Chaplains as Partners in Medical Decision Making: Case Studies in Healthcare Chaplaincy

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Northwestern Medicine®
Mixed Method Study
Phase 3 – Multiple Case Studies

- Present summary of our phase 1 and 2 of research
- Process and Structure of Case Study book
- Method for Analysis of Case Studies
- Preliminary Findings
- Questions for future case study development and research
In a typical week, what percentage of your clinical time is spent supporting patients and families with serious or life-limiting illness in medical decision making?

- Frequently or Always: 10.20%
- Often: 14.00%
- About half the time: 21.00%
- Occasionally: 42.00%
- Never or Rarely: 12.70%
Survey
Percentage of Time: Specific Areas of DM

- **support**
- **communicate**
- **clarify**
- **advance directives**
- **educate**
- **mediate**

41 to 100% of time
Table 3. Predictors of integration in treatment team decision making

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
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<th>Model 2</th>
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<th>Model 3</th>
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<td></td>
<td>OR</td>
<td>95% CI</td>
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<td>OR</td>
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<td>95% CI</td>
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<tr>
<td>Male (ref group female)</td>
<td>1.169</td>
<td>.777-1.757</td>
<td>.454</td>
<td>1.272</td>
<td>.811-1.997</td>
<td>.292</td>
<td>1.272</td>
<td>.811-1.997</td>
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<td>Years of experience</td>
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<td>6-10 years</td>
<td>1.567</td>
<td>.777-1.575</td>
<td>.209</td>
<td>1.361</td>
<td>.654-2.832</td>
<td>.410</td>
<td>1.286</td>
<td>.593-2.79</td>
<td>.525</td>
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<td>16-20 years</td>
<td>1.842</td>
<td>.871-3.821</td>
<td>.111</td>
<td>1.844</td>
<td>.876-4.081</td>
<td>.108</td>
<td>1.650</td>
<td>.730-3.727</td>
<td>.229</td>
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<td>21+ years</td>
<td>3.882</td>
<td>1.962-7.684</td>
<td>.000</td>
<td>4.204</td>
<td>2.060-8.578</td>
<td>.000</td>
<td>3.891</td>
<td>1.831-8.265</td>
<td>.000</td>
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<tr>
<td>Palliative care v. other</td>
<td>1.766</td>
<td>1.111-2.808</td>
<td>.016</td>
<td>1.560</td>
<td>.953-2.553</td>
<td>.077</td>
<td>1.326</td>
<td>.784-2.244</td>
<td>.292</td>
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<td>Oncology chaplain</td>
<td>.533</td>
<td>300-.946</td>
<td>.032</td>
<td>.505</td>
<td>.278-.011</td>
<td>.023</td>
<td>.451</td>
<td>.239-.851</td>
<td>.014</td>
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<td>Care activities</td>
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<td>1.153</td>
<td>1.105-1.203</td>
<td>.000</td>
<td>1.106</td>
<td>1.049-1.166</td>
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<td>Hrs/wk (reference group</td>
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<td>Never or rarely (0-14%)</td>
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<td>Occasionally (15-40%)</td>
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<td>About half the time (41-60)</td>
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<td>Often (61-85%)</td>
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<td>Frequently or always (86-100%)</td>
<td>3.823</td>
<td>1.254-11.652</td>
<td>.018</td>
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Qualitative Findings: Text Analysis
Barriers to Chaplain Participation in DM

- 25% - IDT Role Definition
- 24% - Communication & Timing of Referrals
- 14% - Understanding/Value by medical team
- 11% - Systems
- 9% - Patient/Family
- 5% - None
- 12% - Chaplain
Qualitative Findings: Text Analysis
What Do Chaplains Uniquely Contribute?

Spiritual Dimension & Authority
Religious, Ethical and Cultural Frameworks
Patient Story & Values
Emotions
Family Mediation
Approach/Process
Liaison/Communicator
In-depth Interviews: n=14

Purposive Sample: High integration & Low Integration (High barriers)

Content Analysis and Linguistic Analysis: Chaplain self-understanding, Role in IDT, and Understanding of medical culture/terminology in context of factors necessary for IP-SDM.

High
- Authority/Initiative
- Bilingual
- Valuation of other Roles

Low
- Self-exclusion from “medical”
- Silo Work
- Self definition = spiritual/emotional
Case Study Book

Survey: 150 chaplains indicated interest
Guidelines for content, format and confidentiality
Received 25 summary cases – 9 selected
Process of assisting in writing and revision
Respondents: Guidelines
<table>
<thead>
<tr>
<th>Patient as Person</th>
<th>Emotions and Family</th>
<th>Religious &amp; Cultural Differences</th>
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<tbody>
<tr>
<td>Keith, 59 year old living with stage IV bladder cancer; outpatient infusion center – 10 visits; Mutually expressive writing; Narrative Medicine.</td>
<td>Rita, family matriarch with advanced dementia. “She fed all of us, how can we not feed her”. Religious values embedded in multi-general family system. Family Systems Theory.</td>
<td>Orthodox Jewish parents advocating for daughter with brain injury. Rabbi chaplain bridged to understanding unique approach to decision making of community. Cultural Theory.</td>
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<td>Bob, a middle aged husband and father facing treatment decisions for 2nd life-threatening illness. Chaplain had 7 year relationship with patient/family – doctors asked for her help. Shared Decision Making, Narrative Medicine.</td>
<td>Aaron, 45 year old man with life-threatening cardiac event whose wife and daughter conflicted about “giving up on him”. Use of ritual to address emotions and family roles. Post-Traumatic Growth and Ritual theory.</td>
<td>Ayesah, a 50 year old Palestinian Muslim woman dying in the ICU. Refusal by family of pain medication and brain death determination negotiated by chaplain. Trauma, Cultural Diversity Theory, Family Therapy.</td>
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Author & Respondent Analyses

1. Chaplain attention to narrative and values embedded in patient story promotes value-concordant care: HOW?

2. Chaplain attention to emotions/family dynamics positions them to move the decision making process forward. HOW?

3. Chaplain’s position betwixt and between medical world and cultures/religious worlds of patient/families is the foundation for their ability to negotiate and resolve conflicts that arise in MDM: HOW?
Analysis of Case Studies: Research Method

Interpretative Lens: Cases represent when chaplains assess they have been effective in promoting decision making; barriers to inclusion removed.

Theoretical Propositions:

◦ Integration into IDT facilitates chaplain role in MDM - How IDT structured, chaplain role on team? (descriptive analysis)
◦ Chaplain involvement promotes value-concordant, patient-centered MDM: True or no? If so, what does that look like? (descriptive & causal analysis; rival explanations)
Chaplain Role on Medical Team

Referral Source, Visit Type, Mode of Communication

• Empowers patient voice, decision making without interacting with team but this is the exception (outlier case)
• Care conferences/family meetings
• Present when doctors visit
• Clinicians ask directly for help, insights on how to communicate with family
• One-on-one meetings with team members before or after visits
• Read the medical record

Pre-conditions that enable chaplain to be integrated and effective

• Length of service & trust established
• Knowledge & appreciation of other roles
• Insight into what medical team experiencing/reasons behind recommendations
• Attention to staff moral distress
• Legitimacy from spending extended time getting to know patient and family
Chaplain Role on Medical Team

Authority, Leadership, Initiative

• Speak up, ask questions at strategic points with team
• Educator about traditions or reasons why resistant
• Lead family meeting
• Claim pastoral authority
• Advocate through use of resources
• Awareness and naming of role

What’s absent (re: barriers)

◦ No mention of being paged away or interrupted
◦ One case: "goes around" team when no movement to pt-family
◦ Able to be in outpatient and inpatient settings if needed
◦ Little concern for trespassing
◦ No mention of chaplain documentation in the EMR as a way to communicate!
Value-Concordant Care

• Specific goals, who person is, what really matters

• Identifying approach to mdm more general, timing

• Movement to decision making restored

• Value concordance not static: Hold in tension competing values – “until they can find a version they can live with”

• Person of chaplain/therapeutic presence underlies ability to see patient as person, attend to emotions/family and appreciate cultures thereby promoting value-concordant care.
Causal Analysis
Internal Validity Testing with Rival Explanations

Direct rival: An intervention other than the target intervention accounts for the results

Commingled rival: Other intervention and the target intervention both contributed to the results

Rival theory: Another theory different from the original theory explains the results better

Super rival: A force larger than but including the intervention accounts for the results
## Hypotheses: Future Research

<table>
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<tr>
<th>Research Question</th>
<th>Method</th>
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<tr>
<td><strong>Shared Decision Making</strong></td>
<td>Duke Shared Decision Making Metrics: 3 question survey of patient/family</td>
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<td>If chaplain involved does patient/family report higher satisfaction with shared</td>
<td>EMR data on chaplain visits</td>
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<tr>
<td>decision making?</td>
<td>Self-reported involvement of chaplain in decision making support</td>
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<tr>
<td><strong>Value-aligned care outcomes</strong></td>
<td>Emerging Metrics for Value-concordant care – evidence in EMR of GOC,</td>
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<tr>
<td>If chaplain involved better concordance?</td>
<td>family mtg, advance directives/acp note</td>
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<td>Only if patient/family religious?</td>
<td>EMR data on chaplain visits</td>
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<td>EMR data on level of religiosity?</td>
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<td><strong>ID-SDM Collaboration</strong></td>
<td>Didactics vs. Shadowing</td>
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<td>Best way to educate, promote ID-SDM with chaplain integration?</td>
<td>Survey of colleagues</td>
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Questions for Case Study Development & Research

1. Proscribed format vs. ours (Fitchett & Nolan: A, I, O)
2. Dutch research project – recent case, theoretical lens
3. Does isolating a specific dimension of care promote or impede the task of drawing out unified themes for hypotheses or conceptual framework development?
4. Multiple Case Studies: Replication Claimed?
5. Triangulation with other findings of our study – case studies as part of larger mixed method research design
Discussion

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