Mediation and Advocacy in Chaplaincy

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This article explores the definitions of, and the skills necessary for, mediation and advocacy as utilized by hospital chaplains. Historical development in the Jewish/Christian context and contemporary secular use are compared and contrasted. In the pastoral realm, as opposed to the secular, mediation and advocacy skills operate within a realm of potentially divided loyalties.

One is “working for God” within a “hospital system” where bioethical issues, among others, often arise. Four case studies accompany the article.

First Woman: This is my baby and she is trying to take it.
Second Woman: She lies! It is my baby!
King Solomon: You shall share the baby. I order that the baby be cut down the middle.
First Woman: Oh no! Please no, she can have the baby. Please don’t cut my baby!
King Solomon: The baby is yours. Take it home. (turning to the second woman) You lied....

King Solomon was the wise king in the Bible. Blessed by God, he was able to understand the conflict between the two women about “their” baby. By finding out who spoke the truth, the conflict could be solved.

How often in our profession as hospital chaplains do we wish to have the wisdom of King Solomon? How often are we called to help to create more understanding between families and medical staff who have gotten into a dispute, to offer help in decision-making, or to provide support in spiritual problems? And how often do we have to face our limits in trying to do so? Is it so easy to say what is right and what is not, and which decision we should support? What is our role as chaplains? What do people expect from us?

This article will explore mediation as a useful and necessary skill for hospital chaplaincy. Even more, it will speak about mediation as a “healing art.”

This article has been excerpted from a paper presented by Katrin Wunderwald at Memorial Sloan-Kettering Cancer Center, New York, NY in July 2001 during her residency. See Author's Note on page 17. She has since returned to serve in Leipzig, Germany. For a copy of the full text, which includes an additional five case studies, contact the author <kwunderwald@yahoo.com>
To mediate, one must at times also be an advocate. Advocacy and mediation are intertwined, and if this connection is not always explicitly pointed out, it is implied throughout.

**Mediation and advocacy in the historic Jewish/Christian context**

Mediation and advocacy are very closely tied together. Frank T. Willey defines a mediator as an “agent or means by which the divine and human are brought into communion.” An advocate is described as someone who pleads on another’s behalf, an intercessor. In order to understand these terms, and the ideas that lie beneath them, we need to go back to their roots.

Here we find two conceptions: an idea of God, and a human sense of sin before this God. The intensity of the felt need of a mediator between God and man depended on how exalted was the conception of God, and on how deeply the sense of sin was experienced. The mediator was understood as being necessary to overcome this gap imposed by the hierarchical relationship between God and humanity. In his book, *The Symbolism of Evil*, Paul Ricoeur describes this concept in a comprehensive way.³

In *The Jewish Doctrine of Mediation*, William Osterley explores the concept of mediation in the Jewish context. This concept continues into the New Testament’s mediation of Christ. It is rare, but a few times in the Hebrew Bible there are passages that speak contrary to the idea of a mediator between God and man, i.e., “If a man sinneth against a man, God will mediate (also “arbitrate”) for him; but if a man sinneth against Jahwe, who can intercede for him (I Sam. 2:25).”⁴ God himself can be the mediator for sinful acts against another human being, but not for sin against the Holy One. The sin against God is seen as higher in a hierarchical order. Similarly, Job does not see hope for justification from God; “Oh that there were a mediator between us, that may lay his hand upon us (Job 9:33).”⁵

Osterley contends that, although one can find the principle of mediation in the Hebrew Bible, the idea of mediatorship was not well developed. The Hebrew root for sin means nothing more than to “miss the mark” (to make a mistake), and had not yet the deep moral connotation that it had in the Greek sense. God was seen as majestic and ethically pure so that man’s sense of sin became deeper. With the deeper sense of sin, there came a pressing need for a mediator.

While the idea of mediatorship was not that well developed in early writings, Osterley points out that a “general principle of mediation,” though a one-sided representation, is nevertheless expressed, in particular through the sacrificial system of the priests and kings and through the prophetic office. What is presented is either the side of men before God (priests and the kings), or the side of God before men (prophets).

The more developed concept of mediation required two elements—an intercession and a presentation (such as a sacrifice). Those with a deep sense of sin interpreted their situation as if God would therefore demand a reconciliation offering or compensation offering.⁶

It is my opinion that figures such as Moses and the Old Fathers (Abraham, Isaac and Jacob) as well as the prophets did represent both sides, the side of men before God and of God before man. Abraham interceded between God and the righteous of Sodom. He was an advocate for the people in asking the Lord to spare the city and to not destroy them (Gen. 18:17ff). Moses claimed a unique place as mediator of the law and inaugurator of the covenant of Sinai (Exod. 20:19-21). The prophets confess their guilt to God, speak about the judgment of God to their people, suffer from the sin of their people, and give their lives to the belief in God’s promise. It is interesting in this context that repentance from sin follows the intercessions but is not reason for it.⁷

In later Jewish concepts, Osterley points out that there is no direct doctrine of mediation, although Liturgy, Talmud and Torah have some kind of mediating function. In the Jewish Prayer book, there is frequent direct prayer for divine forgiveness that makes the idea of a mediator unnecessary. Since the Messiah is understood as purely human in his character, the idea of mediation in its full Christian sense does not fit completely. Yet, the Messiah is understood as intercessor for human sins.

In the New Testament, Jesus is seen as the mediator. He is not just the agent or instrument of mediation. Since he is one with
God, his forgiveness can be the forgiveness of God.
Osterley sees the difference between the Jewish and the Christian doctrine on mediation in a twofold way:

Jewish thought never elevated the fall of man to the level of a fundamental article of faith as was done by St. Augustine and other church fathers, and Judaism’s opposition to the Pauline idea of a “saving grace” of God through the agency of an intermediary, and its insistence that man’s power of redemption from the thralldom of sin lies within and not without himself....For God has implanted in him a portion of His own Divine self....

This means that the power of mediation in the Jewish concept lies, to a large extent, with man while in Christian thinking it lies primarily with God himself, in Christ.

What does this imply for hospital chaplaincy, where mediation and advocacy work, in general, can be understood as “a direct ethical consequence of the theological concept of mediation” and where chaplains as mediators and advocates are members of the covenant with the One who is mediated, with God? Though chaplains are both subjects and agents of mediation, they are usually perceived as being closer to God. In contrast, the people for whom chaplains are asked to mediate and advocate are often in a troubled or endangered relationship with God due to suffering, frustration, anger, and hopelessness. They may raise questions about sin or express feelings of injustice. Mediation and advocacy for God as well as for the represented people requires specialized skills, some of which are the same as those employed in secular mediation.

Mediation and advocacy in the contemporary secular context

Mediation in a secular context is probably best described as a goal-directed, problem-solving intervention or assisted negotiation whereby a third party, the mediator, assists in negotiating an agreement that resolves the dispute of two or more parties. Willey tells us that, “The mediator functions as a facilitator, creating an environment in which the disputants are most likely to find a mutually acceptable resolution of their dispute.”

Mediation is a relatively new technique for conflict resolution, which offers an alternative to the adversarial approach to conflict. This technique tries to work for the protection of relationships, for equality between the partners in conflict, and for dignity and mutuality. Therefore, it is very close to the religious concept of mediation. Yet it does not accept a hierarchy as the religious concept does when it talks about the relationship between God and people. Also, in the secular context, there is more of a distinction made between mediation and advocacy than is made in the religious context. Here the mediator needs to be neutral, and only because of this neutrality can the parties trust that a solution fair to each of the involved members will be found.

Any conversation between conflicting parties usually includes misunderstanding and missed communication which result in confusion, hurt, and strong negative feelings. Anger, the most common reason for mismanaging conflict or pushing it underground, needs to be listened to in a deeper way, because inside an angry person there is often a hurt person. In From Conflict to Cooperation, Beverly Potter points out different skills that are required for successful mediation:

1. All involved parties need to be present and willing to participate in mediation.

2. Each person has to tell his or her view of the story, not someone else’s, and should stay focused on the present not the past. The mediator acknowledges that stories told over and over again often express a central concern for the disputant and that attention must be paid to them.

3. Occasionally, the mediator needs to meet privately with each disputant so that the weaker party feels free to express what cannot be said in the presence of the stronger party; however, such private meetings should be limited in order to prevent mistrust from becoming an issue.

4. The mediator needs to exhibit active listening skills in order to demonstrate a genuine effort to understand how the disputant sees the conflict. Leading questions are to be avoided as is questioning the validity of a disputant’s
story or making judgments. Body language should be closely observed and checked out, especially when it contradicts what the person is saying.

5. During the process, the mediator has to maintain control and not get pulled into the conflict. This can be accomplished through maintaining eye contact with the disputants; seating the most angry or potentially threatening disputant in the deepest, softest, most comfortable chair available (this will relax the disputant to some degree); using the body to control the disputants with face, voice, hands and chest, or in actually standing up and stopping any person interrupting by saying “wait/hold on.” Interruptions cannot be tolerated, and provocative language needs to be neutralized both to remove emotional barriers between the disputants and to promote mutual recognition.13

Sometimes mediation can end after this, because “simply hearing the adversary’s story is all that is needed to resolve the conflict.”14 If mediation continues, the mediator repeats and clarifies what has been said and what might be important and asks, “Did I understand correctly?”

The mediator may assist in generating creative options, thus increasing the number of possible solutions for each issue. In this way, the mediator encourages new approaches to problem solving. Finally, the mediator reviews, sums up, and asks “Is there anything else?” Parties share control with the mediator and are the ultimate decision makers. Through this process healing and forgiveness may be possible because through listening to another and figuratively walking in another’s shoes, understanding sometimes follows.15 According to Willey,

In mediation, the dignity of the people involved is protected and promoted. Pace is saved. The potential for consensus is highest. Destructive attacks can be minimized and controlled. When people are willing, just agreements can be reached.16

In a secular context, the mediator often is seen as nothing more than the neutral facilitator of a fair communication. But in giving the process a certain structure and imposing helpful rules on it, the mediator advocates for the weaker, quieter party and makes sure that person’s position is heard and understood.

Do chaplains function in the same way that secular mediators do, or is there a necessary difference? How does religious mediation look compared to secular mediation?

**Mediation and advocacy in chaplaincy**

Chaplains in today’s complex health care setting have multiple functions. They have a unique position in assisting communication and in mediating conflicts involving patients, family members, hospital staff, or associates in conflict.15 In the eyes of believers, chaplains often are seen as persons of wisdom who represent both the moral teaching of the Church and religious truth. For the most part, people trust chaplains, consider them to be positive and fair, and expect solutions from them. For nonreligious as well as religious people, chaplains frequently are perceived as “peacemakers.”

There are at least three areas in which hospital chaplains act as mediators and advocates: nonreligious disputes, religious problems, and instances where religious and non-religious issues cross.

**Nonreligious disputes**

Serving as mediator or advocate in nonreligious disputes between patients, families, and hospital staff basically means ensuring that the medical team is understood correctly and that the voices of the patient and family are heard clearly “rather than [becoming] lost in the welter of institutional policy, hospital procedure, and sheer routine.”16 Mediation and advocacy can easily be performed by a social worker, patient representative, doctor, nurse, or other house staff. The person having this function should have some basic training in mediation skills in order to insure a successful outcome of the dispute. The limitation of this mediation technique lies in the time that is required and allowed for mediation; hospital settings often produce extreme time pressures.

**Religious problems**

In working with patients and their families concerning their relationship with God, chap-
lains act as mediators and advocates in a different kind of conflict. Unlike the secular context, the involved parties are not openly arguing with each other. Conflicts arise in the attempt to make meaning out of suffering. Patients or family members may complain to, or argue with, God, but God’s answer does not come back in kind. Working within their individual religious interpretative frameworks, chaplains support patients and families in their search for meaning. Chaplains even may be perceived by some patients as tools for God’s mediation and advocacy; they may see God working in and with the chaplains.

Chaplains mediate and advocate in a religious context by providing spiritual care to patients and their families. Spiritual care is a mixture of theology, which is as old as the Church, and psychology, which is relatively new. It holds together ethical, religious and psychological perspectives, sometimes concentrating on one of the three. As illness often calls into question one’s purpose in life and threatens one’s feeling of wholeness, healing becomes the restoration to wholeness and the ability to find purpose again. Suffering and loss generally can be handled much better if one is able to find meaning in them.17

Essentially, most chaplains assume an ultimate agent behind growth and change. In this respect, both chaplain and patient are on the same road, having an equal dignity and yearning in terms of healing. There is a degree of mutuality in the process. Chaplains are aware that they represent a message which does not originate from them alone. This transcendental component is what makes the chaplain’s mediation/advocacy different from the secular. The way in which chaplains mediate/advocate is greatly influenced both by their individual personalities and the models of spiritual care that they employ.

Models of spiritual care

An older model, explored by Seward Hiltner, is that of the shepherd whose ministry is to promote healing, sustaining, guiding, and reconciling.18 Henri Nouwen introduced a newer model with his image of the “wounded healer” where he emphasizes the empathic nature of the chaplain.19 Heife Faber compares the chaplain with the “clown” who represents a different order with a “personal dimension.”20 The clown has solidarity with people in the boundary situations of their existence such as sorrow, absurdity and setbacks.

Donald Capps introduced the image of the “wise fool,” which fits to the model of the clown and can be seen as the revisionist model of spiritual care. The wise fool looks at issues from a new, unaccustomed perspective that helps the patient who might be imprisoned in a limited, distorted view.21 This can open up new insights and possibilities. The wise fool knows that truth is simple even if the solution might not be that simple.

The image of being wise and foolish together is paradoxical in the way that every facet of human existence is also paradoxical. There is power in weakness, success that comes out of failure, sorrows that have joy. This model reminds us that the chaplain’s role as mediator in a religious context might be perceived as foolish because chaplains cannot say anything regarding God with absolute certainty.

Mediation and advocacy in the religious context

In order to build a relationship with patients, chaplains need to be settled with their own spirituality. Patients evaluate chaplains emotionally and intellectually and may either open up or pull back depending on what they perceive. When chaplains are secure and willing to let their own needs be challenged, it is more likely that patients will open up and trust.

Relationship building is essential. Chaplains work to create an atmosphere of confidence, to stay in the patients’ place, to understand the situation from their perspectives, to look at their coping mechanisms, their resources, needs, and strengths. In an honest way, chaplains reflect with empathy and help patients to work through issues, to find meaning in their situations, and to make decisions regarding treatment. Chaplains pay attention to the origin and nature of the patients’ conflicts, to their feelings of aggression and guilt, to their values and ideals.

Although chaplains guide the conversation, control lies with the patient. Chaplains may offer to move to more pastoral ground, but they leave patients the freedom to follow or not. They mediate/advocate in using appropriate scripture, other lit-
erature, or religious rituals that speak to patients’ situations.

Chaplains and patients look for God together in the midst of the limited picture of illness. Chaplains help patients to move from dread towards courage, from despair towards hope, from brokenness towards wholeness, from aloneness towards a feeling of belonging, from helplessness towards power, from bondage towards some kind of inner freedom, from guilt towards grace.

Chaplains assist patients in understanding the paradox that is often mystery, even for the chaplain. They advocate for God’s presence when God seems absent, perhaps mediating for patients through intercessory prayer. Sometimes such prayer opens up a whole new conversational dimension. Often, even the most worldly conversations have a religious character.

Compassion as a special form of mediation

Compassion is a unique form of mediation. In the Hebrew Bible, compassion—the root of the word racham—refers to the womb as well as to loving tenderness in relation to Yahweh as the source of life and birth (Gen. 20:18, 29:31; Hos. 9:14). For Arthur Becker, “Compassion requires a movement from our own security base...into the troubled world of another.” It is a perception of another’s pain, hurt, sorrow, and longing, so intense that “you feel it in your guts.” It often resonates with a chaplain’s own hurt, and therefore can be very painful.

This movement into the world of another often takes place as chaplains mediate between God and the patient through prayer. Such compassionate movement is not one “of the superior to the inferior, but rather [of] the one who is relatively more healthy, pain-free, stronger in a sense, confronted by another who is more pain-filled, dis-eased, anxious, burdened, [and] sharing his or her strength, courage, resources with the sufferer.”

The identification with the one who suffers that takes place in compassion moves naturally to a sort of advocacy for that other person. The good Samaritan did not just sit there in the ditch, feeling compassion for the man’s wounds. He made use of the resources he had, pouring medication on the man’s wounds, and when his own resources were exhausted, he moved on to the resources of the available social institutions. Chaplains must do likewise.

Mediation and advocacy where nonreligious and religious issues cross

The third way of mediation and advocacy is the one in which chaplains have less training, but one that requires more and more of their attention. Ethical dilemmas resulting from advances in technology bring chaplains into unique and challenging situations. What is their role in these contexts? How do they mediate and advocate when confronted with bioethical issues?

More and more in medical settings, specific terminology regarding ethical behavior is used, e.g., informed consent, respecting patients’ values, autonomy, non-maleficence, beneficence, justice. It is important to realize that these terms are not neutral and are highly complex. Some of the first to write on the bioethical movement that started about thirty years ago were religious themselves and wrote from a religious bias. Two main contributors to bioethics, Robert M. Veatch and James F. Childress, were trained in divinity schools.

Since then, though bioethics has not been necessarily adverse to religion, “the mainstream of bioethical dialogue has not reflected a serious conversation with religion. Although bioethics has been and continues to be an interdisciplinary field, the contributions of religion have been marginalized at best and ridiculed at worst.” Some bioethicists have looked for their principles in secular moral philosophers such as Immanuel Kant and John Stuart Mill. The context for the core ideas of bioethics was from the beginning, not religion, but “the individual and his or her rights in a public policy context.”

Even though bioethics tries to be neutral and objective, its “moral methodology” is not as neutral and objective as it appears. Many judgments depend on a prior definition of what is justice or beneficence, or what is human well-being and fulfillment. Assumptions about the nature of human beings and human life are present under the surface of secular moral language. If interpreted in a secular and pluralistic context, the understanding of what justice, informed consent and values mean might differ from what they mean in a religious context.
When religious patients, for instance, see life as in reference and response to God, or as "imitation of Christ," they might understand complete autonomy as being nearly impossible, and justice as much more related to the community than it would be in a secular context.

There is a growing awareness of how important religious and cultural values are to patients' decision making regarding treatment. For many, bioethical questions around life and death issues, the meaning of suffering, values, the understanding of personhood, and considerations about justice are essentially religious ones. Often, interpretation and decision making for patients needs to be done within a religious framework of thinking and feeling. Its importance is best described in Richard McCormick's words:

To claim that such distinct outlooks and onlookers (theology) have nothing to do with bioethics is either to separate faith from one's view of the world (which is to trivialize faith by reducing it dualistically to an utterly otherworldly thing), or to separate one's view of the world from bioethics (which is to trivialize bioethics by isolating it from the very person it purports to serve).29

Hospital ethics committees generally focus on the four principles of bioethics: autonomy, nonmaleficence, beneficence, justice. When the committee is convened as a result of a deep conflict, mediation skills are vital to offset the communicative power imbalance between physicians and patients, to protect the rights of all parties, to de-escalate disputes, and to preserve the ability of parties to cooperate in identifying areas of agreement.30 Methodology alone does not answer concrete moral dilemmas. Additional concepts are needed, and these concepts could be religious. What is the chaplain's role as mediator/advocate in this setting?

Religious concepts that contextualize bioethical principles

According to Dolores L. Christie, religion offers a "myth" about one's origin, identity, and destination. It not only defines who one is and what one is worth, it offers answers to questions related to the meaning of life, suffering, death, and afterlife. It tries to make sense out of tragedy and brokenness. Religion can provide an identity that is shaped more by the existence of God and a religious community than by an individualistic concept.31

One problem regarding bioethical questions is that of religious fatalism. Some people see God's determination so strongly that it is as if medicine has nothing to offer. On the other hand, some see the development of medical technology as God inspired and feel they have to use all possible medical interventions. This leaves only a little room for shared moral discussions.32 Physicians are often afraid that such fatalism will undermine the patient's treatment and in order to avoid such issues might prefer not to have chaplains in the picture. Conversely, some chaplains think they need to speak a scientific language and agree to everything the physician points out in order to have a place on the discussion table. Perhaps chaplains contribute more when they maintain a colorful difference and speak up from that perspective, i.e., the louder voice of advocacy as opposed to the gentler voice of secular mediation.

The chaplain's role

Sometimes chaplains are called to function as prophets. They must not only recognize injustice, unethical behavior, or systemic problems, but also find ways to address such situations. Although there is a danger of resentment by the doctor, in terms of bioethical principles that speak against paternalism, intervention is justifiable whenever the chaplain sees that the patient is not being heard.

While chaplains must be faithful to their beliefs, they also are accountable to the system in which they are working, e.g., the hospital. Chaplains may have to shift between theological/ethical and clinical language on a regular basis. According to Marsha Cutting:

Each language employs a model of reality which is only a model, not reality itself. Each may be more or less useful in a given time. But it is challenging to use both models at the same time.33

Do chaplains have enough training in using both models at the same time? Chaplains can be "[bridge builders] with the awesome responsibility to ar-
ticulate clearly and effectively to the greater community the particular perspectives that his or her religion espouses.” To do so, they must learn to speak “a second language that translates clearly the message and moral response of their communities of faith to others.”

Despite the fact that such a clear position of advocacy might be “a better vehicle for understanding than the relativistic presentation of all views as having equal value...” there often is no such thing as a clear moral religious response. Rather, the chaplain is seeking for concrete, sensitive answers that do not exclude the theological perspective on the issue.

One problem arising in this context comes with the fact that chaplains must work under institutional boundaries. Even though chaplains need to be true to their religious traditions, hospitals often require them to respond in more general way to spiritual issues. Chaplains, in this case, have to work under the assumption that sick people are asking more for a general spiritual encounter than the particular religion itself.

H. Tristram Engelhardt asks in this context,

What truth claims must be abandoned by particular religions in allowing their members to accept generic care from those beyond their communion? As fundamentally, what religious commitments must be denied to allow ministers to provide generic spiritual care, that is, spiritual care that does not carry with it the commitments of the religions that ordained them? ... Ministers who were once ordained in particular religions are reprofessionalized into trans-denominational roles. Institutional expectations reshape their vocation into the role of generic chaplains.

Also, as Joseph J. Kotva, Jr. warns, a particular perspective ... [can be] smuggled in and authorized under the guise of something more universal and open-minded: either the chaplain’s own convictions and traditions sneak in or, even worse, the chaplain becomes uncritical representative for other contemporary moral influences.

Does this mediation and advocacy mean to speak up for all positions except our own? Kotva notes that there seems to be an emphasis on bioethical principles which seem to push towards a generic chaplaincy as they “do not envision chaplains as representing the theological wealth and moral wisdom of specific religious traditions. They instead see chaplains as promoters of general principles assumed accessible and compelling to all.”

Secular mediation and advocacy would see this neutrality as its gift. But, in looking for answers to ethical dilemmas, chaplains, like prophets, sometimes need to preach what could be “politically distasteful but religiously-sound...[and] to interpret and to articulate as well and as clearly as possible the reality that is perceived.” In mediation/advocacy work, chaplains should be more proactive and less apologetic in what they have to say. To mediate and advocate effectively, the louder voice of the biblical way is often necessary.

Conclusion

Often the roles of hospital chaplains are mixed. Sometimes they serve as mediators who remain neutral and facilitate in a conflict between disputing parties. In this setting, their advocacy is quiet and more subtle as they are not the ones providing the solutions. In other instances, chaplains are asked to speak loudly as advocates either for the weaker party in issues of justice, or to proclaim religious truth. In so doing, they are no longer neutral mediators. Thus, they must learn to use the voices of both mediation and advocacy, to speak both secular and religious languages, to translate these languages, and to be flexible enough to switch back and forth between them. This is their special challenge.

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References

1 Beverly Potter, From Conflict to Cooperation: How to Mediate a Dispute (Berkeley, CA: 1996), 15.


5 Ibid., 63f.


7 Osterley, Jewish Doctrine, 189.

8 Willey, “Chaplain as mediator,” 80.

9 Ibid., 78.

10 Ibid., 6.

11 Potter, From Conflict to Cooperation.

12 Ibid., 56.


14 Willey, “Chaplain as mediator,” 87.

15 Ibid., 77.

16 Wheeler, 1996, 98.


18 Seward Hiltner, the Christian Shepherd: Some Aspects of Pastoral Care (Nashville: Abington Press, no date).


21 Donald Capps, Reframing: A New Method in Pastoral Care (Minneapolis: Fortress Press, 1990), 169.


23 Ibid., 150.

24 Ibid., 151.

25 Thomas A. Shannon, “Bioethics and religion: a value-added discussion,” in Dena S. Davis and Laurie Zoloth, Notes from a Narrow Ridge: Religion and Bioethics (Hagerstown, MD: University Publishing Group, 1999), 133.

26 Dolores L. Christie, “Relativising the absolute: belief and bioethics in the foxholes of technology,” in Davis and Zoloth, Notes from a Narrow Ridge, 88.


28 Wheeler, 37f.


Mediation and advocacy case studies

Case study 1

Mr. M, an 81-year-old cancer patient who has stopped breathing, is brought into the Emergency Room where the medical staff attempts to resuscitate him. When his wife arrives, she is anxious and wants to be by her husband’s side, but the medical staff will not permit her presence in the ER. In this tense situation, she tells me that he is a Do Not Resuscitate (DNR), which was not communicated to the ER staff when Mr. M was brought in. I give this information to the physician, but by this time resuscitation efforts have ended, and the patient has been pronounced dead.

Later on, when I accompany the wife to say her goodbye, she is sad to see him intubated. She feels very guilty for not having taken care of him in a better way and for having to let him die by himself in the ER. We talk for a long time, and finally she is able to leave with some peace in her heart.

Though in this case the chaplain clearly served as mediator between the medical team and the wife, who had no access to the ER, due to hospital policies, she was not able to advocate for the wife’s wish to be with her husband. Not only did the medical team expect the chaplain to function as a peacemaker, she was asked to advocate for them when the wife became angry about having to wait so long before being allowed to see her dead husband.

Nevertheless, the chaplain also was able to advocate for the wife in her need to know what was going on in the ER. It comforted her to know that the chaplain served also as an advocate for the unresponsive patient, somehow guaranteeing both husband and wife that his dignity would be preserved during the medical procedures.

Finally, in comforting the wife, the chaplain tried to mediate a human touch in a situation that was extremely difficult. This case left a lot of unresolved questions. To what extent can chaplains be effective advocates/mediators in ER situations? Did the wife get what she needed? Could the chaplain have done more or done anything differently?

Case study 2

Mrs. A, an 83-year-old widowed cancer patient is being treated in the urgent care unit, accompanied by one of her five daughters. They share with the chaplain their frustration with the hospital’s lack of compassion.

Due to a holiday, a shortage of staff, and an unexpected change for the better in the patient’s condition, she is to be sent home for the night and to return the next morning for additional tests and treatment.

Transport is a major problem for this elderly lady. She hardly can get into a car and experiences the drive as a torture. Further, she is nauseated and vomiting frequently. She asks to stay in the hospital overnight, but the doctor on call tells her that there is no medical reason to keep her in the hospital.

The patient refuses to leave. Her daughter argues with the doctor. The discussion gets heated, and they finally yell at each other. At that point, I stop their discussion, telling them that I can understand their positions but that the yelling will not bring any solution.

I ask for the possibility of a social admission and get a no from the doctor. Then I ask if it is a money issue. The family offers to compensate for the extra stay. But still this is not agreed to on both sides.

I comment that both sides have clearly expressed where they stand, and I ask if there is somebody else who can be consulted in this case. The doctor speaks to the patient’s attending physician and the administrator while I look for a patient advocate and find the nursing supervisor.

The final solution is that Mrs. A has to leave the hospital that evening, but her medication is changed, so she does not have to come back until further notice. The dispute ends with a solution that satisfies the patient.

The chaplain helped to protect the “face” of the hospital, averting the danger that an elderly woman would have been overpowered physically and emotionally by hospital policies and would have left full of anger.

The doctor, however, was not satisfied. She complained that the chaplain had inserted herself into the dispute and into the process of decision making. In attempting to mediate, the chaplain missed the opportunity to communicate
enough concern and understanding for the doctor's position, taking a stronger advocacy role for the elderly lady to rectify a potential power imbalance. As a result, the doctor obviously felt that she had lost power. Thus, though the chaplain's advocating was successful, her mediation was not.

**Case study 3**

Mrs. S, a 68-year-old woman, suffers from lymphoma with skin involvement.

The psychologist gives me the referral, and when I first meet Mrs. S, she has large open wounds full of puss all over her body. She cannot walk because her feet hurt so much from the wounds. She cannot do much with her hands either, and her face is really distorted.

Her first reaction is to hide her face from me and to say, “God has done something terrible to me.” I touch her shoulder—remembering that Jesus had touched the “outcasts” too—and tell her that I have seen more difficult things than this. This is a lie, but I feel so much compassion for her that I want to help her with her shame.

Despite my strong revulsion, I minister to her each time she comes in for treatment. She seems to get better, and I do not see her for a while.

When she comes back, she is a happy person, full of energy and praising God. Her body is much less swollen, and almost all of her wounds have healed. Only her voice sounds husky.

She welcomes me with a kiss on the hand when I come in. After a little conversation, she begins to cry and cannot stop. I ask her what these tears are about, and she replies, “I don’t know. Just joy at seeing you again. The Lord has been so good to me. I guess I am just rejoicing.” However, two days later Mrs. S has a worried look in her face when I enter.

**C1:** You don’t look so happy today, Mrs. S. What is on your mind?

**P1:** They found something in my throat last night. The doctor will tell me more when he leaves the operating room.

**C2:** (I touch her on her shoulder.) I am so sorry. That’s not what you needed.

**P2:** I was doing so good.

**C3:** Yes, you were. You are such a brave woman.

**P3:** (crying) It feels better when I cry it out.

**C4:** Yes, sometimes we need to cry. Are you afraid now?

**P4:** No, I am not afraid. If the Lord wants me I am ready. Anyway, it is better over there. But I thought I was doing so good.

**C5:** You went through so much, really. You are disappointed, aren’t you?

**P5:** Yes! I feel like a child at Christmas who is expecting a puppy and then doesn’t get it and is disappointed.

**C6:** I understand. There was so much hope in you because you were getting better step by step. It seemed to go only upwards.

**P6:** Yes, I am disappointed. But I will make it.

**C7:** You are a very strong person.

**P7:** I will make it. (She cries again.)

**C8:** Mrs. S, there is not too much I can do for you.

**P8:** Praying, that’s all you can do.

**C9:** I will. Would you like for us to pray now?

**P9:** Yes.

I say a prayer in which I bring to God the disappointment and sadness Mrs. S has expressed and ask for God’s support in the strengthening of her body and soul.

Mrs. S responds, “I feel so much lighter already.” She makes a sign as if she would get something out of her chest. “It really helps you know. Prayer helps.” Later that week Mrs. S is admitted to hospice as her cancer has spread throughout her head and neck.

I see her only one more time during an outpatient treatment. When she sees me, she looks deep into my eyes and says in a ministering way, “Don’t cry baby. I will be all right. Don’t cry.”

She has anticipated my sadness. She hugs me, and as shocked as I am when the diseased skin of her face and my face meet, there is no revulsion in me anymore.

This patient was very religiously devoted, and the chaplain expressed true compassion to her, mediating a physical as well as an emotional acceptance of her. This was only possible because of the chaplain’s own strength augmented by prayer. Through this, the chaplain was able to teach herself to overcome her initial revulsion. In remembering how Jesus
touched the outcasts, a change and growth took place in her. She wanted to mediate to the patient Jesus’ acceptance, independent of how she looked.

The chaplain’s awareness of her role took her beyond what she originally saw as her limits. It brought back memories of her own disease and the shame she had felt when her appearance was less than pleasant and made her able to feel compassion on a very deep level.

With this patient, the chaplain did not need to advocate for God, because it seemed that Mrs. S never lost God. She was not able to understand her situation, and she was upset, yet she still looked for strength from God. The chaplain supported her in this, not knowing where else to turn.

But not only did the chaplain mediate acceptance and compassion to Mrs. S, she in turn mediated her trust and acceptance. Finally, she even cared for the chaplain, telling her not to worry. She was able to heal the chaplain’s revulsion, and the bond that was created between the two became sacred and full of the presence of God.

Case study 4

Mr. G, a 59-year-old leukemia patient, has received one bone marrow transplant which his body has rejected. Now he is experiencing problems from a second transplant. Gradually, over a period of about three months, more and more of his body functions have failed.

When I first meet the patient and his wife, he is bed-bound, needs to be turned, and hardly can speak. His room looks comfortable and inviting, almost like a home. Mrs. G has brought a lot of things in order to make the environment in which she and her husband have "lived" for such a long time a little nicer. Mrs. G begins the conversation with a report about her husband’s medical condition to which I respond,

C1: That is quite a story. It must be hard for you.

W1: It is.

C2: Do you still expect him to get better?

W2: To be quite honest, I don’t. Of course you always hope, but I don’t think so anymore. We have been here since January, and everything has gotten worse.

C3: It’s a lot to carry! I guess you were not really prepared for this.

W3: We were prepared for either the one way or the other way but not for the one in between.

C4: You mean either the way of dying or of surviving?

W4: Yes. But we were not prepared for this.

C5: A long term disability.

W5: Yes.

C6: You seem to deal well with it. I mean, you speak quite rationally about it. (I found that she talked about this situation in a way that showed that she had dealt with it a lot and she somehow appeared calm to me.)

W6: I know, people say this. But behind the front there is a lot.

C7: I am sure there is.

W7: I was always this doer type. I liked to do things, kept myself busy, worked in rehab, and other things. I just had learned a bit to be more. There is this picture of Mary and Martha in the Bible. I think a lot about it. You know Jesus says Mary is as good as Martha, and her way also is valuable. He treasures it even more in this story. And I had a hard time with it—to let things go and just to be.

C8: And now that is not possible.

W8: Yes, it’s really helpful that we are talking. This picture was on my mind a lot last week.

C9: When I came into the room and saw how you behaved and the way you spoke to your husband, and when I saw the peace you radiated, I thought, what a beautiful person. She is just who she is and with this she gives so much to her husband.

W9: (cries) Thank you for telling me.

C10: It’s really what I thought, and I am surprised now that you have told me your story.

W10: I must have learned something.

C11: Yes, you probably did. Otherwise, I would not have gotten this impression.

W11: (smiles)

C12: Something just came to my mind. I have no idea how it fits with the Mary and Martha story, but there might be a connection. When ado-
lесcents who try to become independent from their parents get ill, they often become dependent on their parents again. They don't want this, and yet they need it. They struggle because they want to be independent, and they are forced to be what they no longer want to be. Maybe the point I want to make is that you find yourself again in the role you don't want to be in, and this might feel threatening to you.

W12: I guess that's it. And I also think we get things presented in life again and again to learn.

C13: So this might be a major teaching now?

W13: It probably is.

C14: And knowing this doesn't make it easier!

W14: No, I guess not. But it reminds me that I still have to find my way to do things now. There is so much that needs to have a solution: all these bills, my son, my husband. I stopped working because I could no longer manage everything. I probably have to let go more. But that's not easy for me.

C15: Do you have any help in this?

W15: That's also a hard thing. My husband was my best friend too. (cries)

C16: And now you miss your best friend as well?

W16: Yes, I do. I am a very private person. I have friends, and they call and offer support. But there are not many, and I don't talk much about it.

C17: You must feel very lonely.

W17: I do. I made an appointment for counseling for me and my son. I think we need it.

C18: Good. I hope this helps you.

W18: And I pray a lot and think about everything.

C19: I can tell you have thought a lot about it. You speak with so much depth.

W19: (smiles) It's good to talk about this with you.

At this point, I talk a little to her husband and offer each of them a prayer.

Mr. G dies one week later in the ICU. His wife is supported by her pastor and friends.

In this case, the chaplain mediated presence and care, especially to the patient's wife. In a quite self-disclosing way, Mrs. G acknowledged that she felt isolated in what she was going through.

She communicated that she looked for religious support in her struggle. In a beautiful way, she connected her personality and her everyday life critically with the biblical story of Mary and Martha. She expressed how much she had tried to become Mary, whom she saw as her inner self, but how she often became stuck in the Martha figure.

In looking at this story, the chaplain had the sense that Mrs. G was not only grieving about the situation she was in, but that she also felt threatened by it. It seemed to force her back into a role she did not want to be in anymore. When the chaplain communicated this idea to Mrs. G, she agreed with it. In this, the chaplain mediated understanding to her.