Between Mandate and Patient Need

Chaplains at a Canadian Facility Felt Challenged in Adapting Themselves to Briefer Hospital Stays

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The fundamental question in contemporary pastoral care is a bit like that involving the proverbial chicken-or-egg: Which should be the basis for the delivery of spiritual care—patient need or established departmental mandates? Put another way, how do a health care organization's mission and values inform the way its pastoral care workers think about standards of care and recognize evolving patient needs?

Those of us who give pastoral care at St. Boniface General Hospital, a 550-bed facility in Winnipeg, Manitoba, have had an opportunity in recent years to consider these questions in some depth.

The Trend toward Shorter Stays

In Canada, as in the United States, increasing financial constraints have changed health care delivery in significant ways. For one thing, hospital stays for surgery have become briefer. Services that once required a weeklong admission now take only a few days, or even—when done on an outpatient basis—a single day.

This change has inevitably had an impact on those of us who work in St. Boniface's Mission and Pastoral Care Department. For years we have operated under a mandate pledging that we would, within 24 to 48 hours of admission, visit all new patients, assess their spiritual needs, and draw up plans of care for them. This mandate demonstrated our commitment to attend to patients' spiritual needs, in keeping with our Catholic mission and values. However, the trend toward outpatient care—and the narrowed window of opportunity this represents for pastoral care work—has made it increasingly difficult for us to establish meaningful relationships with patients. And it certainly challenged the 24-to-48-hour mandate.

The Pre-Assessment Clinic

St. Boniface's Pre-Assessment Clinic (PAC) has been one focus of this trend for our department. The PAC was originally established as a pilot project in the late 1980s to be a place where high-risk surgical patients could be screened by anesthetists before their scheduled surgery. Since 1993, however, patients have come to the clinic to meet not just anesthetists but also the other members of a multidisciplinary care team, including a chaplain. The PAC allows the team to both assess the patient's needs and educate him or her about surgical procedures. Most people seen in the clinic are scheduled for what we call "same day admissions" (the patient spends at least one night in the hospital) or "day surgeries" (the patient goes home the same day the surgery is performed).

The coming of the PAC has, of course, required shifts in mind-set and approach for the chaplains who work there. For one thing, the people we interview wear street clothes, not hospital gowns, and will resume their normal lives—perhaps return to work or go shopping—once the interview is over. And because the actual surgery may not occur for several days or weeks, PAC patients have time to prepare for it spiritually and emotionally, including talking it over with their own clergy.

But the PAC's impact has been more far-reaching than the foregoing suggests. Only two or three of the Mission and Pastoral Care Department's chaplains serve at any given time on the clinic's patient care team (we have 10 full-time and part-time staff members). Even so, the PAC has had a dramatic impact on our whole department.

In 1995 our department began what we called a "visioning process," a series of meetings—sometimes several a year—in which we gathered to discuss various aspects of our work at the hospital,

including standards of care. One frequently discussed topic was the 24-to-48-hour mandate. Did it make sense, in a changing health care world, to continue to base the delivery of spiritual care on it? Or should we drop the mandate and instead adopt a more patient-centered approach? In 1997, after much discussion, a new pastoral care director declared that we would no longer follow the mandate. Nevertheless, the debate continued to simmer.

Before surgery, when anxiety is high, pastoral care seems to be most beneficial.

Certainly no one questioned the continuing need for pastoral care. People anticipating surgery typically experience anxiety.[1] The inevitable vague fears, always colored by a profound sense of one's vulnerability, make this a worrisome time for patients. Research shows that those faced with life-altering events—as surgery can sometimes be—often dwell on spiritual concerns.[2] A chaplain can help an anxious patient by validating such feelings as normal and suggesting ways the patient can cope with the stress. By offering prayer and celebration of the sacraments, a chaplain can be especially comforting to worried patients and their loved ones.[3]

In the traditional pastoral care model, chaplains often saw patients both before and after surgery. This approach is not always possible today because patients come to the hospital only two hours before their surgery and are discharged soon after it is performed. Fortunately, the PAC interview gives the chaplain ample time *before* surgery to organize resources, allay fears, and educate the patient and family in what to expect. It is at this time, when patient anxiety is so high, that pastoral care and counseling seem to be most beneficial.

Three Responses to Change

But in the beginning, the PAC represented a significant divergence from pastoral care's traditional delivery model. What would happen, once this change was made, to the energy and commitment that used to go into the old model? How was that energy to be shifted and displaced? Theorists of organizational systems remind us of the predictability of "symptom substitution": When you replace one model with another—without first identifying and addressing the implicit goals and values driving the old model—you often find the same operative goals surfacing elsewhere.[4] In conducting a visioning process, one must look carefully at the underlying assumptions and implicit goals when reviewing standards of care.

I have identified three general responses to visioning change in our department, each revolving around a particular stance. Associating a stance with a particular individual or group would be simplistic and naive. Each of us has struggled with change, gravitating from one stance to another at different times in the visioning process. The process caused a fair amount of conflict, both within ourselves and with each other, as different value systems collided. This conflict closely mirrored what theorists describe as a typical range of response in a group confronted by change—from active, to neutral, to resistant stances.[5]

Whatever the terminology used, in our visioning process we have lived out the process described by Rev. Gerald A. Arbuckle, SM, PhD, in an article regarding a health care culture's slow and often painful adjustment to change.[6] The challenges we encountered in meeting the spiritual needs of surgery patients in our hospital illustrate this dynamic.

Resistance The first stance was resistance to change. Those of us who resisted typically continued to follow the traditional mandate. We tried to see every patient within 24 to 48 hours of admission and focused on inpatient (rather than outpatient) encounters. We downplayed initiatives such as PAC and saw time spent visioning new models of delivery as unnecessary, even unhealthy. When we *did* accept a change in our department, we tended to subordinate it to the mandate, still understood as the primary goal.

Problems soon followed. As all chaplains struggled to meet the goal of seeing every new patient within 48 hours, we resisters assumed that any failure encountered would be the fault of individuals. If the mandate was not working, our perception was that some person was not working hard enough. This tended to polarize the staff, with those who met the goal on one side and those who did not on the other. Inevitably, this bred a tremendous amount of competition and resentment among staff members. Given this

dynamic, our department could make no serious effort at addressing the real problem—the fact that patients' needs were not being met.

The problem persisted despite staffing reassignments and other structural changes. Indeed, it got worse as both patient volume and turnover grew, making it even harder for us to meet the mandate. Focusing narrowly on the traditional mandate had in fact set us up to fail.

> It is at the level of feelings, not ideas, that real change occurs.

Peter Senge argues, in *The Fifth Discipline*, that trying to analyze problems within a too-narrow focus is futile, because the person or team attempting it inevitably fails to recognize complex processes at work at a systemic level. The old 24-to-48-hour mandate flowed from recognized patient needs as they had been determined at one point in the department's history. Unfortunately, it got stuck there. There was no gathering of new data suggesting *other* ways to meet the goal of spiritual care for surgery patients. And thus no new standards of care were established. So when changes were introduced—with same-day admission and day surgery, for example—any gap between standards of care, on one hand, and patient needs, on the other, could only grow.

Eager Acceptance The second stance was an eager acceptance of change and innovation. Those of us who embraced change explored creative ways of delivering spiritual care—in the PAC, for example—resulting from an evidence-based assessment of patient needs. We tried to focus our attention on what patients actually said about their need for spiritual support during the surgical process and about the timing of the support they received.

We who took this active stance believed that, given patient feedback and our own clinical experience, it was impractical and ineffective to wait to counsel patients only a few hours before the actual surgery. We believed it just as ineffective to put off our visit until *after* the surgery, when much of the patient's anxiety would be dispelled. We strongly backed the new director's decision to drop the 24-to-48-hour mandate, a policy that had been integral to our traditional pastoral care model. And, in general, we affirmed and celebrated "thinking outside the box."

However, other staff members perceived the rhetoric involved in change—including "benchmarking," "evidence-based care," and other phrases—as no more than a device for avoiding the real business at hand: seeing patients. And this skepticism appeared valid, given the mounting body of literature indicating that major change initiatives are often unsuccessful.

In most cases, of course, unsuccessful restructuring efforts should be blamed not on the thinking behind them, but rather on the failure of those doing the restructuring to pay attention to the human element involved.[7] Arbuckle argues that it is at the level of feelings, not ideas, that real change occurs.[8] In our department, the trouble with eager acceptance of change was that it failed to appreciate the history, commitment, and feelings of staff members who had given years of faithful service to the mandate model. And the fact that restructuring efforts are often couched in business language kept some chaplains from embracing change, especially when the language used seemed antithetical to mission and the healing ministry of Jesus.

Our department's lengthy visioning process stalled not at the strategic plan, but at a more personal level—the level of perceptions, feelings, and values. This occurred because we had gotten entrenched in one or the other of the two approaches—mandate or patient need—and had failed to appreciate the fact that there was wisdom in both. We soon found that we could make good decisions only when we solicited and respected the collective wisdom of the group.[9] We decided that no single voice would have a sole monopoly of the truth, that no member would be ignored or prevented from contributing his or her own particular piece of wisdom.

Finally, we realized that no resolution could be forthcoming as long as we focused on either/or alternatives. It was at the end of this long process, as we came to recognize the limitations of our analysis of the problem, that we began to see a third stance emerge.

Trust in Mission and Values This third stance has been the most effective. The mandate is important because, like the rudder of the ship, it steers departmental activities and policies. But it is not beyond criticism; mandate *is* a negotiable item. Standards require ongoing evaluation. We must continually ask: Do they still reflect the reality of

patient experiences at St. Boniface? How do we know? By what process can we clarify patient needs and adjust our departmental policies?

Still, guidance is vital—a ship without a rudder is likely to drift aimlessly or run aground. But how are we chaplains to stay on course during times of learning and reevaluation? And how do we know what course to be on in the first place? We have come to realize that mission and values are what are truly non-negotiable. These intangibles have incredible influence over the direction and outcome of organizational life and are increasingly respected even in big business, where the bottom line prevails. Indeed, some consultants insist that spirituality has a direct, proportionate impact on profit and can no longer be regarded as a "soft" management strategy.[10]

If mandate is like a ship's rudder, mission and values are similar to the navigational system that provides the crew with the data necessary to accurately plot and maintain the vessel's course. Much as today's global positioning satellite (GPS) technology employs satellites orbiting the earth to (among other things) help navigators plot ships' courses, mission and values statements give pastoral care workers an elevated perspective from which they can determine where they are and where they are going. Mission and values keep Catholic health care teams on track by reminding them what they believe in.

At St. Boniface, we all believe that patients' spiritual needs are to be respected and honored. The challenge is translating mission and values into realistic, understandable, and achievable goals, in which mandate flows from identified patient needs, and is guided by the values of our Catholic faith. It seems that the chicken follows the egg after all.

Something New under the Sun

The shift in focus that the PAC represented—from inpatient to outpatient care—demanded more of us chaplains than a change in the way we organized our work. We were also required to look at the patient in a new way. And that, in turn, required us to think anew about the 24-to-48-hour mandate.

Why did we put up such a strong resistance to changing the mandate? This happened, I believe, because we sometimes failed to take St. Boniface's mission and values as seriously as we professed.

This tendency is not unusual. Arbuckle has noted that people, when performing their duties, have a propensity to ignore formal mission and values statements and follow informally established customs instead.[11]

Although copies of St. Boniface's mission and values statements adorn our hospital's walls, we caregivers tended to focus more on customary practices. We turned the rudder, so to speak, without consulting the GPS technology. We tended to visit patients after their surgery (if time allowed), even though mission told us we should be seeing them before it, when their spiritual needs were likely to be more acute. Our ministry to patients was not as effective as it could have been because we were focusing on mandate—a static and closed concept—rather than mission, which is inherently dynamic and inclusive.

Real change occurred when we began to critically examine department objectives and mandates in the light of mission awareness and to continually ask ourselves: Is this practice consistent with what we believe? Again, this is nothing new. But the fact that visioning processes can be long and difficult attests to the strength with which people tend to hold on to established patterns of behavior. It demonstrates how important it is to liberate oneself from standards that fail to acknowledge emerging patient needs. When such standards fail to meet patient needs as determined by the evidence (from patient satisfaction surveys, focus groups, and program evaluations, for example), then one is forced to ask: Whose needs are they really serving?

Our visioning process showed us that to alter behavior and practice a shift in cultural awareness is necessary. Mission awareness must be articulated as comprehensible, attainable behavior, rather than left as a series of broad statements that, although they may be momentarily inspiring, ultimately do not change organizational practices. At the same time, it is not good to stay focused on mandate and standards of care, failing to evaluate the ways these standards reflect mission in the context of emerging patient needs. Such behavior only frustrates the creativity necessary to generate novel responses to meet these needs. As Senge insists, we need to see the forest *and* the trees.[12]

Our eventual adoption of mission and values as our guides was the result of more than sheer inspiration or luck. The key ingredients were present from the start.

Frustration with the System We saw that the challenge was to focus on what was wrong with the system, not the people involved in it. Staff members *were* working hard. The problem had to lie elsewhere.

An Urge to Learn More about Patients' Experience We began to ask where, during the surgical process, patients most needed spiritual and emotional help. At what point was the chaplain's presence most effective? We needed to listen to what patients were saying, meanwhile suspending our own judgment.

The Necessity of Clarifying Our Own Beliefs We saw that

we had not clearly formulated our role in the process. What was it that we truly believed in? How did mission and values help us meet the challenges involved in high-turnover outpatient surgeries? What were we willing to let go of? What truly was non-negotiable? We saw that we had to focus on need, not mandate.

A Cautious Approach to Success We saw that we should be wary of success. We might find an opportunity, even in a program that was working smoothly, to make it better by refining or altering its various parts.

An Emphasis on Education We saw that, as has often been said, you cannot overeducate in times of corporate change.[13] If genuine change is to take place, those conducting it must solicit input from frontline staff, as well as direction from the organization's leaders and sponsors. A healthy prophetic voice must be respected, even if the wisdom contained in it seems antithetical to established practices.

Senge reminds us that organizations, which are living entities, should be in a continual learning process. The organization that stops learning soon begins to deteriorate, he says. The five ingredients cited above are features of a learning methodology—an ongoing process of critical self-examination, commitment and education. Mission and values remain constant, but their realization in the organization is a dynamic process promoting flexibility and creativity.[14]

Problems Are Opportunities

In the past year, we St. Boniface chaplains have finally moved beyond the old debate. We are now embarked on an ongoing learning process that focuses on quality improvement, patient/client feedback, and the regular review of models of delivery in the light of mission and values.

Years ago, when as a college student I spent a summer working in the building trades, I was told: "Work smarter, not harder!" Nowadays I hear essentially the same principle in Senge's advice to organizations: "Don't push growth; remove the factors limiting growth."[15]

We St. Boniface chaplains have now learned that the various mental models by which we construct reality can, if we are not careful, limit growth. Today we realize that these mental models are the spectacles through which we see—or don't see—patient needs. We know that when we look at a problem in a new way, and ask new questions about it, we will see a variety of creative solutions.

Although we are mission people, we sometimes forget the very charismatic stories of the founders of our organizations, the women and men religious who shaped our mission. We tend to forget that the original mission was itself forged in a context of change. We need to remember that the founders' creative vision was possible because of the opportunities that emerged when they looked at problems in new ways.

Mandate is necessary for organizing behavior and evaluating performance. But, for us, the ultimate criteria must be, first, patient needs and, second, the things our mission tells us are sacred, for mission motivates us to respond to those needs in a reflective and creative way. □

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NOTES

1. See Daphne Martin, "Pre-Operative Visits to Reduce Patient Anxiety: A Study," *Nursing Standard*, vol. 10, no. 23, 1996, pp. 33-38.
2. M.C. Davis, "The Rehabilitation Nurse's Role in Spiritual Care," *Rehabilitation Nursing*, September-October, 1994, pp. 298-301.
3. See Larry VandeCreek, et al., "The Unique Benefits of Religious Support During Cardiac Bypass Surgery," *The Journal of Pastoral Care*, Spring 1999, pp. 19-29.
4. See Peter M. Senge, *The Fifth Discipline: The Art & Practice of the Learning Organization*, Currency Doubleday, New York City, 1990, pp. 104-113.
5. See Douglas K. Smith, "Making Change Stick," *Leader to Leader*, Fall 1996, pp. 24-29. See also Milan Moravec, "Readiness to Change," *Executive Excellence*, October 1995, p. 16; David A Nadler, *Champions of Change: How CEOs and Their Companies Are Mastering the Skills of Radical Change*, Jossey-Bass, San Francisco, 1998; and Price Pritchett, *Resistance: Moving Beyond the Barriers to Change*, Pritchett & Associates, Inc., Dallas, 1996.
6. Gerald A. Arbuckle, "Mergers in Health Care," *Human Development*, Summer 1999, pp. 42-48.
7. Susan W. Salmond, "Managing the Human Side of Change," *Orthopaedic Nursing*, September-October, 1998, pp. 38-51.
8. Arbuckle, p. 44.
9. See Mary Benet McKinney, *Sharing Wisdom: A Process for Group Decision Making*, Tabor Publishing, Allen, TX, 1987. Sr. McKinney, a Benedictine, served as a consultant to our department during the visioning process.
10. Richard Barrett, *Liberating the Corporate Soul: Building a Visionary Organization*, Richard Barrett & Associates, Waynesville, NC, 1995.
11. Arbuckle, p. 45. Arbuckle distinguishes between what he calls a "public myth" (as articulated in an organization's formal mission statement, for instance) and "operative" and "residual" myths (actual current practices and remembered practices, respectively). "Mission statements are worthless if the operative and residual myths are neglected," he maintains.
12. Senge, p. 127-135.
13. Pritchett, p. 17-18.
14. "Mission-Driven Market Strategies: Lessons from the Field," *Health Progress*, July-August, 1998, pp. 50-53.
15. Senge, p. 95.