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Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for Internal Medicine Residents and Chaplain Interns --Manuscript Draft--

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Abstract:	<p>Improved collaboration between physicians and chaplains has the potential to improve patient experience. To better understand the benefits and challenges of learning together, the authors conducted several focus groups with participants in an interprofessional curriculum that partnered internal medicine residents with chaplain interns in the clinical setting. The authors derived four major qualitative themes from the transcripts: 1. Physician learners became aware of effective communication skills for addressing spirituality. 2. Chaplain interns enhanced the delivery of team-based patient-centered care. 3. Chaplains were seen as a source of emotional support to the medical team. 4. The partnership has three keys to success: adequate introductions for team members, clear expectations for participants, and opportunities for feedback. The themes presented indicate several benefits of pairing physicians and chaplains in the setting of direct patient care and suggest that this is an effective approach to incorporating spirituality in medical training.</p>	

Curtis Hart, MDiv
Editor-in-Chief
Journal of Religion and Health

Dear Mr. Hart,

Accompanying this letter is our revision of “Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for Internal Medicine Residents and Chaplain Interns” JORH-D-15-00234. We thank you and the reviewers for the continued thoughtful consideration of our manuscript. We have revised the paper in response to the reviewers’ comments and we hope that it will now be acceptable for publication in the Journal of Religion and Health. For ease of your review, we have noted each reviewer comment in italics. Our responses are provided directly below each comment.

Reviewer #1: Very important work. Manuscript reads well. the only revision that I would like to see is if the author would provide more about Theme 4 in the text of the manuscript rather than directing me to a Table. As a reader, I only want to go to a table if I want more details. Maybe in the text, an exemplar quote would suffice.

We thank the reviewer for the suggestion in better presenting our findings. Accordingly, we have removed Table 3 from the manuscript, and have instead added a section with an introduction to each component of Theme 4 and representative quotes. To better organized findings for the readers, we have added bold headings for each theme, and underlined headings for the sub-themes in Theme 4. We have also corrected several small errors in the text, and improved the wording of some of the text.

Thank you for this very important work. Hopefully, this will model for other MD's how to address spiritual needs of patients. Interestingly, the curriculum was of benefit to the healthcare provider as well. I see lots of benefits for patient outcomes from this work.

We appreciate the positive regard of this reviewer, and certainly hope that our work will inspire other innovations in the fields of health care education.

In conclusion, we greatly appreciated the opportunity to revise our manuscript. We believe it has been improved by the review process and will make a significant contribution to the fields of medicine and pastoral care.

Sincerely,

Patrick Hemming, MD MPH

Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for Internal Medicine Residents and Chaplain Interns

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Abbreviations: JHBMC (Johns Hopkins Bayview Medical Center), CPE (Clinical Pastoral
Education), PH (Patrick Hemming), PT (Paula Teague)

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**Chaplains on the Medical Team: A Qualitative Analysis of an Interprofessional Curriculum for
Internal Medicine Residents and Chaplain Interns**

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Abstract

Improved collaboration between physicians and chaplains has the potential to improve patient experiences. To better understand the benefits and challenges of learning together, the authors conducted several focus groups with participants in an interprofessional curriculum that partnered internal medicine residents with chaplain interns in the clinical setting. The authors derived four major qualitative themes from the transcripts: 1. Physician learners became aware of effective communication skills for addressing spirituality. 2. Chaplain interns enhanced the delivery of team-based patient-centered care. 3. Chaplains were seen as a source of emotional support to the medical team. 4. The partnership has three keys to success: adequate introductions for team members, clear expectations for participants, and opportunities for feedback. The themes presented indicate several benefits of pairing physicians and chaplains in the setting of direct patient care and suggest that this is an effective approach to incorporating spirituality in medical training.

Key words:

Graduate Medical Education, Chaplain Hospital Service, Health Care Teams, Qualitative Research, Curriculum

1 Introduction:

2 Many patients see spirituality as important in their lives, and state a need to feel connected in
3 their medical care to their faith or spiritual beliefs (MacLean et al., 2003; Pearce, Coan,
4 Herndon, Koenig, & Abernethy, 2012). Spirituality has been defined as “the aspect of humanity
5 that refers to the way individuals seek and express meaning and purpose and the way they
6 experience their connectedness to the moment, to self, to others, to nature, and to the
7 significant or sacred (Puchalski et al., 2009).” As members of patients’ inpatient support
8 structure (Piderman et al., 2010), hospital chaplains specialize in addressing these patient needs
9 and can contribute significantly to patients’ satisfaction with care (Clark, Drain, & Malone,
10 2003; J. A. Williams, Meltzer, Arora, Chung, & Curlin, 2011).

11 In current hospital practice, physicians and chaplains generally have limited understanding of
12 each other’s expertise, and collaborate infrequently in patient care. Although others have
13 published interprofessional curricula pairing chaplains with nurses and social workers (Forrest &
14 Derrick, 2010; Otis-Green et al., 2009), and some curricula report involvement of chaplains in
15 medical student teaching (Talley & Magie, 2014), very little literature exists on interprofessional
16 education that pairs chaplain and physician learners (King & Crisp, 2005).

17 With regard to collaborating in patient care, physicians and chaplains each have gaps in their
18 training. Among physicians, many report feeling inadequate to address patients’ spiritual needs
19 (M. J. Balboni et al., 2014; Chibnall, Bennett, Videen, Duckro, & Miller, 2004). Studies have
20 found that physicians express less positive attitudes toward addressing spirituality than other
21 members of the healthcare team (Phelps et al., 2012), although other studies generally show a

receptiveness to chaplains (Fitchett, Rasinski, Cadge, & Curlin, 2009). Chaplains may not be accustomed to or be comfortable approaching physicians in connection with a patient's care. The potential benefits of pairing physicians and chaplains include greater patient and provider satisfaction, increased degrees of teamwork, improved spiritual care attitudes, and care that is more patient-centered and value-based (Fulford, Peile, & Carroll, 2012). A focus on spiritual care has been associated with positive patient outcomes, such as quality of life (Vallurupalli et al., 2012) and receipt of appropriate end-of-life care (T. A. Balboni et al., 2013). Teaching spirituality in patient care might benefit from an interprofessional approach, especially one that involves physicians and chaplains. Interprofessional education in health care has demonstrated both educational and patient-level benefits in other settings (J. C. Campbell et al., 2001; Morey et al., 2002; Reeves et al., 2010). Existing curricula aimed at teaching physicians about the spiritual care of patients tend to target medical students, only occasionally involve chaplains, and are not set in the context of direct patient care (N. Campbell, Stuck, & Frinks, 2012; Fortin A.H. & Barnett, 2004; Galanter, Dermatis, Talbot, McMahon, & Alexander, 2011). To address these needs, we initiated an interprofessional educational partnership in 2011, pairing chaplain interns and medical residents in the direct care of hospitalized patients. This paper reports on the findings of a qualitative analysis of participants' experience with this curriculum.

Methods

Study design:

Using focus group discussions, we aimed to identify perceived benefits and challenges experienced by participants in the curriculum. To do this, we conducted a qualitative analysis

of transcripts from four different focus groups made up of participants from the first two years of the curriculum at Johns Hopkins Bayview Medical Center (JHBMC) in Baltimore, MD. Focus groups included internal medicine supervising attending physicians, chaplain interns and internal medicine residents. A Johns Hopkins Institutional Review Board approved the study, and we obtained informed consent from all participants.

Setting and participants:

In 2011, The Clinical Pastoral Education (CPE) program for chaplain training and the internal medicine residency program at JHBMC began a rotation partnering chaplain interns with an inpatient medicine teaching service. Chaplain interns at JHBMC are individuals currently or previously enrolled in masters-level theology programs who are seeking a clinical application for their skill (McClung, Grosseohme, & Jacobson, 2006). Our CPE internship, similar to other programs is six months in duration, and requires time spent working with patients on inpatient services. For many chaplain interns in our program, this is their first experience working in a hospital and many have come to chaplaincy from other careers. These interns also have a variety of religious traditions.

The goals of the curriculum are to improve medical residents' ability to provide care that is sensitive to patients' spiritual needs, and to better equip chaplain trainees to work with physicians. Chaplain interns are paired with the medicine team to work together one day per week for 4 consecutive weeks on the Alike service. The Alike service is a unique ward team with a lower patient census where the chief aim is to ensure that residents know their patients as

1 individuals (Ratanawongsa et al., 2009). Since morning bedside work-rounds are standard on
2 this service, we chose this as the setting for the partnership to facilitate opportunities for
3 chaplain and physician learners to observe and learn from one another. All internal medicine
4 residents rotate through this service at some time during their three years on rotations that are
5 2 to 4 weeks. At the time of the findings published here, almost all of the 57 residents had
6 rotated on this service with a chaplain intern. Each year, all four JHBMC chaplain interns had
7 experienced a rotation with the medical team, for a total of 12 participants. Nearly all of the 15
8 faculty physicians who regularly attend on this medical service had worked with a chaplain
9 intern on the service.

10 During the four week rotation, chaplain interns spend one day per week rounding with the
11 medical team. They are introduced to patients as a member of the team and participate in
12 morning rounds at the bedside. During the afternoon, they partner with the team in supporting
13 patient care by returning to see patients identified as having spiritual needs. Patients may
14 decline to have a return chaplain visit. Chaplain interns are expected to teach the medical team
15 briefly about their role as a chaplain and how to do an initial spiritual assessment. Chaplain
16 interns are provided opportunities to role model discussions about spirituality with patients
17 during bedside rounds.

18 *Data collection:*

19 We conducted six separate focus groups between December 2012 and May 2015; one with
20 attending physicians (n=10), three with groups of chaplain interns (n=4, n=3, n=3), and two with
21 medical residents (n=4, n=6). Focus group facilitators used the prompts developed by the

curriculum development team to guide the discussion (**Table 1**). We intended for prompts to be open-ended, exploratory and to elicit both positive and negative aspects of the partnership. Based on prior anecdotal feedback, we hypothesized that participants would learn more about communication skills and interprofessional work. We also anticipated that participants would have challenges related to defining the role of a chaplain on the medical team. Focus groups lasted from 30 minutes to one hour, and were audio-recorded. One physician researcher (PH) conducted focus groups with groups from three years of chaplain interns. The first of these was done with four recent graduates of the internship, and the second on participants' last day of internship. The same researcher conducted the focus group with participating attending physicians at midpoint through the second year of the curriculum. Our director of pastoral care (PT) conducted the interview with a convenience sample of four upper-level medical residents at the end of the second year of the curriculum during a time regularly set aside for ambulatory medicine didactics. A physician researcher (PH) conducted another focus group with a similar convenience sample of six upper-level residents in the third year of the curriculum. An administrative assistant transcribed the focus groups from the audiorecordings and an author (PH) checked the transcript for errors. Two authors (PH and PT) separately coded each of the transcripts for themes, using the editing analysis style in which researchers identify segments of text that are meaningful to the context (Crabtree & Miller, 1992). We compared coding to examine for discrepancies and differences in interpretation. In the few instances where differences in interpretation existed, we adjudicated them by discussion until we reached agreement. We developed an outline of related themes across transcripts from these

codes. We again checked this outline with the initial transcript. We contacted two participating attending physicians, two internal medicine residents and one chaplain intern to review the themes developed from their statements to confirm accuracy. Representative quotes were agreed on by all authors.

Results

Table 2 presents the demographics of the focus group participants. Four major themes emerged from the discussions in each of the focus groups.

Theme one: Both attending physicians and residents became aware of effective communication skills for addressing spirituality

Physicians noted that they were introduced to new ways of approaching patient interactions from observing chaplain interns speaking at the bedside with the patient on rounds. These new techniques included active listening, observing, and using appropriate language for discussing spirituality. Multiple residents described learning how effectively they could help patients by simply being present and using silence. One resident described how she observed patients differently:

“One thing that I learned is to be more observant of the patient’s room. Some people have the bible on the table or some scriptures for the morning and those provided an opening for the chaplain interns to engage the patient in conversation. And I would never have noticed them before.”

One attending physician felt that watching chaplain interns model communication taught these skills more effectively than other potential teaching methods:

1 1 *"I felt that that experience with the team was very educational and more than what we could*
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6 2 *have learned in a didactic session - seeing someone at the bedside discussing spirituality."*

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10 3 A chaplain intern mentioned that after she had spoken with a patient in the presence of the
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12 4 rest of the team, she witnessed residents using the same greeting and introduction with other
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14 5 patients.

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19 6 **Theme two: Chaplain interns enhanced the delivery of team-based patient-centered care**

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22 7 Both attending physicians and residents appreciated the ability of chaplain interns to invite
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24 8 patients to share their own experience, by asking about important aspects of their lives. When
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26 9 chaplain interns shared these interactions with the medical team, everyone was better able to
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28 10 know their patients personally. One resident stated:

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31 11 *"The chaplain can come back and summarize to the team the salient details: social issues,*
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33 12 *family dynamics, personal suffering, and their understanding of how the patients' spirituality or*
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35 13 *religiosity intertwines with what's going on medically."*

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38 14 Also, physicians perceived the chaplain interns as extremely helpful in addressing the care of
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40 15 patients who were viewed as being more difficult to work with, as expressed by one attending
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42 16 physician:

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45 17 *"An example was a very challenging patient, a young man who lacked any social support, had a*
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47 18 *lot of pain and expressions of frustration. The chaplain intern helped the patient work through*
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49 19 *some of them and helped the team work through some of them."*

1 One chaplain intern mentioned that at times she was able to refocus bedside discussion on
2 rounds from a biomedical focus back to the patient's psychosocial experience:

3 *"If the patient would become agitated or anxious, my job is to try to bring calm, or peace or*
4 *understanding where there may not have been. The doctors were often sensitive as to when we*
5 *needed to intervene. "*

6 **Theme Three: Chaplains may be a source of emotional support to the medical team**

7 Multiple physician participants noted instances when, in the event of a challenging patient
8 event (such as a death or the need to deliver bad news), the chaplain intern took the
9 opportunity to lead a brief reflection on the experience. Both attending and resident physicians
10 welcomed this approach. In one case, when a patient was transferred to the intensive care unit
11 and died unexpectedly, the chaplain intern was able to follow the patient and family through
12 these events. When she debriefed the team, it provided a sense of continuity and closure.

13 Regarding the experience, a resident said:

14 *"We were able to sit together as a team to hear a little bit more about what had happened from*
15 *the chaplain's experience and had everyone else reflect on what their experience was with that*
16 *patient or other experiences with patients' deaths in our training."*

17 For chaplain interns, they learned from these interactions that they could lend meaningful
18 support to their physician colleagues. One chaplain intern noted:

1 *"I realized that my presence was helpful to the team when we went to hospice to visit a patient;*
 2 *to see how they depended on me then because it was so emotional for them. Before then I*
 3 *really didn't know what my presence meant to them."*

4 Medical residents saw chaplain interns as individuals who had expertise in handling some of the
 5 negative emotions that arise during patient care. One resident stated:

6 *"Chaplains actually have a lot of training on counter-transference and how to adjust to what*
 7 *patients' actions make us feel, and some of that gets to the idea of how to become a whole*
 8 *provider, and sort through some of the frustrations and anger and sadness that come from*
 9 *dealing in the medical field."*

10 **Theme Four: This interprofessional partnership has three keys to success: adequate**
 11 **introductions for team members, clear expectations, and opportunities for feedback**

12 Adequate Introductions

13 Chaplain interns noted that their integration in the team often depended on whether
 14 introductions occurred or not. In situations where no introduction was made, they perceived
 15 themselves as very peripheral to the team.

16 *"The team always changed, and introductions are really important to the chaplains to show that*
 17 *you're important, or they're glad that you're here: Tell us a little bit about yourself."*

18 Chaplain interns felt more integrated when physicians introduced the chaplains to patients as a
 19 part of the team. Medical residents noted that they appreciated knowing a little bit more
 20 about the CPE trainee, and that this fostered collaboration.

1 Clear Expectations

2 Early in the project, we became aware of the need to clarify for chaplain interns what was
3 expected of them. The lack of clarity caused frustration at times for both physicians and CPE
4 trainees. Attending physicians, unused to incorporating a chaplain on the team found it difficult
5 to bring them into rounds. In other cases, CPE trainees were eager to participate and
6 contributed to rounds in ways that were seen as distracting or inappropriate by the attending.
7 It became apparent that each participant needed up-front expectations of how to interact
8 across professional disciplines in rounds.

9 One chaplain intern noted:

10 *"I had some time with the attending alone the first time I went over. She explained to me what*
11 *they did and how they made their rounds. It's just helpful to get that. It's a matter of clarifying*
12 *what to expect."*

13 One attending noted mismatched expectations with a chaplain intern:

14 *"We just never got a good system down of how and when to have these conversations. We had*
15 *a lot of patients to see and I felt like that the (chaplain intern) didn't pick up on the cues when*
16 *we were in a hurry and would stop rounds and ask a lot of questions."*

17 Opportunities for Feedback

18 Chaplain interns early in the curriculum noted a lack of feedback on their contributions:

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4 1 *"You would just leave at the end of the day and think "I have no idea what any of them thought.*
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7 2 *If there's no direct feedback, you don't have a way of finding out that you really haven't maybe*
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10 3 *been doing what's appropriate."*
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12 **Discussion:**

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17 5 This work describes a new pairing in the field of interprofessional education. Medical and
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20 6 clinical pastoral education have developed in parallel, but without intersection for nearly a
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23 7 century (Gregory, 2003). The first three themes presented suggest strong potential to jointly
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25 8 advance training in core competencies of each profession.
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29 9 Medical schools, and to a lesser degree, residencies are adding training on spirituality to the
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31 10 formal curriculum (Fortin & Barnett, 2004; King & Crisp, 2005; H. G. Koenig, Hooten, Lindsay-
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34 11 Calkins, & Meador, 2010); however, these curricula do not generally use experiential learning in
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37 12 the context of direct patient care. Experiences that are relevant to the learners and allow for
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39 13 cycles of practice and reflection are highly effective in teaching skills and affecting behaviors
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42 14 (Kolb, 1984). In our curriculum, the interprofessional team approach--where participants
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44 15 observe one another and discuss their experiences-- allowed both sets of trainees to directly
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47 16 apply new skills and knowledge.
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50 17 Some medical educators have developed proposed spiritual care competencies for physicians'
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53 18 training (Anandarajah & Mitchell, 2007; Puchalski et al., 2009). In our curriculum, residents
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56 19 participated in activities related to these competencies, such as taking a patient's spiritual
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58 20 history, listening empathically and communicating a follow-up plan. Participants had the sense
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1 that through these activities they knew their patients better as individuals. By eliciting patient
2 values and preferences for care as a context for patients' disease, this biopsychosocial approach
3 fits textbook descriptions of patient-centered care (Smith, Fortin, Dwamena, & Frankel, 2013;
4 Stewart, 2003). Our participants felt that they were able to learn directly from the patient.
5 Other published medical curricula have similarly sought to allow the patient to be the teacher
6 (Henriksen & Ringsted, 2011; Towle & Godolphin, 2013).

7 Additionally, resident and attending physicians reported learning by observing. Social Cognitive
8 Theory suggests that learners adopt attitudes and behaviors commonly through observational
9 learning (Bandura, 1989). Wright and Reed have also described role modeling as invaluable to
10 learners' development (Reed & Wright, 2010). Chaplain interns were able to demonstrate to
11 medicine residents communication skills taught in Clinical Pastoral Education, such as non-
12 judgmental communication, active listening, and reflection on experience (ACPE standards and
13 manuals.2010). Chaplain interns then noticed medical residents using similar language with
14 patients following their shared interactions during rounds, suggesting that residents were using
15 practices they observed.

16 We did not initially envision that chaplain interns and medical teams would engage in mutual
17 emotional support. Without prompting, they took the opportunity to reflect on loss and grief in
18 a way that was therapeutic to members of the team. Residents described these experiences as
19 form of support group. Residents face significant distress in the course of their training and this
20 is linked to burnout, depression, at-risk drinking, suboptimal patient care, absenteeism, job
21 turnover and decreased satisfaction (Balch & Shanafelt, 2010; McCray, Cronholm, Bogner,

1 Gallo, & Neill, 2008; C. M. Williams, Wilson, & Olsen, 2005). Different health professions,
2 including chaplains, have approaches to coping with these stresses (Ekedahl & Wengström,
3 2008) and this role of caring for the medical team has been proposed elsewhere (H. G. Koenig,
4 2014). Other literature suggests that providers benefit from the use of support groups to
5 prevent burnout (Le Blanc, Hox, Schaufeli, Taris, & Peeters, 2007; Walter, Plaumann, &
6 Krugmann, 2013). Focus group residents felt strongly that chaplain interns' interventions
7 provided coping strategies, and in some cases closure, to difficult experiences.

8 Theme four, which focuses on curricular logistics, presents several opportunities to improve
9 team-based learning. Prior work on interprofessional education has identified role definition as
10 important to the team's function (Suter et al., 2009). The Institute of Medicine (IOM) suggests
11 that teams require briefing and debriefing to learn (Institute of Medicine (US), 2011). Briefing,
12 or "when team members look ahead at the work to be performed," includes introducing team
13 members and naming expectations. Based on the focus group findings, we have ensured that a
14 chaplain supervisor is present to introduce chaplain interns to the team on their first day. To
15 better clarify expectations, we have modified chaplain interns' orientation to include
16 instruction on the structure of the medical team, and the function of rounds.

17 The IOM report also emphasizes debriefing in the medical team. Learners require debriefing in
18 the form of feedback on their performance with regard to previously identified expectations.

19 Educational literature suggests that feedback is most effective when it is specific, is based on
20 expectations, is constructive to the learner's performance, includes opportunities for dialogue,
21 and when future observations with targeted feedback occur (Archer, 2010; Van de Ridder,

Stokking, McGaghie, & ten Cate, 2008). To address the need for feedback, we developed a structured feedback form that chaplain interns would use to elicit feedback from the attending physician, which has since been used by participants.

This study has limitations. We were able to include nearly every chaplain intern and a majority of participating attending physicians in a focus group; however, our sample of residents was smaller. Accordingly, the themes and quotes may not be representative of all residents' experience. Additionally, participants may have reported more positive experiences, given the researchers' known involvement with the project. Our residency heavily emphasizes patient-centered curricula, and our residents' attitudes may not be representative of internal medicine residents generally. Also, our sample included a larger proportion of female participants than might have been anticipated, potentially influencing our results. The chaplain interns, as shown in **Table 2** represent a variety of religious affiliations, but we did not ascertain the religious affiliations of physician participants. Finally, as with any qualitative study, interpretations and collection of data may be influenced by the biases of researchers.

This research raises the possibility of testable future research questions. A future survey of curriculum participants may establish the prevalence of these themes, and the impact on learners' skills and behaviors. We also have not yet collected direct patient perspectives, which are essential to understanding the true impact of this educational model. Although patients have reacted positively to the involvement of chaplain learners in their care, it is possible that patients may be uncomfortable with having a chaplain as part of their medical team.

1 In future evaluations, we intend to survey patients regarding their satisfaction with care and
2 perceptions of the team caring for them, as well as inquire directly about potential patient
3 objections to chaplain involvement and concerns about privacy and confidentiality.

4 5 **Conclusions:**

6 Our research suggests that medical residents, attending physicians and chaplain interns
7 working together in an interprofessional partnership can result in rich learning about patient-
8 centered communication, spiritual care and team-based care. Our participants' experiences
9 also demonstrate potential new strategies for addressing provider distress. In addition we also
10 found that, team-building exercises, such as group introductions, setting expectations and
11 feedback on performance are valuable in interprofessional team-based medical education.

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Table 1: Focus Group Prompts

<p>During your experience working on a medical team that included chaplains,</p> <ol style="list-style-type: none">1. What did you learn?2. How did you change?3. What was the value of this experience?4. What could have been improved?
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Table 2: Demographics of Focus Group Members

Attending physicians (n=10)		
Race:	Underrepresented minority	0 %
Gender:	Female	7 (70 %)
Rank:	Professor	2 (20 %)
	Associate Professor	3 (30 %)
	Assistant Professor	5 (50 %)
Subspecialty:	Geriatrics	5 (50 %)
	General Internal Medicine	3 (30 %)
	Hospitalist	2 (20 %)
Chaplain Interns (n=10)		
Race:	Under-represented minority	4 (40 %)
Gender:	Female	6 (60 %)
Faith background:	Protestant	7 (70 %)
	Catholic	2 (29 %)
	Jewish	1 (14 %)
Internal Medicine Residents (n=10)		
Race:	Under-represented minority	1 (10 %)
Gender:	Female	6 (60 %)
Residency Year:	PGY2	7 (70 %)
	PGY3	3 (30 %)