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ORIGINAL PAPER

Chaplain–Physician Consultancy: When Chaplains and Doctors Meet in the Clinical Context

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Abstract This paper summarizes the perspectives of 327 Australian health care chaplains concerning their interaction with physicians within the clinical context. In general terms the findings indicated that nearly 90% of chaplains believed that it was part of their professional role to consult with physicians regarding patient/family issues. Differences of involvement between volunteer and staff chaplains, Catholic and Protestant, male and female chaplains and the type of chaplaincy training are noted, as are the perspectives of chaplaincy informants regarding their role in relation to physicians. Some implications of this study with respect to chaplaincy utility and training are noted.

Keywords Chaplain–physician consultancy · Pastoral care · Pastoral medicine

Introduction

The provision of pastoral and spiritual care to patients and clinical staff within most Western health care contexts has been predominantly and traditionally undertaken by health care chaplains. More recently there has been some debate about the role of physicians providing spiritual care and that physicians, rather than undertaking such tasks, should preferably be 'making links with chaplains and other religious representatives' as part of a holistic approach (Pembroke, On-line first). There has, however, been very little empirical research concerning the interaction between chaplains and physicians in the provision of holistic care.

During the 1970s, Clinebell (1971) suggested some basic essentials to enhance physician–clergy relationships (Table 1). Nevertheless, by the 1990s VandeCreek (1991) argued that 'subtle antagonism' seemed to harbor between the two professions due primarily to the different values internalized over many years of seminary and medical school. Within the

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Table 1 Five essentials for strong physician–clergy/chaplain relationships (Clinebell 1971)

1. Mutual understanding and appreciation of each other's unique competencies, views, insights and contributions to the helping-healing enterprise
2. Willingness and the opportunity to communicate
3. Openness to learn from each other
4. A robust sense of professional self esteem
5. More frequent opportunities to work together in helping the same patient/parishioner

clinical context, Underwood et al. (1991) argued that 'chaplains and physicians were often ambivalent toward each other,' that chaplains projected their 'unfinished authority/power conflicts onto physician colleagues' and that physicians projected 'their mixed feelings concerning religious and spiritual issues onto the chaplain'—a dualistic situation leading to 'confusion,' 'hostility,' and 'distance.' Unfortunately Underwood et al. failed to provide any evidence to support such dynamics.

According to Eyer (1991), however, individual physicians and chaplains sometimes developed a collegial respect for each other due to medical staff witnessing a chaplain providing 'support to suffering people' who needed 'personal care during objective and clinical medical procedures' and that chaplains had, in various ways, 'just as equally cared for physicians,' particularly given 'patient deaths,' personal 'dependency issues' and reputation damaging 'malpractice' accusations.

Other authors such as Faulk (1991) argued that issues such as 'grief' following patient death, 'moral and ethical issues,' plus 'religious/pastoral education,' are all areas in which chaplains can assist physicians and thus develop better chaplain–physician relationships. These in turn can facilitate a more integrated quality of care for chaplains, physicians, and patients. Likewise Underwood et al. (1991) (given their emphasis upon teamwork within cardiopulmonary rehabilitation and blood pressure clinics), noted that through 'interdisciplinary consultation,' 'combined study programs' and 'patient/family pastoral counselling,' that chaplain–physician relationships can be highly productive for achieving holistic patient outcomes.

More recently Williams (2008a) noted (based on the work of Orchard 2000 and Handzo and Koenig 2004), that while the physician's agenda may involve spiritual assessment, nevertheless physicians do not have the training, expertise, or time to provide total spiritual care but rather any such pastoral person–centered-care was the unique contribution of chaplains in three particular ways: (i) assisting with the search for meaning, (ii) as experts in maters of life and death, and (iii) as experts in religious ritual (Williams 2008a). The World Health Organization ICD-10 Pastoral Intervention Codings (Australian Modification) also summarizes and codes the unique contribution of chaplains as, (i) Pastoral Assessment (including spiritual assessment), (ii) Pastoral Ministry (including presence and support), (iii) Pastoral Counselling and Education, and (iv) Pastoral Ritual and Worship (WHO 2002). Given a common lack of knowledge about the role of chaplains however, Williams argues (similar to Underwood et al. noted earlier), that there is a need for more dialogue and collaboration between doctors and chaplains which, she argues, can be achieved through: (i) teaching and training, (ii) teamwork, and (iii) developing credible evidence-based research (Williams 2008b).

Chaplaincy–Physician Teamwork

Arguably the first credible empirical study to explore chaplaincy–physician consultancy was that of Raymond Carey's ground-breaking research entitled, 'Hospital Chaplains: Who

Needs Them?' (Carey 1972). The research involving over 400 personnel at the Lutheran General Hospital, IL, USA, explored the perceptions of doctors, nurses, chaplains, and patients concerning various chaplaincy tasks categorized under seven main roles: (i) witness, (ii) thanatonic (death), (iii) counseling, (iv) teaching, (v) sacramental, (vi) prayer, and (vii) team-worker role.

Under the category of 'team-worker' a question was asked as to whether patients, clinical staff, and chaplains believed it was part of the role of a chaplain 'to consult doctors and nurses as part of a team working for total patient care?' The results indicated that the majority of nurses (97%), chaplains (96%), doctors (89%), and patients (59%) believed it was an expected role of chaplains to consult with medical and nursing staff (Figure 1). While such results clearly affirmed the role of chaplains working in holistic teamwork, unfortunately the question was 'double barreled' and thus impossible to distinguish respondent's expectations about chaplains consulting with just 'nurses' or just 'doctors.' Further the research did not involve any statistical analysis to test the significance of association between answers given by respondents supporting a religious persuasion compared to those with 'nil' or alternate religious belief—particularly important given that the research was undertaken within a religiously based hospital. A qualitative component was also absent and thus the research provided no explanation as to any possible informant reasoning behind such responses. Nevertheless the study did provide a platform to develop further research.

Research conducted at the public Royal Children's Hospital (RCH) in Melbourne (Carey et al. 1997) involving 390 clinical staff (comprising doctors, nurses, chaplains, and allied health staff) indicated that, like the previous study (Carey 1972), greater credence was placed by clinical staff upon the traditional roles of chaplaincy, particularly sacramental and thanatonic duties, while other 'teamwork' roles of chaplains such as, 'to consult medical staff as part of total patient care,' gained a majority of chaplains (80%), nurses (58.9%), and allied health staff (58.5%) but <50% support by medical staff (Figure 2). Interestingly the researchers noted that there was found to be no statistically significant difference in responses among medical, nursing, and allied health staff respondents when comparing those declaring a religious allegiance to those of 'no' or 'nil' religious belief.

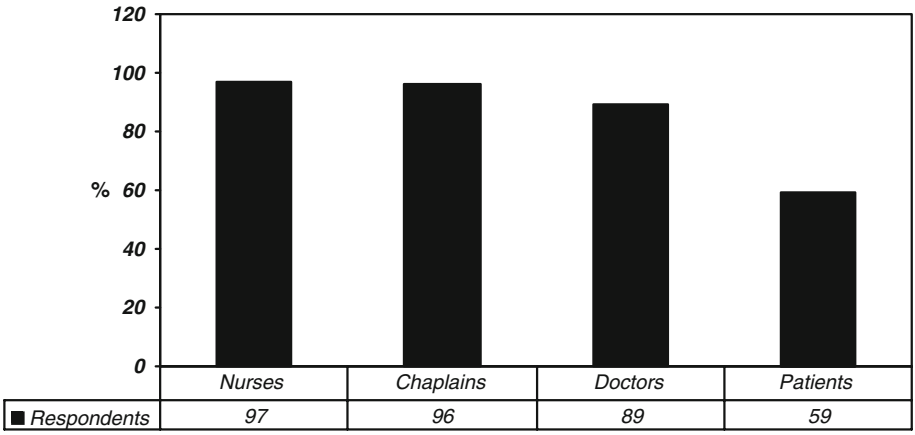

Fig. 1 Percentage of chaplains ($n = 26$), nurses ($n = 99$), patients ($n = 189$), and doctors ($n = 122$) at the Lutheran General Hospital, IL, USA, who expected the role of the chaplain 'to consult with doctors and nurses as part of a team working for total patient care' (Carey 1972)

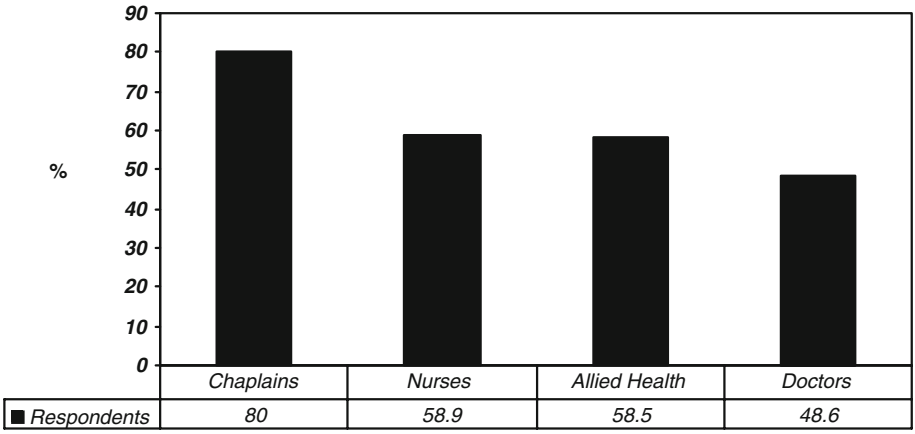

Fig. 2 Percentage of chaplains ($n = 10$), doctors ($n = 115$), allied health staff ($n = 94$), and nurses ($n = 171$) at the Royal Children's Hospital Melbourne, who expected the role of the chaplain 'to consult medical staff' (Carey et al. 1997)

One of the significant advantages of the RCH study was the inclusion of in-depth interviews involving informants from every clinical specialization (medical, nursing, and all allied health staff). Over 80% of all clinical staff (88.23%) affirmed that chaplains should be part of the hospital system given their contribution in terms of: (i) teamwork—particularly improving time management, (ii) providing religious and psycho-social support to patients and staff through the mechanisms of "religion,", "God," and "church," (iii) providing specialist skill support to families and staff particularly at times of death and grieving and (iv) providing input into the hospital environment in terms of (a) ethics, (b) being a community link, (c) providing a non-diagnostic communication role within the hospital, and (d) alleviating emotional discomfort for staff and patients within a complex and sometimes frightening institution (Carey et al. 1997, p. 202).

Some physicians [D] acknowledged that it was appropriate for chaplains to be part of the team but *'only when invited to be part of the team by family'* [D4] or *'if a person requests a chaplain'* [D9]. The majority of physician informants [D] however indicated being particularly favorable about team-working with chaplains as: *'chaplains cover a wide variety of religions'* [D2], *'they are part of the nursing and allied team'* [D6], *'patients have a right to chaplains as part of team'* [D7], *'our team is more successful with a chaplain'* [D8], *'using a chaplain makes it easier for staff'* [D10].

Religion, Health, and Chaplaincy

More recently some clinical practitioners have, amidst debate (Peach 2003, p. 415; Koenig 2003a), acknowledged the potential importance of physicians understanding a patient's spiritual/religious beliefs and the effective role of chaplains addressing relevant issues (Peach 2003, pp. 86–88; Koenig 2003b). A review of literature exploring the link between health and religiosity (i.e., an individual's actual religious practice) has suggested, based upon the work of Durkheim (1912), that there are at least four ways in which religious involvement might alter a person's health: first, in terms of a patient's/client's health behavior; second, their sense of social cohesiveness; third, personal cognitive coherence and mental health; and fourth, positive theological understandings of life and death. Mol

(1976, 1983) also suggested that all religions play an important part in the 'sacralization of identity' through such mechanisms as commitment, ritual, myth, and transcendental ordering which provide a sense of stability for people during times of crisis or encourage progression when their is need for change. It has been argued that through such mechanisms of religiosity that chaplains, due to their unique role, can assist people in their healing process (Carey 1998; Carey et al. 2008).

Indeed over the years various literature has affirmed the contribution of chaplains with regard to helping people deal with such issues as cancer (Handzo 1992; Godell 1992; Milne 1988; Brungardent 1977), pain control (Carey et al. 2006), palliative care (Rumbold 1989; Irion 1988), abortion (Carey and Newell 2007a), strokes, colostomy, and ileostomy procedures (Reimer 1984), euthanasia (Newell and Carey 1998), disabilities and rehabilitation (Ritter 1994; Blair and Blair 1994; Stainton 1994; McCarthy-Power 1989), brain injury (Ireland et al. 1999), organ transplants (Elliot and Carey 1996; Browning 1988), surgery (Bryce 1988), pediatrics (Stoter 1987; Carey et al. 1997; Hesch 1987; Donnelley 1983), withdrawal of life support (Carey and Newell 2007c), AIDS (Dugan 1987), in vitro-fertilization (Carey and Newell 2008), not for resuscitation orders (Carey and Newell 2007b), working within intensive care units (Thompson 1990), and outpatients (McSherry 1994), plus assisting staff and patients with grief, loss (Kenworthy-Toohey and Carey 1995), and identity issues (Carey 1998). Further, research such as that by Davoren and Carey (2008) has indicated that the pastoral care contribution of many chaplains has been provided to people irrespective of their race or religious/spiritual beliefs.

Research Focus

Thus while some literature has indicated clinical team-work that includes or acknowledges the work of chaplains, there is still insufficient empirical data specifically about chaplaincy–physician consultancy—particularly from a chaplaincy perspective. In response to the literature reviewed above, two key questions are addressed here: (i) *'Do chaplains believe that consulting medical staff is part of the work of a chaplain?'* and (ii) *'What is the perspective of chaplains about consulting with medical staff concerning patient care?'*

Method

As part of a larger study (Carey et al. 2006b) members of the largest ecumenical chaplains association in Australia (Australian Health & Welfare Chaplains Association: AHWCA) were surveyed concerning their views about consulting medical staff and then invited to undertake an in-depth interview questioning their perceptions about their actual involvement with medical staff.

Data Collection

The research program included a two-stage non-experimental 'parallel paradigm' cross-sectional study (Peterson 1997) collating descriptively both quantitative (Schwartz and Polgar 2003) and qualitative data (Grbich 1997; Swinton and Mowat 2006) using the in-depth interview process (Minichiello et al. 1996). Given the emerging literature regarding the influence that religiosity and spirituality can have upon a person's state of health and well-being (Carey 1993; Mueller et al. 2001; Koenig et al. 2001; Seeman

et al. 2003; Stefanek et al. 2005; Carey et al. 1997; Cobb 2001) the triangulation of quantitative and qualitative methodologies were used in this study to facilitate the most valid assessment of the pastoral role of chaplains.

Chaplaincy Respondents and Informants

Full lists of chaplain members were obtained with the permission of the AHWCA from each Australian State (New South Wales, South Australia, Victoria, Queensland, Western Australia, Tasmania,) and Territory (Australian Capital Territory, Northern Territory). Surveys were individually distributed to each member either in person or by mail. Of the 410 chaplains surveyed, the majority completed a survey ($n = 327$, 79.7%) (refer Table 2). Basic demographic information concerning the survey respondents is provided in Table 3.

The qualitative component of the research involved chaplain informants being interviewed using the in-depth semi-structured model of interviewing (Minichiello et al. 1996). A total of 100 chaplains volunteered as informants to this component (i.e., staff chaplains $n = 79$; volunteer chaplains $n = 21$) (Table 2). Basic demographic information concerning those interviewed is provided in Table 3. The interview, based on the survey, sought to explore at a deeper level, the various perspectives of chaplains with regard to consulting medical staff about patient and family issues. The interviews, following signed consent, were tape recorded and lasted, in most cases $\sim$2 h. The transcribed data were collated and analyzed according to the thematic responses of informants (detailed later).

Results

Due to the large volume of quantitative and qualitative data gathered from this study only some of the results can be presented within this article.

Quantitative Data

In overall terms the survey results indicated that the majority of chaplaincy respondents (89.6%) believed that it *was* part of their work as a chaplain to consult with medical staff regarding patient care. A minority of chaplaincy respondents (5.81%) however believed that this role was not appropriate to their work and even less chaplains were uncertain as to whether the role was appropriate or not ('Not Sure': 4.59%) (Fig. 3).

A χ^2 test was used to investigate the association between the professional status of chaplains (i.e., staff *cf* volunteer chaplains) and their perspective about consulting medical

Table 2 Australian chaplaincy survey respondents ($n = 327$) and interview informants ($n = 100$) by the state of origin

Australian states	NSW[a]	SA	VIC	QLD	WA	TAS	NT	Total (*n*)
Survey respondents	75	65	62	54	40	12	9	327
Informants	25	25	18	11	10	6	5	100

[a] NSW, New South Wales (includes chaplaincy personnel from the Australian Capital Territory: ACT); SA, South Australia; VIC, Victoria; QLD, Queensland; WA, Western Australia; TAS, Tasmania; NT, Northern Territory

Table 3 Demographic data of chaplaincy respondents and informants

Category	Column 1: survey respondents $n = 327$ (%)						Column 2: interview informants $n = 100$ (%)					
Appointment	Staff	218 (66.7)	Volunteer	109 (33.3)			Staff	79 (79)	Volunteer	21 (21)		
Gender	Male	144 (44)	Female	183 (56)			Male	59 (59)	Female	41 (41)		
Denomination[a]	Protestant	196 (60)	Catholic	129 (39.4)			Protestant	61 (61)	Catholic	39 (39)		
Status	Ordained	151 (46.2)	Religious	61 (18.7)	Lay	115 (35.1)	Ordained	64 (64.0)	Religious	13 (13)	Lay	23 (23)
Employment	Full time	153 (46.8)	Part Time	174 (53.2)			Full time	57 (57)	Part Time	43 (43)		
Tertiary[b]	Religious	132 (40.4)	Secular	37 (11.3)	Dual	117 (35.8)	Religious	44 (44.0)	Secular	6 (6.0)	Dual	43 (43.0)
Clinical	Yes	223 (68.2)	No	104 (31.8)			Yes	74 (74)	No	26 (26)		

[a] NB 1: percentages indicated in (parentheses)

[b] NB 2: no response rates are provided within the relevant notes (i.e., NB 4 & 6); NB 3: staff chaplains = stipend/salaried chaplains via government/hospital, church, community, or combination funding; volunteer chaplains = non-paid chaplains; NB 4: Catholic = Roman Catholic ($n = 129$); Protestant: Adventist = 1, Anglican = 94, Baptist = 14, Church of Christ = 9, Pentecostal = 3, Presbyterian = 13; Salvation Army = 5, Uniting Church = 57 ($n = 198$); No response = 2; NB 5: Status—ordained = ordained ministers/priests; Religious Orders, brothers and nuns; Lay chaplains, chaplains who are not ordained nor commissioned by a religious order but are approved by their denomination to undertake pastoral visitation to their own denominational adherents; NB 6: Tertiary education—religious: Chaplains indicated a variety of diploma, bachelor, masters, or doctorate degrees in theology, ministry, or divinity, usually comprising subjects in philosophy, history, systematic theology, ethics, biblical studies, pastoral care, and counselling undertaken at theological colleges; Secular: chaplains indicated a variety of bachelor, master, or doctorate qualifications in arts, education, economics, science allied health applied science and nursing; Respondent no response = 14 (12.5%), Informant no response = 7 (7%); NB 7: Clinical = CPE undertaken as undergraduate or post-graduate study comprising an internship under a clinical supervisor usually within a clinical context

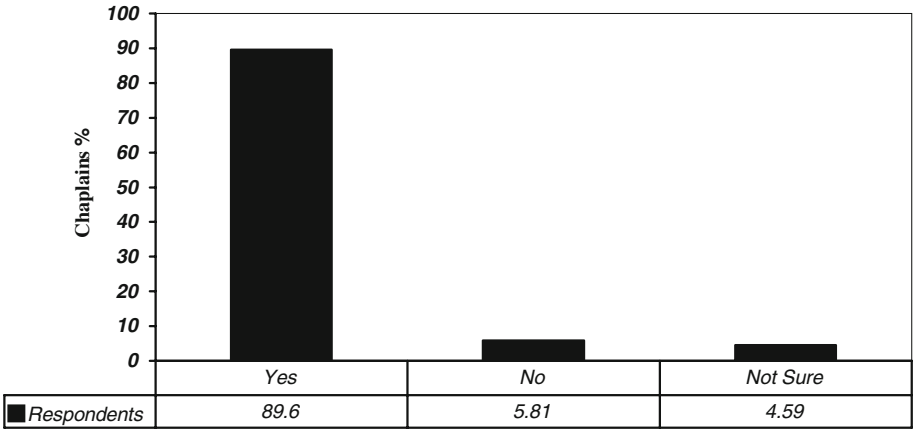

Fig. 3 Overall percentage of chaplaincy respondents ($n = 327$) who expected the role of the chaplain 'to consult medical staff as part of total patient care'

staff. While the majority of staff chaplains (92.2%) and volunteer chaplains (84.4%) believed it appropriate to consult with medical staff (refer Fig. 4) the results indicated a statistically significant difference due to a greater percentage of volunteer chaplains being unfavorable or uncertain about chaplains consulting medical staff ($P = 0.0174$). Likewise, while the majority of both Protestant (94.4%) and Catholic chaplains (82%) believed it appropriate to consult medical staff (refer Fig. 4), a statistically significance difference was found between Catholic and Protestant chaplains due to a greater percentage of Catholic chaplains being uncertain or responding negatively about consulting medical staff ($P = 0.0015$). There was however *no* statistically significant difference with regard to gender (male *cf* female chaplains) ($P = 0.677$).

Statistical analysis was also undertaken to investigate the relationship between chaplaincy training and chaplains' views about consulting with medical staff. χ^2 tests revealed that chaplains who had completed tertiary education were significantly more favorable towards consulting medical staff, than those who had not completed tertiary education ($P = 0.0015$). However those who had completed religious tertiary education were found

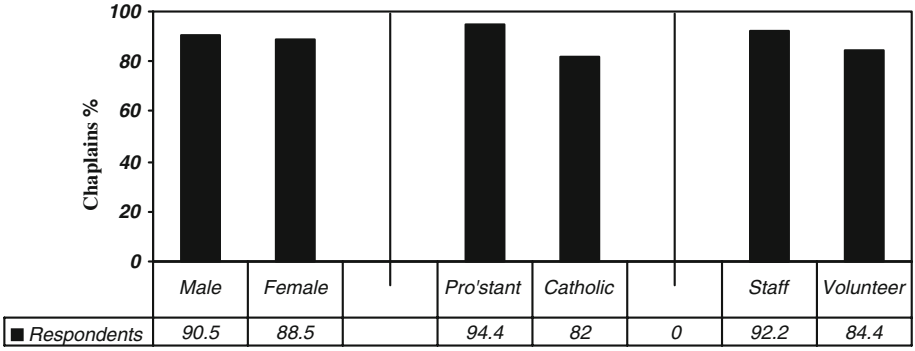

Fig. 4 Percentage of chaplaincy respondents ($n = 327$) who affirmed their role to consult with medical staff by chaplaincy 'Gender' (Male *cf* Female), 'Religious Affiliation' (Catholic *cf* Protestant), and 'Status' (Staff *cf* Volunteers)

to be more favorable about consulting medical staff than those who only completed secular tertiary education ($P = 0.0452$). Further, those who had completed specialist clinical pastoral education (CPE) were more favorable about consulting medical staff about patient/family issues than those chaplains who had not done CPE ($P = 0.0031$).

Qualitative Data

Given the limited literature regarding this topic, it was considered important to include qualitative data to clearly demonstrate the involvement and broad opinion of chaplains that in turn would augment greater objectivity and assist future research. Of the 327 chaplains surveyed, 100 chaplains consented to being interviewed as chaplaincy informants ('CI' 1–100). Ninety-nine chaplains (99%) provided in-depth information regarding their experiences concerning medical consultancy.

Chaplaincy–Physician Consultancy Affirmed

Similar to the survey data the majority (78%) of Australian CI considered it was part of a chaplain's work to consult with medical staff. The reasons for this perspective varied. However two general themes could be identified among CI. First chaplains believed that doctors needed to be informed of the *'spiritual dimension and ethical views'* (CI:21) of patients, their family or significant others. As one chaplain summarized:

> Well I think there are too many medical staff making the decisions. Albeit they have a great deal of knowledge, and I respect that, but sometimes they haven't taken into consideration that there are other ethical points of view, both from the person receiving or making the decision - the decisions being made over or about them - as well as other people they're involved with (i.e., may be the carer, may be husband, may be child, um, any part of any family). I just feel there's a moderating influence that chaplains have with regards to decisions [CI:1].

Secondly, chaplains acknowledged that medical consultancy was not simply to achieve advocacy for the patient, nor to warn the doctor of a patient's rights. There was also a reciprocal benefit. Many chaplains acknowledged that in order to help patients and *'not be at cross purposes with any treatment plan'* (CI:87), chaplains needed to have a better understanding of a patient's medical prognosis to *'assist chaplain-patient dialogue*' (C:19) and *to clarify issues with families* (CI:14) and thus ensure appropriate pastoral interventions (WHO 2002) that would, in turn, *'enable the best holistic practice'* (CI:21).

Chaplains noted various ways by which chaplain–physician consultancy was achieved—namely through, *'inter-team meetings'* (CI:10), *'doctors conferences'* (CI:16) *'ward staff meetings'* (CI:15) and, failing these, some chaplains *'work[ed] hard at coming alongside doctors to overcome their allusiveness'* (CI:7) and deliberately *'initiated discussion about patients who were distressed and needed reassurance'* (CI:56). One chaplain determinedly ensured holistic medicine by *'using answering machines, mobile phone, emails and fax machines to communicate with some "too busy doctors"'* (CI:60). Other chaplains noted however that they (as chaplains) were *'part of the clinical team, regularly in consultation with doctors'* (CIs:76, 83, 97), and that they had a *'good rapport with doctors who shared information as part of total patient care'* (CI:95) that encouraged a '*positive element of holistic co-operation throughout the hospital'* (CI:100).

Chaplaincy–Physician Consultancy Conditional

The interview data revealed that while the majority of chaplains agreed in principle with the role of consulting with medical staff, some chaplains (12%) wanted to qualify what that involvement actually meant. Two common themes emerged. Some chaplains believed that doctors could be 'very self-confident' and 'dismissive of the chaplain's perspective' and that doctors had limited time to consult with chaplains. As one chaplain stated:

> Medical consultancy… it very rarely happens … Occasionally the doctors will say something, but its usually, I often find … it difficult … the doctors have all the answers in their opinion, and so it can be difficult. That's from my, yeah, that's my point of view. I think other chaplains would probably have much the same opinion of some doctors anyway. [So, regardless of that, do you strive to consult with medical practitioners, or do you sort of feel, well, its fairly pointless … ?]. I probably veer to 'not doing it', basically because the (doctors) are always in such a hurry when they come in and I think its better for them to spend a bit of time with the patient … [CI:12]

One chaplain admitted however that it was not always doctors having insufficient time to consult with chaplains. The pragmatics of medical staff and chaplains being within timely and close proximity was equally problematic. Likewise some informants would not commit themselves to whether they would or would not necessarily consult with medical staff and indicated that consultancy with medical staff usually 'depended' upon a variety of factors.

> … Its possible with some medical staff but not with others. … I think there are heaps of issues. I think there are some religious issues, they (doctors) don't want any part of this … Others I think (it is) personality issues of control … There are all sorts of things I guess. Others are so heavily into the scientific model that their decision is purely a clinical one. Yes … chaplains seem to be ancillary things, you know, this patient is going to die … bring the chaplain in … as a last resort … IF they (doctors) use the word 'holistic', some of them most probably wouldn't. I mean there are some (that would) again its a philosophical question, it depends on what, some of the doctors' religious or spiritual ideas are [CI:4].

Chaplaincy–Physician Consultancy Restricted

Similar to the survey results, a minority of informant chaplains (9%) did not believe that it was part of a chaplain's role to consult with medical staff. Three types of thematic responses could be discerned. First, some chaplains believed that the structure and rules of chaplaincy departments prevented them from consulting with medical staff. Secondly, that some medical staff and their respective health care institutions, while espousing principles of holistic practice, were in actual fact not holistic and limited the contribution of chaplains. As one chaplain summarized:

> For the majority of chaplains, at the hospital where I am a chaplain … their primary role has been with patients, a minor role with ward staff and no contact at all allowed with medical staff. … I haven't had close contact with medical staff, which may prove the point - we are not holistically team working … the 'holistic' language is used, ah, and this hospital would believe it is holistic, and on formal occasions they

> will refer to it as being holistic, but my experience of it, in my role as a chaplain, is that the hospital's holistic practice has been limited [CI:68].

Several chaplains indicated that they no longer even attempted to consult with medical staff because doctors were, *'rude'* (CI:30), *'inpatient, lacked the ability to listen'* (CI:31), *'arrogant—failed to listen then stuff things up'* (CI:39), *'stubborn about patient wishes'* (CI:38), *'hold a hierarchical view—"nobody criticizes us!"'* (CI:62), *'think they know the answers to everything but have no spiritual appreciation'* (CI:29), or have an *'attitudinal exclusion about religion, spirituality and chaplains'* (CI:47).

Another factor identified by several informants was simply medical staff being ignorant of pastoral care and spirituality services or the breadth of the chaplain's role. Chaplains identified that some medical staff were not even aware of the chaplain's existence or whether their hospital even had a pastoral care department—but given time and familiarity one chaplain stated that consultancy can occur more frequently:

> I mean a lot of doctors ignore you. But there are a some who don't. I think it depends – once you get yourself established in an area, they (doctors) … often are grateful that chaplains are there because (chaplains) take the steam off them. Particularly in, you know, difficult things [CI:8].

Chaplaincy–Physician Consultancy Benefits

Irrespective of the chaplain's viewpoint concerning chaplain–physician consultancy, nearly all CI acknowledged some form of benefit by assisting physicians with the holistic care of patients. These included that chaplains *'often gain insight into how patients feel culturally, ethically and about family issues'* (CI:40) because patients *'unburden their issues on chaplains'* (CI:59) which allows chaplains to *'provide doctors with information about a patient's spiritual and ethical issues'* (CIs:21, 25, 46, 85) that, in turn, *'helps doctors respectfully consider their patient's fears and concerns'* (CI:31).

In terms of specific spiritual/religious issues CI identified that physicians can use chaplains as *'communication facilitators'* (CIs:36, 79) and *'effective advocates'* (CI:26) to *'help patients with spiritual inclinations'* or '*religious issues and beliefs'* (CI:69), to express *'the different dimensions affecting them other than medical issues'* (CI:91), and thus, chaplain–physician consultancy can *'hopefully encourage a respect for patient/family wishes and reduce, if not prevent inappropriate treatment being administered'* (CI:88).

In terms of clinical decision-making some chaplains argued that the chaplaincy–physician holistic approach can '*be vital as sometimes there is no evident answers to problems'* (CI:7) and that physicians can call chaplains to assist *'given significant changes* (*e.g., increase in morphine or death*)*'* (CI:13) and *'to help calm down patients/family members'* experiencing considerable distress or pain (CI:78). Another area of benefit acknowledged by some chaplains was the personal support they offered *to 'help doctors face difficult issues … assist with their reasoning about ethics issues'* (CI:35) and *'provide support to doctors under considerable stress'* (CI:28).

Discussion

The results indicated that a significant majority of chaplains believed that it was part of their role to consult physicians as part of total patient care. While there was no significant

difference between the perspective of male and female chaplains in terms of consulting medical staff, there was some evidence however that Catholic chaplains and volunteer chaplains were less likely to consider it part of their role to interact intentionally with medical staff. There was also evidence that chaplains who had *not* completed tertiary level religious education, and/or who had *not* undertaken CPE, were less favorable about consulting medical staff compared with those chaplains who had completed such training.

Such factors of course are more than likely interrelated. Just over 40% of volunteers were Catholic 'lay people' (42.8%) with no ordination or religious order training and approximately one-third (33.5%) had not completed basic 'CPE.' This lack of education combined with the fact that all volunteer chaplains are only part time or causal (and thus do not have the frequency of exposure or unrestricted access to either patients or physicians compared with staff chaplains) naturally means that volunteer chaplains, and particularly Catholic volunteer chaplains, may have been at a distinct communication and educational disadvantage.

Nevertheless, given previous research that indicates approximately 50% of all volunteer chaplains engage with patients/families and approximately 25% engage with clinical staff concerning bioethical issues (Carey et al. 2006), the impact of volunteer chaplaincy pastoral intervention should not be underestimated and needs to be taken into account when considering the future training, deployment, and utility of volunteer chaplains. Likewise, the considerable percentage of staff chaplains (60–80%) that are estimated to be involved in bioethical issues with patients, their families and clinical staff (Carey et al. 2006) should also not be undervalued and suggests that staff chaplains could offer important tacit knowledge and support to physicians particularly given the physical and psychodynamic demands of the physician–patient relationship (Goldberg et al. 2000).

Indeed the qualitative data obtained, affirmed the support that chaplains could offer physicians given professional reciprocity. Such support included (i) pastoral education about religious, spiritual, and ethical issues, (ii) communication facilitation about patient/family issues that ensures valuable feedback to physicians (that may reduce the likelihood of costly litigation), plus (iii) personal support to physicians given the complications and stress of their workload. The data also affirmed however that subtle antagonism or at the very least ambivalence or indifference about chaplain–physician collegiality could develop—this in turn could lead to professional distancing and a lack of awareness about each other's services, which would, more than likely, be unbeneficial to patients, their families, or other staff.

It can also be argued from the data gathered however that chaplains (both staff and volunteers) may potentially be key personnel within the health care context to help ensure that any medical assessment looks beyond the physical and anatomical diagnosis to include the emotional, social, cultural, religious, and spiritual aspects that contribute to a patient's health and well-being (Carey et al. 2006). From such a perspective it would be important for policy makers to re-consider Clinebell's 'classic' essentials for professional relationships (Table 1) (Clinebell 1971) and assist in creating better health outcomes for patients, their families, and staff by helping to ensure that the contribution of chaplains is fully valued and that hospitals are holistic in their practice and not just practicing tokenism (Carey et al. 1997).

Future Research

While the results of this research may, in general terms, support a case for positive chaplain–physician relationships for the benefit of patients, their families, and even

medical staff themselves, nevertheless this article also raises several questions for future research. Questions such as, 'Should chaplains be more involved in physician consultancy and if so how?,' 'What is the perspective of physicians about consulting with chaplains?,' 'Should chaplains, whether lay or ordained, be required to have tertiary and CPE training so as to encourage consultancy that is more frequent and professional and thus help to ensure a holistic and ethical service for the benefit of patients, their families, and staff?,' 'Should (suitably qualified) chaplains be involved in the continuing education of medical staff?,' and—vice versa—'Should physicians be more involved in the continuing education of chaplains?.' Finally, 'If chaplains and physicians are to be more involved in each other's education, what strategies should be in place to more effectively integrate such training?' We would anticipate that any such research would enhance the commitment and potential utility of chaplain–physician consultancy as part of any health system committed to holistic care in the 21st Century.

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