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Exploring Challenges of Hospital Chaplains in Transdisciplinary Teams

Stephen A. Spates[1]*, Catherine Y. Kingsley Westerman[2], Leslie A. Laam[3] and Ryan Goke[4]

[1] Department of Communication, Missouri State University, Springfield, MO, United States, [2] Department of Communication, North Dakota State University, Fargo, ND, United States, [3] Geisinger Health, Danville, PA, United States, [4] Department of Communication, North Dakota State University, Fargo, ND, United States

Hospital chaplains experience obstacles in contributing to team objectives when a part of transdisciplinary teams. This case study explores the communication challenges of membership on transdisciplinary teams for hospital chaplains, using a fictional account based on data from a previous study. Chaplain David Howard is one of three chaplains at Grace Hospital and is assigned to the newly formed palliative care transdisciplinary team. The purpose of this team is to work towards providing quality care to patients in the upcoming integrative medicine wing. Although the team is tasked with improving the quality of life for patients, David notices that his concerns of quality care often clash with his medical colleagues' concerns about improved medical health outcomes. As the team's differing perspectives are revealed, it is evident that their communication is crucial to their ability to work together successfully.

Keywords: transdisciplinary, chaplain, palliative care, team, health

INTRODUCTION

This case study is based on recorded interviews with hospital chaplains from around the United States. The names of the chaplain, the characters, and the hospital are fictional, but the story is representative of a qualitative collection of 29 interviews with chaplains in a previous study. Consent was obtained through an ethical process approved by the IRB at the University of Tennessee. In this case study, we will highlight two problems in communication among hospital chaplains and other members of transdisciplinary care teams. First, we will look at communicating across organizational silos. Organizational silos are structural and cultural barriers to communication and information exchange in organizations (Bento et al., 2020). Hospitals have many separate but interdependent units, making clear and smooth information exchange across silos necessary for decisions involving multiple units. Transdisciplinary teams confront this challenge head-on. Second, we will look at challenges of organizational hierarchy in transdisciplinary teams. Although chaplains may have valuable spiritual perspective, especially on a palliative care team, the medical hierarchy present in transdisciplinary hospital teams might make it difficult for them to be heard.

NEW PLANS AT GRACE HOSPITAL

Grace Hospital recently completed the addition of a new Integrative Medicine wing that includes a focus on palliative care. The mission is to "connect the health of mind, body, and spirit," creating a seamless experience for patients, which requires the hospital's already existing departments to coordinate effectively. Coordinating is particularly important in palliative care as patients endure

deteriorating health conditions. Chaplain David Howard was named as the representative of pastoral care on the new transdisciplinary palliative care team, and he was excited to receive this new assignment. The purpose of this new team was to consider all aspects of health as they coordinate care for patients facing the end of life.

One of David's first tasks as a member of the new transdisciplinary palliative care team was to attend a meeting regarding end-of-life provisions. The team included Mark (a physician), Alberto (a nurse), Tracy (a physical/occupational therapist), Jess (a case worker), Brian (a social worker), and Janet (a pharmacist). As a part of the hospital's new initiative, this transdisciplinary team was created to include all areas of expertise in healthcare. The team members were familiar with each other but had not previously worked closely with each other.

David arrived and greeted everyone, paying particular attention to those he already knew well. "Good morning! Hi Tracy, nice to see you again. Good morning, Al. How's your son doing in college?" David poured himself a cup of coffee while continuing to chat. It was a collegial atmosphere despite varying levels of familiarity among them; they were excited to work together on this new initiative. After everyone arrived, Mark led brief introductions and announcements, and then came around to the main issue: thinking of ways to get patients and their family members participating in end-of-life provisions. In the past, family conflicts and delayed responses were contributing to lack of end-of-life planning, so the team wanted to find ways to work together to improve the finality and completeness of plans.

"So, what can we do for our patients making plans for end-of-life?" asked Mark. Ready to start the conversation, Alberto jumped right in. "I think it's all about service. We need to make sure the patient, and their loved ones, are getting what they need from us. This is different from the temporary patient." David wanted to offer his perspective as a chaplain but decided to listen some more as Mark began to speak. "I agree, Alberto. We need to do everything we can to make sure that our patients are receiving quality care, and we minimize the severity of their symptoms." The room agreed. Everyone seemed to share the same thoughts and opinions, focused on quality of care.

Then David added his point of view. "These are all good points. I would add that many patients that I visit with also talk about making sure that they resolve issues with their spouse or parents or children–what we might call emotional or spiritual health. They want to make things right, or 'get right with god,' before they slip away. I try to help them, but I am not always present to hear about issues related to emotional and spiritual health when they come up. For example, Mark, Brian, Alberto, or Tracy, any of you may be able to hear about a conflict with a family member that weighs on a patient's mind. It may be helpful if everyone who encounters patients is open to hearing about these issues from patients, noting them, and considering how we can address them in end-of-life planning. Sometimes patients are nervous about dealing with long-standing conflicts and need encouragement from us."

The room was quiet. Mark broke the silence, "I get that it's your job to think about alternative kinds of health, but for me, I just don't have the time to hang around with patients to listen to these drawn-out stories; I have a lot of patients to see and work to do. That's why we have chaplains–to deal with that stuff for us." Others in the meeting seemed a bit uncomfortable with the tone of his response, but no one spoke up in support of David.

Janet responded by changing the subject. "I do think it's important to make sure that patients feel good, as much as possible, during their final days. However, I know that what they really want is to get better or prolong their health as much as possible. In pharmacy we want to make sure that medication levels are being ethically distributed. We need to have conversations with patients and their family members, to make sure that we stress the importance of taking meds as scheduled, and reducing negative side effects." The other members continued the conversation in the direction of compliance and improvement of medical outcomes.

Near the end of the meeting, Jess, who took notes, double checked to make sure that she recorded everything. "We've covered several ideas and thoughts that could really help us move patients toward end-of-life planning more effectively. Is there anything else that we should cover?" she asked. David took the opportunity to reiterate his point from earlier. "Well, I think that it's important for me to remind us how important the emotional and spiritual health of the patient really is, in part because it can affect their physical health as well. Aren't we here to focus on Integrative Health? Although emotional and spiritual health are more a focus of my job as a chaplain, it will really help the patients if others can take note of issues you observe patients struggling with. Inviting patients to seek and find peace can contribute to a higher quality of life, which is the ultimate goal of the team, right?"

Unfortunately, David's comments seemed to fall on deaf ears as the meeting ended by prioritizing compliance, health checks, and increased notifications for family and loved ones. It was clear to David that he had not been heard by his coworkers. In fact, if he was going to contribute to this team, something would have to change in the team's communication.

Later that day, David spoke with Brian and Jess to see if his perspective made sense to them. "I do think you're right," said Brian, "but the hard part is getting our other team members to think about something else besides diagnoses and prescriptions." Jess concurred with Brian's assessment of the situation. Their agreement was a confirmation for David, but how was he going to convince his medical team members to listen?

Over the next few months, the bi-weekly meetings were the same. Medical staff continued to dominate the conversation, prioritizing physical health outcomes, and ensuring regulatory compliance for care provided. Even reports from non-medical members, like Brian and Jess, were mostly focused on the diagnoses of patients. David decided that the way to make this new team assignment worth it would be to break down the differences among the team members–highlighting their various areas of expertise, and the purpose of being a transdisciplinary team. Since Mark was the doctor and the de facto leader of the team, David decided to request a one-on-one meeting with Mark to try to bring these challenges to his attention.

Mark agreed to meet for lunch in the hospital cafeteria. David hoped this casual atmosphere would allow for an open discussion

and minimize Mark's defensiveness. "So, what did you want to discuss, David?" David took a deep breath, "I am concerned our transdisciplinary palliative care team is not meeting the goals of the Integrative Medicine wing. In our meetings, we do not give equal concern to all elements of patient health; we are heavily focused on diagnoses and medications. I realize this is the way things have always been done. But I am hoping we can be part of the change to move to holistic care as that is our mission."

Mark took this in as he sipped his soup. "I can see what you are saying. It is hard for us to get out of our old habits. My training is so ingrained that I just don't think about that other stuff much. That's probably true for everyone in the meeting. But what do you want me to do about it?" David replied, "I think it would be helpful if you as a high-status member of the team led the charge in elevating concerns regarding emotional and spiritual health of our patients. When you dismiss these concerns as 'alternative treatments' and lesser concerns, it has a silencing effect on others in the meeting. You can help solve this problem by inviting people to discuss those issues in equal time with the other issues we discuss." Mark seemed a bit skeptical but agreed to give David's idea a try.

At the next meeting, things were happening like usual, with the medical staff valuing medical information over other perspectives. However, in this meeting David decided to challenge this dynamic. "I know we have been focusing on the physical health of patients, but I still want everyone to think about all the needs of the patient. They also have emotional and spiritual health which can be just as important." Mark seemed to forget the conversation he and David had had over lunch. Instead of inviting others to chime in regarding emotional and spiritual health, Mark seemed a little frustrated by the comment. "Those are important things, but their quality of health and life are things that we can actually manage and track." Alberto expressed his agreement, "We know that's why patients come to us, to get better or improve their quality of health. If we aren't focusing on that, then we are not really doing our job." To challenge these views, David responded. "But is that all we should focus on? Shouldn't we use an approach that allows us to consider all the aspects of health? I think this is what's keeping our scores from improving, we're forgetting about the complete picture for the patients."

Mark was offended at David's remarks; mentioning their scores hit a particularly sore spot for him. He responded, "I believe our scores will improve when patients see that we are doing all we can to help them in their challenging health conditions. We don't need to ask patients about how they are feeling when we could be spending our time providing care that will actually do something." Frustrated himself, David replied, "Then why am I here? Why am I a part of this team if we aren't trying to treat our patients holistically?" Alberto explained his reasoning, "You're here because when patients are about to die, they do require spiritual services and it's an important part to their closing moments. That's why you're here." David was discouraged by how quickly Mark reverted to his previous way of thinking. He left the meeting wondering how their team could support the new Integrative Medicine wing when the members of the team remained so firmly anchored in their own expertise and departmental perspectives.

DISCUSSION

David is dealing with two challenges inherent to transdisciplinary teams: organizational silos and organizational hierarchy. David had the right idea when he requested a private meeting with Mark, who is a high-status member of the team because of his expertise and the clinical hierarchy present in hospitals. Although it was not immediately successful, this meeting and future encounters could help begin to manage the two main issues present in the case.

First, silos are different groups in a hospital that do not necessarily talk to each other and often have different ways of interacting, even down to different jargon. The members of David's transdisciplinary palliative care team each join the team from their home silos to form this new team. Social identity theory (Tajfel and Turner, 1979) suggests that the social interactions of a group are used to develop the identity of that group and determine who is part of the "in-group" and who is not. Members are considered a part of the in-group when they can identify with the language, behaviors, and beliefs of the rest of the group. If members do not identify with the language, behaviors, and beliefs, they are considered a part of the out-group. Based on interactions in their palliative care meetings some members are quickly able to identify others as a part of the in-group (e.g., Mark, Alberto, Tracy, and Janet) and other members (i.e., David) are identified as a part of the out-group.

David is seen as an outsider on the team because of how his viewpoint differs from what the rest of the team seems to agree on. To begin to bridge the silos of "chaplain" and "physician," David can generate additional social interactions with Mark that would give David a chance to be seen as part of the in-group. If Mark begins to understand David as a person outside of the context of the larger meetings where they appear to be at loggerheads, David may develop some idiosyncrasy credits (Hollander, 1958) with Mark and by extension, with the transdisciplinary team. In essence, David's deviance from the normative thinking in the group will be seen more positively if David can do two things: join the in-group and develop idiosyncrasy credits. Mark will become more forgiving of David's different viewpoints and potentially more open to them both in private and in their team meetings. This will lay the groundwork for Mark to open up the conversation to the spiritual and emotional health of patients.

Organizational hierarchy is commonly established based on an organizational chart identifying direct reporting relationships. Hospitals function differently in that there is an unwritten but understood "clinical hierarchy" wherein physicians hold both expert power and political, or referent, power (French and Raven, 1959). Here, Mark has the ear of the people who can make decisions and he will be heard over other people simply because he is a physician. David wisely requested a private one-on-one meeting with Mark to discuss his criticisms of the team. Privacy allows David to challenge Mark's laser focus on physical health without threatening Mark's position in the hierarchy. Mark is able to appear to make a decision to change the way he treats emotional and spiritual health without David being seen to have control over him. David was also careful to choose an informal

setting for the meeting to reduce the likelihood that Mark would feel threatened by David's criticism. Finally, David was prepared with a specific communication-based behavior that he wanted to request from Mark (to give more time to discussions regarding emotional and spiritual health). It was David's hope that speaking with Mark would allow for a more welcomed reception of non-medical perspectives among the team.

PRACTICAL IMPLICATIONS

We offer several recommendations for hospitals using transdisciplinary teams. Organizational silos can be addressed by transdisciplinary team members participating in identity creation. Earlier, we discussed how social identity theory explains how groups develop identity by identifying similarities among the group's members through social interaction. Transdisciplinary teams could benefit by using their initial meeting to identify shared language, behaviors, and beliefs to support team creation and cohesion. In addition, team members could show unity and acceptance of their new identity by creating a team name.

To help manage the clinical hierarchy, the group should strategically use the formation stage to structure and organize the team in ways that relieve the hierarchy when needed.

They can begin by honestly recognizing the different levels of power present in the group. Teams can also agree on which communication behaviors best suit the team in order to balance these powers and encourage participation (Wang et al., 2019). For example, they might agree to assign roles within the meeting that circumvent that power dynamic, such as assigning powerful people to play devil's advocate or to serve as allies for those with lower degrees of power.

By implementing these recommendations, transdisciplinary team members in palliative care and other areas can improve their likelihood of leveraging the advantages of transdisciplinary teams to help patients in the best way possible.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by University of Tennessee IRB (Compliance Office). The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct and intellectual contribution to the work, and approved it for publication.

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