may have acted upon his faith; however, their love for him responded to his need.

I have witnessed that the faithfulness of family and friends varies from patient to patient. Many patients suffering with cancer are accompanied by their loved ones.

However, all too frequent are the lonely sufferers; they are left to lick their wounds alone. The need of the family to “do something” can be hindered by the family members’ own sense of inadequacy. “What do I have to offer?” “I’m not trained to handle this,” are the thoughts of many. They do not realize that just being near, sometimes, is all that is needed. Wilkinson notes, “With reference to ‘social suffering’ researchers aim to attend to the ways in which the subjective components of distress are rooted in social situations and conditioned by cultural circumstance” (Wilkinson, n. d.).

If Wilkinson is correct, his theory coincides with the nature that God gives us towards community. In journeying with patients in their “stuff” chaplains are able to come alongside the patient, affording them a non-anxious presence resulting in trust and relief. Trust is necessary to lessen the environment of loneliness and develop a space for companionship.

A non-judgmental attitude is another gift offered by the chaplain. Many infectious diseases keep family and friends at bay. During terminal illnesses community is essential. However, the fear of “catching something” from an infectious patient can be a real concern even for hospital workers. Even so, chaplains gird themselves up with protective gear and in the name and power of the Lord they enter the patient’s space to offer the comfort of community so desperately needed.

The paralytic trusted his four companions; otherwise, he never would have allowed them to take him to a Jesus crusade. He trusted them to carry him some distance on a cot. He trusted them to safely carry him to the top of a roof and lower him down to Jesus. A popular song, performed by Ann Margret, is very accurate when it states, “Everybody Needs Somebody Sometimes” (Sabu, 1981). The paralytic needed his friends

and together they needed Jesus. Oncology patients often request the services of a chaplain. Chaplains have been trained to be that “Somebody” in their suffering.

Spiritual Suffering

Another Scripture reference dealing with suffering can be found in Mark 5:25-34, more commonly recognized as the story of “The Woman with the Issue of Blood.” This story can be found in the books of Matthew, Mark, and Luke; however, Mark’s account provides more detailed information than the other two writers.

²⁵ Now there was a woman who had been suffering from hemorrhages for twelve years.
²⁶ She had endured much under many physicians, and had spent all that she had; and she was no better, but rather grew worse. ²⁷ She had heard about Jesus, and came up behind him in the crowd and touched his cloak, ²⁸ for she said, “If I but touch his clothes, I will be made well.” ²⁹ Immediately her hemorrhage stopped; and she felt in her body that she was healed of her disease. ³⁰ Immediately aware that power had gone forth from him, Jesus turned about in the crowd and said, “Who touched my clothes?” ³¹ And his disciples said to him, “You see the crowd pressing in on you; how can you say, ‘Who touched me?’” ³² He looked all around to see who had done it. ³³ But the woman, knowing what had happened to her, came in fear and trembling, fell down before him, and told him the whole truth. ³⁴ He said to her, “Daughter, your faith has made you well; go in peace, and be healed of your disease.” (NRSV)

As noted in the story of the paralytic, spiritual suffering, for a believer, is thought to be associated with a sin, past or present. It is one thing to be plagued with sin that has not been repented of; it is a totally different matter when the thought of that sin isolates one from normal activities of living. This woman’s illness classified her as more than sick; she was unclean. “Women with this condition were considered unclean and were prohibited from entering the temple” (Dybdahl, 2010, p. 1,303). Additionally, “by law she was considered so unclean that she was to be divorced by her husband” (Leadership Ministries Worldwide, 1996).

This prohibition was well known amongst the Jewish people. “And if a woman has an issue, *and* her issue in her flesh be blood, she shall be put apart seven days: and whosoever toucheth her shall be unclean until the even” (Luke 15:19, KJV). Far too often I have encountered cancer patients who are no longer able to attend worship services or any church functions due to the limitations of their disease. This absence or lack of connectedness in being part of their church community creates a sense of isolation from God. As a result, their spiritual life has a tendency to diminish.

It could be speculated or argued that this woman only sought out Jesus for a physical healing. However, her healing would do more than that. Her physical healing, like that of many cancer patients, would also have a huge bearing upon her spiritual healing. It would open the door for her to be reunited with her family and friends, and participate in religious ceremonies. “She wanted merely to touch Jesus’ clothing, be healed and steal away unnoticed. That would set the stage for her to perform the rituals of purification and reenter society without embarrassment” (Kernaghan, 2007, p. 109).

Though this woman wanted a healing without being noticed, Jesus wanted something much deeper for her. He was interested in her salvation. “For her own benefit He desired her to acknowledge the blessing she had received. To be ‘saved’ (see on v. 28) from her disease, but without being ‘saved’ from the disease of sin would prove only of temporary benefit” (Nichol, 1980, p. 608). I am convinced that chaplains, like Jesus, are concerned with the whole person and not just what seems to be the obvious.

For the doctors who tried to treat this woman, the obvious issue was her bleeding disorder, something physical. However, for Jesus the obvious issue was a spiritual problem. Jesus is able to look inward to the heart and address the issues that sometimes

the sufferer is unaware of. Through her healing, Jesus solved both. For the cancer patient at AnMed Health, the chaplain skillfully ministers to the spiritual needs of the patient while acknowledging the obvious physical needs.

It is not always prudent for the chaplain to immediately delve into spiritual issues without first developing a safe place for the patient. This can be done by acknowledging their physical needs. Once patients are comfortable with the chaplain, they are more likely to share spiritual issues and concerns that they might have. And, then, there are some exceptions. Jesus' dealings with this woman shows one exception. Jesus did not have a dialogue with the woman prior to her touching Him. Yet, He was able to meet the needs of her unspoken request. Chaplains are frequently called under emergent conditions. The opportunity for pleasantries is not always afforded and the chaplain must get straight to the point, asking, "How is your relationship with God?" Though the question may seem stunning, patients are usually ready to accept the brevity of it and answer truthfully.

In verse 30, Jesus asked, "Who touched my clothes?" Even though in the midst of a crowd, Jesus knew He had been touched differently from the others thronging about Him. It was a touch of faith. Chaplains, too, must realize when they are privileged to participate in a holy moment. These moments vary from hearing a confession to baptizing a patient, and witnessing the death of the repentant patient. "But the natural man receiveth not the things of the Spirit of God: for they are foolishness unto him: neither can he know them, because they are *spiritually discerned*" (1 Cor 2:14 KJV, emphasis supplied).

Emotional/Psychological Suffering

Twelve years of physical suffering is bound to cause emotional and/or psychological suffering for anyone. We can look at verse 26 to get a glimpse into the cause of this woman's emotional suffering. "A long succession of physicians had treated her, and treated her badly, taking all her money and leaving her worse off than before" (*The Message* Translation). Not only was her condition worse than before, she was destitute from trying to find treatment and a cure.

Cancer patients at AnMed Health often find themselves in a similar condition. I have been told by patients of their journey through chemotherapy and radiation therapy only to be told by the doctor, "There is nothing else that we can do." The family has incurred huge debt and the patient is not better but worse. It is in situations like this that chaplains must help the patient to touch the hem of Jesus' garment. This touch may not bring physical healing as it did for the woman in Mark; however, it often brings emotional and psychological healing that otherwise might not occur.

The fact that this woman would risk moving through a crowd to get to Jesus is evident of the toll her suffering had taken. "She was in the same category as a leper. That this woman would press through the crowd, thus defiling many, and intentionally touch Jesus, shows her desperation, faith, and hope" (Dybdahl, 2010, p. 1,303). This did not matter to her. After 12 long years of suffering, she did not have anything to lose. This was possibly her only real opportunity to be made whole and she did not want to allow it to pass her by.

I have seen patients, after exhausting all efforts, end up at AnMed Health emotionally and psychologically expended. Some cancer patients have retorted that they

have suffered through so many treatments they can no longer physically, emotionally, or financially tolerate another. When dealing with emotional stress it is fair to say that it can be seen exhibited in a number of ways. They range from anxiety and depression to loss of self-worth and suicidal ideation.

We are not privileged to know the 12-year course the woman with the issue of blood may have taken. However, numerous articles show a correlation between stress and emotional suffering and chronic illness. Such may have been the case with this woman. Whatever her mental state may have been, she had clarity of mind to seek out Jesus. She found in Jesus all she needed.

Physical Suffering

Physical suffering denotes some form of lingering pain, a pain that is excessive and torturous. “Suffering: The term used literally means ‘whip.’ Since people of this time generally believed that illness was caused by supernatural forces, they often spoke of illness as a deliberate affliction or harassment” (Barry, Heiser, Custis, Mangium, & Whitehead, 2012). Mark notes that the suffering of this woman lasted for a period of 12 years. Some forms of cancer can last 12 years and longer with sporadic bouts of remission. However, for this woman, according to verse 26, for all the money she spent, she was not getting better but worse. “The same verse is equally emphatic and categorical: she suffered *much* from *many* physicians, exhausted *all* her resources, and gained *nothing*” (Edwards, 2002, p. 163). It should be noted that for her to seek help from a doctor would have been proper at that time. “The Jewish Talmud records treatments and medicines that were prescribed for such conditions” (Dybdahl, 2010, p. 1,303). Additionally, Cooper (2000, p. 32) notes,

Adding to the woman's physical disorder was her financial distress. For twelve years she had made the round of doctors, and none of them could help her. Many of the cures listed in the Talmud and probably tried on her—such as carrying the ashes of an ostrich egg in a cloth—would seem like superstitious magic to us. She did not get better but only grew worse.

It is not clear what her bleeding was. Some suggest a uterine discharge. Others suggest that this was not a continual bleeding but excessive bleeding that had continued off and on for twelve years. She probably suffered from physical exhaustion as well and possibly pain. An even greater source of pain would have been the interruption of daily social activity because of her disease.

Regardless of its type or the cause of her bleeding, “Her hemorrhaging was a personal, intimate matter for her, something she did not want to be known and discussed. She was considered unclean; therefore, she felt unworthy to approach Jesus” (Leadership Ministries Worldwide, 1996). Whether insurance, some form of debility, mistrust of system, or the lack of self-worth that causes a patient to linger far too long in their suffering before seeking medical help, it is the chaplain who approaches patients with a non-judgmental attitude.

Chaplains help patients to realize that no one is worthless. If the patient is a Christian, this is done by helping him or her to recall the Gift of God in Jesus and His selfless sacrifice of redemption. The patient is encouraged to put his or her faith in Christ and seek to draw near to Him, like the woman with the issue of blood. For the non-Christian, the chaplain must depend upon his or her ability to engage the patient to the point of determining when he or she last felt worthy and what has hindered that self-worth now.

A trained chaplain realizes that this type of engagement can lead down a road the patient is not ready to travel. In this case, patience and care must be practiced. I am sure that Jesus knew that He would have an encounter with the woman with the issue of blood that day. But, as the Ultimate Chaplain, He allowed her to come to Him. He did not

force Himself upon her. He allowed her to be healed without causing any embarrassment to her. It was not until she tried to slip away that He called her attention to the blessing.

This woman was capable of walking; however, she was no different from the paralytic. Her illness also caused a form of paralysis of her body and soul. For 12 years she was “stuck” in that condition. Her bleeding was to some degree debilitating. She must have been weakened from the constant blood loss; tired and easily exhausted. And if it were not for Matthew 14:36, “And besought him that they might only touch the hem of his garment: and as many as touched were made perfectly whole,” we could say that her body may have already been in an awkward position. However, this woman was intentional in her action. Likewise, cancer patients and anyone else suffering from some form of physical malady must be intentional in seeking Jesus.

Social Suffering

The inability to socialize with others creates its own form of suffering.

According to the Torah, a woman was unclean for seven days after her monthly period, but if she had a protracted gynecological problem, as does this woman, she remained unclean throughout its duration. Anyone who came into contact with her during menstruation would be banished until evening (Lev. 15:19-27). Josephus’s testimony that “the temple was closed to women during their menstruation” (*War* 5.227) indicates that this particular Torah ruling was carefully observed in Jesus’ day. Accordingly, a menstruating woman—and whoever touched her—was banished from the community until purification (Edwards, 2002, p. 163).

Unlike the paralytic, this woman did not have friends that could assist her to getting to Jesus. After all, she was unclean. Who would dare risk touching her and becoming unclean themselves? From all human reasoning, this had to have been a deplorable situation to be in. We are not told of her having siblings, a husband, or children. However, we do know that if she did have family she would not have been permitted to have any contact with them.

I remember when I was in my late twenties, the health department in Greenwood, SC contacted me. They informed me that I had TB (tuberculosis). I was devastated. I had two small children and knew that my husband could not attend to them alone. The only thought that occupied my mind was, “I would have to go into some isolation camp.” I thought that I would lose my mind being separated from my family, friends, work, and church. I learned only a few days later that the information given to me was not totally correct. My PPD (purified protein derivative), the test used to determine TB, was positive; however, my chest x-ray was negative, meaning I had been exposed to someone with TB but did not have the disease. When I read the story of the woman with the issue of blood I am able to sympathize and empathize with her.

With all that being said this woman would allow none of the prohibitions of socialization keep her from getting to Jesus. “But as she heard of the great Healer, her hopes revived. She thought, ‘If only I could get near enough to speak to Him, I might be healed’” (White, 1905b, p. 79).

In the hospital setting, cancer patients are placed on isolation for a number of reasons. Isolation can be to protect the patient or protect the visitor. One reason for isolation is that the patient is neutropenic. “People with neutropenia have an unusually low number of cells called neutrophils. Neutrophils are cells in your immune system that attack bacteria and other organisms when they invade your body” (WebMD, n.d.). As a result, anyone wanting to visit this patient must wear a protective gown, mask, and gloves. This is done not to protect the visitor from the patient but protect the patient from any ailment of the visitor, such as a cold, which could prove fatal for the neutropenic patient.

Another reason a cancer patient may be placed on isolation is *Clostridium difficile* colitis or C-Diff. According to the CDC, “*Clostridium difficile*... (*C. difficile*) is a bacterium that causes inflammation of the colon, known as colitis” (Center for Disease Control, n.d.). Additionally, according to the CDC,

People who have other illnesses or conditions requiring prolonged use of antibiotics, and the elderly, are at greater risk of acquiring this disease. The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to patients or contaminate surfaces through hand contact.

In this case, visitors are required to wear the same protective gear. However, with C-Diff, the visitor is being protected from the patient. In either case, the chaplain will visit the patient to diminish isolation of humanity from humanity. There are no barriers with Christ and there should be no barriers for chaplains. Thus, chaplains become the hands, feet, eyes, ears, heart, and mouth of Christ. Their hands touch the untouchables. Their feet go where there is a need. Their eyes look upon all as children of God. Their ears hear the cries and pain of the sufferer. Their heart demonstrates compassion, while their mouth speaks words of encouragement. Spiritual suffering can only be cured by a relationship or reconciliation with God. “The man who seeks forgiveness of sins—truly seeks with a desperation that will not quit—will be forgiven. This is the great lesson learned from the man with palsy” and the woman with the issue of blood (Leadership Ministries Worldwide, 1996). Thus, “the first prerequisite to forgiveness is coming to Jesus. A person must come to Jesus for forgiveness, even if he has to be brought.”

The paralytic and the woman with the issue of blood both found what they needed in and from Jesus: forgiveness of sin. “I, even I, am he who blotteth thy transgressions

for my own sake, and will not remember thy sins” (Isa 43:25, KJV). When Jesus forgives, He forgives completely and the sinner can be at peace even when death is near.

Emotional and/or psychological suffering can be alleviated in much the same way as spiritual suffering. It is Jesus who calls the weary, burdened, and overloaded. This is stated by Jesus in Matthew 11:28, “Come unto me, all ye that labour and are heavy laden, and I will give you rest” (KJV). Emotional rest is priceless. The paralytic and the woman with the issue of blood experienced such a gift from the Savior. Cancer patients at AnMed Health seek this same emotional rest. The rest that Jesus offers goes beyond medications and therapies. “For I have satiated the weary soul, and I have replenished every sorrowful soul. Upon this I awaked, and beheld; and my sleep was sweet unto me” (Jer 31:25-26).

Physical suffering can be unbearable for many. I have heard patients question, “How much longer will God allow me to suffer like this?” “I can’t take any more.” God is the answer for any type of pain. He was the answer for the paralytic and for the woman with the issue of blood. “And God shall wipe away all tears from their eyes; and there shall be no more death, neither sorrow, nor crying, *neither shall there be any more pain*: for the former things are passed away” (Rev 21:4, KJV, emphasis supplied).

God’s answer to pain may not come in the same form it did for the paralytic or the woman with the issue of blood. For them, their relief was a result of Jesus forgiving them of their sins. As a result, this forgiveness brought healing. Sadly, for many cancer patients their relief will only come at death. This is a true reality that chaplains help patients and/or family to understand and accept.

Social suffering can and is often the result of isolation: from family, friends, religious associations, and community in general. What an awful feeling it must be to be isolated from loved ones especially as a result of an uncontrollable illness. For the paralytic, the woman with the issue of blood, and for all believers of God, Jesus promises, “I will never leave thee, nor forsake thee” (Heb 13:5). This promise is reassuring and provides a sense of security for the lonely.

No matter the type of suffering, I have found in the story of the paralytic and the woman with the issue of blood, Jesus is the answer. He is the solution to the problem. He is the ultimate healer when no healing can be found elsewhere. White adds,

“Prayer moves the arm of Omnipotence. He who marshals the stars in order in the heavens, whose word controls the waves of the great deep—the same infinite Creator will work in behalf of His people, if they will call upon Him in faith. He will restrain all the forces of darkness, until the warning is given to the world, and all who will heed it are prepared for His coming. (White, 1905a, para. 3)

There is a common thread that is noticed with each of these varying types of suffering, the desire to be healed and made whole. As seen with the paralytic and the woman with the issue of blood, this desire can be, and is often, exhaustively expensive and long lasting. Oncology patients and their families, I am sure, would agree with this assessment.

CHAPTER 3

LITERATURE RELATING TO EDUCATING ONCOLOGY NURSES ON WHEN TO REFER PATIENTS FOR CHAPLAINCY SERVICES

In researching the topic, I found endless amounts of information regarding oncology, nursing, and chaplaincy. However, not much is written on the combination of the three, especially when it comes to referring oncology patients to the services of chaplaincy. The literature review covers information that addresses various aspects of chaplaincy from using biblical relevance to medical and chaplaincy journals in order to provide understanding of the importance of chaplains and their role in the care of oncology patients

The works cited have been divided into four sections: first, works addressing the theology of sickness and disease, second, works addressing chaplaincy and what chaplains do, third, spiritual care and chaplaincy as it relates to oncology, and fourth, literature relating to the spiritual needs of the oncology.

It should be understood that the term *chaplain* for this review refers to a trained chaplain as identified by The Association of Professional Chaplains (APC) Standards.

The following is an explanation of those standards from the APC:

Definition of a Board-Certified Chaplain

A person who has demonstrated professional excellence as a chaplain, meeting all eligibility requirements including a bachelor's degree, 72-semester-hour graduate

theological degree from an accredited school, four units of clinical pastoral education (CPE), ordination or commissioning to function in a ministry of pastoral care, and ecclesiastical endorsement by a recognized faith group, is recommended by a Certification Committee, approved by the Commission on Certification, and ratified by the Board of Chaplaincy Certification Inc. Board of Directors. (Association of Professional Chaplains, n.d.)

Chaplaincy: What Chaplains Do

The question, what do chaplains do is common. Are you a pastor? Do you just pray with people? Paget and McCormack (2006) answer these questions and so much more. Highlighting the foundation of chaplaincy, the work, and the person of the chaplain, Paget and McCormack go to great lengths to provide adequate information, regarding education, training, and the expectations to which these chaplains must adhere. I would not say that their work is exhausted, as the demands for chaplains continue to grow and change so will their responsibilities.

While looking at the foundation of chaplaincy, our authors present its beginning and how it has developed over the years. Since the early inception of chaplaincy, chaplains have been given specialized training making them the spiritual experts in their area. Paget and McCormack agree, “Today many health-care chaplains in the United States are trained in theology, psychosocial development, ethics, and a variety of other disciplines through seminaries, supervised clinical training, and other highly specialized forms of learning” (p. 3).

There are a number of areas in which chaplains serve. These areas include: military chaplains, healthcare, chaplains, workplace (corporate chaplains), correctional and prison chaplains, police, fire, and crisis chaplains. Each of these positions requires special training. Even though there may be a difference in some of the training, the

fundamental work is the same. Our authors provide us with a list of the following roles performed by chaplains. They are ministers; they provide rites and rituals, and ceremonies. They are often called upon as religious witnesses. They provide spiritual counseling, personal and institutional advocates, make referrals, and carry out many other responsibilities as noted by Paget and McCormack (p. 14).

No matter the education, training, or responsibility, chaplains must maintain various levels of accountability. According to our authors, this accountability comes in the form of institutional accountability, ecclesiastical accountability, professional accountability, legal accountability, and ethical accountability. This book shows that there is more to being a chaplain than praying with and for people. All too often chaplains have been diminished to this one simplicity of our service.

Institutional Accountability

Paget and McCormack (2006) suggest that when referring to institutional accountability, that there is “an explicit commitment to abide by the policies and procedures of that institutions” (p. 96). In other words, chaplains are not lone rangers who do and act as they please. There must be some form of governance that is applicable to all staff members regardless of their position. Additionally, they add, “Regular meetings, reviews, and evaluations are routine practices for maintaining accountability” (p. 96).

Ecclesiastical Accountability

For me, Ecclesiastical accountability is extremely important. I not only must remain true to my faith tradition and beliefs, but also to those who trust that I will represent them in a professional and Christian way. Paget and McCormack (2006)

concur: “Chaplains do not minister in a vacuum. They are members of a specific religious body and are affiliated with a denomination or other faith group. When the Chaplain’s actions and words conflict with the teachings of the faith group, various forms of discipline may occur” (p. 97).

Professional Accountability

There are a number of professional organizations in which chaplains may attain professional membership. The Association of Professional Chaplains, the National Association of Catholic Chaplains, or the American Association of Christian Counselors are such organizations. Each group has a code of ethics for chaplains and other member professionals. “Chaplains are held accountable by these organizations through their membership and by participating in various activities within the organization” (Paget & McCormack (2006, p. 98)

Legal Accountability

This level of accountability can be particularly under-estimated. Chaplains do not normally go to work with intentions of breaking the law but this is not an area where ignorance is bliss. The following, given by Page and McCormack, should be taken into account when considering the chaplain’s legal accountability:

1. The chaplain is also accountable to international treaties or conventions to which the United States has agreed (p. 99).
2. The chaplain is expected to follow all orders for the sake of efficient function except in the case of conflict to professional conscience or sacerdotal mission (p. 99).
3. The chaplain is accountable to this statute in safeguarding a client’s health information (p. 99).

4. Chaplains are “mandated reporters” (p. 100). In cases of physical, sexual and financial abuse or neglect, the chaplain must report to the proper authorities.

Ethical Accountability

Chaplains answer to a higher power, (not that other professions do not) but, “To whom much is given, much will be required” (Luke 12:48, KJV). Paget and McCormack (2006) follow this thought by adding, “They are accountable to God for their attitudes, motives, and actions. Ultimately, God wants the chaplain’s heart not a forced sense of accountability” (p. 100). Chaplains are ambassadors of Christ. Therefore, “God requires the right response from chaplains as the people of God” (p. 100). True, chaplains are human; however, they subscribe to a higher code of ethics.

Holst (2006) also gives a good inside look into the role of a hospital chaplain. His use of imagery, I would say, is spot on when describing these various roles of the chaplain and how they play out in hospital ministry. He begins by asserting that there is a dual paradox, one within the role of the chaplain and the other in the hospital itself. For example, “When one enters the privacy of another’s suffering, one is indeed on sacred ground. However, he notes, “Yet, the chaplain is not there to remove suffering so much as to help people find its deeper meaning for their lives” (p. 10).

I can appreciate Holst’s inclusion of the two worlds in which chaplains operate. As a hospital chaplain myself, this is truly a reality of what I see on a continual basis. Holst state, “The hospital chaplain walks between two worlds: religion and medicine” (p. 12). As I understand the author, there seems to be a dichotomy here for most chaplains. So, what is the dichotomy? Our author puts it this way, “Medicine does not consider them [chaplains] ‘medical enough’ and questions their relevance; the church often does

not consider them ‘pastoral enough’ and questions their identity” (emphasis supplied) (p. 26).

White (1933) writes, “God calls not only for your benevolence, but your cheerful countenance, your hopeful word, the grasp of your hand. Relieve some of God’s afflicted ones. Some are sick, and hope has departed. Bring back the sunlight to them” (p. 23). Therefore, the work of the chaplain is an opportunity to co-labor with God. Furthermore, White goes on to demonstrate the necessity of healthcare ministers, chaplains, at the end-of-life; which is precisely why chaplains are vitally important on the oncology unit.

Spiritual Care and Chaplaincy as it Relates to Oncology

Providing spiritual care to oncology patients is not always easy nor is it a job that everyone can do. Klipper (2007) makes this abundantly clear. The first challenge for the oncology chaplain is confronting his/her personal history and feelings associated with cancer (p. 20). These patients need a chaplain who can meet them where they are and journey with them without any counter-transference. Klipper adds, and I agree, “the chaplain must become aware of and to face his/her fear of contracting cancer so that it wouldn’t interfere with working with patients” (p. 20). When this happens, the visit becomes more about the chaplain than the patient.

Klipper provides a statement I have found to be very beneficial when providing spiritual care. If a relationship of trust is established during the first encounter, patients often will share their feelings about the illness and how they are dealing with it, including where they are spiritually or theologically (p. 21). Being a chaplain does not automatically ensure trust. The patient and most often the family must feel that they can trust their feelings and emotions with the chaplain.

Holst (2006) provides an arrangement of “voices” chaplains listen to from the viewpoint of contributing authors. Each hospital unit has its own voice. The voice in the Pediatric Unit is different from the voice heard in ICU. Here I must agree; the population is different. And, if the population were the same, people and their needs vary. Holst cites Alden Sproull. Sproull looks at varying stages of cancer: pre-cancer: vision wide, broad, and clear; cancer detection: the picture is jumbled; cancer under control: renewed clarity; cancer recurs: the focus is jumbled and narrowed; and dying: vision narrowed and sharpened. He concludes with pastoral care to cancer patients, which is, in part, the focus of my study.

Each of the stages above represent a roller-coaster ride for the patient and his/her family. According to Holst, these patients need the care of a skilled chaplain, one who is able to realize that their intense emotions are appropriate vehicles of communication (p. 125). The chaplain is able to tap into that source that brings hope, comfort, and stability for the cancer patient. Often the voice of the cancer patient is lost or silent due to illness or family desires for the patient. Again, the chaplain helps the patient to find his/her voice and creates an environment so that his/her wishes may be known. Holst puts it this way that the chaplain brings a symbolic and personal presence to this quest for the basic issues of life. He then adds that through this presence the chaplain tries to meet some of the obvious needs for respect, love, appreciation, listening, and hope. And finally, according to Holst, the chaplain seeks to provide constancy to the shifts and changes in mood and condition. So, if I understand Holst correctly, the chaplain has a vital role in the care of the cancer patient. This cannot and should not be overlooked.

Cooper (2011) seems to agree with Holst. She adds,

oncology chaplains have a unique role in the healthcare team as those whose primary role is to provide care for the patient in spiritual distress and mediate a meaningful connection with a transcendent presence, particularly for those who may be out of touch with the practices of their inherited faith tradition or religious community. (p. 20)

The chaplain has the unique opportunity to become a spiritual companion and, thereby, journey alongside the patients in their distress and provide encouragement, support, reflective listening, and direction (p. 20). The chaplain's contribution to the healthcare team has become twofold, the care of the patient and the care of the staff. This can only be done by a chaplain who is attentive to the needs of those he/she ministers to.

What is more profound is knowing that the aim of spiritual care is not to stand apart from the other, but to join the person in the struggle just as the Holy One joins us all in our daily living and dying (p. 35). In other words, the chaplain moves alongside patients, walks with them in their "stuff" and listens empathetically to them as Jesus did with the disciples on the road to Emmaus in Luke 24:13-35. Then, he/she attends to their needs.

It has been shown that patients give higher ratings of satisfaction with their care when they feel their spiritual concerns have been addressed and a lower rating of satisfaction with care and the quality of care when their spiritual needs go unmet, according to Blanchard, Dunlap, and Fitchett (2012, p. 1,077). And though this has been documented, Blanchard et al. suggest, "There is also some evidence suggesting that patients with greater religion/spirituality needs will not initiate requests for spiritual care" (p. 1,077). I have not been able to determine why this is.

Sinclair and Chochinov (2012) agree with the need of spiritual care for the oncology patient. They conclude, "failing to address cancer patients' spiritual needs

impacts patient wellbeing, satisfaction with care, perceived quality of care and is associated with higher healthcare costs” (p. 159). This is phenomenal when considering that something that seems so unimportant, to some, can and does decrease healthcare cost.

Sinclair and Chochinov note that a study of cancer survivors reported that participants with low levels of spirituality were more likely to have high levels of worry at six and 12 months post cancer treatment than individuals with high levels of spirituality (p. 261). This gives concrete evidence to what is being said as to the importance of spiritual care. They were able to provide more documentation in support of spiritual care. A study involving 68 advanced cancer patients found that 78% of participants stated that religion and/or spirituality had been important to their cancer experience (p. 261). I was unable to find any information to refute this data.

Finally, Sinclair and Chochinov conclude by adding, “The integration of spiritual care professionals within oncology teams promotes a proactive, routine, and standardized approach to addressing patients’ spiritual needs” (p. 264). Being a part of the interdisciplinary team allows the chaplain to gain meaningful information that will become beneficial to his/her spiritual care of a patient. Likewise, that team will gain pertinent information from that chaplain that may shed light on the care of the patient. For example, some of the information that is important to the patient and should be important to those providing healthcare to this patient include: complicated family dynamics, financial hardships, recent losses, and religious or faith traditions requiring unusual accommodations.

I have gathered from my research that the spiritual care provided to oncology patients is of utmost importance. This is partly due to the fact that of all the resources available to the chaplain, prayer is his or her greatest asset. In quoting St. John Chrysostom, *Homilies Against the Anomeans* verse 6, Larchet (2002) writes, “prayer is the first among all the religious healing arts because it is the foundation and a necessary element of all the others, and because it is uniquely efficacious in combating illness” (p. 86). It is here that the chaplain becomes a conduit for the working of God.

Nursing and the Spiritual Needs of the Oncology Patient

The fact that chaplains are needed on the oncology unit does not mean that nurses cannot provide spiritual care. In fact, they can. However, chaplains are specially trained ministers who confront matters of grief, bereavement, loss, spiritual distress, abandonment, and ethical issues regularly. Nonetheless, it is imperative that chaplains and nurses have a good working relationship in order to provide optimum patient care.

I was not able to find an abundance of information regarding nurses providing spiritual care to patients in the hospital setting. There are hospital and parish nurses, who provide a modified form of spiritual care to church groups in order to connect them with a hospital or physician’s office. The fact that hospital nurses do not provide spiritual care does not mean that they are not aware of those needs and do not seek to make sure that those needs are provided for. Blanchard et al. note, “reflecting their concern for the religion/spirituality needs of their patients, nurses make more referrals to chaplains than any other health professionals, and by a very large margin” (p. 1,078). I suppose this is in part due to the fact that nurses are with the patients continuously and therefore are

more likely to recognize their spiritual needs. This is why I intend to educate the nurses on the oncology unit at AnMed Health to these needs in order to ensure that chaplains are appropriately notified.

Blanchard et al. share information showing that research indicates that spiritual care providers, i.e. chaplains, may identify spiritual distress through spiritual assessments, but in most clinical settings the ratio of patients to chaplains is so high that screening of every patient by a chaplain is not logistically possible (p. 1,082). This being the case, chaplains depend upon a collaborative effort with the nursing staff. However, the nursing staff must have some way of determining when a patient needs a chaplain. And, this is where I find the breakdown often occurs at AnMed Health. Far too often patients and/or their families experience spiritual distress or death and a chaplain is never notified.

A study performed by van Leeuwen, Schep-Akerman, and van Laarhoven (2013), suggests that having only a religious characterization of spirituality in health care no longer is appropriate. Hence, health care workers, including nurses, should consider the spirituality of patients from more than just the religious perspective (p. 207). I agree. However, a trained chaplain is more suitable to determine the spiritual needs of the patient and should be consulted to do so. This process takes place during his/her assessment of the patient.

The study performed by van Leeuwen et al. (2013) was to determine an adequate spiritual assessment tool that could be used by their oncology nurses. According to the authors, eight oncology nurses from a university medical center in the Netherlands were selected to assist in their study. It was noted that the nurses questioned whether it was

their role to perform a spiritual assessment. Here, I must agree, in that additional training on the part of the nurses would be necessary in order to be proficient in conducting a spiritual assessment. It may be more helpful for them to obtain a spiritual screening. A spiritual screening only requires the nurse to ask a set of prescribed questions without delving into any psycho-social issues.

I propose to provide the oncology nurses at AnMed Health with a tool that will make their screening process even simpler. For example, a question may be asked, does your patient have a terminal illness? If yes, a chaplain should be contacted for a spiritual assessment. The chaplain would then determine the spiritual needs of that patient. With that being said, van Leeuwen et al. agree, “allow for structural implementations of spiritual assessment in cancer nursing practice, nurses should gain sufficient competence” (p. 214). It is difficult to get nurses at AnMed Health to consult chaplains to perform this duty. I am not sure that they would be open to the idea of additional training to do the job themselves.

With all the work involved in this study, the nurses were left with a great appreciation of the work of the chaplain. The study showed that evaluation of these spiritual screening tools, (in which 120 tools were identified), made nurses more aware about spiritual issues regarding their clinical practice (p. 214). Furthermore, the nurses became more aware of their own spirituality which is, in my opinion, a great reward for their efforts.

The training and work of the chaplain is not always an easy endeavor. Their academic training in conjunction with their clinical training produces a minister who is able to identify the spiritual needs of the patients they encounter and provide for those

needs. Theologically speaking, they are the professionals in dealing with those suffering with sickness and disease. Though their role is often underappreciated; what occurs at the patient's bedside is frequently referred to as a "holy" moment.

Patients on the oncology unit benefit from the care of a chaplain. The chaplain makes sure that the patient's spiritual, social, emotional, economic, and physical needs are being addressed. Their role on the interdisciplinary team is crucial meeting to these varying needs. As a result of the relationship developed between the chaplain and the patient, the patient will often reveal problems or concerns to the chaplain they feel uncomfortable sharing with anyone else. The chaplain, then, is able to discreetly share the concerns of the patient with the appropriate person, being careful not to break confidentiality.

When considering the spiritual needs of oncology patients, nurses do well to consult and include the chaplain. Though oncology nurses can adequately provide a spiritual screening, when it comes down to a spiritual assessment, this should be done by a trained chaplain. A tool to determine when a chaplain should be notified will be useful for the oncology nurse. I plan to provide such a tool to enable the oncology nurses at AnMed Health to ensure that their patients' spiritual needs are addressed appropriately.

CHAPTER 4

DESIGNING THE POCKET GUIDE FOR ONCOLOGY NURSES CONCERNING WHEN TO REFER PATIENTS TO CHAPLAINCY SERVICES

The work of the chaplain in caring for the sick has come a long way since its inception with founder Anton Boisen. No longer are chaplains utilized just for their deeply pious praying abilities. The care offered by trained chaplains affords opportunities for spiritual wholeness and reflection that otherwise may go unnoticed or acknowledged. However, patients at AnMed Health do not receive as much care as they might.

Additionally, “Research indicates that spiritual care providers, i.e. chaplains, may identify spiritual distress through spiritual assessment, but in most clinical settings the ratio of patients to chaplains is so high that screening of every patient by a chaplain is not logistically possible,” according to Blanchard et al. (2012). They also suggest, “it seems appropriate for spiritual care providers to pursue collaborations with nurses and others that would facilitate screenings and referrals.”

Therefore, I found it necessary to devise a simple means whereby the oncology nurses at AnMed Health could readily determine the various needs of their patients who may require a chaplain. In addition to creating a tool outlining when a chaplain should be notified, I included a summary explanation called “What Is a Chaplain?” It is my belief that this explanation was necessary for answering not only what a chaplain is but why the chaplain should be notified for specific tasks. The book of James provides the following

counsel: “Is any sick among you? Let him call for the elders of the church; and let them pray over him, anointing him with oil in the name of the Lord” (Jas 5:14). The chaplain serves in this capacity to provide anointing if necessary, but also a number of other services such as baptism, communion, marriage, end-of-life counseling, ethical deliberation, etc. These are just a few of the services needed by patients on the oncology unit at AnMed Health.

For this project, I chose the Constant Comparison/Grounded Theory of Qualitative Analysis for my research. “This form of research compares data to find consistencies and differences” (Strauss, 1987). Notwithstanding, Frechtling and Sharp (1997) suggest, “At the simplest level, qualitative analysis involves examining the assembled relevant data to determine how they answer the evaluation question(s) at hand” (Chapter 4). Whether educating oncology nurses when to refer patients for chaplaincy services at AnMed Health Center increases the utilization of their chaplains is the question I pose to answer.

Four-Center Call Record Pre-In-Service

After gaining approval from my department director and the nurse manager of the oncology unit, I developed a call record to be used by the chaplain staff and a spread sheet record for me to tally requests for chaplain service (see figures 1 and 2). The pre-in-service data was collected from January through May, 2015. The call record included the date, which was necessary to determine if a certain time of the month was busier than at other time and thus increasing chaplain services. The date also allowed me to stay within my time constraints and differentiate pre- from post-in-service data.

The record included space for the chaplain to indicate who was making the request. For example: the nurse, the doctor, the patient, a family member, etc. Patients often ask for a chaplain. They are dealing with issues they feel are most likely to be handled best by a chaplain. Rhonda Cooper (2011) seems to agree. She adds,

Oncology chaplains have a unique role in the healthcare team as those whose primary role is to provide care for the patient in spiritual distress and mediate a meaningful connection with a transcendent presence, particularly for those who may be out of touch with the practices of their inherited faith tradition or religious community. (p. 20)

Additionally, the purpose of the research was to educate the nursing staff to refer to chaplain service. Therefore, if someone other than the nurse made the referral, that piece of information was needed for delineation.

And finally, the record asked for the reason of the request for a chaplain. Those reasons varied: RRT (Rapid Response Team), Code 99 (Potential Death/Resuscitation), death, patient given bad news, etc. It is the latter three that I was most concerned with due to the fact that a RRT or Code 99 is an automated pager system response. Anyone touching the keypad beside the patient's bed or the keypad on the wall near the door will automatically trigger the hospital operator with the appropriate emergency need along with the room number.

**Four-Center Chaplaincy
Call Record**

Date: _____

**Requested by
Whom:** _____
(Example: RN, Doctor, Patient, etc.)

**Reason for
Request:** _____
(Example: RRT, Code 99, Death, etc.)

Figure 1. Call record.

Oncology Pre-Inservice January 2015							
Date	RRT	Code 99	Death	Patient	RN	Doctor	Other Staff
Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8
1/1/2015							
1/2/2015							
1/3/2015							
1/4/2015							
1/5/2015							
1/6/2015							
1/7/2015							
1/8/2015							
1/9/2015							
1/10/2015							
1/11/2015							
1/12/2015							
1/13/2015							
1/14/2015							
1/15/2015							
1/16/2015							
1/17/2015							
1/18/2015							
1/19/2015							
1/20/2015							
1/21/2015							
1/22/2015							
1/23/2015							
1/24/2015							
1/25/2015							
1/26/2015							
1/27/2015							
1/28/2015							
1/29/2015							
1/30/2015							
1/31/2015							
Totals	0	0	0	0	0	0	0

Figure 2: Pre-in-service record.

The Pocket Guide

I compared chaplain services provided by other hospitals in South Carolina and the services provided at AnMed Health and felt that the services provided at AnMed Health were no different than others. I designed a card listing those services as indicators when

to call a chaplain. I chose to bullet point each service by being as precise as possible to avoid complicated jargon and/or unnecessary verbiage (see figure 3).

1. In the event of a death: The chaplain is present to provide comfort and spiritual support. “As a minister, the chaplain is a spiritual and religious provider. Chaplains provide the religious ministry that is attached to various faith traditions, but they also provide spiritual care to people who profess no religion” (Paget & McCormack, 2006, p. 17).

2. When you must give bad news: Contrary to what most people may think, many doctors have difficulty in giving bad news to patients and/or their families. Thus, the chaplain often serves as support to the doctor, who knows that the chaplain will step in to assist if the doctor blunders.

3. When a patient receives bad news: Once bad news is given to a patient, the patient is often left alone to process the details of what has been shared. If the chaplain offers to stay, then he/she can make sure the patient and family have full understanding of the doctor’s discourse, and can be present to attend to the various emotions that may arise.

4. During an ethical dilemma: Chaplains are usually consulted when ethical situations arise. However, there are times when a team approach is warranted to determine the optimum course to a decision. In this case, an ethics meeting is requested. According to AnMed Health Policy and Procedure, “During an ethical consult, the panel helps the physician and patient (or their surrogate) identify and address the ethical issues involved in the dilemma; may suggest alternative rationales for making decisions and provides a forum for discussion of the issues involved. The Consult Panel does not make

decisions concerning a specific course of action, but facilitates decision-making by the physician and patient.”

5. To counsel during a family meeting: “Through their participation in the mutual journey, chaplains help patients, family, and staff reevaluate values and beliefs that give meaning to life and relationships. As chaplains facilitate listening, they help all parties involved understand, integrate, and respond to the transcendent—even (and especially) in times of uncertainty, suffering, and pain” (Paget & McCormack, 2006, p. 54).

6. When you are in spiritual distress: According to The National Association of Catholic Chaplains, “Spiritual pain is defined here as emotional distress due to spiritual and religious issues” (Spiritual Suffering). On the other hand, “Emotional suffering causes a great (*sic*) of pain to the mind as well as the body. It can cause us to be ill or even worse, nervous breakdown, self-pity, depression, anger, stress and so on” (Wasioleski, 2008).

7. When you need support: Cooper suggests, “The chaplain has the unique opportunity to become a spiritual companion and, thereby, journey alongside the patient in their distress and provide encouragement, support, reflective listening, and direction” (2011, p. 20).

8. During a staff crisis: This is a time when the chaplain’s skills are particularly needed. When staff fall apart this can cause a ripple effect. “Whenever people experience an event that disrupts their emotional or psychological balance (homeostasis) to the extent that their usual coping mechanisms fail, they are in crisis” (Paget & McCormack, 2006, p. 31). Chaplains bring a non-anxious presence into the situation allowing people to take a deep breath and work through their event.

9. If you desire sacrament: “Chaplains are often called upon to provide rites and rituals. These may include the celebration of marriages, infant dedications, christenings, and baptisms” (Paget & McCormack, 2006, p. 14). Additionally, chaplains provide communion and anointing as requested by patients. Rituals and sacraments that are most often performed in a parish, temple, synagogue, or other place of worship are performed by hospital chaplains.

10. To discuss advanced directives: Paget notes, “Health-care chaplains are also intercessors and advocates. They advise and encourage people in the health-care system so they may be free to choose their own path, to make difficult decisions, or to establish personal boundaries that meet their needs and affirm their values” (Paget & McCormack, 2006, p. 54).

11. To discuss end-of-life issues: This is a conversation that most healthcare providers dread to have and patients and their families dread to hear. Not that it is any easier for the chaplain; however, the chaplain has been trained to move in alongside the patient and assist him or her to add voice to their emotions, without judging them. It is a step-by-step process, moving from wanting everything possible to be done to acknowledging and accepting the inevitable: “I’m dying, just make me comfortable.”

At the bottom of the card is the pager number to contact the chaplain, thus making it readily available to the staff. The back of the card outlines “What is a Chaplain” and includes the necessary requirements to become a chaplain.” The Adventist Chaplaincy Ministries site along with The Association of Professional Chaplains site provided the information needed to address both queries. I consulted with my department director for

approval of the card before type-setting and printing in the AnMed Health print shop (see figure 4).

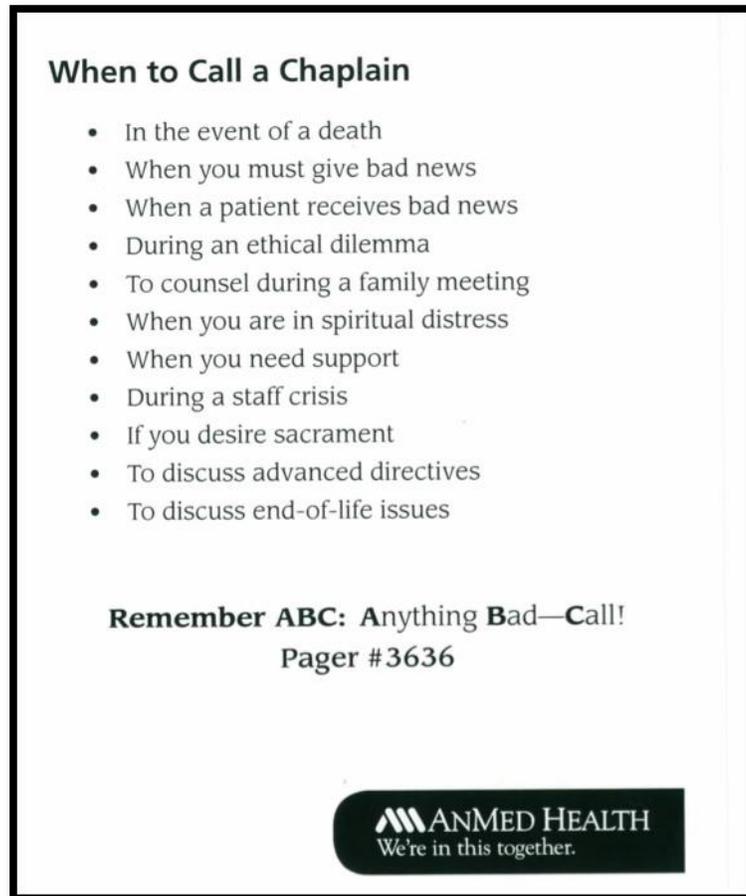


Figure 3. Pocket guide front cover.

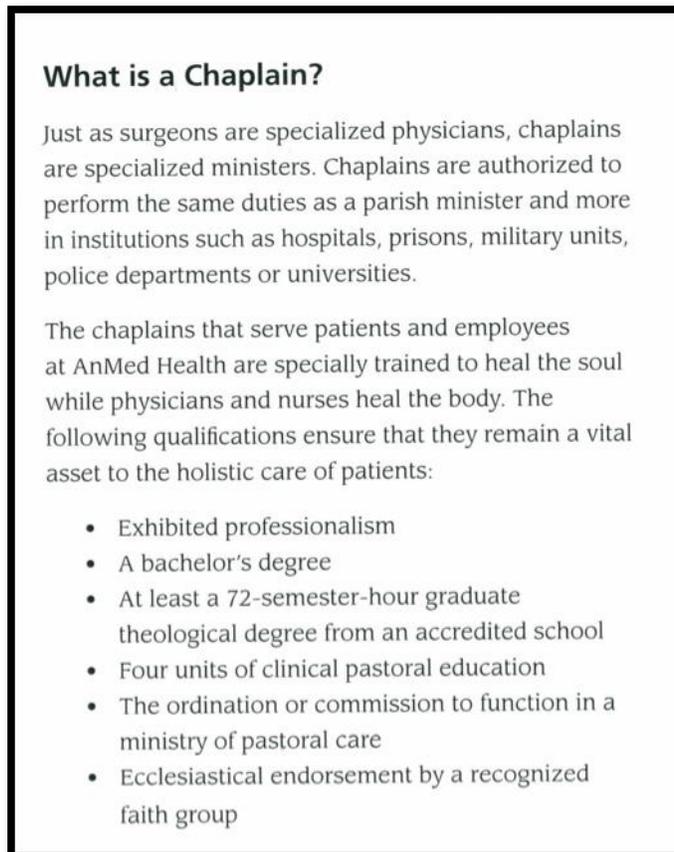


Figure 4. Pocket guide back cover.

In-Service Training

I contacted the nurse manager for the oncology unit in April to be added to her May staff meeting. I informed her that I would conduct an in-service with her staff to present a pocket guide for their use in determining when to contact a chaplain. A study performed by van Leeuwen et al. (2013) suggests, “Having only a religious characterization of spirituality in health care no longer is appropriate. Hence, health care

workers, including nurses, should consider the spirituality of patients from more than just the religious perspective” (p. 207). It is safe to say that chaplains along with patients depend upon nurses to be able to identify the needs of their patients whether medical or spiritual.

Four-Center Call Record Post In-Service

For consistency, I used the same Four-Center Chaplaincy Call Record form used in the collection of the Pre-In-service data for the Post-In-service data collection. (See Figure 1) This would be less confusing for the staff collecting the data. Once again, the information was transferred to a spreadsheet corresponding with the months June through October.

Follow-Up

For two additional months, I decided to spend extra time on the oncology unit. This was suggested to me by a member of my context committee. It was an effort to see if my presence on the oncology unit made a difference in the number of referrals. I increased my attendance during the daily multi-disciplinary rounds. The multi-disciplinary team visits each patient to determine if optimum care is being provided, answer any questions that the patient or family may have, and to ensure that everyone taking part in the patient’s care is functioning together towards a common goal. Thus, these meetings are making safety and continuity of care a priority. Sinclair and Chochinov (2012) agree with this approach, “The integration of spiritual care professionals within oncology teams promotes a proactive, routine and standardized approach to addressing patients’ spiritual needs” (p. 264).

I did my patient charting at the nurses' station. This allowed me to be present among the staff as a visual reminder of the availability of spiritual care for their patients. In addition, I intentionally engaged the staff more. By doing so, this allowed the staff to become more comfortable with me and therefore, trust me with their patients as well as their own personal issues.

CHAPTER 5

NARRATIVE OF THE IMPLEMENTATION

After an initial research at AnMed Health, and not able to find a similar study online, I decided to proceed with trying to help our nurses answer the question, “When should I refer patients to chaplains?” The implementation of this project began with IRB approval by Andrews University Seventh-day Adventist Theological Seminary and the AnMed Health IRB Committee. The process of completing the necessary applications and waiting for committees to meet took approximately two months before approval was granted from both organizations. The project and collection of data took 12 months to complete. This is taking into consideration the two additional months added at the end by my increased visits to the oncology unit and association with the staff.

The data collection has resulted in the following layout: Pre-In-Service Results, In-Service Results, Post-In-Service Results, and Additional Two Months Results. The compilation of the results includes a few figures for comparison from month-to-month and from data point-to-data point. This method made it easier for me to glance across the spectrum to readily observe the fluidity of the measurements. The varying colors also facilitated in distinguishing one data point from another. I will discuss the variability of the data as I reach each data point, noting changes where they occur. If the data did not change I have noted that, as well.

Pre-In-Service Results

Data were collected from full-time and part-time chaplaincy staff, using the call record provided to them, as noted in chapter 4. Having the support of my department director was very instrumental in soliciting other chaplains to follow through in filling out call record forms. In figure 5, there is a monthly comparison of the information outlined below. Note that life threatening issues, such as RRT (Rapid Response) and Code 99 (CPR) are included.

1. January, 2015, there were 2-RRT, 1-Code 99, 0-Deaths, 2-Patient request, 1-RN requests, 0-Doctor request, and 0-other request. The results did not improve over the remaining four months.
2. February: 0-RRT, 0-Code 99, 1-Death, 2-Patient request, 1-RN request, 0-Doctor request, and 0-Other request.
3. March: 0-RRT, 0-Code 99, 1-Death, 0-Patient request, 2-RN request, 0-Doctor request, and 0-Other request.
4. April: 0-RRT, 2-Code 99, 1-Death, 0-Patient request, 2-RN request, 1-Doctor request, and 0-Other request.
5. May: 0-RRT, 0-Code 99, 0-Death, 4-Patient request, 1-RN request, 0-Doctor request, and 0-other request

According to the data above, the five-month pre-in-service period had a total of two rapid responses or RRT, three code 99, three deaths, eight patient requests, seven registered nurses' or RN requests, one doctor request, and no category other request. I am pleased that the number of incidents in which an automated page would have alerted a

chaplain was low. This would indicate that not many patients died or were near death during this period. However, one can easily see that receiving only seven referrals from the nurses of a 30-bed unit which maintains a census of 95-100% warrants some form of intervention.

Pre-In-Service

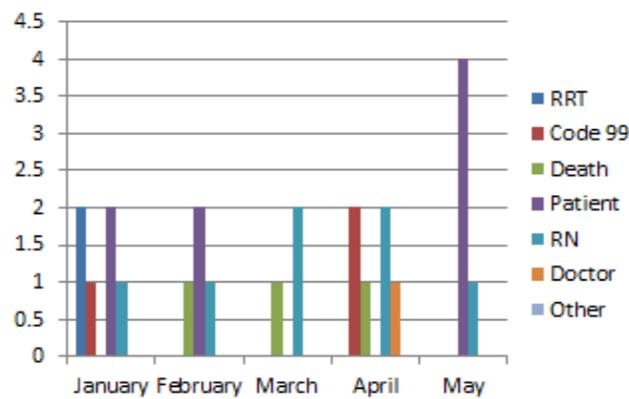


Figure 5. Pre-in-service.

I would like to add to this that Puchalski et al. (2009) suggest,

The goal of palliative care is to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care is viewed as applying to patients from the time of diagnosis of serious illness to death. (p. 885)

It should be noted that in all of the hospitals in South Carolina offering palliative care, a skilled chaplain is part of their team.

I was not surprised by this pre-in-service data (see figure 5). The whole idea of doing this research was to show that the oncology unit did not utilize the services of chaplains as much as they might, and to help improve the working relationship between

the two. In turn, the nurses on the oncology unit would realize the support gained from collaboration with chaplains, and as a result patients would be the beneficiaries of their teamwork.

It was easy to see from the pre-in-service data that I had to really emphasize the importance of utilizing the pocket-guide during my in-service with the oncology nurses. If the nurses did not grasp the importance or see the need for teamwork with the chaplain, the pocket-guide would be of little to no use to them. Another reason for teamwork is positive patient outcomes. Patient outcomes often determine, and in most cases, are directly related to hospital reimbursement. When patient scores are low, then Press Ganey (an outside and unbiased company which gathers patient engagement scores from one organization and compares them with similar organizations resulting in a percentile of favorability) scores are low. Gibbons, Thomas, VandeCreek, and Jessen (1991) when referring to the results of their research regarding the value of chaplains, they propose, “These data strongly suggest that the chaplain’s relationship to patients and their families is a significant influence on their selecting again and recommending a hospital” (p. 125). Gibbons et al. give the following reasons for this conclusion:

1. Chaplains are more highly valued by patients than either of the other support services (p. 123). Patients’ families and friends place a high value on chaplain services. That families often need pastoral care is not newsworthy. That they might need and value that service as much as patients do, or even more so (p. 123).

2. Extended stay and repeat admission patients and their families see hospital pastoral services as very important (p. 123).

3. More frequent visits lead to a higher level of patient satisfaction with each of the professions (p. 123).
4. The patient's attitude toward the hospital appears to be considerably affected by the counseling and support provided to the family by the chaplain (p. 124).
5. Chaplains seemed to be especially valued for their ability to provide support and counseling (p. 124).

The bottom line is chaplains are highly valued by patients and their families when their services are provided.

In-Service Results

The nurse manager for the oncology unit informed me in April of her May staff meeting. This unit routinely has monthly staff meetings to inform staff of changes or additions to any plan of care. Updates to policies and hospital inspections are noted during staff meetings, as well. It is not unusual for some form of in-service to be provided during these meetings.

Sharing my pocket guide was considered an in-service; and therefore, the staff had to sign an attendance record. Once the manager completed a few unit housekeeping issues and updates, she introduced me to the staff. Most of the staff I already knew; however, there were a few night shift staff members, along with a few weekenders, who were unfamiliar to me.

I gave every staff member a pocket guide before explaining the guide and my desire to make sure that I was available to them. I made a point of reminding the staff that they could call a chaplain anytime, seven days a week. Each of the nurses acknowledged their understanding of the pocket guide and assured me that they would

refer to it as the need presented. Given the opportunity, no one asked any questions. I felt that the in-service presentation went well and left with the expectation that the pocket guide would be of benefit and referrals would increase.

Puchalski et al.'s (2009) three models of spiritual care are considered. They are: (a) Spiritual Care Model, (b) Biopsychosocial-spiritual Model of Care, and (b) Interprofessional Spiritual Care Model. Each of these models looks at a person as a whole to determine his or her overall spiritual need. The team approach is certainly a positive approach to patient care. Puchalski et al. recommend, "If there is an interprofessional team involved then a board-certified chaplain, as the expert in spiritual care, provides the input and guidance as to the diagnosis and treatment plan with respect to spirituality" (p. 891).

Of the three models of spiritual care, I like the interprofessional model best. This is, according to the authors, "a relational model in which the patient and clinicians work together in a process of discovery, collaborative dialogue, treatment and ongoing evaluation, and follow-up. This is another example of the team approach to care" (p. 890). The patient and family are now part of the team and are fully aware of what is going on. This is the type of care that I would choose for myself. I believe that this type of spiritual care fosters trust and allows the patient/families to feel free to express themselves, even spiritually. This is the type of care that I would like to emulate on the oncology unit at AnMed Health. However, it starts with the small step of utilizing the chaplain appropriately.

Post In-Service Results

Once again, full-time and part-time chaplaincy staff were used to collect this data. The following information is also compared in figure 6 with notable variances. Over the same period, there was an increase in RN requests of 0.64%; there was also a decrease of 0.25% in patient requests.

1. June: 1-RRT, 0-Code 99, 0-Death, 1-Patient request, 2-RN request, 0-Doctor request, 0- Other request.
2. July: 2-RRT, 0-Code 99, 3- Death, 0-Patient request, 4-RN request, 0-Doctor request, 0-Other request.
3. August: 2-RRT, 0-Code 99, 1-Death, 1-Patient request, 2-RN request, 1-Doctor request, 1-Other request.
4. September: 0-RRT, 0-Code 99, 0-Death, 0-Patient request, 1-RN request, 0-Doctor request, 0-Other request.
5. October: 0-RRT, 0-Code 99, 0-Death, 0-Patient request, 2-RN request, 0-Doctor request, 0-Other request.

Though there is a slight increase in referrals made by nurses, the evidence does not show an overwhelming increase as I had expected, especially after a well-planned and carried out in-service. Sad to say, the nurses had not grasped the importance of not only recognizing spiritual distress, but the need to refer those patients to the care of a chaplain. While reviewing this data, I was reminded of what Puchalski et al. (2009) had written about spiritual assessments. They determined, “failure to assess spiritual needs may potentially neglect an important patient need; it also fails to consider patients as whole

persons” (p. 891). It was here that I noted the authors’ differentiation between a spiritual assessment and a spiritual survey.

They reasoned that spiritual assessments should be done by a board-certified chaplain, but that “Spiritual screening or triage is a quick determination of whether a person is experiencing a serious spiritual crisis and therefore needs an immediate referral to a board-certified chaplain” (p. 891). In essence, the nurses on the oncology unit should be able to provide a quick spiritual screening of their patients. If they determine that their patient is in spiritual distress or requires some other spiritual intervention, they are to notify the chaplain assigned to their unit.

I should add that Blanchard et al. agree with Puchalski et al. Blanchard et al. (2012) suggest, “When so engaged, and provided with a screening protocol, nurses are likely to make consultation requests electronically in greater numbers than was the case without a screening protocol.” Examining the post-in-service (see figure 6) data will show that was not the case at AnMed Health. Additionally, the data shows a decline in patient requests for which I cannot account.

Post-In-Service

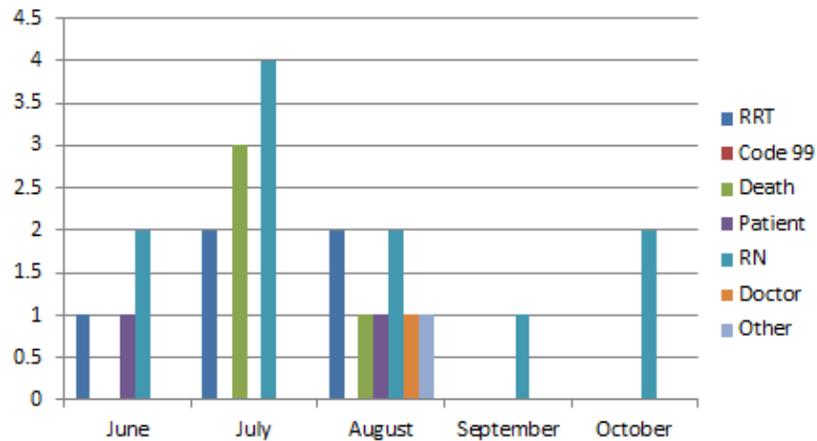


Figure 6. Post-in-service.

Additional Two Months Results

I decided on two additional months of data collection. Instead of using other staff members to obtain data, I collected it myself. I needed to know if there was something wrong with the pocket guide or the in-service, or if there were inconsistencies with the staff collecting the data. I quickly learned that there was nothing wrong with the pocket guide, the in-service, or the staff's ability to properly collect the data. There had to be some other reason as to why the nurses were not referring to chaplaincy services. With this in mind, I became intentional about spending more time on the oncology unit. I checked with each individual nurse to ask about the status of his or her patient. In addition to inquiring about their patients, I made a point of asking about the nurses' physical, social, and work life.

My visits became opportunities to learn more about the nurses and to help them feel more comfortable with me. This is not to say that I had not done this in the past; I had. However, I increased my time on the unit with the goal of being seen as an accountable and trustworthy team player. In chapter 2 of this work, I noted that it is imperative that chaplains and nurses have a good working relationship in order to provide optimum patient care. This is exactly what I was trying to foster.

The lack of referrals to chaplaincy care at AnMed Health, might have been greatly due to the nurses' lack of "trust" and understanding of the role chaplains play in patient care, and perhaps, their own spiritual discomfort. van Leeuwen et al. (2013) suggest, when referring to oncology nurses' hesitancy in performing some type of spiritual assessment of their patients, "Several other barriers to spiritual assessment may be identified: uncertainty of the nurse's role in providing spiritual care, unawareness, uncertainty, and lack of comfort with one's own spirituality and confusion about the definition of spirituality."

At AnMed Health, nurses are not expected to perform a spiritual assessment; however, they are expected to complete a spiritual screening upon admission. The primary reason for this is "Research indicates that spiritual care providers, i.e. chaplains, may identify spiritual distress through spiritual assessment, but in most clinical settings the ratio of patients to chaplains is so high that screening of every patient by a chaplain is not logistically possible" (Blanchard et al., 2012). Therefore, nurses must be educated in determining spiritual distress in their patients. The pocket guide is a well thought out tool to assist them.

My additional two months on the oncology unit was successful. As a result, the staff relationship with me greatly improved, so much so, that they began sharing personal details of their lives without my solicitation. Staff members who would seldom say “hello” in the hallways became like chatter boxes with laughter and funny gesturing. And, most of all, I was able to show that nurse referrals increased from 0.64% to 16%. Nurses referred patients who received bad news from their doctors and when notified early enough, they would ask for a chaplain when the doctor was to deliver bad news. They referred patients who did not have family to visit or whose countenance was low. If they were uncertain of a spiritual concern they did not hesitate to ask. Their firsthand experience with a chaplain who made herself available to patients and staff made the difference.

The turnaround in this two month period was remarkable. This is not to say that it was optimum, but an improvement, nonetheless. The nurses continue to feel more comfortable with chaplains and the care we provide. A collaborative effort towards patient care was being noticed.

CHAPTER 6

PROJECT EVALUATION AND LEARNINGS

This project sought to “Educate Oncology Nurses When to Refer Patients for Chaplaincy Services at AnMed Health.” This was due to oncology nurses not referring newly diagnosed cancer patients, bereaved patients, spiritually distressed patients, or patients with ethical dilemmas to the care of chaplaincy services. Research shows that chaplaincy services made a marked difference in the comfort level of patients and their family, staff members, as well as patient outcomes.

My evaluation and learning of this research is provided in this chapter in hopes of enlightening other chaplains on a method used to increased referrals here at AnMed Health. This research also shows the importance of building relationships with staff members to foster teamwork in providing optimum patient care, as reflected in chapter 5. I will provide an evaluation of chapters 2, 3, and 4, as well as my personal transformation resulting from this research project.

Evaluation of the Data: Chapter 5

Though the data in this chapter did not increase tremendously during the allotted 10 months, there was a slight increase. On the other hand, with the additional two months added, the increase should definitely be appreciated for what it is worth. There

are at least two reasons I believe the data was diminished: first, there was no perceived teamwork or partnership, and two, the staff was uninformed of the study and expectations.

1. There must be a clear understanding amongst staff members that each member is on the same team with the same set of patient goals and outcomes; this includes members of the interdisciplinary team. Trust is vital, as well as accountability. The additional two months spent on the oncology unit gave evidence of this. Once the nurses felt comfortable with me and experienced my pastoral care firsthand, their willingness to refer patients to chaplaincy services increased

2. Hindsight being 20/20, had the staff known that a study was being conducted I believe their attitudes towards results would have been different. This is not to say that patient care should not always be first and foremost, because it should. We should always seek to provide the very best care, treatment, and therapy possible. However, I have noticed that people are generally intentional about achieving good scores and /or results when they know someone is watching or keeping a close record of their actions.

I wanted the nurses to trust me with their patients without knowing that I was conducting a study for a research project. After building a relationship with the nurses my numbers improved. However, I wonder how much more they would have improved had I told them of my research project.

Likewise, there are two recommendations I would add; first, chaplains should make sure that they are visible and attending to the needs of their staff as well as their patients. Again, this will afford opportunities to develop relationships with the staff and improve their trust in the chaplain's pastoral care. Secondly, chaplains would fare better

by including their nurses in their research project and telling them about the project. This would create a sense of accountability, if not ownership, of the project.

Theological Conclusion: Chapter 2, A Theology of Suffering

I examined the theology of suffering by looking at two individuals found in Scripture who, in my mind, epitomize suffering. The first sufferer is “the paralytic” found in Mark 2:1-12. The second sufferer is “the woman with the issue of blood” found in Mark 5:25-34. I chose an outline which included spiritual suffering, emotional/psychological suffering, physical suffering, and social suffering for each sufferer.

Though each of the above sufferers’ maladies was different, the complexity of their suffering was the same. For example, it was a common thought during their time, that sin was the cause of their illnesses. Therefore, their “physical” malady was directly related to “sin” which caused their “spiritual suffering” leading to their “emotional/psychological suffering” and contributing to their “social suffering.” In this study, it was discovered that sin was not the direct cause of the sufferers’ malady, but that God would be glorified in their healing. Each of the aforementioned suffering types can be and is often seen at AnMed Health. However, sad to say, some of the suffering is self-inflicted.

Theoretical Conclusion: Chapter 3, Literature Review

The Bible was my first source of reference, since I began by answering the question as to the origin of sin. From Genesis 3:17-19 to Revelation 21:4 we are saturated with the notion that a man is born and will die. This dichotomy of life and death, I found,

can be explained by verse 19 of Genesis chapter 3. The sources used, such as, Mark Beuving's blog on A Theology of Sickness, Jean-Claude Larchet's book, *The Theology of Illness*, and Ellen G. White's book, *Medical Ministry*, agreed that sin was the cause of most illnesses suffered today.

I followed this by explaining what chaplains do since this was vital to my project. It was necessary for me to describe the specialized training of chaplains and why they should be contacted during any type of spiritual distress. Since chaplaincy has ventured outside the sterile walls of hospitals, the information in this chapter allows the reader to grasp the magnitude of varying areas and roles of chaplains. The congruency of the literature in this chapter was overwhelmingly supportive of chaplains and the calming presence they often bring to stressful situations.

I was limited by the availability of data including both oncology nursing and chaplaincy. The materials found all suggested that nurses and chaplains should work together to provide spiritual care for their patients. I realize from my study and research that had I included the nursing staff in my research from the standpoint of spiritual caregivers my results would have been different. The literature read gave evidence to why nurses should be adequately trained to perform a spiritual screening and/or assessment. This is certainly not to say that they should replace a trained chaplain; but that they should be able to work together to provide the spiritual care needed by the patient.

Methodological Conclusion: Chapter 4

Utilizing staff chaplains to collect data as to when nurses referred to chaplaincy service was the means of collection for this study. There were outliers to this study

because calls for chaplains were often made by other staff members. However, this study was to determine if a pocket guide would increase the request made to chaplains by nurses (see figure 7). The initial referrals of 7 made by the nurses increased to 11 after the in-service. However, after the additional two months there was a markedly increase of 67 referrals during that period of time.

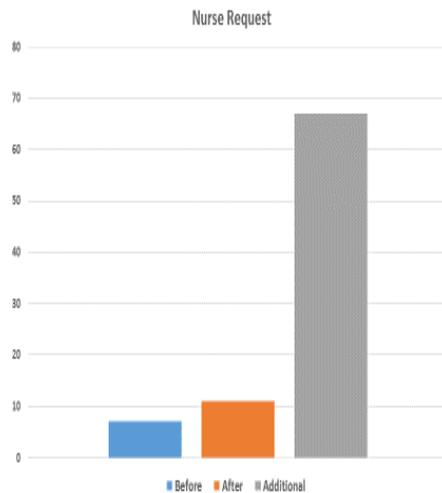


Figure 7: Nurse Request

The simple comparison of data before and after my in-service with the oncology nurses deemed that a type of measurement directed at this form of collection would be benefited by the approach of qualitative analysis. Therefore, the qualitative analysis for

this project was appropriate for the type of study conducted. I believe that the time period of this study was sufficient in that it allowed for ample data collection. The only hindrance I found to the data collection was in the relationship and trust of the oncology nursing staff with that of the chaplain.

As noted earlier, the evidence shows that the intentionality I took with the staff during the additional two months added to the study proved to be invaluable. It also shows, I believe, that had this approach been taken from the beginning the referrals from the oncology nurses would have been much higher. Additionally, I believe that further research is needed in order to better understand and formulate a compliance of the medical plan with the spiritual aspect so as to increase numbers for referrals to chaplains.

Since my study, the pocket guide is currently being used during the new nurses' orientation with much success throughout AnMed Health with one additional caveat: Teamwork. As noted earlier, teamwork is essential to optimum patient care.

Personal Transformation

This project, along with my studies, has been informative and transformative for me in several ways.

Informative: I have learned not to quit. As I worked comparing data from this project the numbers were not impressively good. What a difference an additional two months made.

The literature read during this project helped me to understand some of the dynamics of oncology patients, oncology nursing, and oncology chaplaincy. And though each is different, they all want the same thing: what is best for the patient.

Hospitals depend upon good patient satisfaction scores for Medicare and private insurance re-imburement. Hence, patient outcomes are “generally” directly related to patient satisfaction.

Transformative: The concept of work relations, though it may seem practical, is not always practical. However, since this project, as I make rounds throughout AnMed Health it has become portable for me. I no longer assume that people will automatically work with me because I am the chaplain. I have returned to the basics of CPE and come alongside others so that they know that I care and I am in it with them. Relationship is vital!

My prayer time has become more reflective and more inclusive of staff members and their personal problems, along with their specific needs. The joy of intercessory prayer brings added value to those I pray for. They are no longer “just” people I work with; they are “needy” souls I am working for.

It is my prayer that AnMed Health’s oncology nursing unit provides better care as a result of my Doctor of Ministry project. I have enjoyed the process and the learning and I am already contemplating another. Under God, I feel responsible for my self-development and partly for the growth of others. On the Andrews University Doctor of Ministry Program webpage, a slogan reads, “Changing the People Who Change the World” (Andrews University, n.d.). This can only be done if I continue on this path I have begun. I am truly grateful for this opportunity.

APPENDIX

POCKET GUIDE FRONT AND BACK

When to Call a Chaplain

- In the event of a death
- When you must give bad news
- When a patient receives bad news
- During an ethical dilemma
- To counsel during a family meeting
- When you are in spiritual distress
- When you need support
- During a staff crisis
- If you desire sacrament
- To discuss advanced directives
- To discuss end-of-life issues

Remember ABC: Anything Bad—Call!
Pager #3636

 **ANMED HEALTH**
We're in this together.

Pocket Guide Front

What is a Chaplain?

Just as surgeons are specialized physicians, chaplains are specialized ministers. Chaplains are authorized to perform the same duties as a parish minister and more in institutions such as hospitals, prisons, military units, police departments or universities.

The chaplains that serve patients and employees at AnMed Health are specially trained to heal the soul while physicians and nurses heal the body. The following qualifications ensure that they remain a vital asset to the holistic care of patients:

- Exhibited professionalism
- A bachelor's degree
- At least a 72-semester-hour graduate theological degree from an accredited school
- Four units of clinical pastoral education
- The ordination or commission to function in a ministry of pastoral care
- Ecclesiastical endorsement by a recognized faith group

Pocket Guide Back

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VITA

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Background: I was born on November 10, 1958, in Philadelphia, PA and came to live in SC at the age of twelve. I have a brother and sister older than me and a brother and sister younger than me. I am a fourth generation Seventh-day Adventist Church. However, I wasn't baptized until 1977.

Family: I was married on July 2, 1992 to John Simmons, from Clinton, SC. I have three adult children from a previous abusive marriage, Xavier (Born in 1977), Karla (Born in 1979), and Robert (Born 1983).

Education:

2017 DMin, Andrews University, Berrien Spring, MI
2008-2011 MDiv, (Pastoral Care Emphasis) Wesley Biblical Seminary (Jackson, MS)
2004-2006 Med, (Clinical Ministry) Atlantic Union College (South Lancaster, MA)
2003-2004 BA, (Theology and Religion) Atlantic Union College (South Lancaster, MA)

Commissioned:

2009- Commissioned by South Atlantic Conference of Seventh-day Adventists and currently hold ministerial credentials from Adventist Chaplain Ministries of the North American Division of Seventh-day Adventists.

Experience:

2012- Staff Chaplain for AnMed Health Center (Anderson, SC)
2007-2012 Staff Chaplain for Hospice of Laurens County (Clinton, SC)
2005- Head Elder for Zion Temple SDA Church (Greenwood, SC)
2005-2007 Chaplain Resident at Palmetto Health System (Columbia, SC)
1990-2005 Respiratory Therapist at Laurens County Hospital (Clinton, SC)
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