Lost in Translation: *The Chaplain's Role in Health Care*

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Chaplains often describe their work in health care as "translation" between the world of the patient and the world of hospital medicine. Translators usually work with texts, interpreters with words. However, when chaplains use this metaphor, it describes something other than a discrete task associated with the meaning of words. While medical professionals focus on patients' medical conditions, chaplains seek to read the whole person, asking questions about what people's lives are like outside of the hospital, what they care about most, and where they find joy and support in the world. Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns. Some chaplains are skilled at translating patients' experiences and sources of meaning in real time, allowing medical teams to better understand the person they are treating. "Translation" is also defined as metamorphosis. Chaplains

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provide this sort of translation when they are alone with patients, listening to their deepest concerns, helping them redefine their lives.

Unlike a professional interpreter, who helps patients and clinicians communicate when they do not share a common language, the chaplain is not just a conveyor of the spoken words of others. A patient, family member, nurse, or physician may seek out the chaplain for help in translating a situation: Is the family in denial? Is the team giving up? Is the patient ready to go home, like her husband says, or ready to rest, like she says?

Ironically, chaplains—skilled at mediating between patients and hospital staff—often have no one they can rely on to advocate for them at budget time, no one who can "translate" the tangible benefits chaplains provide to patients, families, and staff into terms hospital administrators can understand.

The Professional Chaplaincy and Health Care Quality Improvement research project was initiated, in part, in response to this dilemma: If chaplains wish to be recognized as a health care profession, they need to be able to describe, to themselves and to others, what constitutes "quality" in their area of patient care. Like other health care professionals, they need to specify how their profession and their day-to-day work in the hospital contribute to the ongoing task of quality improvement in health care. This is no easy task. The work that chaplains do is difficult to measure in conventional QI terms: the precise duties of their job are unspecified, and chaplains often find themselves improvising to meet the needs of patients and caregivers. In this situation, how can chaplains define their role in improving health care? External perceptions of chaplains and chaplaincy also complicate this translational task: is chaplaincy best understood as a specialized form of religious ministry, in—but not of—the health care setting? Or is it truly a *health care* profession, and if so, what is the nature of the health care service that chaplains provide, and how is it relevant to patients' health care needs and their treatment? Is it, in some way, both of these? Without attention to these broader sociological questions, it is difficult for chaplains to see themselves as a "professionalizing profession," and to make the special nature of their work understood to the administrators who must make decisions about investing in services that have no reimbursement code.

Raymond de Vries and Wendy Cadge, two of the authors of this essay, were invited by project codirector Nancy Berlinger, the third author, to participate in this project as sociologists who would observe, reflect, and offer a series of thinking points about the profession and future of hospital chaplaincy. De Vries comes to the project as a sociologist of bioethics (another occupation struggling with its identity and place in worlds of medicine and science) and with expertise in the sociology of culture and the professions. Cadge is a sociologist of religion who studies, among other things, the formal and informal presence of religion and spirituality in hospitals. The three of us offer our thinking in the spirit of continued conversation and with deep respect for the work of health care chaplains.

The Road to Professionalization

Seen from the point of view of the social sciences, the desire of chaplains to strengthen their profession—to more clearly define their work and to establish agreed-upon standards of practice for those eligible to be called "chaplain"—is a predictable stage in the natural history of an occupational group. Changes in society and technology bring with them changes in the division of labor. Not only does the nature of and need for work change (think of the new occupations created by the computer revolution); so, too, does the way the work of society is divided among occupational groups.

Sociologists have long observed the comings and goings of occupational groups, and they pay particularly close attention to the strategies and social conditions associated with the successful and unsuccessful efforts of these groups to secure a place in the division of labor.[1] As chaplains consider the work they must do to establish their profession, insights derived from the sociology of occupations are useful. The following metaphor, drawn from the sociology of work and occupations, offers a helpful perspective on chaplains' place among other occupational groups:

> Think of all the work that has to get done in a society as the landform upon which a city is based. The division of labor is the street grid that defines this landform: some areas are zoned for manufacturing, others for services, some for respectable tasks, others for deviant ones; some areas are identified for the market, others for domestic labor. Each zone . . . is a site for potential ecological struggle. Some are securely occupied by well-entrenched occupations. Others are scrapped over: some want to annex new areas to territory they already control; some wish to abandon a declining area in order to colonize a more desirable one; others desire to take over a neglected patch and displace or organize the existing occupants to improve it.[2]

Similarly, as chaplains seek to "stake a claim" in the terrain of health care they are, in some cases, seeking to "annex" areas that others control, and in other cases they are moving into territory abandoned by other professions.

Also relevant to the situation of chaplains are the ideas about labor markets developed by Eliot Freidson, the preeminent twentieth century sociologist of the professions. According to Freidson, human labor may be divided into four "economies of work" based on the nature of labor markets. Best known, of course, is the *official* labor market, where work is legally and economically recognized, included in measures of production, and categorized in the census lists of job titles. But alongside the official market for work exist three other markets: the *criminal* labor market, the *informal* labor market, and the *subjective* labor market. It is this last market—the subjective—that is most pertinent to chaplaincy. Freidson defined this arena as the market where goods and services are traded

without direct economic exchange, and he saw it as both the cradle and the grave of many occupations. Chaplaincy can be understood as work that moved, or perhaps is moving, from the "subjective" to the "official" labor force: having begun as "volunteer" work by clergy whose "real" job was ministering to a congregation, it is now an occupation paid to be a pastoral presence in health care settings.

As chaplains seek to map out their territory in the world of work—to move their occupation from the subjective labor market to the official labor market—they must overcome certain challenges generated by their history and the nature of their work.

No clear jurisdiction. First, hospital chaplains do many things. This "jack-of-all-trades" approach serves the needs of a new occupation well—in seeking to establish a foothold, occupational groups are wise to serve the needs of established professionals and ingratiate themselves with occupations that have more political power. But what works to get one's foot in the occupational door harms efforts to professionalize. In some ways, being a chaplain is a "vacuum identity"—the work of chaplains can be seen as filling the many vacuums that arise among the jobs of other professions in medical settings. Chaplains fill a void rather than offering a well-defined service. In order to secure a place as a profession, an occupational group must have a clear boundary around its work. It is difficult to stake a jurisdictional claim with an ambiguous definition of one's jurisdiction.

Disagreement within the occupational group. Not surprisingly given the many tasks and varied educational backgrounds of chaplains, disagreement exists within the group about the proper definition of a chaplain. The leaders of the main professional groups of chaplains have established credentialing standards to answer two basic questions: What must a professional chaplain know, and what kind of training is required to gain that knowledge? On the other hand, these same leaders have not yet reached agreement on standards or scope of practice: What should all chaplains do, or refrain from doing, in recognition of a duty of care? What are the boundaries in which they do these things? Disagreements about the answers to these questions slow the move toward full professional status. Those who prefer the status quo and those who feel threatened by the move toward professional status can undermine efforts by the occupational group to professionalize.

Self-defining. Because chaplaincy is not yet broadly recognized as a distinct profession, others may feel entitled to use or be granted the title "chaplain" when they are doing certain things. For example, clergy who do not work as health care chaplains may claim the title "chaplain" when they are visiting hospitalized members of their congregation. Volunteers in chaplaincy departments are frequently called "chaplain" by patients and family members. These realities work against efforts to distinguish the work of professional chaplains, and they make it difficult for other professional groups, and the public, to see chaplaincy as a distinct health care profession. A patient in a U.S. hospital is unlikely to encounter a "volunteer" physician—the category of "physician" is understood to be a professional category. However, understaffed pastoral care departments rely on volunteers to meet specific, often religious, needs of particular patient groups. An internist would be professionally remiss if she called herself a "surgeon" solely on the grounds that both internists and surgeons have medical degrees. However, a community clergyperson might defend his right to be called "chaplain" even though the only thing he or she shares with a health care chaplain is the same postgraduate degree. Defining what professional chaplains do, what volunteers do, and what community clergy do with respect to "chaplaincy," and determining which of these activities are health care services and which are religious services, are further challenges for this profession.

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Challenging others' turf. In staking their claim for a piece of property in the world of medical work, chaplains trespass on the work of others. Some occupational groups will not mind giving up a bit of their property (see "dirty work" below), but others will be more reluctant. Two groups that may resist incursions in their work are social workers and local clergy. Many of the tasks that chaplains do can be seen as tasks that social workers do—for example, making arrangements for family members or helping to solve disputes between medical staff and patients and families. It is likely that some medical social workers will not look kindly on those who threaten their livelihood. Also, local clergy may see professional, hospital-based chaplains as encroaching on the important work they do with members of their congregations.

Taking over "dirty work." Sociologist C. Everett Hughes was the first to examine how dirty work is passed among and within occupational groups, typically flowing down the ladder of prestige. Chaplains may not regard the work they do as being "dirty," but in the eyes of more established professions—such as physicians—talking with patients about spiritual concerns or ensuring that their pastoral care needs are

met are distractions from the "real" work of medicine and can be a source of discomfort for members of these professions. As a presence that relieves physicians from this unpleasant work, chaplains can use this aspect of their job description to advance their efforts to professionalize.

The "theology problem." Chaplains are products of recognized faith traditions: they graduate from seminaries, divinity schools, or rabbinical schools; most are ordained; and they are required to document their relationship to a recognized faith tradition as one of the requirements for chaplaincy certification. However, once certified, many are called on to be "multifaith" and to be available to patients who reply "none" when asked if they have a religious preference. Deploying chaplains outside of the religious traditions in which they were trained further confuses their professional identity: most other professions do not work this way. (One that does is clinical bioethics, an interdisciplinary field in which many practitioners were trained in a specific academic or professional discipline, rather than in "bioethics." However, this may change as more universities offer bioethics degrees that can function as a professional credential.)

This problem is compounded by the fact that some chaplains work in faith-based institutions that have their own religious ethos. In these situations, chaplains may be responsible for adhering to religious guidelines in delivering health care services, but they may also be called to serve a multifaith patient population. How chaplains in these settings negotiate the institutional religious ethos is an open question.

No agreement on best practices. As part of the health care work force, chaplains are being asked to join the quality improvement movement. But unlike medical work where interventions can be tested in rigorously controlled clinical trials, chaplaincy work is difficult to measure. Quantity is frequently substituted for quality: chaplains may be encouraged to "make the numbers" by focusing on the number of patients visited each day, rather than on the quality of the encounter with each patient and the outcomes for that patient's care. The lack of evidence for the medical efficacy of practices that may promote patient well-being presents another challenge to chaplaincy. (It is a challenge sometimes shared with palliative care and integrative medicine: these services differ from chaplaincy in that they are not perceived as "religious," however, and they are done by members of recognized medical professions.) In this climate, chaplains are inclined to argue among themselves over best practices, once again dividing the occupational group and slowing efforts to professionalize. If members of the occupation cannot agree on how to define and measure their own work, then why should society grant them professional status?

Many credentials, no license to practice. Chaplains who are ordained clergy are already members of a professional category. (Some chaplains come from faith traditions that do not ordain clergy or do not ordain women.) However, ordination, board certification, or specialized certifications available to chaplains are not the equivalent of a state license to practice medicine, nursing, clinical social work, or clinical psychology. This is one important mark of a "profession"—state recognition of an occupation as a profession by using licensure to "close the market"—to prevent competition from those not properly certified. Sociologists disagree about the politics of licensure. Some believe that state licensure is given in response to the demands of a well-organized occupational group, while others believe that states grant licensure only when "closing the market" is in the interest of the state. Chaplains do not have to settle this debate, but regardless of which theory is correct, they do have work to do if they are to gain the advantages of licensure.

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Soft skills. The work of medicine is often divided into curing and caring, with the "hard" skills of curing or controlling disease accorded much more respect than the "soft" skills of caring or "healing." The "harder" the skill, the more the prestige: thus the status of surgeons is much higher than that of family doctors or palliative care specialists. Chaplains are clearly on the caring, soft side of medicine, and while this will not prevent them from claiming professional turf, it will be the turf of the ancillary medical occupations.

Salaried, yet responsible to patients and families. Like nurses, chaplains who are paid by health care organizations are in a difficult position. Their paycheck makes them answerable to their employer, but their duty is to meet the needs of patients, families, and staff. Often, these obligations coincide—good care for patients and staff members benefits the hospital—but there are cases where chaplains (and nurses) are asked to bite the hand that feeds them by calling attention to care that is not as good as it could be and to unreasonable organizational demands on staff. This situation presents challenges to the autonomy of the occupation that more established professions do not face. Also, while nurses are a large profession that is often unionized and whose services are in demand, chaplains are a small profession that lacks the collective power to protect their autonomy at the negotiating table.

Self-Interest and Public Interest

In their journey toward professional status, chaplains must find a way to balance professional self-interest and the interest of the people they serve. The official party line of most professions is that all their organizational efforts are undertaken on behalf of their clients, but decades of sociological analysis show this claim to be hollow. The best-known examples of professional self-interest come from the field of medicine, where we have seen doctors in the United States consistently resisting changes that would improve access to health care. The American Medical Association famously fought the legislation that created Medicare (health care for the elderly and disabled) in the 1960s, arguing—with a strong dose of self-interest—that the plan would reduce the quality of care for all. More recently, "white coat" rallies calling for malpractice reform have at times cast physicians as the victims of greedy, litigious patients.

The "bedside" orientation of chaplains may make them less likely to put professional interests ahead of the interests of patients and families. However, some chaplains tell us that they avoid these uncomfortable conflicts by "flying under the radar." This metaphor suggests that chaplains may view their employing institutions or their professions as antagonistic to their interests: a pilot flies under the radar to avoid getting shot down by the enemy, not merely to avoid being noticed.

Our review of the strategic plan of the Association of Professional Chaplains shows how easy it is to conflate professional and patient interests. Here are the seven goals of the APC described in their 2007–2008 strategic plan:

> Goal A: Increase collaboration and interaction with other appropriate chaplaincy, spiritual care, and human service organizations.
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> Goal B: Increase awareness of the value of Board Certified Chaplains.
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> Goal C: Increase members' ownership of the APC.
>
> Goal D: Increase the participation by those of diverse backgrounds in activities of the APC at all levels.
>
> Goal E: Identify and develop resources sufficient to fund and accomplish APC programs.
>
> Goal F: Nurture the spiritual life of APC members.[3]

The first five of these goals are about building the credentialing organization itself. With the possible exception of the final item, none of these goals seeks to improve the capacity of chaplains to meet the spiritual, emotional, and physical needs of patients, families, or health care workers. Also absent from these explicit goals is a commitment to conduct or contribute to research that could provide empirical evidence of the value of chaplains to patients. Doubtless the drafters of these goals sincerely believe that strengthening the credentialing organization will improve service to clients. However, the sociology of organizations teaches us that means often become ends.

How can chaplaincy avoid the extremes of "flying below the radar" (which works against unifying the profession) and the self-interested move of reducing the goals of health care to the goals of health care organizations? How can the profession correct these errors of translation—self-understandings that seem to offer security but in fact may create barriers to professional maturation by perpetuating a vision of a profession as insular or marginal?

Here are our recommendations. Chaplains and their organizations should think about how to translate the meaning and value of their work into terms that hospital administrators and others in decision-making positions can understand. In health care, translations must be clear and accurate if they are to provide an adequate basis for understanding and policy. Chaplains should make a practice of translating *from* the terminology of health care systems *into* that of their own profession. By paying close attention to the nature of institutional decisions about patient care, how various patient care professions are deployed, and the concerns of decision-makers in general, chaplains will be able to identify research questions that can yield reliable information about the chaplain's contribution to patient care. These activities should not be confused with "making the numbers" or merely reacting to institutional concerns.

We also encourage chaplains and their organizations to look for examples of individual chaplains or chaplaincy departments that are proficient translators and to analyze what makes them good at explaining the value of what they do to others.

Finally, because chaplains seek to work in the complex culture of health care delivery, and because claiming a professional role in this culture means acknowledging one's organizational responsibilities, we encourage chaplains who aspire to lead chaplaincy departments to receive some training in health care organization and management. We also encourage organizations that offer continuing education to chaplains to recognize this need and provide credit for this training.

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1. This discussion of the sociology of occupations is borrowed from an analysis of the professionalization of bioethics found in R. de Vries, R. Dingwall, and K. Orfali, "The Moral Organization of the Professions: Bioethics in the United States and France," forthcoming in *Current Sociology* 57, no. 4 (July 2009).

2. Ibid.

3. Association of Professional Chaplains, "2007–2008 Strategic Plan," http://www.professionalchaplains.org/uploadedFiles/pdf/Strategic%20Plan%202007-2008%20-%20no%20imp%20points-portrait.pdf.