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A new kid on the block? The spiritual practitioner in the modern hospital

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Essay/Personal Reflection

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> "Chaplains are no longer chaplains — they are now spiritual practitioners. Spiritual practitioners are experts on spirituality, which is broader than religion. Spirituality includes meaning, representations, and beliefs. Spiritual practitioners are trained professionals, part of the interdisciplinary health care team and use scientifically validated tools. They make people talk about themselves, be they patients or health care professionals. They bring a different, 'non-health care' perspective, integrating spirituality into holistic care. Spiritual practitioners are summoned in difficult situations to restore meaning when health care professionals reach their limits and have no idea what to do, or when patients receive bad news and are tempted to give up."

These views were expressed during an international symposium dedicated to the role of spirituality and spiritual care in health care. Entitled *Health Care and Spirituality*, the event was held to honour Cosette Odier, the retiring chief of the chaplaincy at Lausanne University Hospital (CHUV). The participants insisted that an important transition was taking place from *religion* to *spirituality* and from *chaplain* to *spiritual practitioner*. Indeed, that day celebrated the official renaming of the CHUV chaplains to spiritual practitioners. The event can be situated in a broader context of persistent calls to integrate spirituality into health care and promote "bio-psycho-socio-spiritual" models of care (Sulmasy, 2002; Silvestri et al., 2003; Koenig et al., 2012).

The conference in Lausanne provided an excellent opportunity to critically appraise how spirituality and spiritual care are discussed among health care professionals and their newly re-baptized colleagues, spiritual practitioners. In particular, we examined the debates of the round table that concluded the day. *Perspectives of Tomorrow's Professionals* gathered junior professionals — a nurse, a physiotherapist, a medical resident, and a spiritual practitioner — who provided, in turn, their views on the role of spiritual care in clinical work. The discussion brought forth the perspective from within the "field" that complemented other, more theoretical contributions of the day. The introductory text in italics is a characterization of spiritual practitioners articulated during the round table discussions, and presented using aggregated, slightly modified (and translated) quotes from the participants.

At the conference and during the round table, spiritual care was presented as a novel, emerging phenomenon, the spiritual practitioner being contrasted with the "old" chaplain. This assertion was based on two distinct arguments. First, whereas the chaplain's grounding is religion, the spiritual practitioner's realm is "spirituality," said to be "broader than religion." Such a delimitation of the domains of spirituality and religion may appear conspicuous. However, it raises, in our view, a number of problems. Logically, it implies that there are elements specific to spirituality and others that are shared with religions. According to what was said at the conference and the literature more generally, it appears that *purpose*, *connectedness*, and especially *meaning* are deemed the essential elements of spirituality. For instance, Puchalsky et al. (2009) state "spirituality […] refers to the way individuals seek and express meaning and purpose and the way they experience […] connectedness." Therefore, one may ask: are these notions, in some way, specific to spirituality? It is indisputable that they are relevant to various faiths; they are also fundamental to disciplines such as psychology, psychopathology, anthropology, literature, and philosophy — and, as we argue below, to clinical practice. However, we dispute that there exists a unique, "spiritual" approach to *meaning*, for instance, that would constitute the basis for a unique, "spiritual" contribution to health care. Additionally, we wish to note, without elaborating, that situating religions *within* spirituality is actually debatable: spirituality can also be viewed as one element, not necessarily the central focus, of the broader domain of religions (e.g., Sufism in Islam, or Kabbalah in Judaism) (Jobin, 2012).

Therefore, the first argument advanced at the conference to establish spiritual care as a new, independent, legitimate professional practice on conceptual grounds (defining spirituality with respect to religion), is not convincing. We now turn to the second argument, which is an attempt to specify the practice of spiritual care, this time with respect to health care. The contribution of the traditional chaplain was relatively clear and demarcated: the consolations of

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faith, by a minister of an official religion (perhaps, more recently, in an ecumenical fashion). Things are more problematic for spiritual practitioners, who find themselves in a paradoxical position (Rumbold, 2012). They claim to be specialized members of the interdisciplinary team using "scientifically validated tools"; yet, spiritual care is also characterized as a "non-health care perspective."

At the conference and also noted in the medical literature (Gordon et al., 2011), spiritual care is set forth as a professional practice consisting of (1) listening to "people talking about themselves," (2) exploring patients' values, and (3) offering a human presence. These aspects are all very important to consider but, in our view, they are clearly integral to the classical clinical professions. Is then the unique contribution of spiritual care to be found in the notion of meaning, so central to definitions of spirituality? The mandate of spiritual care was indeed stated as to "restore meaning," for patients who are facing "bad news," as well as for health care professionals who "reach their limits." However, such a statement implies two underlying assumptions that we find untenable (1) that health care tends to lose significance when prognosis is poor and cure is not an option and (2) that, in difficult situations, the meaning of clinical care should become a prerogative of spiritual practitioners rather than clinicians.

Where does this critical discussion leave us? Spiritual practitioners seem to be lost in a transition, having left the land of religion, but without roots in the clinical world. As "new kids on the block," they struggle with issues of identity, legitimacy, and competence. Moreover, spiritual practitioners are not the only new kids on the block in the modern hospital: mediators, communication specialists and psychologists, patients-as-partners, peer helpers, and case managers all propose to fill in perceived gaps in contemporary medicine, mostly with regard to relational issues (Schaad et al., 2015). In other words, the field has become quite competitive. In our view, the major issue is how to conceive clinical communication, therapeutic relationships, and more broadly existential issues, as within or without the purview of clinical care.

Spiritual practitioners may be struggling to find their way in the modern hospital. However, our actual concern is for health care professionals, who seem to concede that listening to patients and paying attention to what they want is a "different" and, to be more precise, a "non-health care" practice. Thereby, professionals are restricting clinical practice to the material body and strangely abdicating their roles as physicians and caregivers (Saraga et al., 2019). We conceive that this may sadly be the case in contemporary medicine. The uncomfortable truth may be that spiritual practitioners are surrogates, filling in for health care professionals who are not doing their job. Thus, all these new kids on the block are perhaps capitalizing on the shortcomings of physicians and nurses. We worry that, paradoxically, the current clamor for the integration of spirituality within health care will contribute to an increasingly reductionist clinical practice.

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