itual care offered by other health care providers. To clarify and promote recognition of such boundaries, chaplains should be candid about what they do that can be done by someone else as well as what is done by chaplains, what they do that is generally done better by chaplains, and what they do that can be done well only by chaplains. Further, chaplains must consider what should not be done by chaplains. For example, it is not unusual for an experienced chaplain, well versed in the language and practices of the hospital, to act as the interpreter of unintelligible or minimalist medical explanations to patients and families. Is this an appropriate role? Are chaplains trained to carry out this task—and should they be? Should it be a standard of practice?

There are other questions, of similar practical relevance, that should be asked: Should chaplains serve as cultural brokers? As mediators and conflict resolution facilitators? The process of defining chaplaincy as a profession calls for setting limits, even if broad, on what counts as appropriate professional work for chaplains. Setting these limits must precede the establishment of standards for the performance of that work, and it can only then be followed by consideration of quality improvement.

There are obviously more questions than answers in this discussion, questions that are rightly answered only by the chaplains forming this profession. However, it does seem that any professional ethic for chaplaincy must contain a thoughtful consideration and explanation of the particular ethical obligations entailed by the health care context of chaplaincy, not only because of the central status and vulnerability of patients, but also because of the intensity of commitment and the confusion that characterize the work of health care providers. It must include careful attention to the demands, dangers, and limitations inherent in a moral practice of ministry, justifying the practice and safeguarding both the practitioners and their patients. And it must delineate and justify the responsibilities of chaplains, transforming their multiple lines of accountability into an ethical framework for chaplaincy as responsible health care ministry.


3. There are now interfaith seminaries in the United States, some of whose students enroll in order to become hospital chaplains. It remains to be seen whether the educational content of their professional vocational preparation is sufficiently robust to constitute its own tradition, especially if “interfaith” includes both theist and nontheist faiths, and to engender allegiances that produce the sorts of conflicts I refer to here. That is, the hypothetical conflict of a deeply theist chaplain asked to avoid talk of God with a nonreligious patient could be mirrored in that of a thoroughly “interfaith” chaplain confronted by a deeply traditionally religious patient who desires specific practices and references to a very particular God.


6. In many medical centers, chaplain trainees are categorized as medical house staff, subject to the same limitations on work hours that apply to interns and residents. In some medical departments, the constraints on house staff time have led to significantly increased demands on the time of junior faculty, a development that the profession of chaplaincy should certainly try to avoid as it works to protect the well-being and the time of both its members and its aspirants.

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**Lost in Translation: The Chaplain’s Role in Health Care**

**BY RAYMOND DE VRIES, NANCY BERLINGER, AND WENDY CADGE**

Chaplains often describe their work in health care as “translation” between the world of the patient and the world of hospital medicine. Translators usually work with texts, interpreters with words. However, when chaplains use this metaphor, it describes something other than a discrete task associated with the meaning of words. While medical professionals focus on patients’ medical conditions, chaplains seek to read the whole person, asking questions about what people’s lives are like outside of the hospital, what they care about most, and where they find joy and support in the world. Chaplains offer a supportive presence that serves to remind patients and caregivers that people are more than just their medical conditions or their current collection of concerns. Some chaplains are skilled at translating patients’ experiences and sources of meaning in real time, allowing medical teams to better understand the person they are treating. “Translation” is also defined as metamorphosis. Chaplains

provide this sort of translation when they are alone with pa-
tients, listening to their deepest concerns, helping them redefine their lives.

Unlike a professional interpreter, who helps patients and clinicians communicate when they do not share a common language, the chaplain is not just a conveyer of the spoken words of others. A patient, family member, nurse, or physician may seek out the chaplain for help in translating a situation: Is the family in denial? Is the team giving up? Is the patient ready to go home, like her husband says, or ready to rest, like she says?

Ironically, chaplains—skilled at mediating between patients and hospital staff—often have no one they can rely on to advocate for them at budget time, no one who can “translate” the tangible benefits chaplains provide to patients, families, and staff into terms hospital administrators can understand.

The Professional Chaplaincy and Health Care Quality Improvement research project was initiated, in part, in response to this dilemma: If chaplains wish to be recognized as a health care profession, they need to be able to describe, to themselves and to others, what constitutes “quality” in their area of patient care. Like other health care professionals, they need to specify how their profession and their day-to-day work in the hospital contribute to the ongoing task of quality improvement in health care. This is no easy task. The work that chaplains do is difficult to measure in conventional QI terms: the precise duties of their job are unspecified, and chaplains often find themselves improvising to meet the needs of patients and caregivers. In this situation, how can chaplains define their role in improving health care? External perceptions of chaplains and chaplaincy also complicate this translational task: is chaplaincy best understood as a specialized form of religious ministry, in—but not of—the health care setting? Or is it truly a health care profession, and if so, what is the nature of the health care service that chaplains provide, and how is it relevant to patients’ health care needs and their treatment? Is it, in some way, both of these? Without attention to these broader sociological questions, it is difficult for chaplains to see themselves as a “professionalizing profession,” and to make the special nature of their work understood to the administrators who must make decisions about investing in services that have no reimbursement code.

Raymond de Vries and Wendy Cadge, two of the authors of this essay, were invited by project codirector Nancy Berlinger, the third author, to participate in this project as sociologists who would observe, reflect, and offer a series of thinking points about the profession and future of hospital chaplaincy. De Vries comes to the project as a sociologist of bioethics (another occupation struggling with its identity and place in worlds of medicine and science) and with expertise in the sociology of culture and the professions. Cadge is a sociologist of religion who studies, among other things, the formal and informal presence of religion and spirituality in hospitals. The three of us offer our thinking in the spirit of continued conversation and with deep respect for the work of health care chaplains.

The Road to Professionalization

Seen from the point of view of the social sciences, the desire of chaplains to strengthen their profession—to more clearly define their work and to establish agreed-upon standards of practice for those eligible to be called “chaplain”—is a predictable stage in the natural history of an occupational group. Changes in society and technology bring with them changes in the division of labor. Not only does the nature of and need for work change (think of the new occupations created by the computer revolution); so, too, does the way the work of society is divided among occupational groups.

Sociologists have long observed the comings and goings of occupational groups, and they pay particularly close attention to the strategies and social conditions associated with the successful and unsuccessful efforts of these groups to secure a place in the division of labor.1 As chaplains consider the work they must do to establish their profession, insights derived from the sociology of occupations are useful. The following metaphor, drawn from the sociology of work and occupations, offers a helpful perspective on chaplains’ place among other occupational groups:

Think of all the work that has to get done in a society as the landform upon which a city is based. The division of labor is the street grid that defines this landform: some areas are zoned for manufacturing, others for services, some for respectable tasks, others for deviant ones; some areas are identified for the market, others for domestic labor. Each zone . . . is a site for potential ecological struggle. Some are securely occupied by well-entrenched occupations. Others are scrapped over: some want to annex new areas to territory they already control; some wish to abandon a declining area in order to colonize a more desirable one; others desire to take over a neglected patch and displace or organize the existing occupants to improve it.2

Similarly, as chaplains seek to “stake a claim” in the terrain of health care they are, in some cases, seeking to “annex” areas that others control, and in other cases they are moving into territory abandoned by other professions.

Also relevant to the situation of chaplains are the ideas about labor markets developed by Eliot Freidson, the preeminent twentieth century sociologist of the professions. According to Freidson, human labor may be divided into four “economies of work” based on the nature of labor markets. Best known, of course, is the official labor market, where work is legally and economically recognized, included in measures of production, and categorized in the census lists of job titles. But alongside the official market for work exist three other markets: the criminal labor market, the informal labor market, and the subjective labor market. It is this last market—the subjective—that is most pertinent to chaplaincy. Freidson defined this arena as the market where goods and services are traded...
without direct economic exchange, and he saw it as both the cradle and the grave of many occupations. Chaplaincy can be understood as work that moved, or perhaps is moving, from the “subjective” to the “official” labor force; having begun as “volunteer” work by clergy whose “real” job was ministering to a congregation, it is now an occupation paid to be a pastoral presence in health care settings.

As chaplains seek to map out their territory in the world of work—to move their occupation from the subjective labor market to the official labor market—they must overcome certain challenges generated by their history and the nature of their work.

**No clear jurisdiction.** First, hospital chaplains do many things. This “jack-of-all-trades” approach serves the needs of a new occupation well—in seeking to establish a foothold, occupational groups are wise to serve the needs of established professionals and ingratiate themselves with occupations that have more political power. But what works to get one’s foot in the occupational door harms efforts to professionalize. In some ways, being a chaplain is a “vacuum identity”—the work of chaplains can be seen as filling the many vacancies that arise among the jobs of other professions in medical settings. Chaplains fill a void rather than offering a well-defined service. In order to secure a place as a profession, an occupational group must have a clear boundary around its work. It is difficult to stake a jurisdictional claim with an ambiguous definition of one’s jurisdiction.

**Disagreement within the occupational group.** Not surprisingly given the many tasks and varied educational backgrounds of chaplains, disagreement exists within the group about the proper definition of a chaplain. The leaders of the main professional groups of chaplains have established credentialing standards to answer two basic questions: What must a professional chaplain know, and what kind of training is required to gain that knowledge? On the other hand, these same leaders have not yet reached agreement on standards or scope of practice: What should all chaplains do, or refrain from doing, in recognition of a duty of care? What are the boundaries in which they do these things? Disagreements about the answers to these questions slow the move toward full professional status. Those who prefer the status quo and those who feel threatened by the move toward professional status can undermine efforts by the occupational group to professionalize.

**Self-defining.** Because chaplaincy is not yet broadly recognized as a distinct profession, others may feel entitled to use or be granted the title “chaplain” when they are doing certain things. For example, clergy who do not work as health care chaplains may claim the title “chaplain” when they are visiting hospitalized members of their congregation. Volunteers in chaplaincy departments are frequently called “chaplain” by patients and family members. These realities work against efforts to distinguish the work of professional chaplains, and they make it difficult for other professional groups, and the public, to see chaplaincy as a distinct health care profession. A patient in a U.S. hospital is unlikely to encounter a “volunteer” physician—the category of “physician” is understood to be a professional category. However, understaffed pastoral care departments rely on volunteers to meet specific, often religious, needs of particular patient groups. An internist would be professionally remiss if she called herself a “surgeon” solely on the grounds that both internists and surgeons have medical degrees. However, a community clergyperson might defend his right to be called “chaplain” even though the only thing he or she shares with a health care chaplain is the same postgraduate degree. Defining what professional chaplains do, what volunteers do, and what community clergy do with respect to “chaplaincy,” and determining which of these activities are health care services and which are religious services, are further challenges for this profession.

**Challenging others’ turf.** In staking their claim for a piece of property in the world of medical work, chaplains trespass on the work of others. Some occupational groups will not mind giving up a bit of their property (see “dirty work” below), but others will be more reluctant. Two groups that may resist incursions in their work are social workers and local clergy. Many of the tasks that chaplains do can be seen as tasks that social workers do—for example, making arrangements for family members or helping to solve disputes between medical staff and patients and families. It is likely that some medical social workers will not look kindly on those who threaten their livelihood. Also, local clergy may see professional, hospital-based chaplains as encroaching on the important work they do with members of their congregations.

**Taking over “dirty work.”** Sociologist C. Everett Hughes was the first to examine how dirty work is passed among and within occupational groups, typically flowing down the ladder of prestige. Chaplains may not regard the work they do as being “dirty,” but in the eyes of more established professions—such as physicians—talking with patients about spiritual concerns or ensuring that their pastoral care needs are
Chaplains should think about how to translate the meaning and value of their work into terms that hospital administrators can understand.
Self-Interest and Public Interest

In their journey toward professional status, chaplains must find a way to balance professional self-interest and the interest of the people they serve. The official party line of most professions is that all their organizational efforts are undertaken on behalf of their clients, but decades of sociological analysis show this claim to be hollow. The best-known examples of professional self-interest come from the field of medicine, where we have seen doctors in the United States consistently resisting changes that would improve access to health care. The American Medical Association famously fought the legislation that created Medicare (health care for the elderly and disabled) in the 1960s, arguing—with a strong dose of self-interest—that the plan would reduce the quality of care for all.

More recently, “white coat” rallies calling for malpractice reform have at times cast physicians as the victims of greedy, litigious patients.

The “bedside” orientation of chaplains may make them less likely to put professional interests ahead of the interests of patients and families. However, some chaplains tell us that they avoid these uncomfortable conflicts by “flying under the radar.” This metaphor suggests that chaplains may view their employing institutions or their professions as antagonistic to their interests: a pilot flies under the radar to avoid getting shot down by the enemy, not merely to avoid being noticed.

Our review of the strategic plan of the Association of Professional Chaplains shows how easy it is to conflate professional and patient interests. Here are the seven goals of the APC described in their 2007–2008 strategic plan:

Goal A: Increase collaboration and interaction with other appropriate chaplaincy, spiritual care, and human service organizations.

Goal B: Increase awareness of the value of Board Certified Chaplains.

Goal C: Increase members’ ownership of the APC.

Goal D: Increase the participation by those of diverse backgrounds in activities of the APC at all levels.

Goal E: Identify and develop resources sufficient to fund and accomplish APC programs.

Goal F: Nurture the spiritual life of APC members.3

The first five of these goals are about building the credentialing organization itself. With the possible exception of the final item, none of these goals seeks to improve the capacity of chaplains to meet the spiritual, emotional, and physical needs of patients, families, or health care workers. Also absent from these explicit goals is a commitment to conduct or contribute to research that could provide empirical evidence of the value of chaplains to patients. Doubtless the drafters of these goals sincerely believe that strengthening the credentialing organization will improve service to clients. However, the sociology of organizations teaches us that means often become ends.

How can chaplaincy avoid the extremes of “flying below the radar” (which works against unifying the profession) and the self-interested move of reducing the goals of health care to the goals of health care organizations? How can the profession correct these errors of translation—self-understandings that seem to offer security but in fact may create barriers to professional maturation by perpetuating a vision of a profession as insular or marginal?

Here are our recommendations. Chaplains and their organizations should think about how to translate the meaning and value of their work into terms that hospital administrators and others in decision-making positions can understand. In health care, translations must be clear and accurate if they are to provide an adequate basis for understanding and policy. Chaplains should make a practice of translating from the terminology of health care systems into that of their own profession. By paying close attention to the nature of institutional decisions about patient care, how various patient care professions are deployed, and the concerns of decision-makers in general, chaplains will be able to identify research questions that can yield reliable information about the chaplain’s contribution to patient care. These activities should not be confused with “making the numbers” or merely reacting to institutional concerns.

We also encourage chaplains and their organizations to look for examples of individual chaplains or chaplaincy departments that are proficient translators and to analyze what makes them good at explaining the value of what they do to others.

Finally, because chaplains seek to work in the complex culture of health care delivery, and because claiming a professional role in this culture means acknowledging one’s organizational responsibilities, we encourage chaplains who aspire to lead chaplaincy departments to receive some training in health care organization and management. We also encourage organizations that offer continuing education to chaplains to recognize this need and provide credit for this training.

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2. Ibid.