My lesson on the incalculable value of chaplains came when I was doing some weekend moonlighting at a local hospice during my fellowship training. There was a younger woman in her late 40s dying of metastatic breast cancer. She was signed out to me as a “difficult patient with lots of mental issues” with pain that was extremely difficult to control. I don’t remember the doses of opiates, but they were some of the highest I had ever seen with a subcutaneous methadone infusion, dilaudid, and multiple other adjunctive medications. Both the hospice medical director and the pharmacist were struggling to find a solution that would help her stop screaming in agony.

When I went to see her, the weekend chaplain put his hand up to me without looking away from the patient clearly indicating “not now doctor!!”

I went back to the nurse’s station and waited. I finished my notes, joked with the nurses and staff (hospice workers are generally quite funny, especially on the weekends), and waited. Three hours later, the chaplain came in to the office. His look was a combination of extreme exhaustion and deep satisfaction, as if he had just battled the devil and emerged victorious. I asked what they had talked about and he hinted in vague terms about some deep spiritual fears. However, he said he promised her multiple times to not tell the other hospice providers any details and he wanted to honor that.

Then the miracle happened. When I went to see her, she wasn’t screaming. She was sleeping in the kind of deep and peaceful sleep one can only have after an exorcism. She stopped pushing her patient-controlled analgesia button. Her total opiate use dropped precipitously and she died quietly three days later.

People who work in hospice easily reject the biomedical model and prefer instead the biopsychosocial model. However, on that day, I learned that the model should be expanded even further to the biopsychosocial–spiritual model. I’ve come to realize (or believe?) that part of what causes us humans so much angst in many aspects of life is the feeling that we are immortal souls stuck in a mortal existence.

Enter chaplains.

An article in this issue of the Journal of Palliative Medicine by Eppley Jeuland et al. reports on a large and well-designed survey that gives us some insight into chaplains’ perceptions of what they’re actually doing when they consult with patients. They noted that the most common tasks they do are building relationships (76%) and care at the time of death (69%). Notably, however, they also reported that they address existential or spiritual issues 49% of the time.

What does it mean to address an existential or spiritual issue? How do we study the work of the chaplain when he or she is doing this most important task? What is the difference between religiosity and spirituality? Certainly as healthcare becomes increasingly expensive, services such as chaplaincy are going to need to justify their activities to assure ongoing support. The research community can help.

From a brief perusal of the literature, it appears that proving the obvious—that chaplains help patients and families—is both hard research to do and hard research to fund. However, there are lots of people thinking about this. One systematic review of spiritual interventions demonstrated that there may be benefits for psychoneuroimmunological outcomes among people diagnosed with breast cancer. Another fascinating functional MRI study explored the brains of Buddhist monks when they got to their deepest state of meditation and noted that different areas of the brain were lighting up. Dr. Chochinov’s work on dignity therapy may be a way of helping people find meaning in their lives, which is a common domain of spirituality measures.

As I write this, I discovered a consensus conference article on improving the spirituality of spiritual care as a dimension of palliative care published in this Journal eight years ago. The report outlines many aspects of spiritual care. Two of their recommendations were related to research and are worth mentioning here:

- Research that will contribute to improving spiritual care outcomes to palliative care patients should be supported.
- Recognizing the complex definition of spirituality and its difficulty in measurement, studies should use multiple quantitative and qualitative methods for evaluation.
- Funding to evaluate the current state of the science, establish a research agenda, and facilitate research opportunities for spiritual care research should be sought.

Arguably, this is about as challenging as research can get. However, the importance of understanding and proving the sacred work of chaplains is only becoming more important lest we risk losing them as members of the team. As another chaplain once taught me, distinguishing between fears that occur before the last breath and fears that occur after the last breath is a great way to help determine whose expertise is needed at the bedside.
References


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