When, in 2014, five chaplain thought-leaders issued their “international call to action” (Handzo et al., 2014), the unarticulated dynamic driving their call was the challenge posed to chaplaincy by the emergence of evidence-based medicine. The movement for evidence-based medicine had been building for about two decades, and had come into focus when Sackett and co-workers from the Universities of Oxford, England, and McMaster, Ontario, published their paper, “Evidence based medicine: What it is and what it isn’t” (Sackett et al., 1996).

Something of the spirit of “evidence-based medicine” informs the movement within chaplaincy for “outcome oriented chaplaincy” (OOC). The movement was launched at the turn of the century in a series of journal articles, published simultaneously in the *Journal of Health Care Chaplaincy* and as a standalone book (VandeCreek & Lucas, 2001). The articles, by a group of chaplain writers associated with the Barnes-Jewish Hospital at Washington University Medical Center, St. Louis, explain and expound what they describe as the “foundations for outcome oriented chaplaincy”. Although these writers do not actually use the term “evidence-based”, their work is clearly in harmony with the aims of Sackett and colleagues.¹

As the then Director of Spiritual Care Services at Barnes-Jewish, the late Arthur Lucas led the Barnes-Jewish chaplaincy team. Introducing *The Discipline for Pastoral Care Giving* (*The Discipline*, as it became known), he described a step-by-step, action-reflection model of chaplaincy care.

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¹ The concept of having an “evidence base” was introduced into chaplaincy by O’Connor & Meakes (1998); see also O’Connor (2002).
In brief, a chaplain begins by assessing a person’s needs, hopes and resources. From this initial assessment, the chaplain will develop a profile of the person to whom they will provide care. This profile in turn informs one or more desired contributing outcome(s) for the person, which then shapes the chaplain’s care plan and appropriate interventions, against which the chaplain will subsequently measure or evaluate their work. Evaluation closes the cycle and informs any subsequent cycle(s) of care, which may be provided by one or more chaplains over a shorter or longer period (VandeCreek & Lucas, 2001, pp. 6–7).

The motivation that inspired Lucas and his team was their concern “to increase their integration into and accountability with the [wider hospital] care teams” (VandeCreek & Lucas, 2001, p. 2). They saw that the path to greater accountability lay through “intentionality”. Lucas noted what he saw to be a distinctive difference between the philosophy of care operated by chaplains and that of other care teams.

In other words, whereas the hospital teams were intent on the outcome of their care, for chaplains, it was enough just to show up and offer what some call “presence ministry/ministry of presence”. For Lucas and his team, this would no longer be acceptable; their work was to be marked with an explicit intention to benefit those to whom they provided spiritual care.

Although the literature on OOC remains limited (largely confined to the references listed below), Lucas’s distinction articulates the polarities of attitude – if not debate – among chaplains. On the one hand, there are those who, as George Handzo notes, believe passionately that this form of intentional, outcome-focused practice violates some basic premises of who chaplains are – including not having an agenda and being the one person on the health care team who can simply be with the patient as a caring human being without a concern for outcomes. (Handzo, 2012, p. 22)

Arguably, Robin Brown-Haithco would be one such chaplain. She argues that being “just there” means she can be “a consistent and supportive presence, a constant companion who is willing to walk alongside staff during critical times in their vocational space as well [as] in their personal lives” (Brown-Haithco, 2012, p. 210). For such chaplains, being “just there” means...
they are the healthcare professionals who have time for people and are able, therefore, to humanize a healthcare system that is driven by expediency and medical technology. The perspective of such chaplains finds support in a view typical of psychotherapists that “pastoral care is less about technique and more about our attitude and presence … The most important part of what you will bring to pastoral care is your presence” (Ashley, 2012, p. 124).

On the other hand, there are chaplains such as Handzo who believe that all questions about “whether professional chaplains should have outcomes, demonstrate value, and have measurable outcomes … are resolved” (Handzo, 2013). While sympathetic to those who think that OOC is the wrong model, Handzo argues emotively that

chaplains can only support imposing themselves on patients who are sick and suffering and can only support the claim that they should be financially supported as a part of the healthcare team to the extent that they can make the case that their presence and interventions make a difference and that difference contributes positively to the patient’s and family members’ coping with their situation and their healing. (Handzo, 2012, p. 22)

Handzo’s conviction underwrote his leadership of the “international call to action” (Handzo et al., 2014), which, in effect, implicitly endorsed OOC. In a similar vein, D. W. Donovan framed the argument ethically in terms of a mandate to be “good stewards” (Donovan, 2012, p. 43). Going further, given his chance, he claims he would outlaw the word “presence” as a descriptor for the chaplain’s work (Donovan, 2012, p. 58).

Brent Peery has emerged as a leading advocate of OOC. As he describes in this first book-length treatment of the subject, Peery and his colleagues at Memorial Hermann Health System, Houston, first encountered OOC in 2005. Motivated by their health system’s quality improvement programme, which had required all employees to have annual measurable performance improvement objectives (2021, p. 30), members of the chaplaincy team read VandeCreek and Lucas’s book (2001) and began implementing an OOC model across their system.

Elsewhere, Peery has argued that healthcare chaplaincy is in need of a “paradigm shift” (Peery, 2012, p. 346), essentially a move away from a model of chaplaincy based on presence or process to one in which chaplaincy is built on what he here terms the three foundational commitments of OOC, the “ABCs of OOC”(!): accountability, best practice and collaboration (2021, p. 34). Following a brief Chapter 1, in which he argues for an approach to chaplaincy that takes “the gifts of historical chaplaincy training and build[s] upon and integrate[s] with them the insights and practices of OOC” (p. 19),
and a short Chapter 2 detailing the history and principles of OOC, Peery devotes a chapter each (Chapters 3–5) to what he calls the three fundamental or primary components of OOC: assessment (Chapter 3), interventions (Chapter 4) and outcomes (Chapter 5).

Chapter Three, on assessment, focuses on what, for some, is a controversial topic among chaplains. Although the professional standards for chaplains in many countries commit chaplains to assessing the spiritual needs of patients, the idea of formally assessing a patient shifts chaplaincy away from what has been its traditional trajectory – as a form of ministry – into an orbit that is essentially biomedical. For Peery, the rationale for this shift is, in part, located in OOC’s foundational commitment to accountability and the not unreasonable assumption that because chaplains are paid for their work their work should be open to scrutiny and both quantitative and qualitative evaluation. But equally, Peery justifies the shift by a claim that the Rogerian paradigm of person-centred therapy, which since the 1960s has influenced practices such as therapy, education, business and ministry, has in recent years been undermined.

However, drawing on an analysis by Gleason (1998), Peery’s claim (2021, p. 29) that, since the 1990s, the overall decrease in the duration of hospital admissions, coupled with an increasing emphasis within chaplaincy on assessment, outcomes and research, has undermined the “Rogerian paradigm”, seems hardly credible. In fact, Rogers’s person-centred therapy has proved itself adaptable to short-term, “brief” work. While it is almost certain that Rogers’s nondirective approach informed the so-called process model of chaplaincy against which OOC is contrasted, what actually militates against Rogers, and therefore identifies the origin of OOC’s challenge to “traditional” chaplaincy, is the turn to assessment, since it implies a form of “diagnosis”. Rogers set his face against any form of diagnosis on the premise that he believed individuals have within themselves all the necessary resources to deal with the challenges life poses to their psychological well-being. He termed this the “actualizing tendency”. Diagnosis – or assessment – situates the therapist (or chaplain) as the one who, by whatever evidence-based means, has the expert knowledge to be able to assess and treat the patient. The sometimes (less than) subtle power imbalance this implies is apparent in Peery’s frequent reference to patients as (passive) “care recipients” (2021, p. 14 and throughout), and is even more obvious in Lucas’s explication of outcomes (VandeCreek & Lucas, 2001), on which more below. It appears, then, that OOC’s emphasis on assessment may be less a part of an

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2. The idea that ministry might involve diagnosis was first proposed by Paul Pruyser (1976).
expedient response to person-centred chaplaincy and more a philosophical challenge arising from a felt need to answer the newly altered context of practice, which Peery details (2021, pp. 24–28) as a set of cultural changes within healthcare that are increasingly driven by academia, business and science. It may also issue, as Handzo articulates (2012, p. 22), from a fear that chaplaincy could be excluded as a profession within healthcare.

Peery’s chapter on assessment, by far the longest chapter in his book, provides a useful summary of recent thinking on the subject. Helpfully, Peery delineates assessment (more specifically, what he terms “conscious assessment”) according to Fitchett and Canada’s (2010) three-part process that includes: spiritual screen, “completed at admission by someone other than a chaplain” (2021, p. 36); spiritual history, using, for example, FICA, HOPE or SPIRIT; and chaplaincy assessment, “completed by a professional chaplain” (p. 38). It is significant, here, to note again the implied connection that exists between OOC and the imperative towards evidence-based practice. Handzo has been a leading advocate of evidence-based chaplaincy practice and its manifestation as OOC (Handzo, 2012, p. 36; 2013; Handzo et al., 2014), and has gone so far as to advocate that, as an “evidence informed” profession, chaplaincy should offer “replicable and predictable outcomes” (Handzo et al., 2014, p. 48). It seems reasonable to assume that outcomes that are replicable and predictable would depend upon robust forms of assessment. However, Peery makes clear the extent to which assessment is an act of skilful interpretation, based on professional judgment:

our assessment work involves, first and foremost, attentive, careful, and empathic listening … observation of nonverbal communication through appearance, body language, verbal tones … [and] details of the setting in which our care takes place. (2021, p. 38)

Tellingly, when it comes to assessment, the chaplain’s professional judgment is informed by “years of education, training, and experience” and crucially “our intuition” (2021, p. 38). While Handzo has argued that chaplaincy is both a science and an art (Handzo & Nolan, 2020, pp. 107–109), Peery makes clear the extent to which assessment is the work of artistry.

If assessment is controversial for chaplains, it is equally something with which chaplains struggle professionally. Peery notes that even within the clinical pastoral education that all North American chaplains must undertake in order to gain certification, relatively little training is offered on chaplaincy assessment. In the rest of the chapter, Peery argues for a form of “conscious chaplaincy assessment” (2021, pp. 43–45), providing examples of assessment models and ways of assessing such models, before briefly
outlining his own, minimally directive (oddly Rogerian?), semi-structured conversational approach based around Lucas’s (VandeCreek & Lucas, 2001) threefold assessment of needs, hopes and resources. Particularly helpful here is Peery’s annotated list of 33 potential needs, under the headings, spiritual, emotional and relational needs.

Chapter 4, “Interventions”, and Chapter 5, “Outcomes”, are short and consist mainly of annotated lists. Motivated by the observation that chaplains’ “skill at offering chaplaincy interventions exceeds their ability to articulate them” (Peery, 2012, p. 351), Peery first describes 44 interventions he and his Memorial Hermann colleagues have identified. These include items subgrouped as interventions of empowerment, exploration, collaboration, relationship building and ritual.

Oddly disappointing, given the title of the book, is the very brief chapter on outcomes. Fully four of its six pages are given to the familiar annotated listing, here describing 32 common chaplaincy outcomes. On the positive side, Peery’s lists are helpful insofar as he is right that chaplains are generally more effective in doing their job than they are at explaining what it is they do. As such, his lists provide descriptive vocabulary. However, they also betray the extent to which OOC is more about presentation than it is about shifting the paradigm.

Even a relatively superficial reading of Lucas (VandeCreek & Lucas, 2001) shows that the “outcomes” intended in The Discipline were not meant to be actual, patient-defined outcomes, such that may have some real-world, measurable, post-intervention objectivity (Snowden et al., 2013). They are, rather, the chaplain’s “desired contributing outcomes”, the “difference we hope and intend our ministry will make for the healing and well being of the person in our care” (VandeCreek & Lucas, 2001, p. 18). Less obvious, in Lucas, is the extent to which patients should be actively involved in shaping and agreeing the “desired contributing outcomes”, or whether they are simply informed about what the chaplain feels they have to offer. Peery glosses Lucas on this point. Whereas Lucas says, “patients own the desirability and definition of the intended outcome along with the chaplain” (VandeCreek & Lucas, 2001, p. 19), Peery clarifies that outcomes are “formulated with our care recipients” (2021, p. 75). What is clear is that OOC is defined by its emphasis on being outcome oriented. This may seem an obvious thing to say; however, the point brings home the fact that OOC intends to define itself against and as an alternative to what Lucas and his colleagues saw as the traditional, so-called process model of chaplaincy: an active model of chaplaincy in contrast with a model perceived to be passive. Hence the stress on intentionality. Thus, Lucas wrote about a creative tension between “presence/process and doing/outcomes” (VandeCreek &

It is intentionality, rather than evidence-based practice, which appears to be the defining quality of OOC. If so, then one is left to wonder what the fuss is about. I doubt I have ever met a chaplain who did not intend their work to benefit those for whom they were caring. For his part, Peery describes OOC as “intentional caring”, which he contrasts with “the somewhat unintentional language we occasionally use to describe our work” (2021, p. 21). He means, of course, phrases like “I show up with no agenda”, or “I am simply present”, passive phrases that he, rightly, argues fail to communicate “the reality that many, if not all, chaplains approach their work with the clear agenda of wanting to be helpful to others” (p. 21).

It would appear, then, that the paradigm shift for which Peery has advocated is less about a shift in practice and more about a shift in presentation; that OOC announces a new way of talking about what we do rather than a new way of doing what we do. (The two, of course, are not mutually exclusive; chaplains will do well to talk more and more clearly about what we do.) If so, this explains why Peery’s second longest chapter (Chapter 6) is on documentation, another area about which he is passionate and on which has published elsewhere (Peery, 2020). For Peery, documentation is one of the secondary components of OOC, the remainder – chaplaincy care pathways, chaplaincy education, quality improvement and research – being covered in the following Chapter 7. Particularly helpful, indicatively, is what he has to say on chaplaincy care pathways, which includes an example of a pathway for chaplaincy care for patients with a left ventricular assist device (LVAD) as destination therapy.3

In his final Chapter 8, Peery attempts to pull it all together and show how OOC can work in clinical practice. Those who practise the “passive”, so-called presence/process model of chaplaincy Peery earlier critiqued will notice little in his account of OOC that differs from their own day-to-day work. Thus, he asserts chaplaincy as being personal work: “We accomplish the outcomes of our work through who we are and how we relate to others” (2021, p. 110). Drawing on Nouwen’s concept of “hospitality”, he describes the work as creating “a safe interpersonal space for a care recipient to be able to share his or her innermost beliefs, emotions, thoughts, concerns, dreams or questions” (p. 111). This is because, “[t]he heart of a chaplaincy care encounter is listening to the care recipient’s story” (p. 111), the “care recipient’s” storytelling being where the bulk of assessment takes place, as

“[w]e listen with all of our senses” (p. 111). Peery, Lucas, Handzo and others articulate intentionality as the key distinctive of OOC, and for this reason Peery’s intention is that, at some point, the storytelling will transition to content that is more specifically spiritual, emotional or relational. To that end, Peery “might invite them to transition by asking a broad question like, ‘So, what has all of this been like for you?’ or ‘How are you holding up through (or coping with) all of this?’ ” (p. 112). It is interesting to note Peery’s observation that “[s]ometimes empathic listening serves as both a means to assessment and the only intervention the person needs to realize their desired outcomes” (p. 112, emphasis added). Being intentional may prompt Peery “to briefly review or discuss a plan for intended spiritual, emotional, or relational growth” (p. 113), which may or may not include further chaplaincy care. If not, “I want to make sure the care recipient at least knows how to assess our help in the future … They may need us later” (p. 113). So far, so Rogerian! The final part of the work is for the chaplain to document the encounter (p. 113).

What stands out from reviewing Peery is the way in which both he and Lucas characterize OOC as “intentional caring”, which Peery clarifies as “a determination to act in a caring manner” (Peery, 2012, p. 358). Ignoring the thinly veiled criticism of the “traditional” presence/process model of chaplaincy, it is clear that behind, and informing every aspect of this characterization, is the awareness that OOC is a response to the imperative that chaplaincy must be/become accountable. Specifically, that it is professionally accountable to both its healthcare colleagues and, more significantly, to the business model of the healthcare institutions that employ it. It is inarguable, as Peery observes, that “[a]ccountability is here to stay in healthcare” (2021, p. 33), but what such accountability will do to traditional values and practices of chaplaincy is a moot point. Equally moot, however, is whether OOC will prove to be, as Sue Wintz claims, “[b]y far the most effective approach” to true patient-centred care (Wintz, 2014, p. 20).

References
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