How hospital chaplains develop and use rituals to address medical staff distress☆

Robert Klitzman [a],[*], Jay Al-Hashimi [b], Gabrielle Di Sapia Natarelli [c], Elizaveta Garbuzova [b], Stephanie Sinnappan [b]

[a] Columbia University, 1051 Riverside Drive, Mail Unit #15, New York, NY, 10032, USA
[b] Columbia University, 203 Lewisohn Hall, 2970 Broadway, MC 4119, New York, NY, 10027, USA
[c] Columbia University, Lewisohn Hall, 2970 Broadway, MC 4119, New York, NY, 10027, USA

A B S T R A C T

Physicians and nurses face high levels of moral distress and burnout, exacerbated by the COVID-19, yet are often busy, without time for extended interventions. Hospital chaplains have recently been asked to assist staff, but many questions arise concerning whether they do so, and if so, how and when, and whether they may vary in doing so. Thirty-one telephone interviews of ~1 h each were conducted with 21 board-certified chaplains to examine these and related issues. Respondents reported how they help staff, often creating, on their own, innovative kinds of practices that appear to take the form of rituals. These rituals vary in audience (physicians, nurses and/or other staff, with or without patients or families), form (from open-ended to structured), formality (from formal to informal), timing (at hospital discharge, time of death or after death), duration (from a few minutes to longer), frequency (from once to several times or ongoing), content (expressing and/or reframing feelings and experiences), and activities (e.g., talking, eating and/or making commemorative objects). Such rituals can help staff cope with death, grief, and other stresses. Challenges arise, including hospital leaders' wariness, resistance or lack of support, and staff time constraints, making briefer sessions more practical. These data highlight how chaplains can assist staff through use of rituals, and learn from innovations/initiatives devised by colleagues elsewhere. Chaplains can thus enhance what they do as individuals and as a profession. These data have critical implications for future research, education and practice for physicians, nurses, hospital administrators, chaplains and others.

1. Background

Physicians and nurses face high levels of distress and burnout, exacerbated by the COVID-19 pandemic (Anders, 2021; McLernon. 2020; Melnikow et al., 2022; Norman et al., 2021; Shanafelt et al., 2012; Wan, 2021), yet are often busy and may not have time for extended interventions. Moral distress happens when healthcare workers feel forced to act against their values (Jameton, 1964), and are unable to "preserve all interests and values at stake" (Kälvemark et al., 2004). Burnout occurs when employees experience emotional exhaustion, lack of personal accomplishments, and depersonalization, which can include cynicism, detachment from the work and loss of idealism and

withdrawal (Hiver & et al., 2022; Maslach & Jackson, 1981; Maslach et al., 2008).

Even before the pandemic, physician burnout was increasing, with almost half of physicians (45.8%) experiencing it (Shanafelt et al., 2012). COVID has increased such distress, with almost a third of healthcare workers feel stressed and depressed, and contemplating leaving the profession, exacerbating staff shortages, especially of nurses (McLernon. 2020; Wan, 2021). Burnout rates among hospital staff have increased about 62% – from 27% to 44.2% (Melnikow et al., 2022). Such distress has been associated with post-traumatic stress disorder symptoms, and interpersonal and work difficulties (Norman et al., 2021). In hospice and palliative care, proposed solutions to staff burnout have included

developing generalist palliative care, frequent rotations on-and-off service, and organizational support for self-care (Kavalieratos et al., 2017).

Hospital chaplains engage in various activities and have recently been asked to assist staff. In one study of chaplains, 83.9% were asked during the COVID-19 pandemic to provide spiritual care for staff, and 58.9% regularly did so (Tata et al., 2021). In an online assessment of qualitative responses from 52 chaplains, 56% reported providing support for healthcare team members (Kwak et al., 2021). An international survey of 1657 chaplains found that many did so in several countries, especially in North America (Snowden, 2021).

Several recent studies have examined how often chaplains engage with patients in various broad categories of activities or of discussions of topics, but many questions remain concerning *how* and *for whom* they perform these and may differ in doing so – what strategies they employ, with what effects and challenges. In a 2015 national online survey, 382 full-time chaplains working in palliative care reported that their most common activities with patients and families were building relationships (76%), care at the time of death (69%), and providing ritual support (64%) (Jeuland et al., 2017). "Performing a religious rite/ritual" is one of the top activities in which chaplains engage, along with crisis intervention, emotional enabling, counseling, bereavement, and empathetic listening (Handzo et al., 2008; Handzo et al., 2008a; Timmins et al., 2018), but questions arise as to what these rituals entail and exactly what kinds of activities are performed.

Physicians and nurses are also often busy and may not have time for long discussions, raising critical questions arise of *how* exactly chaplains can best assist them. One intervention, Code Lavender at the Cleveland Clinic, has been described, in which chaplains assist a particular staff member after a stressful event, providing support and relaxation (Stone, 2018). But questions emerge of whether chaplains use this or other interventions, and if so, which, when, how, and why or why not, and what barriers or facilitators might exist.

Interviews were thus conducted with chaplains to explore these and related issues.

These issues are critically important, since chaplains are often under-resourced and marginalized, and efforts to document the beneficial effects of chaplains are needed but have faced challenges and thus been limited and had mixed results. Chaplains perceive barriers from institutions, other staff, patients and chaplaincy itself (Best et al., 2022), often seeing a disconnect between doctors and themselves, with the former unfamiliar with chaplains' roles, and often not seeing it as helpful (Gomez et al., 2021); and 62% of chaplains feel they are infrequently integrated into medical team discussions (Wirpsa et al., 2019). Even palliative care physicians, nurses and social workers, though broadly understanding what chaplains do, were rarely aware of chaplains' roles in assisting with treatment decision-making and communication among patients, families and medical teams, and caring for the medical team (Damen et al., 2019). Clinicians and patients are often unaware of chaplains' existence or have misconceptions about what these professionals do, seeing the work as related primarily to narrowly-defined religious activities, leading to marginalization of chaplains, and needs to enhance recognition and appreciation of these professionals.

Though several studies have tried to demonstrate quantitatively that chaplains provide clear, concrete benefits by increasing patient satisfaction, the results have been mixed. Specifically, in one study, 5.6% of patients at one institution saw a chaplain, and were more likely to have higher patient satisfaction on 6 items, regarding religious/spiritual and general psychosocial care activities (Marin et al., 2015). Yet in another, much larger study of 11,741 patients, 26.5% saw chaplains, but were more likely to have poorer health and patient experiences (Damen et al., 2020a). The relationships among these variables may thus be complex, since sicker patients may be more likely both to see a chaplain and to have worse prognoses and thus less satisfaction with care.

Hence, evidence of others ways that chaplains can assist hospitals – not only patients and families, but doctors and nurses as well – is crucial.

2. Methods

The Principal Investigator (PI), who has extensive experience conducting and analyzing qualitative interviews (Klitzman & Daya, 2005; 2012; 2015; 2019; 2020), conducted the interviews. As seen on Table 1, 31 formal telephone interviews of approximately 1 h each were conducted with 21 board-certified chaplains. Among these interviewees, 12 were men and 9 were women, 81.0% were Caucasian, 14.3% were African American and 4.8% were Latino, the mean age was 63 (range 42–72), they were from throughout the U.S. and represented diverse religions, 38.1% had Masters degrees and 23.8% had doctorates, 95.2% were Board Certified and they had practiced for a mean of 18; 8 years (range 3–30). About half of the interviewees (12) were interviewed more than once in order to cover the questions in the semi-structured interview guide, since some interviewees responded at greater length than did others to the questions posed.

Qualitative methods were chosen because these can best elicit the full range and typologies of attitudes, interactions and practices involved, and can inform subsequent quantitative studies. From a theoretical standpoint, Geertz (1973) has advocated studying aspects of individuals' lives, decisions, and social situations not by imposing theoretical structures, but by trying to understand these individuals' own experiences and perspectives, drawing on their own words to obtain a "thick description."

2.1. Participants

Initial informational background conversations were held, as pilot interviews, with 15 chaplains and 12 physicians, recruited through word of mouth, regarding these issues, to help inform the 33 formal interviews with chaplains. For the main, formal study itself, the chaplains were recruited through the listservs of the Association of Professional Chaplains and through word of mouth. Chaplains who were interested in

Table 1
Characteristics of sample.

Variable:	Number:	Percentile:
Gender:		
Male	12	57.1%
Female	9	42.9%
Race & Ethnicity:		
Caucasian	17	81.0%
African American	3	14.3%
Latino	1	4.8%
Age:		
Range	42–75	years
Mean	63	years
Geographic Region:		
Northeast	10	47.6%
Midwest	4	19.0%
Southeast	3	14.3%
Southwest	3	14.3%
West	1	4.8%
Religion:		
Protestant	6	28.6%
Catholic	4	19.0%
Christian, not otherwise specified	5	23.8%
Jewish	2	9.5%
Muslim	2	9.5%
Buddhist	1	4.8%
Other: Not disclosed	1	4.8%
Highest Degree Held:		
Master's	8	38.1%
Doctorate	5	23.8%
Bachelor	1	4.8%
Associate	1	4.8%
Unknown	6	28.6%
Years Practiced as Chaplain:		
Range	3–30	years
Mean	18.8	years
Percentage Board Certified:	20	95.2%

participating contacted the PI by email. Individuals who responded to the recruitment announcement were chosen, with an effort to include differing geographic locations. Participants were from across the U.S. Interviews were conducted until "saturation" was reached (i.e., "the point at which no new information of themes are observed in the data" (Guest et al., 2006). The Columbia University Department of Psychiatry Institutional Review Board approved the study.

2.2. Instruments

The semi-structured interview questionnaire was drafted, drawing on the prior literature on chaplains. Questions explored chaplains' views, experiences, and decisions. The PI conducted all the interviews. Sample questions, asked of all participants, appear in Table 2.

2.3. Data analysis

The methods for the present study adapted key elements from "grounded theory" (Corbin & Strauss, 2014), and were thus informed by techniques of "constant comparison," with data from different contexts compared for similarities and differences, to see if they suggest hypotheses. This technique generates new analytic categories and questions, and checks them for reasonableness.

Interviews were audio-recorded and were professionally transcribed. The PI kept field notes and transcriptions and initial analyses of interviews occurred during the period in which the interviews were being conducted, helping to shape subsequent interviews. Once the full set of interviews was completed, subsequent analyses were conducted in two phases, primarily by trained research assistants (RAs) and the PI. In phase I, each independently examined a subset of interviews to assess factors that shaped participants' experiences, identifying categories of recurrent themes and issues that were subsequently given codes. The PI and RAs read each interview, systematically coding blocks of text to assign "core" codes or categories, such as types of individuals chaplains sought to help (e.g., patients, families, physicians, nurses, and/or other staff).

While reading the interviews, a topic name (or code) was inserted beside each excerpt of the interview to indicate the themes being discussed. The PI and RAs then worked together to reconcile these independently developed coding schemes into a single scheme. Next, a coding manual was prepared, defining each code and examining areas of disagreement until reaching consensus. New themes that did not fit into the original coding framework were discussed, and modifications made in the manual, adding these themes, or sub-dividing existing codes, as deemed appropriate.

In phase II of the analysis, the PI and Ras independently content-analyzed the data to identify the principal subcategories, and ranges of variation within each of the core codes. They reconciled the sub-themes identified by each coder into a single set of "secondary" codes and an elaborated set of core codes. These codes assessed subcategories and other situational and social factors (e.g., specific types of rituals chaplains performed for staff, and challenges involved).

Codes and sub-codes were then used in analysis of all of the interviews. To ensure coding reliability, two coders analyzed all interviews. Where necessary, multiple codes were used. Similarities and differences were assessed among participants, examining categories that emerged,

Table 2
Semi-structured interview questionnaire: Sample questions.

- What kind of work do you now do as a chaplain?
- What have been your most rewarding experiences or cases as a chaplain? What were the most difficult?
- Have you addressed issues faced by hospital staff? If so, when and how?
- What have been the biggest challenges you have faced as a chaplain? How do you view these?
- Has the COVID-19 pandemic affected the work you do? If so, how?
- What additional thoughts do you have about these issues?

ranges of variation within categories, and variables that may be involved. Areas of disagreement were examined through closer analysis until consensus was reached. Consistency and accuracy in codings was checked regularly by comparing earlier and later coded excerpts. The themes that emerged in the data are illustrated below by excerpts from the interviews.

3. Results

As shown on Fig. 1 and described more fully below, chaplains not only engage in traditional religious activities with patients (e.g., praying) but at times also create their own innovative, new kinds of rituals for staff as well that vary in both form and content, specifically in timing (e.g., in frequency), audience, size and formality, and in goals. These rituals help families and staff cope with death, grief, and other stresses. Various characteristics of these rituals are described below. The examples interviewees presented each reflect several of these elements.

3.1. When?

Chaplains may perform rituals, especially when a single or multiple patients die at a particular time, to mark the sudden pivotal point of transition from battling to save a patient's life to suddenly giving up and accepting death. A patient's death can cause an awkward transition for families as well as for staff and for their interactions. Chaplains can create a space to help both groups, at times together, that can help guide and structure otherwise disturbing experiences.

> When a patient has died, it is impossible to walk out of the room for the last time. Everyone stands around. The attending usually comes and says, 'I'm so sorry. Your daughter was wonderful.' The parents say, 'What do we do now?' When the family is getting ready to leave, I come in and say, 'Before you say goodbye for the last time, would you like to pray again?' [Chaplain #15]

Doctors at times join these rituals, though may do so less commonly than nurses.

> I'll say, 'I've written a prayer for your daughter. Would this be a good time to pray?' … The first time I did that, I thought, 'Is the doctor going to flee, or stay? We pray, which makes it possible for the doctor afterwards to leave, and the parents know they're going to be leaving soon, too. It makes the moment *sacred*. People are grateful. [Chaplain #15]

Chaplains may hold these events, which can take the form of, and serve as, "debriefings" after a particularly difficult death of a patient.

> We provide a *diffusing* or *debriefing* for exceptionally traumatic group experiences such as a labor and delivery team caring for a woman in a relatively normal full-term delivery who all of a sudden arrests and dies, which rattles everybody involved. [Chaplain #4]

These events can probe physical, emotional, and spiritual aspects of staff experiences. As another chaplain said,

> I tried doing a shorter session for the front-line staff called '*The Spirit of Caring*', which was going ok, until COVID hit. If a distressing event occurred on a unit – a long-term patient died or an unexpected death occurred, or a team member has died – we can offer a session to the staff, almost like a *debriefing*, to be able to talk about what it's been like, what's been happening physically, emotionally, and spiritually, and what strategies and resources are available. We are now doing that more regularly with the oncology staff, because unfortunately, they have a lot of patient deaths. [Chaplain #21]

Chaplains may organize such rituals in response to not only the difficult death of a particular patient, or multiple cumulative deaths, but more recently, in response to the COVID-19 pandemic more broadly.
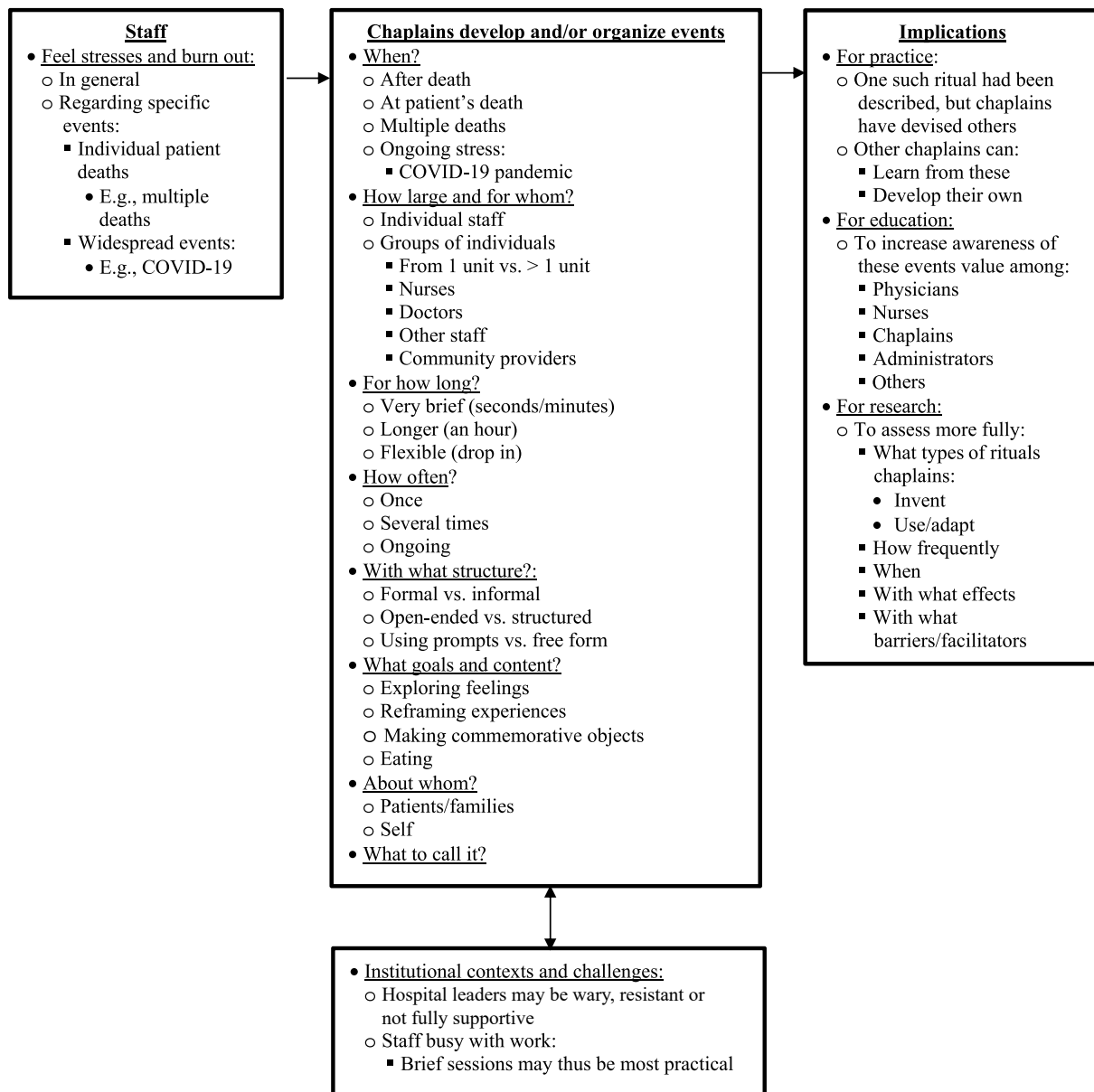
Staff	Chaplains develop and/or organize events	Implications

• Feel stresses and burn out:
   ○ In general
   ○ Regarding specific
     events:
     ▪ Individual patient
      deaths
       • E.g., multiple
        deaths
     ▪ Widespread events:
       • E.g., COVID-19
	• When?
	   ○ After death
	   ○ At patient's death
	   ○ Multiple deaths
	   ○ Ongoing stress:
	     ▪ COVID-19 pandemic
	 • How large and for whom?
	   ○ Individual staff
	   ○ Groups of individuals
	     ▪ From 1 unit vs. > 1 unit
	     ▪ Nurses
	     ▪ Doctors
	     ▪ Other staff
	     ▪ Community providers
	 • For how long?
	   ○ Very brief (seconds/minutes)
	   ○ Longer (an hour)
	   ○ Flexible (drop in)
	 • How often?
	   ○ Once
	   ○ Several times
	   ○ Ongoing
	 • With what structure?:
	   ○ Formal vs. informal
	   ○ Open-ended vs. structured
	   ○ Using prompts vs. free form
	 • What goals and content?
	   ○ Exploring feelings
	   ○ Reframing experiences
	   ○ Making commemorative objects
	   ○ Eating
	 • About whom?
	   ○ Patients/families
	   ○ Self
	 • What to call it?
		• For practice:
		   ○ One such ritual had been
		     described, but chaplains
		     have devised others
		   ○ Other chaplains can:
		     ▪ Learn from these
		     ▪ Develop their own
		 • For education:
		   ○ To increase awareness of
		     these events value among:
		     ▪ Physicians
		     ▪ Nurses
		     ▪ Chaplains
		     ▪ Administrators
		     ▪ Others
		 • For research:
		   ○ To assess more fully:
		     ▪ What types of rituals
		      chaplains:
		       • Invent
		       • Use/adapt
		     ▪ How frequently
		     ▪ When
		     ▪ With what effects
		     ▪ With what
		      barriers/facilitators

• Institutional contexts and challenges:
  ○ Hospital leaders may be wary, resistant or
    not fully supportive
  ○ Staff busy with work:
    ▪ Brief sessions may thus be most practical

Fig. 1. Chaplains developing and using rituals.

"We're going to do a service for all the COVID losses we've had" [Chaplain #16].

3.2. How large and for whom?

The various rituals chaplains hold for staff vary in size from involving just a single staff member to including many, depending on perceptions of staff needs. Several chaplains have adopted Code Lavender from the Cleveland Clinic for a single staff member, using this practice for a wide range of different types of incidents, but also developing other mechanisms as well. As one chaplain said,

> You can tell that somebody's having a bad day – maybe a family member, in the midst of their grief and difficulty, just cussed you out, accused you of being an incompetent nurse and stormed out. Or a patient spit in your face or called you a racial epithet. These things happen to healthcare professionals much more than people realize. A coworker or manager can call for a 'Code Lavender,' and chaplains pull that healthcare professional out of work for a few minutes and give him or her a chance to vent, providing a little extra TT and some

good active listening, and a process for discussing some of the emotions. Code Lavender is for emotional distress in a staff member, just like a Code Blue is for a patient in cardiac arrest. [Chaplain #4]

Other rituals can include a group of staff involved in the care for a particular patient, including even, for instance, the ambulance team. One chaplain described how the staff held a memorial service of a patient,

> This week, we held a memorial service for a two-month-old baby who was born at home, addicted to heroin. The people in her house continued to give her heroin. Last week, she died here alone, without family. I held her and sang to her when she died. We included the staff who knew her, and the ambulance team who brought her. In retelling and reliving it, we were taken aback afresh by how it made us all feel. The case was harder than we thought. [Chaplain #17]

Rituals could also be for particular whole hospital units. Given that staff are busy and rarely, if ever, able to all attend simultaneously, these events may be briefer and more informal, and at times serve food, to further nourish and potentially further attract attendees.

We do a program called 'Refreshment for the Soul' for any nursing unit that had an exceptionally traumatic patient care experience or rough few weeks. The nurse manager says to me, 'I think we could use a 'Refreshment for the Soul.' We find a conference room, redecorate it a little, pushing things around, bring in a teapot with a variety of teas, hot chocolate or instant coffee, and home-baked goodies, soften the lighting, put on soft music, and bring in some aromatherapy. For a couple of hours, staff are welcome to come and go, and we're available to talk. It's simple but remarkably effective. [Chaplain #4]

While Code Lavender aids only one staff member, this chaplain's 'Refreshment for the Soul' assists many members.

Chaplains can establish and conduct rituals for not only frontline clinicians, but also administrators, including, for instance, nurse managers. A chaplain at a Catholic hospital offers "debriefings" for hospital leaders as well.

Once a month we offer spiritual grounding to leadership for an hour, a chance to come together and take a step back from pressures, to reenergize, and remind ourselves why we're in healthcare, and form relationships with our colleagues outside of needing to transfer a patient to their unit. [Chaplain #13]

With COVID, this chaplain offers these sessions at different times of day and does so for healthcare and social service professionals in the community as well. While these events may seem similar to psychotherapy, they are often far more informal and unstructured and less goal-oriented or focused on psychopathology.

3.3. How often and for how long?

While some rituals that chaplains provide to staff occur only once, following a particularly traumatic event, such as a patient's difficult death, other such rituals occur repeatedly over time. Chaplains have continued such groups, depending on perceived needs, and can thus help staff who feel existential, spiritual or moral distress. Such events can recur, and include the same and/or different staff and trainees rotating through a ward. One chaplain, for instance, started a group for doctors. "A pediatric palliative care physician and I started a session called 'What Matters at the End of the Day.' We did it at the end of the rotation for medical residents in neonatal intensive care, the pediatric intensive care and pediatric oncology – the units most likely to have serious illness or death. [Chaplain #13].

At times, chaplains have initiated such activities in conjunction with one or more staff members who may have felt unhelped by clergy or others they have approached. Another chaplain described, for instance, how she co-started an ongoing group in response to a particular medical resident's needs and interests.

A beautiful eight-year-old child in the pediatric intensive care unit (PICU) was fine in the morning, and dead from sepsis that night. A resident went to a priest to discuss what happened, and got nothing. A PICU nurse also told me, 'I just shut down after the ninth death because it was just too much' … So I formed a group which meets a couple of times a year. There are no answers to these questions, but being able to explore the mystery together and talk about it, and the feelings that come up around traumatic events helps. [Chaplain #15]

These practices can vary in length (from minutes to hours to weeks or months) and can in fact be very brief. Another chaplain developed a different, very short, but welcome approach:

There are Grand Rounds, so I do *Chocolate* Rounds! I walk up to caregivers and staff with a little basket of chocolate Hershey Kisses and say, 'Hi, are you in need of chocolate today?' They say, 'Yes! I'm *absolutely* in need of chocolate today.' I then say, 'I just wanted to thank you for all that you've been doing. I know it's been rough lately.' Sometimes they'll say, 'Yeah, it has been rough!' 'Really?' I

ask. 'What's been the hardest part about it for you?' 'Last week we had three codes and five deaths – three of them were unexpected.' Chocolate Rounds have been very successful. [Chaplain #21]

3.4. With what structure?

These rituals range, too, in structure and how guided or free-form they are. Chaplains may start each meeting of such groups with a single, general opening line or a more focused prompt, or be wholly free-form with no opening statement or prompt at all, depending on the particular event. For the session mentioned earlier that a chaplain began for administrators, "There's usually a theme for the month. It might be gratitude, or hope. I use a poem, a video, an article, something to get the conversation going. It's not a therapy or complaint session, but a chance to pause. We often talk about coping skills." [Chaplain #13].

With other groups, this chaplain continued, "All we have to say is, 'What case is keeping you up at night?' Then, for the next hour, we just listen. I think we've helped some doctors stay in the profession because they were ready to leave." [Chaplain #13].

In the "Refreshment for the Soul" sessions mentioned above by another chaplain, the sessions are free-form: "Staff are welcome to come and go, and we're available to talk." [Chaplain #4]

"Chocolate rounds," described above [Chaplain #21], involves both verbal and gestural, non-verbal structures, offering, giving and taking of chocolate, followed by a general question about coping.

3.5. What goals and content?

3.5.1. Exploring emotions

These rituals can have different goals, foci, and functions, often including expressing and exploring emotions, offering support, and/or helping staff to reframe events and feelings positively. These rituals can help staff reflect on the emotional and existential, not just medical, aspects of difficult cases.

We gather everybody involved and give space for processing the emotions, like a root cause analysis at a Mortality and Morbidity conference, but dealing with emotional, rather than strictly medical sides of the decisions made. When people try to second guess the clinical decisions, we redirect them toward, 'there'll be a context for that, but what was it like for *you*? What were you *feeling* when you were making that decision?' Opportunities to talk about those traumatic events collectively with a group of people who went through them are beneficial and reduce long-term sequelae. [Chaplain #4]

These events can uniquely help staff process and sort through confusing and conflicting emotions generated by difficult clinical cases.

The spiritual grounding and debriefing sessions we offer can help people *unpack* what is happening: 'Is it because you feel moral distress, or that you've added to that patient's suffering, or that the institution made an error, or you feel short-staffed?' We can work with staff in different ways, trying to strengthen resilience. [Chaplain #13]

3.5.2. Reframing experiences

These rituals can also help families and providers *reframe* their experiences and regrets, especially after a patient has died, establishing a helpful sense of community in the face of apparent sheer loss. Psychological researchers have described, in other areas, a therapeutic technique of cognitive "reframing" (Robson & Troutman-Jordan, 2014), to help patients view their situations differently in order to change their perceptions of stresses they confront from negative to positive, to enhance their well-being or alter their behavior. The rituals described in the present study can help staff reframe experiences concerning both patients and treatment course. Staff often experience moral distress due

to conflicting feelings that rituals can explore and help address. A chaplain can assist in part by helping staff remember why they entered healthcare in the first place, and connect to that purpose.

> If staff are feeling, 'We did a poor job here. We didn't support the parents well,' or, God forbid, 'We made a mistake,' we need to address that and say, 'What can we put in place to ensure that this never happens again?' which is different than, 'We cared for this child for the past three months, and she touched all our hearts and we are really grieving for this one individual child.' It is important to help people sort out the difference. In all of these situations, it comes down to: could people say how they made a difference in this child's care even if the child died? They might say: 'I made her look beautiful when her parents came to see her for the last time. I brushed her hair, washed her face, and put real clothes on her, not just a johnny.' Or: 'I could tell she was in pain. She was grimacing and crying. I advocated that we had to address that.' Or, 'We were able to do something special.' We've had graduations in the intensive care unit (ICU)! For one child, a major Hollywood studio flew in an advance video copy of a film so he could watch it before he died. If the staff feels, 'We did something that really made that child's life better,' that is important for them. [Chaplain #11]

Especially with added stresses due to COVID, chaplains may draw on multiple such techniques, not only positive reframing, but relaxation methods as well.

> With COVID, nurses say to me, 'It's all bad. Everything is terrible, the world is falling apart.' I say, 'Yes, I'm sorry about that. You're doing such a good job. It sounds like it's so hard.' But I try to give staff space to talk about that, and to remember what's going *well*, to bring them around at least to *neutral*. I lead '*listening circles*' to give staff space to talk about what's bad, but I don't want it to end there. Our bodies need to get back. So, I say, 'Was there any time during the last week that you even felt neutral? I don't need for you to feel good or grateful. That's too big an ask. But can you find a time over that last week where you felt even just in the middle?' Lots can. Even as small as 'looking out the window and seeing birds.' I'll say, 'Tell me about that. What kind of bird?' 'A bluebird.' 'What was it like?' I want to take them back to that experience … [Chaplain #16]

At other times, such sessions might encourage or facilitate staff to explore how a patient's death might raise issues concerning prior difficulties in staff members' lives.

> I try to allow staff the space to grieve for the child, but also get a sense of whether they are grieving *their own* mortality. Was this death reminding them of someone in their family, or of feeling they did a poor job as a healthcare team? [Chaplain #11]

3.5.3. Making commemorative objects

Rituals can also include not only discussion, but construction of objects of remembrance. Chaplains can create patient-specific documents or mementos. One chaplain, for instance, writes and then reads to patients and staff "Going Home" prayers.

> I'll talk to the parents and write a prayer about their child and print it on parchment paper, so they take it with them. I want them to have something to read in three months, when everything falls apart and slips away. [Chaplain #15]

These written prayers can move both families and staff.

> A virus had climbed up one boy's spine and killed him. Our hospital did everything. We sent his biopsies to other hospitals, but they never could identify the virus. When I read my prayer for him, eight or nine people were in the room. They had tears in their eyes. [Chaplain #15]

Chaplains have also arranged for staff to be involved in creating such objects of remembrance.

> It sometimes helps to do something with your hands. I do a "*Time of Remembrance*" for staff, bringing a grapevine wreath in the shape of a heart onto ICUs and other units – it's especially nice on the heart units – along with little pre-cut three-inch narrow ribbons. We hold a brief memorial service and read the names of patients who have died and invite staff to share a memory of that person and tie a ribbon onto the wreath in remembrance. As they're tying the ribbon onto the wreath, I'll ask them what they remember about this person. Sometimes they won't recollect the name, but remember the bed space. I'll say, 'I can see that this really bothered you. What touched your heart, or bothered you the most?' They'll remember that they talked to the patient and established a connection before the patient became intubated or died. Or 'It reminded me of when my own dad died.' Sometimes they won't say anything with other staff around, but I follow up with them later. [Chaplain #21]

Yet with these and other rituals, chaplains may need to be flexible, given that staff are frequently very busy with work tasks to do. As this chaplain continued,

> If the ICU is busy, I won't do a group session, but take the wreath door-to-door and say, 'I've got a memory wreath. Would you like to remember anybody?' [Chaplain #21]

Especially during the COVID pandemic, such a ritual can aid staff with loss of their own loved ones as well as of patients.

> Before the pandemic, it was almost 100% about patients. Afterwards, staff remembered a lot of their own family members who died years ago, but were brought to mind by the pandemic. One unit actually filled up their wreath. I had to start a second one because we got so many ribbons on it, which is sad, but also a testament to how used it is. [Chaplain #21]

These rituals can also assist staff when a co-worker dies.

> I've done a couple of *special* wreaths. A beloved physician died – a sudden, unexpected cardiac death. The unit was devastated. So, he got his own wreath. Everybody contributed to it, and people bought not just ribbons, but things that reminded them of him – like a special ID badge holder. It now hangs in the breakroom of the unit. We leave the wreaths up, sometimes in the breakrooms or on the breakroom door. Units are proud of their wreaths, and know what they represent. [Chaplain #21]

3.5.4. Physical and mental relaxation

Chaplains also draw on relaxation, behavioral and psychotherapeutic approaches, reconnecting with more positive feelings they've had.

> I say, 'You are dealing with so much. Your body, your nervous system and spiritual system are taking a hit. Would it be ok if we did an exercise, where we try to bring your nervous system a little bit out of that?…I say, 'Tell me about that stress … As you talk about that, where in your body are you feeling it?' 'In my gut, my chest, my heart.' I say, 'Go back to that place in your body. Let's just sit and stay there a while and feel that. What's it like for you to tell me about this? What do you feel in your body?' [Chaplain #21]

3.6. Institutional contexts and challenges

Institutional and social contexts can affect chaplains' abilities to carry out such rituals and either facilitate or impede these practices. Creating and implementing these rituals can pose challenges. Hospital staff, especially physicians, may have limited time for these activities. Staff can be too busy or wary.

We're trying to find ways to be visible and present, without people feeling, 'Why are they here, what did we do wrong? I have to care for the patients, so I don't have time to talk to you.' II can be soft, like bringing treats, or scheduled, showing up at your huddles, breaking down barriers of feeling I'm either going to bother them or be in the way. [Chaplain #13]

3.6.1. Resistance from hospital leaders

Many hospital administrators and others also resist, minimize or dismiss staff needs for these activities. Hospitals may purport to support staff, but according to staff and chaplains, not always do so sufficiently, especially concerning spiritual issues. "The hospital would probably say it supports the medical residents and fellows pretty well, but when you talk to them, they want more." [Chaplain #15].

One chaplain tried to establish a group for nurses, but the nursing director said nurses should just "suck it up."

I tried doing that on the ICU with nurses. The nursing director said, 'They don't need that. We just tell them, 'Suck it up. This is how it is.' I said, 'Would you mind if I just tried? I'd like you to attend as well.' [Chaplain #21]

Such sessions vary, too, in the degrees to which chaplains probe providers' feelings. As this chaplain continued,

We did a session, and new nurses broke down sobbing, saying, 'This is the first death I've ever experienced in my life. No one I know has ever died. Other nurses tell me: Just suck it up.' They were just in real distress. Luckily, the nurse manager heard that, and told me to schedule more sessions for the nurses. She could see that it was important to them. [Chaplain #21]

Within the long-standing hierarchy of hospital wards, the involvement of staff may depend on the specific chaplain's status, related to length of time on the ward and earned respect.

I've been there long enough now that I'm respected and know the intensive care unit and the oncology attendings, so they're comfortable with me and know I'm ok. I'm not going to make anybody uncomfortable by being too preachy or religious, even though I'm religious – I'm a priest. [Chaplain #15]

4. Discussion

These data show how chaplains, in trying to assist staff, often develop various practices that appear to take the form of rituals, in part given the time pressures staff members face. While one such standardized ritual, Code Lavender, has been described (Stone, 2018), the present data reveal how individual chaplains also devise, on their own, other such rituals that vary in both form and content – in frequency, duration, number and types of staff, degrees of formality or informality, structure and aims. Chaplains tend to conduct these rituals on their own initiative. These practices are critical to note since they provide important examples, models, and insights from which other institutions, medical staff and chaplains can learn. Such interventions are especially important since the COVID-19 pandemic has added stresses for countless physicians and nurses (Gregory, 2021).

Prior studies have sought to enumerate quantitatively the activities in which chaplains engage (e.g., saying a prayer, performing a ritual) (Handzo et al., 2008; Handzo et al., 2008a; Jeuland et al., 2017; Timmins et al., 2018), but the present data suggest the breadth, depth and variability of such activities – in this case, rituals – revealing how these vary in both form and content, including frequency, length, structure, size, audience, aims, and activities involved. These data thus highlight, too, the values of qualitative research.

Previous research has suggested, too, that chaplains assist staff, but has not explored *how*, especially given competing staff time pressures. The present data suggest that many chaplains engage in such rituals, adopting and adapting these on their own, and vary in doing so, and face decisions regarding when and how to employ these interventions. Chaplains frequently must figure out how to create and conduct these rituals on their own, not having been trained to do so, but are often resourceful and innovative. These data thus highlight the importance of how chaplains carry out, adapt and enhance their practice, and learn from innovations others have devised, thus improving what they do as individuals and as a profession.

The development and provision of such rituals appear to constitute important potential functions of chaplains, but have not been explicitly viewed or examined as such. This analysis can, however, help in understanding and highlighting key aspects of the work and benefits of chaplains, and in developing and improving best practices. Staff may be helped by -one-on-one psychotherapy as well, but not have the time or inclination to pursue it.

Anthropologists have long described the key roles that rituals can have in social groups. In general, rituals preserve social order and group stability, and offer ways of understanding emotionally difficult aspects of human life, such as death and dying, while marking key transitions in social status. (Romanoff & Terenzio, 1998; Turner, 1970). All cultures have rituals surrounding bereavement, which can validate relationships with the deceased, and help in 'saying goodbye' (Romanoff & Terenzio, 1998). Such practices often involve rites of passage that facilitate such transition through phases between different statuses, helping individuals reintegrate and find a new identity (van Gennep, 1909). These events can employ performance and symbols, and be psychotherapeutic and healing (Rando, 1985). Yet scholars have argued that contemporary American culture has minimized and de-ritualized such bereavement practices, and that rituals surrounding grief have lost meaning, becoming inauthentic, empty practices, and leading to insufficient resolution of grief (Bolton & Camp, 1987).

The present data suggest that in hospitals, chaplains may now take on these functions and roles, picking up the slack. Moreover, while scholars have tended to see bereavement rituals as culturally prescribed, many chaplains are now establishing these events on their own.

These rituals vary in whether they are long- or short-term. As the data indicate, some rituals are "one-offs," occurring only once, for instance, when a particular patients dies. Other events are ongoing, and often receive particular names: "The Spirit of Caring," "Code Lavender," "Refreshment for the Soul," What Matters at the End of the Day," "Time of Remembrance," or "Chocolate Rounds," appearing to become entities in and of themselves, or are defined or described in particular ways, as "Debriefings" and "like a Morality and Morbidity conference," or structured and defined by other characteristics (e.g., the unique use of wreaths). The fact that chaplains commonly name and label these events suggests recognition of these activities as specific, distinguished and separated from other endeavors, marking them as "special." This diversity of names also suggests the degrees to which chaplains are developing these independently.

Certain institutional or administrative leaders may oppose or resist these efforts, not fully recognizing the benefits staff can receive and the needs to respond to the distress that providers on the front lines may experience and struggle to endure. Increased awareness of these issues among institutional leaders can thus help.

Chaplains created these rituals across differing geographic locations, types of hospitals, religious backgrounds, and patients. The present data suggest that one factor that may shape the establishment of such rituals is the support or wariness of hospital administrators regarding such events. As described here, certain administrators were wary of having nurses take time away from direct clinical care to discuss these issues, while some other administrators quickly recognized the value of such activities

and encouraged such innovation. Chaplains may also vary in how inclined they are to innovate and be proactive in their approaches, and interested and/or ready to embark on such endeavors, which may be seen as lying outside the types of activities that chaplains usually pursue (e.g., praying and talking with individual patients).

Given that these issues are highly personal and emotional, a key element in both starting and continuing such rituals over time may be the level of trust the individual chaplain has established with staff, which appears related partly to the length of time the chaplain has worked on the particular service, and the type of service (with hospice and palliative care services appearing, overall, to appreciate chaplains more). Medical staff requesting or expressing a need for such a ritual, and providing "buy-in" can help establish and continue the ritual, especially if an individual doctor or patient co-start the activity, Chaplains who started a ritual in conjunction with a staff member appeared to know this individual beforehand. Religiously-affiliated institutions may also generally have more commitment to chaplains taking on more roles within the larger institution, besides one-to-one interactions with individual patients (e.g., having a group for administrators).

These data have several implications for future education, practice and research. While prior efforts to demonstrate the beneficial aspects of chaplaincy (e.g., attempting to show increased patient ratings in hospital satisfaction scores) have been mixed (Damen, 2020a,b; Marin et al., 2015), the present data suggest other sets of key benefits that chaplains can provide. Given the critical needs to document the benefits of chaplaincy (Gomez et al., 2021; Wirpsa et al., 2019), the present data are thus valuable.

While one such ritual has been described (Stone, 2018), the present data reveal others that chaplains and other professionals and institutions can use, adapt, and learn from in developing their own. These data also suggest needs to increase awareness of the potential benefits of such rituals among doctors, nurses, hospital administrators, chaplains and others, and to assist chaplains in recognizing the advantages and potential ways of devising such practices. Importantly, documentation of the types of forms and contents of such examples, as done here, can potentially assist. Creative development, use, and sharing of these varied activities should also be encouraged, so that others can gain from them. Not all chaplains currently engage in such approaches, but heightened recognition about these possibilities can help inspire others to do so.

These findings also have critical implications for research, to investigate more fully, among larger samples, how frequently, and when chaplains develop and use these practices, and with what effects, barriers and facilitators.

These data have several potential limitations. These findings are based on a sample of 21 chaplains, which is sufficient for qualitative analyses. However, future studies with larger samples can further elucidate these issues and factors that may be involved (e.g., training or number of years of practice as a chaplain).

In short, these data highlight a range of ways in which chaplains, as individuals and as a group, can improve their work through use of rituals, and learn from innovations or initiatives others have devised, thus enhancing what they do as individuals and as a profession, to assist physicians, nurses, other medical staff and therefore patients, especially during the COVID-19 pandemic or other stressful situations.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence their work reported in this paper.

Acknowledgements

References

Anders, R. L. (2021). Patient safety time for federally mandated registered nurse to patient ratios. *Nursing Forum, 56*(4), 1038–1043. https://doi.org/10.1111/nuf.12625

Best, M., et al. (2022). 'This ward has no ears': Role of the pastoral care practitioner in the hospital ward. *Journal of Health Care Chaplaincy, 28*(2), 179–193.

Bolton, C., & Camp, D. J. (1987). Funeral rituals and the facilitation of grief work. *Omega: The Journal of Death and Dying, 17*(4), 343–352. https://doi.org/10.2190/VDHT-MFRC-LY7L-EMN7

Damen, A., et al. (2020a). Can outcome research respect the integrity of chaplaincy? A review of outcome studies. *Journal of Health Care Chaplaincy, 26*(4), 131–158. https://doi.org/10.1080/08854726.2019.1599258

Damen, A., et al. (2020b). Examining the association between chaplain care and patient experience. *Patient Exp, 7*(6), 1174–1180. https://doi.org/10.1177/2374373520918723

Corbin, J., & Strauss, A. (2014). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Damen, A., et al. (2019). What do chaplains do: The views of palliative care physicians, nurses, and social workers. *American Journal of Hospice and Palliative Medicine, 36*(5), 396–401. https://doi.org/10.1177/1049909118807123, 2019.

Geertz, C. (1973). *The interpretation of cultures: Selected essays.* New York: Basic Books.

van Gennep, A. (1909). *The rites of passage* (2nd ed.). Chicago: University of Chicago Press, 2019.

Gomez, S., et al. (2021). Chaplain-physician interactions from the chaplain's perspective: A mixed method analysis. *Journal of Hospice Palliative Care, 38*(11), 1308–1313. https://doi.org/10.1177/1049909120984390. Epub 2020 Dec 30.

Gregory, D. (2021). Code Lavender: Designing healthcare spaces to enhance caregiver wellness. *HERD, 14*(2), 13–15. https://doi.org/10.1177/1937586721993785

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods, 18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Handzo, G. F., et al. (2008). What do chaplains really do? I. Visitation in the New York chaplaincy study. *Journal of Health Care Chaplaincy, 14*(1), 20–38. https://doi.org/10.1080/08854720802053838

Handzo, G. F., et al. (2008a). What do chaplains really do? II. Interventions in the New York chaplaincy study. *Journal of Health Care Chaplaincy, 14*(1), 39–56. https://doi.org/10.1080/08854720802053853

Hiver, C., et al. (2022). Burnout prevalence among European physicians: A systematic review and meta-analysis. *International Archives of Occupational and Environmental Health, 95*(1), 259–273. https://doi.org/10.1007/s00420-021-01782-z

Jameton, A. (1964). *Nursing practice: The ethical issues.* Englewood Cliffs, NJ: Prentice-Hall.

Jeuland, J., et al. (2017). Chaplains working in palliative care: Who they are and what they do. *Journal of Palliative Medicine, 20*(5), 502–508. https://doi.org/10.1089/jpm.2016.0308

Kälvemark, S., et al. (2004). Living with conflicts ethical dilemmas and moral distress in the health care system. *Social Science & Medicine, 58*(6), 1075–1084. https://doi.org/10.1016/s0277-9536(03)00279-x

Kavalieratos, D., et al. (2017). It is like heart failure. It is chroniand it will kill you": A qualitative analysis of burnout among hospice and palliative care clinicians. *Journal of Pain and Symptom Management, 53*(5), 901–910. https://doi.org/10.1016/j.jpainsymman.2016.12.337. e1.

Klitzman, R. (2012). *Am I my genes? Confronting fate and family secrets in the age of genetic testing* (Chinese edition). New York: Oxford University Press, 2019.

Klitzman, R. (2015). *The ethics police?: The struggle to make human research safe.* New York: Oxford University Press.

Klitzman, R. (2019). *Designing babies: How technology is changing the ways we create children.* New York: Oxford University Press. Chinese Edition: Good Publishing Company, 2020.

Klitzman, R., & Daya, S. (2005). Challenges and changes in spirituality among doctors who become patients. *Social Science & Medicine, 61*(11), 2396–2406. https://doi.org/10.1016/j.pec.2005.11.013

Kwak, J., et al. (2021). Perspectives of board-certified healthcare chaplains on challenges and adaptations in delivery of spiritual care in the COVID-19 era: Findings from an online survey. *Palliative Medicine.* https://doi.org/10.1177/02692163211043373

Marin, D. B., et al. (2015). Relationship between chaplain visits and patient satisfaction. *Journal of Health Care Chaplaincy, 21*(1), 14–24. https://doi.org/10.1080/08854726.2014.981417

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Burnout, 2*(2), 99–113. https://doi.org/10.1002/job.4030020205

Maslach, C., Leiter, M. P., & Schaufeli, W. (2008). Online publication date, 2009). In S. Cartwright, & C. L. Cooper (Eds.), *Measuring burnout, the oxford handbook of organizational well-being.* Oxford: Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199211913.003.0005.

McLernon, L. M. (2020). *November 30. COVID-related nursing shortages hit hospitals nationwide.* University of Minnesota. CIDRAP [Cited 2022, March 31]. Available at: https://www.cidrap.umn.edu/news-perspective/2020/11/covid-related-nursing-shortages-hit-hospitals-nationwide.

Melnikow, J., Padovani, A., & Miller, M. (2022). Frontline physician burnout during the COVID-19 pandemic: National survey findings. *BMC Health Services Research, 22*(1), 365. https://doi.org/10.1186/s12913-022-07728-6

Norman, S. B., et al. (2021). Moral distress in frontline healthcare workers in the initial epicenter of the COVID-19 pandemic in the United States: Relationship to PTSD symptoms, burnout, and psychosocial functioning. *Depression and Anxiety, 38*(10), 1007–1017. https://doi.org/10.1002/da.23205

Rando, T. A. (1985). Creating therapeutic rituals in the psychotherapy of the bereaved. *Psychology & Psychotherapy, 22*(2), 236–240. https://doi.org/10.1037/h0085500

Robson, J. P., Jr., & Troutman-Jordan, M. (2014). A concept analysis of cognitive reframing. *Journal of Theory Construction & Testing, 18*(2), 55–59 [No doi].

Romanoff, B. D., & Terenzio, M. (1998). Rituals and the grieving process. *Death Studies, 22*(8), 697–711. https://doi.org/10.1080/074811898201227

Shanafelt, T., et al. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine, 172,* 1377–1385. https://doi.org/10.1001/archinternmed.2012.3199

Snowden, A. (2021). What did chaplains do during the covid pandemic? An international survey. *Journal of Pastoral Care and Counseling, 75*(1_suppl), 6–16. https://doi.org/10.1177/1542305021992039

Stone, R. S. B. (2018). Code lavender: A tool for staff support. *Nursing, 48*(4), 15–17. https://doi.org/10.1097/01.NURSE.0000531022.93707.08

Tata, B., et al. (2021). Staff-care by chaplains during COVID-19. *Journal of Pastoral Care and Counseling, 75*(1_suppl), 24–29. https://doi.org/10.1177/1542305020988844

Timmins, F., et al. (2018). The role of the healthcare chaplain: A literature review. *Journal of Health Care Chaplaincy, 24*(3), 87–106. https://doi.org/10.1080/08854726.2017.1338048

Turner, V. (1970). *The ritual process: Structure and anti-structure.* Oxfordshire, UK: Routledge.

Wan, W. (2021). *April 22. Burned out by the pandemic, 3 in 10 health-care workers consider leaving the profession.* The Washington Post [Cited 2022, March 30]. Available from: https://www.washingtonpost.com/health/2021/04/22/health-workers-covid-quit/.

Wirpsa, J. M., et al. (2019). Interprofessional models for shared decision making: The role of the health care chaplain. *Journal of Health Care Chaplaincy, 25*(1), 20–44. https://doi.org/10.1080/08854726.2018.1501131