
Introduction

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Institutions stand free of the larger society, yet are expressions of that society. Health care, as an institution, and the institutions where health care is delivered, both express and are victimized by the dynamics that both guide and distract contemporary society.

Rapid change. It has been said that modern medicine has seen more introduced to it in the last fifty years than in the whole previous human experience, and it is an acceleration of change exceeded only by what has been experienced in the last five years.

The geography of health care has changed. Large, fortress-like, "safe" institutions, once places where people "went to die," are being reconfigured, occasionally torn down, and often replaced with drive-by, convenience oriented, "stop-and-shop" centers offering everything from prescription service to surgery to psychotherapy. Diseases that yesterday meant certain death, today are treated with antibiotics and may require only a visit to a physician's office. Outpatient/same-day surgery now applies to over 60 percent of contemporary surgery schedules. Major discoveries with anti-depressants have shut down many inpatient psychiatric units and led to group homes, outpatient care, and private therapy sessions with individual counselors. It has also led to a whole new population of people living on the streets.

"Length of stay," "discharge planning," "utilization review," and "prior authorization" are the watch words of modern medicine and, sadly as some would argue, have become the new language of diagnosis and treatment. Physicians often are guided more by people in distant legislative and funding offices than the tools of medicine.

Ethics committees, unheard of only a few decades ago except for in large teaching hospitals, now are in most hospitals and also appear in hospices, home health agencies, and nursing homes. These committees, combining monitoring, decision making, education, and a screen of legal protection, reflect not only the burgeoning content of new information that needs interpretation and clarification, but the ethical values and weight that come with more and more decisions. Nothing seems simple or straightforward anymore. Many ethics committees now deal more with the morale and needs of the staff, and all of them are shadowed by this age of litigation.

Alternative medicine has become complementary medicine, including new expressions and experiences of spirituality, and they are slowly chipping away at one of the last strongholds of resistance to change: Western medicine. This has also introduced a cast of new characters, new job descriptions, and new approaches to how we provide medical care and what care we will offer.

Spirituality, the "hot" subject in conversation and publications, has gained new attention in health care. Standards for accreditation now include the language of spirituality and also emerging standards for pastoral care. Physicians and other professionals, led by the research offered at the National Institute of Healthcare Research, are investing more of their time and expertise around spiritual matters. Research is providing the data that has given evidence to what chaplains and other spiritual care providers have long known. Spiritual care, once the domain of chaplains and, in many ways, nurses, is now the responsibility of all health care providers. This is redefining the role of chaplains, the providers of pastoral care who must work harder to claim their place as the resources and teachers in spiritual matters, who now find themselves spending more of their time working with staff (training, pastoral care, and counseling) than with patients.

Our awareness of spirituality and religion, how they relate and how they differ, has also been influenced by another strong dynamic in our society and in our institutions. We are becoming more aware of cultural diversity and the diversity that is captured in gender issues, ethnic values, spiritual practices, and how people do and do not make decisions.

There are many other issues that reflect what is happening in medicine and to medicine, medical providers, and health care institutions. What has not changed is the human experience or expression which is at the heart of all that we do in medicine. We still are living with life and living while dying. We still work to provide palliative care for the dying in a society, and in institutions, that still denies our mortality and still sees death as the enemy. Some things never seem to change.

What also has not changed is the ultimate struggle of what it means to be a patient. We have added ventilators, outpatient surgery, discharges that often seem premature, and easy access clinics, but the questions remain the same: "What is happening to me?" "Why is this happening to me?" "How will I cope?" "Is there any hope?" These are the questions of life and death, the language of our patients, and, in some form, the language of those who provide for their care and explore what these issues mean for their own lives. These are also the questions of spirituality, the center of who we are, how we feel about ourselves, how we face the world around us, what/who transcends it all to bring meaning and direction, and what will be our inner strength as we are forced to cope with new experiences in the wilderness of disease, trauma, violence, and aging.

These issues become the stories we call contemporary health care delivery. They are the stories encountered daily by physicians, nurses, social workers, chaplains, therapists, technicians, dietitians, administrators, and the rest of the people who make up the health care team. These stories are people, people who demand that we listen to their story, who work with them to assess, to give meaning, and provide the caring, the appropriate care to address their needs, their stories, their whole selves. We have tried to capture these stories through the balancing of story/experience, data, research, and the details of contemporary health care.

This book is about people and their stories. It is about the response of health care delivery systems to these stories. *First*, the book seeks to be a wake-up call to health care professionals. We have been moved to the margins. The paradigm shift is ongoing. Power and control are shifting away from the medical model to those who set the standards and control the dollars. We are scurrying about to claim our professional identity and standards as the "system" pushes us further into the margins. What does it mean to be a doctor, nurse, social worker, chaplain or another professional these days? Who makes that determination? Are we really free to say or are others seeking to say it for us? So the wake-up call to say that we are in the margins, things are changing, and we must change with the process. Change still doesn't come easily.

Doctors are having to listen to more "authorities," additional "experts," and slow down to work with the team. It no longer works to sneak in, make rounds early so that you can rush through and get to the office. Fortunately it is becoming a team of allies with a common cause or concern, not just "one more thing to slow me down." Teams have meetings. Families want time. Documentation is increasing at a rapid fire pace. Nurses went into their profession in response to the

sacredness of a profession committed to the care of people. Much of this "care" is now realized through meetings, charting, more charting, and as "electricians" who reluctantly spend more time responding to equipment than to people. It has led to an enormous morale issue for many nurses who state, "I don't have time to spend with people anymore." Social workers train for case management, advocacy, therapy, and intervention, and find the very name "social worker" often redefined as a discharge planner. Many social workers have been pulled off the floors, moved away from the patients, and confined to a desk and telephone to "move people through the system." More and more chaplains are losing their jobs, and those remaining do "God-on-the-run" pastoral care, while trying to keep pace with change, the rush of schedules, the relocation of patients to a variety of new campuses and delivery styles, while still trying to listen, counsel staff, work with families, train clergy, recruit volunteers, and keep up the twenty-four-hour-a-day, seven-day-a-week pace that is essential to chaplaincy. The largest single group of chaplains identified in their professional organizations is "one person departments." The only "cut" left may be the entire program. Life in the margins.

Second, in the stories and data presented by the various contributors, we are also offering the perspective that nothing has changed. We can lash out about what has happened to health care, and those messages must be raised. It does take us away from our professional/vocational responsibilities for listening, assessing, caring. We do have to rethink our priorities, how we spend our time, and how to work more effectively as a team. It does mean that we become wary of the turf battles that can easily arise in a paradigm shift, and keep ourselves focused on the patient. It means that all of us commit to the listening that is still the bottom line of health care, despite a few voices who would suggest that the bottom line is the budget. It means that nurses do nursing, and that that includes spiritual care, spiritual assessment, and working with the chaplains. It means that, while insurance companies legislate the amount of time physicians are to spend with the patient, the doctors still can ask the important questions, add the important pieces of the story to their assessment, and willingly listen to the messages of the entire team. Even when limited to the desk and the telephone, social workers have a great opportunity to claim the story of the patient and include it as the vital message in discharge planning. Chaplains may not have as many opportunities just to sit at the bedside and listen (the patients may not be there), but they still are the people called, as Holst describes in his writings, as those who walk in two kingdoms, the kingdom of God/spiritual/mystery and the kingdom of the institution.

The vocation remains the same because the stories, the people, remain the same.

Finally, as marginalized professionals forced to answer to many new authorities and expectations, it is in the margins where we do our best work. It is in the margins where we meet the patients and their families, marginalized by disease, trauma, violence, aging, emotional distress, spiritual crisis, and the many other experiences of life that bring them into our margins as we seek to enter theirs. It is there, in the margins, when we move, even momentarily, from the system to the person, where we will again recognize that there is a story, hear that story, and, working with the patients and their loved ones, work through meaning/assessment to quality care.

Even with some hoped-for chapters omitted, the book grew too large. As a result we had to delete the extensive annotated bibliography and the descriptive information on The Association of Professional Chaplains and The National Association of Catholic Chaplains. This information is available from the editor.

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We are indebted to the many along the way who, verbally or otherwise, "said" this story needed to be told, to Stuart Cohen, Baywood Publishing Company, and to the many contributors (especially the non-clergy who spoke so eloquently about these issues). It is impossible to thank Jack Morgan sufficiently for all he means to me personally, to health care, and especially to the worlds of ethics, care of the dying, and bereavement care. To me he is the consummate friend, mentor, teacher, confessor, and priest.

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