

The Ideal Intervention (Proposed Practice) Project

Background Paper

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Abstract

The Ideal Intervention (Proposed Practice) Project is a cooperative effort of chaplains and clergy to address some inadequacies that have been recognized in the practices of ministry for persons who are ill. The project has three interdependent facets that are designed to offer synergistic benefits when developed together:

I - The consolidation of reflective learning in clinical pastoral education programs through the *Ideal Intervention Paper* exercise.

II - The support of continuing education of chaplains and clergy through use of the *Ideal Intervention Form (Practitioners)* and shared reflective practice for performance improvement and the cooperative reflective refining of proposed ideal descriptions of practices for specific needs.

III - The development of a core knowledge base of proposed replicable interventions for chaplaincy through an on-line database of replicable descriptions of spiritual care *Potential Best Practices* tailored to specific patient needs, problems and circumstances that lead toward *Tentative Best Practices* and, ultimately, to evidence-based *Spiritual Care Best Practices*.

Synergism through the interdependent development of these three activities will also help to address the need of chaplains and clergy to demonstrate credible evidence of proficiency in the disciplined systematic effort to improve performance in providing spiritual care to patients, and will provide experience-based data for the stimulation of hypothesis development and further pastoral and spiritual care research.

The Ideal Intervention (Proposed Practice) Project is in its formative stages and has received support and participation from a number of chaplains and clergy since its beginning in 2006.

Introduction

The current institutional context in which religious, pastoral, spiritual, and existential care is provided to persons who are ill poses many challenges for chaplains. These challenges can discourage systematic research and performance improvement initiatives. The chaplain's workload usually does not provide time for systematic analytical work; there is no "publish or perish" incentive system in hospital or hospice chaplaincy, in contrast to academic positions; applied research in the form of systematic analysis of pastoral care processes has not been a prominent aspect of clinical pastoral education training; there are few tangible rewards for systematic research or

performance improvement initiatives, beyond the possible respect of colleagues and other professionals.

In addition the data that chaplains do find in their practice often is incomplete for performance improvement studies or research projects: the brief hospital stays by most patients in acute care do not allow chaplains to get to know many patients well enough to develop information for thorough case studies; during their short hospital stays, patients often are not clear-headed or free of the effects of anesthesia or pain control medication when a chaplain is available to visit; and patients also may be somewhat disoriented by the unfamiliar surroundings and the procedures of the hospital. The pastoral care needs of the patients are often, if not typically, inadequately known in advance of the chaplain's visit, and the chaplain usually must determine the most appropriate pastoral care plan and provide that care with little or no advance preparation. It is in this context that the chaplain must identify the most appropriate religious, pastoral, spiritual or existential intervention for each patient visited.

The need for systematic research and performance improvement studies by chaplains in health care has been articulated by many in the profession for many years. Some of the more recent overviews of the history, methods, needs and problems encountered in pastoral research for performance improvement have been provided by Larry VandeCreek (1988, 1999, 2000, 2003), Orlo Strunk (1989), Rodney Hunter (1990, 1991), John J. Gleason (1993, 2004), and Andrew Weaver, Kevin Flannelly and Clarence Liu (2008).

Gleason (2004) outlined the pragmatic problem which has recently been echoed in the Hastings Center Report (Kaebnick, 2008) on professional chaplains and health care quality improvement: the appearance that most clinical chaplains, community clergy, rabbis, imams, and lay spiritual caregivers who work in correctional, mental health and general health care settings minister in essentially idiosyncratic ways:

- they appear to bring various approaches to the spiritual relationship with patients without reference to any disciplinary norms or standards of practice;
- they approach the patient with their own unique styles of practice;

- they appear to be unresponsive to any effort to objectively identify what may be the best practices or consensus about their practices;
- and they appear to not comprehend their professional role in contributing to the improvement of health care quality.

Gleason (2004) noted that all clinical chaplains and clergy have a four-fold moral imperative: to stay abreast of religious, pastoral, spiritual, and existential research findings; to test the applicability of those findings for their practices in order to possibly improve their own quality of care; to engage in reflection-on-practice to more fully understand the outcomes of their practices; and to cooperate with their colleagues in systematically developing a knowledge base of applied practice experience.

The Ideal Intervention (Proposed Practice) Project Description

The Ideal Intervention (Proposed Practice) Project recognizes that there is variability in the ways that different chaplains, clergy and counselors provide spiritual or pastoral care, but views this variability of practice in the broader context of the variability that has been identified in the practice of medicine and in the therapeutic approaches of psychiatry and clinical psychology. As many authors have confirmed through empirical studies, there is much variability in the perceptions and decisions of physicians, even with the benefit of scientific tests and instruments for observing and measuring health problems and conditions (Wennberg, 1984; Eddy, 1984; Rutkow, 1982; Fisher et al, 2003a, 2003b). Dr. Eddy, after reviewing the evidence of the significant variation in the diagnostic perceptions and decisions of practicing physicians and specialists, addressed the very real concern of everyone who must seek medical treatment:

“The plain fact is that many decisions made by physicians appear to be arbitrary – highly variable, with no obvious explanation. The very disturbing implication is that this arbitrariness represents, for at least some patients, suboptimal or even harmful care. . . .

“Observer variations have been recognized for decades, but the findings are still startling, and the problem has not been solved. . . Substantial variations in what physicians see have been reported in virtually every aspect of the diagnostic process, from taking a history, to doing a physical

examination, reading laboratory tests, performing a pathological diagnosis, and recommending a treatment. A 1985 bibliography listed more than 400 articles that describe this problem. (p. 287)

“Where does this leave us? First, it must be emphasized that medicine is not practiced at random and is not a fraud. Physicians are not the Keystone Kops. Decisions might be variable but they are not whimsical or flippant. The variability occurs because physicians must make decisions about phenomenally complex problems, under very difficult circumstances, with very little support. They are in the impossible position of not knowing the outcomes of different actions, but having to act anyway.” (p. 289)

(Eddy, David M. (1990). The challenge. JAMA, 263(2): 287-290.)

Eddy outlined the many types of uncertainties which confront the physician in the practice of medicine (Eddy, 1984). The variation in psychotherapy and psychiatric treatments is also acknowledged to be significant. (Drake et al., 2003, 2008)

“... the gap between evidence-based practices and usual services is enormous in mental health.” (p. 1385)

(Drake, Robert; Skinner, Jonathan; Goldman, Howard H. (2008). What explains the diffusion of treatments for mental illness? American Journal of Psychiatry,165(11):1385-1392.)

Seen in this context, variations in the practices of chaplains and clergy are not surprising. Chaplains also are confronted with the many types of uncertainties in deciding what may be best for a patient. The Ideal Intervention (Proposed Practice) Project addresses the intersection of these types of uncertainties and the problematic environment in which religious and spiritual care currently must be offered and provided to persons who are ill. The project recognizes that institutional chaplains and congregational clergy face similar dilemmas and must accomplish their care-giving work in a context of organizational complexity and uncertainty.

The project is a voluntary collaborative effort of chaplains and clergy to develop jointly a core knowledge base for the profession of religious and spiritual care giving. This development is to be accomplished through sharing reflective practice experiences and fostering the specification of appropriate religious and spiritual care practices that

will be described adequately in terms of the professional norms for the operationalization of practices. This core knowledge base will link descriptions of patients' specific spiritual and religious needs with proposed chaplain and clergy practices that directly address those needs and problems.

Method

The goals of the Ideal Intervention (Proposed Practice) Project are to inculcate self-motivated reflective practice for life-long learning and personal professional development of chaplains and clergy, to facilitate the cooperative sharing of reflective experience and insights, to foster the search for pragmatic consensus on common purposes and practices, and to develop a core knowledge base of replicable descriptions of spiritual care practices tailored to the specific concrete needs and problems of patients and congregants.

Achieving these goals begins with the careful and perceptive description of the religious and spiritual needs and problems of patients. The *Ideal Intervention Papers* that clinical pastoral education students can develop, derived and elaborated from the verbatim reports that they prepare for peer discussions, are a starting point. The developing of *Ideal Intervention Papers* is a pragmatic way for those beginning to practice spiritual and religious care to learn how to incorporate reflective practice into their care for patients or congregants. This reflection on personal experiences of ministry should lead to identifying and formulating personal guidelines and individual portfolios of practice descriptions for caring activities that are tailored to the specific needs and problems of individual patients or congregants.

This progressive reflective practice should be conducted by experienced practitioners as well in collaboration with peers for the sharing of experiences and insights, and for the cooperative refinement of perceptions and proposed practices for addressing patients' and congregants' specific needs and problems. This collaborative sharing and refinement of perceptions and practices using the *Ideal Intervention Form (Practitioners)* can then provide pragmatic descriptions of proposed spiritual care

practices specifically designed to meet the specific spiritual needs and problems of patients. These descriptions then can become the contents of an on-line and accessible knowledge base of pastoral and spiritual care practices.

With a shared knowledge base of practices, the project is intended to support systematic cooperative efforts for confirming the effectiveness of specific religious and spiritual care practices for addressing particular kinds of problems and needs of patients in health care environments.

In summary, the dimensions or facets of the project are:

- I. Supporting and enhancing the clinical pastoral education learning process through the *Ideal Intervention Paper* exercise and broadening the perspective of students;
- II. Supporting Reflective Practice for life-long learning, personal professional development, and performance improvement initiatives through use of the *Ideal Intervention Form (Practitioners)*, with opportunities to comment and refine draft practices in a database of *Potential Best Practices*;
- III. Developing a knowledge base of specific spiritual care *Potential Best Practices* through consensus refinement and clarification of the proposed ideal interventions.

The replicable descriptions of specific interventions will have been tailored to various different needs and problems experienced by those who are ill. The detailed description of the interventions which are deemed appropriate for addressing those needs and problems--*Potential Best Practices*--enables these interventions to be replicated, tested, critiqued, and refined by other spiritual care givers, leading toward *Tentative Best Practices* and, ultimately, evidence-based *Spiritual Care Best Practices*.

Synergism through the interdependent development of the above three activities will also help to address the need of chaplains and clergy to demonstrate credible evidence of proficiency in the disciplined systematic effort to improve performance in providing spiritual care to patients, and will provide experience-based data for the stimulation of hypothesis development and further pastoral and spiritual care research.

Progress 2006 - 2008

The initial phase during the first three years of the project has focused on developing and confirming the usefulness and effectiveness of the *Ideal Intervention Paper* exercise for clinical pastoral education programs. The experience of a number of CPE supervisors has confirmed that the *Ideal Intervention Paper* can be effective in consolidating the learning of the students, as well as for making explicit the various specific needs and problems of the individual patients encountered by the students in their patient visits. The *Ideal Intervention Papers* give the students an opportunity to propose spiritual care practices that they deem appropriate and effective for addressing the specific needs and problems of the patients. The *Ideal Intervention Paper* exercise is consistent with and supports the goals and standards of accredited CPE programs by consolidating the learning gained from the traditional CPE peer group presentation of a verbatim record of pastoral care, and by introducing students to the discipline of reflective practice that supports life-long learning and continuing personal professional development. The *Ideal Intervention Paper* exercise also articulates and illuminates the concrete specific spiritual and religious needs and problems of patients, and provides initial descriptions of the needs for which appropriate responses by chaplains and clergy can be described.

This initial phase has included the design ideas for a prototype knowledge database of *Potential Best Practices*, based on the *Ideal Intervention Paper* descriptive documents that have been developed in the participating CPE programs. Examples of these initial *Ideal Intervention Paper* documents have been made available in a special section of the ACPE Research Network www.acperesearch.net web site.

Other Resources

Two other Background Papers by Heffernan, Reflective Practice for Performance Improvement and The Knowledge Bases of Professions, are available at mariejohn50@att.net upon request.

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Notes

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