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# The Chaplain in the Pediatric ER: A Nurse and Mom's Perspective

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**Abstract**

The day after a holiday, our medically complex son, who was acutely ill, needed care at the local children's hospital. Once in the emergency room (ER), he was triaged to a trauma room. Without our knowledge or consent, a chaplain entered the crowded and chaotic room. Although pleasant, the chaplain was not a person who comforted us. Her presence (1) increased our anxiety to panic level, (2) took our attention away from our acutely ill son to worst-case scenarios, (3) made us extremely uncomfortable, and (4) was counterproductive. We strongly feel that the patient/family should be asked if they want a chaplain or other spiritual/support person to enter the room.

**Keywords**

chaplain, spiritual support, pediatric ER

## Introduction

Traditionally, hospital chaplains provide comfort and spiritual care to patients and families. Thirty-seven thousand children die each year in the United States,[1] and 500 000 children face life threatening conditions each year in the United States.[2] And while chaplains provide care and comfort to families affected by a child's death or life-threatening event, there is no standard of care for providing bereavement services to families.[3] There is a recognized need for more research that investigates the role of spiritual care and religion in the pediatric population.[4]

I have always thought of chaplains as being instruments of comfort and solace. As a nurse, I have called upon chaplains and witnessed them consoling patients and families. I have also received comfort from chaplains when my peers in healthcare organizations and academic settings died. However, my wife and I had an experience with one of our medically complex children in a pediatric emergency room (ER) that changed how we both think of chaplains and their place in healthcare, specifically pediatric ERs.

The day after a major holiday, my wife and I found ourselves at the ER of the local children's hospital with our 8-year-old medically complex child, Kennedy. We were anxious. Kennedy was acutely ill; his temperature was low at 94.6, and our normally pale Irish son was almost translucent. His breathing was more shallow than normal, he was vomiting nonstop, and he was crying when he was not throwing up or seizing. Kennedy rarely cried but his cries amplified the intensity and urgency of our trip to the ER.

When he was an infant, Kennedy was abandoned by his birth parents who joined a traveling carnival. His biological aunt and uncle became his official guardians and ultimately severely neglected and abused him. He was airlifted to a children's hospital when he was around 9 or 10 months of age. As a result of being shaken, he had a traumatic brain injury, cerebral palsy, cortical vision impairment, Lennox-Gastaut syndrome, dysphagia, hypotonia, and global developmental delays. Kennedy was pre-verbal and totally dependent on us. Eventually, Kennedy was placed on a ketogenic diet via a g-tube. After he was released from the hospital post-injury, his aunt and uncle released him from their guardianship, and he was placed in foster care. We picked him up from the local pediatric unit on his very first birthday.

We were scared during the trip to the ER and once we arrived our emotions did not stabilize. My wife and I adopted 4 special needs babies from foster care and while fostering, we took care of some extremely sick babies. We were hardly ever scared but we were that day in the ER. We knew that he was critically ill. As his moms, we wanted to cry, but realized that this was not the time. Kennedy was triaged into a trauma room which automatically triggered a

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chaplain visit. We did not know this, nor were we told that a chaplain was coming into the room.

My wife was pale and anxious. She became paler and almost fainted when the chaplain came into the trauma room and introduced herself. My wife, in that moment, looked at me with panic and heartbreak in her eyes. She was convinced that our fragile child was going to die. On the other hand, I was unhappy that a chaplain was in our midst which sounds harsh and counter-intuitive, but I did not need my usually upbeat and positive wife to face plant on the germ ridden ER floor. I have always embraced chaplains when they were at my patient's bedside, so I was surprised and taken aback by my own emotions. Even though we knew that Kennedy was acutely ill, neither of us were ready to give up on him or his health care team.

The chaplain was nice but her presence in the room drew our attention away from Kennedy and his immediate and urgent needs. We became focused on the what if's that we did not necessarily want or need to focus on at that moment. The what if scenarios that went through our minds reenforced our anxiety which was counterproductive.

A couple of years prior to this event, after his adoption was finalized, we discussed a do not resuscitate/do not intubate order, but we were not convinced that it was appropriate or the correct decision for Kennedy. At that moment in the ER, he was 8 and we felt that he had a good quality of life when he was not acutely ill. He'd recently started to laugh spontaneously and interact with his family, therapists, and educational team. He was a happy child who enjoyed Irish music, his family, tastes of food, being outside, and his Toniebox ™ (a wireless system that plays stories and music when a figurine is set on the box).

## Key Factors for Consideration

It is our premise that not everyone welcomes a chaplain during a traumatic health scenario. We feel strongly that patients/families should be consulted before a chaplain enters the room. This will give the patient/families time to adjust to the idea, but more importantly, this will afford the patient/family the ability to agree, disagree, or ask for a different spiritual or support person. The patient/family response to spiritual care depends on their culture, medical diagnoses, and preference.[5] Some may not have any religious beliefs and may not want anyone in the room during a crisis. Spirituality and religious practices are personal preferences and it is presumptuous to disregard patient/family preferences.[6]

## Conclusion

This experience with the chaplain left an indelible mark on us. Since that experience, we have discussed this situation many times and the panic that we both felt when a chaplain appeared. Because of this interaction, we have a different perspective on the presence of chaplains. We maintain respect for chaplains and their services; however, this experience as moms of an acutely ill child taught us that the presence of a chaplain should be a choice for the patient/family to make and not an automatic response to a complex and traumatic situation. There is a recognized need for more research that investigates the role of spiritual care and religion in the pediatric population.[4] We are convinced that this need extends to the ER when acutely ill medically complex children present.

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