Marsh Institute for Chaplains White Paper

Culture Change in Hospice: A Call to Return to Its Foundations

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The Marsh Institute works collaboratively to equip, support, and advocate for chaplains in diverse and global settings, thereby enhancing chaplain competency and effectiveness. We solicit thoughtful discussion and respectful dialogue among chaplains, organizations, and institutions to think critically about issues affecting chaplains and chaplaincy.

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EXECUTIVE SUMMARY

Hospice has drifted from its founding ethos—holistic, interdisciplinary, mission-driven care inspired by Dame Cicely Saunders—toward a narrow, medical-reimbursement model. The predictable outcomes are visible everywhere: declining family satisfaction, higher turnover, and staff burnout. Reversing this trend requires culture change led from the top, anchored in Saunders' "Total Pain" framework (physical, psychological, social, and spiritual), and supported by rigorous onboarding, clear professional standards for chaplains, and empathy-centered operations. This paper outlines a practical blueprint to realign hospice culture with its roots—and to improve outcomes for patients, families, and teams.

THE PROBLEM WE MUST NAME

Over the past few decades, a pattern emerges:

- **Medical dominance displaces the whole person.** Because reimbursement most directly rewards symptom control, other domains—especially spiritual and emotional care—are marginalized.
- **Consequences follow.** Families perceive indifference, staff shoulder unresolved secondary trauma, and organizations absorb costly turnover and low satisfaction scores.
- **Historical amnesia persists.** Many leaders and staff do not know the movement story of hospice or Saunders' Total Pain, losing the "why" that sustains resilience and empathy.

THE FOUNDATION WE MUST RECOVER

Dame Cicely Saunders built modern hospice on three pillars:

1. **Total Pain**—care for the full human experience: body, mind, relationships, and spirit.
2. **Interdisciplinary Teaming**—shared planning and accountability across disciplines.
3. **Movement Identity**—a humane, values-driven alternative to purely clinical throughput.

When hospice forgets it is a movement as well as a medical service, the result is compliant documentation without compassionate presence.

THE GAP IN PRACTICE: SPIRITUAL CARE STANDARDS

A critical driver of drift is **inconsistent chaplaincy preparation**. Many agencies now hire chaplains with only one unit of Clinical Pastoral Education (CPE). One unit introduces the process; it does not form a clinician. Without deeper CPE and supervised practice, chaplains may lack core competencies (e.g., transference/countertransference, projection, parallel process, grief dynamics, and documentation linked to goals/outcomes). The downstream effects include perfunctory visits, weak team collaboration, and family experiences that feel transactional at the very moments that should be most human.

Minimum standard recommended:

- **CPE:** At least **3 units**, including **Level II** work (with a pathway toward four units/Board Certification).
- **Core competencies:** Emotional intelligence; capacity to "read the room"; self-awareness; disciplined documentation tied to care goals; facility across diverse belief systems; team-based care planning.
- **Onboarding & mentoring:** Structured orientation, shadowing, targeted case reviews, and documented proficiency checks at 30/60/90 days.

CULTURE CHANGE: A PRACTICAL BLUEPRINT

Transforming culture is not nebulous if you define the target behaviors and build systems that reinforce them.

1) Lead With Empathy as an Operational Standard

- **Model** from the C-suite: Leaders share patient/family narratives, round with teams, and publicly recognize empathic practice.
- **Train all roles** (including executives) in brief, behaviorally specific empathy skills. A simple, memorable framework such as **S.A.V.E.**—Support, Acknowledge, Validate, Emotion-name—becomes shared language.
- **Practice empathy upstream:** in performance reviews, meeting facilitation, and how feedback is delivered.

2) Re-Center Care on Total Pain

- **IDT Care Plans:** Every patient's plan must show goals/interventions across **physical, psychological, social, and spiritual** domains—with named owners and timelines.
- **Daily huddles/IDT rhythm:** Short, structured reviews that ask, "What changed in each domain? What's our next best action?"
- **Documentation discipline:** Chaplain notes explicitly link visit content to plan goals/outcomes (e.g., reconciliation, meaning-making, anticipatory grief support), not just "support provided."

3) Raise the Bar for Chaplaincy

- **Hiring:** Prefer candidates with 3+ CPE units (including Level II) or active Board Certification track; use competency-based interviews (scenario mapping, reflective capacity).
- **Mentorship:** Pair new chaplains with seasoned preceptors; require case presentations that demonstrate insight, boundaries, and team integration.
- **Ongoing formation:** Monthly reflective practice groups; annual skills refreshers (ethics, trauma-informed care, diverse traditions).

4) Build Leaders Who "Have Been There"

- **Experience requirement (where feasible):** Leaders complete field "ride-alongs" and periodic clinical immersions (e.g., CNA or chaplain shadow shifts) to keep strategy tethered to reality.
- **Feedback integrity:** Employee surveys are used to learn—not to locate dissent. Report back themes and the actions taken.

5) Make Measurement Meaningful

Track a small set of leading and lagging indicators, review them visibly, and tie them to learning (not punishment).

- **Family experience:** Spiritual/emotional support items; narrative comments coded for empathy.
- **Staff well-being:** Burnout/secondary trauma screens; retention by role; psychological safety scores.
- **Clinical integration:** % of patients with complete Total Pain plans; time-to-intervention after psychosocial/spiritual trigger events.
- **Competency growth:** CPE units completed; board-certification progress; case-review proficiency ratings.

Implementation Roadmap (90/180/365 Days)

First 90 Days

- Declare the aim: “Return to Total Pain—empathy as our operating system.”
- Launch leader rounding; adopt a 2-hour empathy skills module for all staff.
- Standardize IDT care-plan templates across four domains.
- Begin chaplain competency audit; create 30/60/90-day onboarding checklist.

By 180 Days

- Embed daily huddles with four-domain check; adjust documentation prompts.
- Start monthly reflective practice groups (all disciplines welcome).
- Implement a pilot mentorship program for new chaplains.
- Publish a simple metrics dashboard; review it in open forums.

By 365 Days

- Tie leader evaluations to team well-being and family-experience trends.
- Establish a CPE/Board-Certification advancement pathway (tuition support, study time).
- Conduct an after-action review: what shifted in experience, outcomes, and retention?

What Changes at the Bedside

- Families feel **seen and safe**, not processed.
- Teams speak a **shared language** of Total Pain and empathy, making handoffs and plans tighter.
- Chaplains practice at a **clinical standard**, linking presence to measurable goals.
- Leaders manage with **stories and data**, not spreadsheets alone.

Conclusion

Hospice became a global force for dignity because it insisted the whole person matters. Reclaiming that identity is not nostalgic—it is essential. When leadership models empathy, teams plan across every domain of Total Pain, and chaplains are formed to a serious professional standard, families notice. Staff stay. Outcomes improve. And Saunders’ conviction is honored: *“You matter because you are you, and you matter to the end of your life.”* The work is demanding, but the path is clear—and the time to turn is now.

References

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