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From the Editors
William R. DeLong • Rozann Allyn Shackleton

General Articles
Charles Christie
Beyond Hospital Walls:
Gwinnett Health System Moves
Chaplaincy into the Community

Katrin Wunderwald
Mediation and Advocacy in Chaplaincy

Kay Miller
Making the Rounds with the Pastoral Care Dog

Focus: Chaplaincy and CPE
Alexander Tartaglia • Paula Ropeclewski
Nancy Hauser • et al
Staff Chaplains as Educators:
The Clinical Pastoral Education Program at
Virginia Commonwealth University

George Handzo • Margot Hover
What a Pair!
Department Director and CPE Supervisor
Collaborate at Memorial Sloan-Kettering

Essay
Georgia Gojmerac-Leiner
God Does Not Give Me More Than I Can Handle

On Holy Ground
William Shirk
19 y.o. white male, m.v.a.

Susan Simonds Yutzy
One Too Many

Dialogue

In the Literature
W. Noel Brown

Expression of Faith
Dick Millsbaugh
One Vision. . .

Chaplaincy Today, the Journal of the Association of Professional Chaplains, is a semiannual publication whose mission and vision is to connect all of us who do the work of chaplaincy by giving voice to the individual expression of our collective experience in order that we may more effectively care both for others and for ourselves.

. . . Two Voices

Editors

The last issue of Chaplaincy Today was sent to print before September 11, 2001. Almost three months after those events, I feel obligated to speak to all of our readers about that tragedy. I, like you, can remember the shock, disbelief, and horror I felt as I saw videotape replay the ending of thousands of lives. As I learned more about the cultural, political, and religious beliefs of the men who carried out these acts, I wondered about our role as pastoral care providers.

In the days and weeks that followed I was aware of many of our interfaith organizations working to assist families, healthcare workers, police, and firefighters. I was impressed with the reports that came in about chaplains in the New York area responding to many of those touched by this tragedy. I was aware of chaplains in hospitals all over the country leading interfaith prayer services for hospital employees.

I live almost in the center of our country, hundreds of miles from New York, and I have no personal connection to the events that took place there. Yet, I felt a part of this tragedy. My mind calculated the distance between my daughter’s apartment and the WTC at about one mile while at the same time registering the fact that she should be on her way to work uptown or, hopefully, already at the office.

As one who serves a hospital in suburban Chicago, half a country away from the sites of the September 11 tragedies, I have found that I, and indeed many of my colleagues, have a foot in two worlds.

On that particular Tuesday morning, there was the immediate reality of the woman sitting next to me in the ICU waiting room, whose mother teetered at the edge of cardiac arrest. As the daughter told me of the ER doctor’s unexpected diagnosis of a terminal condition and his conclusion that her mother only had a few weeks to live, the television screen before us recorded the crash of the second plane into the south tower of the World Trade Center.

My mind calculated the distance between my daughter’s apartment and the WTC at about one mile while at the same time registering the fact that she should be on her way to work uptown or, hopefully, already at the office.

There was no time for further speculation. My focus returned to the woman next to me, to her mother’s precarious
York City; Washington, DC; and Pittsburgh. Yet, on that day, I counseled four employees in our hospital who had family or dear friends in the Trade Towers or at the Pentagon. I was reminded again of how closely interwoven we are as a national family, as a human family. I was reminded again of the special calling and training of professional chaplains that let them work well in the midst of this kind of shock and despair. In all, I was gratified to be a part of an organization of people dedicated to caring for others in the bleakest hours of their lives.

**Chaplaincy Today** will be devoting an upcoming issue on the many ways that chaplains work with disaster. Whether it be a disaster created by flooding, earthquake, or the result of human hands, chaplains around the world respond at those times. I encourage you to reflect upon your recent or past events in working with those forever changed by disaster. What encouraged you? What informed your pastoral care practice? What sustained you?

In the mean time, most of us continue the daily care for the sick and the dying. My hope is that these events have caused you to reflect again on what keeps you in this form of ministry. I hope you are finding within yourself a rekindled commitment to our profession, our calling, and the people whom we serve. The Journal in your hands is committed to assisting you to do that work the best way you know how.

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Rozann’s voice...

Rozann’s voice...

condition, to contacting her pastor, and to obtaining some food to sustain her through her watch.

Throughout the day, I observed my fellow staff members move in much the same fashion: voicing concerns for family and friends living in New York, Washington, or Pennsylvania; weeping throughout a prayer service; asking, “How will I explain this to my children?”; and then swallowing their fears, drying their tears, and returning to care for the patients in their charge.

This split psyche feeling lingered a week later as I flew over the eastern half of the country on my way to New York. The Bette Midler song, “From a Distance,” echoed in my mind, and I was amazed at how peaceful things looked from thirty thousand feet.

Even walking the streets around my daughter’s apartment revealed little of what was taking place further south. To the casual observer it appeared as though people were going about their business as usual, as if nothing had changed—at least until one noticed the flyers taped to every available space and was reminded that each represented a loved one still unaccounted for.

Weeks later, as I write this looking out at an oak tree which stubbornly clings to its leaves, the feeling remains. The peace that pervades my small space seems farther than ever from the wider world.

It is often said that each generation has its defining moment when innocence is lost forever, the moment that is recalled by what one was doing “when....” For my parents it was Pearl Harbor, for me it was John F. Kennedy’s assassination, for my daughter it undoubtedly will be September 11, 2001.

May the pages of this journal continue to explore the effects of such moments both on who we are and on what we do.

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Beyond Hospital Walls:
Gwinnett Health System Takes Chaplaincy into the Community

Charles Christie

Early on a Monday morning our chaplaincy staff responded to a call to attend to the family of a cardiac arrest victim. This is not unusual; it is what chaplains do in most settings. However, what happened next was somewhat unusual although it is becoming a model for our chaplaincy department as we continue to look for ways to reach out to our community.

Our hospital system is a not-for-profit health system with a strong sense of community. Hospital leadership has fostered a sense of promoting health in the community. In fact, one of the five corporate values is “service to the community.” The chaplaincy staff has been part of this initiative, making ourselves available to churches, schools, and other groups. We lead grief groups in local schools, speak to church and community groups on end-of-life issues, provide supervised ministry settings for local seminary students, cross-train and help with the police and fire critical incident stress management teams, and provide critical incident stress management services to schools and businesses when asked. We have always seen outreach to the community within our mission as a health system as well as our calling as chaplains. Chaplains have unique gifts, training, and expertise which may be helpful beyond hospital and institutional walls.

Chaplains have unique gifts, training, and experience which may be of benefit beyond institutional walls. In an effort to add value to their institutions, chaplains can look for opportunities to provide “community chaplaincy.” One such opportunity for community chaplaincy is in the area of critical incident response. This article outlines the response of chaplains in one institution to a local business which experienced a workplace death. This intervention may serve as a model and inspiration for future opportunities as chaplains make themselves available to the community on behalf of their institutions.

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A death in the workplace

This particular Monday began like any other at the office/warehouse of a local business with workers arriving, catching up, and starting the business day. In a large room with office cubicles, they were just starting work when one of their coworkers fell in the aisle next to her desk. As coworkers rushed to lend aid, they thought she had fainted but found her to be pulseless and not breathing. According to plans in place, first responders from the work force quickly began CPR. Others lent what aid they could: someone called 911; someone else ran to the parking lot to flag down the paramedics and direct them into the building; the others looked on in horror, watching their friend and coworker of fifteen years dying despite everyone’s best efforts. After what seemed like an eternity, the paramedics took over and transported her to the ambulance. The associates who had not heard what was going on now saw the stretcher go out with their coworker, CPR in progress.

The human resources (HR) director followed her associate to the hospital to assist with information and render aid to the family. When she returned to work, the HR director looked for ways to help her associates. This horrific scene and subsequent death had left palpable effects among the work force. Those witnesses were obviously suffering the effects of traumatic stress, and shock waves had reverberated throughout this building of more than one hundred associates.

The community relations arm of our health system’s psychiatric unit had recently provided a Drug Free Workplace Program, and the HR director had the name of our community relations representative. When the HR director asked for assistance for her associates, our community relations representative thought of the health system’s Critical Incident Stress Management Team.

Chaplains respond with critical incident stress debriefing

In addition to being a staff chaplain, I serve as the clinical director of this team. I was put in touch with the HR director to act as consultant and coordinate assistance for her associates. There was no question that we would help in whatever way we could.

Our team uses a debriefing model developed by Dr. Jeffery Mitchell. While the critical incident stress debriefing (CISD) is the centerpiece of a critical incident stress management program, it is not a stand-alone response to critical incident stress. A critical incident stress management team uses many tools to mitigate the effects of critical incident stress. In fact, the response presented here is an example of how a critical incident team can use several tools, including the CISD.

A critical incident is any incident which might overwhelm persons’ normal ability to cope and function in their normal activities and roles. While the CISD model is usually reserved for use with emergency workers, it can be adapted for use with the public. Cardiac arrests may be nearly daily occurrences for paramedics and emergency room staff, however they are highly unusual for persons outside emergency services. Certainly the stress of witnessing and experiencing the death of their coworker constituted a critical incident.” Early on we were cognizant, not only of the critical incident stress, but also of the grief which many coworkers would experience. In our consultations with the HR director, we were sensitive to the deep sense of loss experienced with the death of this well-liked, long-time associate.

While this was a very significant loss, the business was part of an international company and could not close during debriefings. Also, there were potentially 60-100 associates who might wish participate in debriefings, far too many for one or two meetings. With the HR director’s approval, we decided to hold three debriefings the morning after the death of the associate.

The first debriefing was for the associate’s closest friends and coworkers as well as the first responders and caregivers, who attempted to resuscitate their friend. The second debriefing was for those who worked near the associate or who interacted with her in their duties. The third debriefing was for anyone else who wanted to come. All of these meetings were voluntary, and while most in the first meeting were specifically invited, it was understood that one could attend any one of the debriefings, depending on time and comfort level.
The debriefings were very well attended. The depth of feeling expressed was remarkable. CISD follows a seven-stage process in which the participants are guided from facts, to thoughts, to feelings, back to thoughts, and then facts again. The hope is to guide people into the affective dimension and return them to “solid footing,” all the while normalizing their feelings. Many persons who experience strong affective reactions after trauma feel isolated. Often they also feel they should be able to manage anything and may feel “crazy” if their thoughts and feelings are uncontrolled. It is incredibly affirming to meet with others who feel much like oneself. A constant reminder to participants in debriefings is, “you are a normal person having normal reactions to an abnormal event.”

Our response team consisted of two chaplains and a former psychiatric nurse who is now in community relations. All are part of our CISD team and familiar with the process. We all had worked together in hospital and community debriefings. Our team served as consultants to the HR director, offering suggestions in addition to the debriefings. In the education phase of the debriefings we provided significant information on grief and loss, including what to expect and suggestions for coping. The team provided contact numbers for individual follow-up if needed.

The education phase of the debriefing can be a place where participants explore ways of self care. The leaders offer some standard stress management skills and information which are important; however, the participants may have excellent ideas for their particular situation. As we worked with the debriefing groups, some themes began to develop. Certainly issues of critical incident stress were evident. However, as chaplains we were especially sensitive to issues of grief and loss.

**CISD program is tailored to specific needs**

One of the ideas which sprang from the group and HR director was the idea of a “time out” room. For a week or so, the company agreed to provide a space where associates could go for brief periods if they felt overwhelmed. It was understood that associates would be able to go there without being asked if they were O.K. or explain why they were there.

Another issue explored by the groups was how to reorganize the work space. We discussed how the family could retrieve personal effects and how to leave the work space. Included in this discussion was the inevitable issue of replacing the associate.

The group setting provided a safe forum to express otherwise inexpressible issues. The group was able to ask questions which many had but were afraid to address individually. This also provided a service to HR and management as associates were allowed to participate in some of the discussion. They already felt disempowered by the fragility of life. Having management make arbitrary decisions about such basic questions as what to do with their friend’s personal items would have added to this feeling.

The theme which seemed to be most striking was the “broken-off” nature of this loss. CISD validates and normalizes one’s loss of control in the face of horrific experiences. However, we also were aware the sense of disenfranchised grief and loss. Normal rituals around death and loss pay attention to the family and home and often do not give voice to friends and coworkers when the reality is that many of us spend more time with our coworkers than our families. At funeral services, a place of honor is given to a third cousin from another state while the coworker of the deceased must stand in the back of the chapel. What we heard from the associates was their keen sense of loss. Some of these people had worked with the deceased eight hours a day, five days a week, for over fifteen years. They knew about her family, her loves, her likes and dislikes. Yet there was little opportunity to have their loss validated or to say as a group what this loss meant.

CISD is an effective vehicle for managing traumatic stress, and group work is also a vital tool in working through grief and loss. However, an equally vital aid in healing is ritual. As chaplains and ministers we have an ear and sense for ritual and community, and this situation seemed to cry out for such an avenue of expression.

Most forms of crisis intervention and grief work are “talking cures.” While expressing one’s feelings and gaining cognitive understanding is important, an
act or task can make a direct connection with the unconscious. The ritual act thus becomes an avenue to connect themes which may never be expressed in words.

This sudden loss of a coworker had broken into the workplace community and raised far too many issues to be dealt with solely by talking. Group ritual offered a way to acknowledge the loss and begin to incorporate it into the life of the community.

Providing a memorial service

About two weeks after the debriefings the HR director contacted our department about planning a memorial tree planting. We planned a nonsectarian service of dedication with attention to the lost associate, corporate loss, and sense of spirituality which joins all who feel loss. We invited the associate’s family to attend the service, which allowed coworkers to participate by sharing stories, memories, or words about their coworker.

As chaplains, we represent “the community of faith”; however, we do not have to represent any particular brand of faith. In this way, we were able to go to a place of business in which a diverse group of persons felt a strong sense of community and to celebrate their shared sense of spirituality without endorsing any particular religion or spirituality.

We asked that the tree be placed in its hole prior to the service with its roots left uncovered. We planned to have the associates and family finish planting the tree at the close of the service. Upon our arrival, we learned that the shovel had been forgotten.

A ritual is a very conscious act which pays special attention to the needs of its participants. The intention is to provide a vehicle for unconscious connections and expression, and a well-planned ritual provides the setting for serendipitous moments.

As the service began, each person was given a twig, and every third or fourth person was given a piece of rough string. The homily or lesson was a story in which participants were asked to tie their twigs together in bundles of three or four and asked to try and break the bundles. Of course, a bundle of twigs is much stronger than a single twig. During the benediction, the groups held the bundles of twigs high with hands joined as the blessing was spoken. Afterward they were invited to come and lay their bundles at the foot of the tree. As we had no shovel, we ended the invitation here.

As participants brought their bundles of twigs to the tree, instead of just laying the bundles down, they carefully placed them in the hole around the root-ball. Then, as if on cue, several coworkers got down on their knees and began to rake dirt over the bundles with their bare hands. Everyone gathered around as the bundles of twigs were tenderly planted by hand along with the tree.

Conclusion

Certainly, even in this case a group of mental health professionals could have conducted the debriefings, and local clergy could have provided a memorial service. However, as chaplains who live and work with crisis, death, and spirituality every day, we offer unique perspectives. Very few mental health professionals have the exposure and experience of health care chaplains to crisis situations and death and dying. As chaplains, we also see and experience much more in the way of critical incidents than local clergy do. We also were able to bring a nonsectarianism to this situation which local clergy from a particular congregation could not. Critical incidents such as the cardiac arrest and death of this associate bring many issues and questions which chaplains are uniquely equipped to address. Attending not just to religious questions, but to the broader spiritual questions and issues which crisis situations raise is what chaplains do every day. In this case we were able to validate the kinship of loss, sense of vulnerability, fragility and sacredness of life and also to facilitate a corporate expression of these very spiritual issues.

This case is just one example of how chaplains can make themselves available to the communities in which their institutions are located. In fact, chaplains may be an important untapped resource for both their institutions as well as their communities. All of us feel the need to see as many patients as possible and may even be pressured by our institutions to do so. However, we sell ourselves short if we limit our vision to those within our hospital walls. Health care chaplains are experts...
in crisis care, death and dying, grief issues, conflict resolution, and spirituality.

This particular business would never have been able to have its own institutional chaplain, but we were able to provide that service in the name of our health system. By being who we are and doing what we do best, chaplains can add tremendous value both to the institutions and to the communities in which they serve.

References


2 Ibid., 2.


Mediation and Advocacy in Chaplaincy

Katrin Wunderwald

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.

In The Jewish Doctrine of Mediation, William Oesterley 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)?" 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)."

Oesterley 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, Oesterley 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.

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 for 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.

In later Jewish concepts, Oesterley 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."10

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.\(^{11}\)

Sometimes mediation can end after this, because “simply hearing the adversary’s story is all that is needed to resolve the conflict.”\(^{12}\) 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.\(^{13}\) 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.\(^{14}\)

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.

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. Henri Nouwen introduced a newer model with his image of the “wounded healer” where he emphasizes the empathic nature of the chaplain. Heide Faber compares the chaplain with the “clown” who represents a different order with a “personal dimension.” 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. 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, “Compas-
sion 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-
articulate 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."34

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.35 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.36

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.37

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."38

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."39 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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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 a chance 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 pus 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 a 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-
lescents 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.
Making the Rounds with the Pastoral Care Dog

Kay Miller

The use of animals in therapeutic settings has been around a long time. Greek mythology tells us that a centaur (half-man, half-horse) was the first physician. We have grave figures from China, dated before Christ's birth, which depict dogs in harnesses and indicate that those dogs were "working" at some useful function, perhaps therapeutic.

In 1792, a Quaker merchant in England used farm animals in the treatment of the emotionally ill. Less than a century later in Germany, pets were used to treat epileptics as it was found that dogs can communicate an impending seizure before it actually occurs.

At the end of World War II, the American Red Cross used dogs, horses, and farm animals in the rehabilitation of airmen. In the 1960s, a blind man in Norway used dogs and horses to encourage blind and otherwise disabled patients to exercise.

Also in the sixties, Boris Levinson, a child psychologist, used companion animals as part of a diagnostic and therapeutic technique. He also surveyed his colleagues and found that most either used animals therapeutically or recommended pets to their outpatients. In addition, the majority felt that animals could be used to treat adjustment problems of children and adolescents.

Approximately a decade later, Samuel and Elizabeth Corson conducted studies in a psychiatric institutional set-

The chaplain-author, who also is a licensed therapy dog handler, documents her pastoral care visits to patients experiencing difficulty in communication for a variety of reasons. The article includes a review of research that indicates the physical and emotional benefits of interaction with animals, parameters for the pastoral care dog visits, anecdotal cases, and criteria for successful replication of the program.

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ting where individual animals, mostly dogs, were used on a one-to-one basis with each patient. They reported that although patients in their study had not responded to other types of therapy, e.g., psychotherapy, drugs, electroshock, occupational, recreational, only 6 percent failed to respond to the animal therapy.

Alan Beck and Aaron Katcher have documented the therapeutic benefits of animal companionship:

Patients who are unwilling to approach or talk to a therapist are able to reach out to an animal. After playing with, touching, and talking to the animal, they begin to talk to humans again.

Beck and Katcher reported a number of other findings:

1. Almost everybody with a pet talks to it as if it were a person, and the way people talk to cats, dogs, and birds resembles the way we talk to infants.

2. While talking to people usually raises blood pressure, sometimes to very high levels, the touch-talk dialogue we establish with pets reduces stress and lowers blood pressure.

3. Just having a pet in a room makes people feel safer and lowers blood pressure.

4. People with pets make fewer doctor visits.

5. Pets can coax smiles and words out of socially withdrawn institutionalized patients of all ages.

6. Pets can make psychotherapy progress faster.

According to Beck and Katcher, 99 percent of the clients at the University of Pennsylvania veterinary clinic said that they talked to their pets. Over 30 percent said they confided in their pets. Most of the children who talked to their pets believed that the pets understood the meaning of the words they were using. More than 70 percent of adolescents owning horses confided in the horse.

Further, relationships with animals have been shown to have favorable effects on patients with heart disease. A study of heart disease conducted from 1977 to 1979 at the University of Maryland found that pet ownership was one of the best predictors of survival for patients with heart disease.

In a large Australian study of animals and cardiovascular health, Gregory L. R. Jennings, Christopher M. Reid, Irene Christy, et al reported, cardiovascular risk factors were examined in 5,741 healthy participants attending a screening service. Pet owners had significantly lower systolic blood pressure and plasma triglycerides than nonowners. There were also significantly lower cholesterol values in men but not in women.

This group also reported on the 1994 Australian People and Pet Survey, which included an actual calculation of money saved through fewer doctor visits, hospitalizations, and use of pharmaceuticals as a result of pet ownership. Obviously, many people feel comfortable and receive benefit from communicating with animals.

Even more important, perhaps, is the emotional effect pets have on humans:

When people face real adversity—disease, unemployment, or the disabilities of age—affection from a pet takes on new meaning. Then the pet's continuing affection is a sign that the essence of the person has not been damaged.

Research showing the health benefits of pet ownership and interaction with animals is voluminous. Others have studied the use of animals in the psychotherapeutic setting and shown that animals can enable patients to communicate more effectively; however, there is a dearth of research in the pastoral care setting. Based upon the findings from other communications-type research, one would expect that animals also would facilitate pastoral care communications in a hospital setting.

The pastoral care dog project

The hypothesis for this study was that an animal, in this case a trained therapy dog named Scruffy, can aid in the chaplain's delivery of pastoral care and can serve as a "bridge" to restore normal human communication when such communication has been disrupted for some reason.

The study involved a team of one chaplain intern and her trained therapy dog working for four months during the chaplain's
Staff members were invited to make referrals at any time by calling a designated digital pager number. The patient was visited as soon as possible following referral, generally within one hour. During the visit, the dog was used in whatever manner was deemed appropriate by the chaplain/handler.

Visits were made only when the dog was completely clean, healthy, comfortable, and happy. No visits were made to patients with open wounds. Standard precautions were incorporated for all visits as follows:

1. Thorough hand washing by the chaplain/handler before and after each visit
2. Application of dander remover to the dog immediately before visiting
3. Application of a light coat of hand-sanitizing gel to the dog between visits
4. Use of draw sheets or other hospital linens to cover any area where the dog was placed, e.g., patient's bed or bedside chair
5. Immediate removal of used linens after the visit and their placement in laundry hampers

Additional precautions were taken within the Intensive Care Unit (ICU). Prior to the visit, the patient's nurse indicated the location of all IV lines and catheters to the chaplain/handler. After the visit, the nurse washed any part of the patient which had come in contact with the dog.

Each visit was documented in the following manner:

1. Date and number of the visit, e.g., first, second, third
2. Patient's referral category, e.g., depressed mood, anger, communication problem, coma
3. Anecdotal description of the visit, written by the chaplain, which included observations by other professionals, e.g., physicians, nurses, chaplains, social workers

At the end of the study period, patient records were grouped two ways: by number of visits, to determine whether the number of visits affected the outcome, and by referral category, to determine whether any particular type of patient was more likely to respond to the "dog as bridge" hypothesis.

**Study observations**

Twenty-three patients and four family members were visited during this study. A total of seventy-five visits were made to patients, with each patient receiving from one to seven visits. None of the visits was found to affect a patient's communication with others in a negative way.

Although the overall assessments were subjective, with one exception, the eleven patients who were visited two or more times showed increasingly positive responses to the pastoral care dog. The exact number of visits did not appear to be a factor.

Of the three patients who were referred for highly physical reasons (two for coma and one for a physical impediment to communication), no change was noted after the initial visit.
Observers did not note positive changes on succeeding visits.

The four family members appeared to benefit as much as the patients and should be considered appropriate recipients for this kind of care.

Many patients enjoyed reminiscing about their own pets as they stroked Scruffy and talked to her. Several who had not been cooperative with physical/occupational therapy prior to visits from the pastoral care dog returned to active participation in the exercises.

Further anecdotal observations

Case 1

While Mr. J was in the hospital to have his shoulder repaired, his wife died unexpectedly. He refused to discuss her death with family members or staff. They had had a long happy marriage, and their three children were grown and married.

When the children tried to talk about their mother and her death, Mr. J informed them that he did not want them to wait until his discharge for the funeral arrangements and burial, and said that he would discuss nothing more about her. He refused to reminisce, to express any emotion, or to allow those around him to express their emotions. He insisted, “I refuse to deal with any of that now. I will handle it when I get home. Now talk about something else.”

The children were very frustrated with him—saying that this just wasn’t like him, that he normally shared his feelings rather freely. Hospital chaplains as well as the family’s religious leaders and a psychologist all visited with Mr. J. In each of these cases, his response was the same as it had been with his children. It was simply not a topic for conversation. He was always very pleasant and very willing to discuss any subject except his wife or death in general. “I’ll deal with that when I get home!” was his only response.

Knowing that he owned a dog, we decided to try our Pastoral Care Dog, Scruffy. Arriving at his door, I said, “Mr. J, I thought you might like to see my dog.” He responded, “Ah, poohchie, come here to Papa!” Almost immediately, he became totally focused on Scruffy, seemingly unaware of my presence even though I sat on a chair about two feet to his side and in front of him. He began by telling Scruffy about his own dog and then progressed to stories about things he and his wife had done with their dog.

Soon he was telling Scruffy about his wife, the things they had done together, and how very much she meant to him. As he talked to Scruffy, she responded appropriately by resting her head on his lap, licking at his hand, and nuzzling into the crook of his arm. The conversation had taken nearly an hour by this point. He had laughed, cried, and smiled. Scruffy seemed to be feeling with him.

Then he said, “That’s why I have to do it, old boy. I just can’t go on without her.” At this, Scruffy pulled away from him and gave him what appeared to be a very disapproving look. He reached for her, but she wouldn’t budge. Finally, he softened and said, “You’re right, old boy. I can’t do it. Anyway, if I did, she’d make heaven a living hell for me. I’ve got to stick around down here for a while more. It’s just not my time yet.” As he said this, Scruffy nuzzled back into his lap. He went on to tell her about the things he was going to do with his grandchildren, planning a fishing trip with them as he talked about how much they still needed him and of his influence on them. Occasionally, he chuckled and said that his wife really would approve of all these things.

After another half hour, he seemed startled, and even frightened, as he said, “But I can’t go on and do these things without you, old boy!” Finally, I spoke, and he seemed shocked that he was not alone with Scruffy. I reminded him that his own dog waited for him at home, and that this dog knew and loved his wife so he should be an even better listener than Scruffy had been. After all, Scruffy had never had the opportunity to meet his wife. He laughed and agreed, thanking me and hugging Scruffy.

The pastoral care nurse who followed Mr. J after his discharge reported that he appeared to be dealing with his grief appropriately. As for Scruffy, this visit left her exhausted. She fell asleep in the car before we got home. Then at home she slept soundly for more than five hours. This kind of “work” is hard on a dog, and a significant recovery period is necessary to avoid burnout.
Case 2

Mr. S's condition was described as terminal. He was in a coma and totally unresponsive to any stimuli. His wife desperately wanted to talk with him before he died. She also said that he always had loved dogs deeply. With her encouragement, we decided to have Scruffy visit him.

I positioned Scruffy at his bedside. Mrs. S took her husband's limp hand and placed it on Scruffy's back. Then, with her hand on top of his, she began moving his fingers through Scruffy's fur. She continued these motions for about five minutes and then left his hand resting on Scruffy's back.

As she and I began to talk, we noticed that Mr. S was moving his fingers by himself. He began to pet Scruffy, and then, using his own strength, he turned on his side and started stroking her with both hands. He opened his eyes, and said, "A dog." Then he looked up at his wife and said, "Jane, I love you." She responded to her husband, and they began having a real conversation. As his focus shifted to his wife, I quietly left with Scruffy.

Mr. S subsequently died as expected, and it is my hope that this final conversation brought peace both to him and to his wife. In this case, Scruffy's extensive training probably made little difference. Any dog that would stand still for an extended period probably would have had the same success.

Case 3

Scruffy and I stayed with one man while life support was withdrawn from his wife. Although the rest of the family wanted to be with her when she died, he said that he could not. While stroking Scruffy's fur, he said, "I never could survive this terrible time if you weren't here with me." Then he sobbed and hugged her.

Case 4

A patient's daughter stopped me in the cafeteria to say, "Mom is in bad shape. I know the only thing that will help her right now is to see Scruffy again!" (We visited immediately.)

Case 5

A woman who had been on life support in the ICU for months admitted that Scruffy was her only reason for living. The Ethics Committee decided that Scruffy was a comfort measure for this woman and that her support should be continued.

Case 6

An ICU physician taking a patient's vital signs as I placed Scruffy on the bed apparently noted a beneficial effect on the patient's heart rate. "I want that dog in bed with my patient every day," he said.

Conclusions

The information gathered through this study supports the hypothesis that the "pastoral care dog" can serve as a communication bridge for people when normal communication has been disrupted. In validating previous research that animals have a generally therapeutic effect, it makes the case for their use in pastoral care.

Additional benefits of Scruffy's presence included the following:

1. The patient's family members and visitors expressed appreciation and seemed comforted.
2. Informal visits with those in the hospital waiting rooms provided distraction as well as soothing comfort.
3. Employee morale appeared to be greatly improved when the dog was in the area. They seemed more understanding of each other and more available to respond happily to patient needs. "Come over here. I need my doggie fix for the day," was often heard.

Although quantitatively significant data were not obtained, the project was deemed a success, and it was decided to utilize the pastoral care dog on a permanent basis. It is the author's hope—and prayer—that other hospitals across the country will adopt this type of program, and she is willing to assist them in that process.

Criteria for a successful program

The following ingredients contribute to a successful Pastoral Care Dog Program:

1. A chaplain experienced both in providing quality pastoral care and in handling the animal
2. A well-trained dog, one with experience as a therapy animal
3. A facility that understands the value of animals in a health care setting

Probably the easiest and least expensive way to acquire these
"ingredients" is to start with a professional chaplain who has a well-loved, obedient dog as a pet and to have them go through obedience training. A formal "team evaluation" by the Delta Society to determine whether the team of chaplain/handler and dog has the skills and aptitude for animal therapy work is the next logical step. Salt Lake Theological Seminary offers a course, titled "Christian Ministry and Animal Assisted Therapy," which provides both the theological background and the practical animal-related skills needed, followed by the formal Delta evaluation administered through Intermountain Therapy Animals.

Following a successful evaluation, the chaplain completes an eight-hour workshop and written test. Finally all this paperwork, together with results of a careful veterinarian examination, a photo of the team, and a membership fee are sent to Delta Society. When the process is completed and an identification badge returned, the team has the professional respectability of meeting nationally accepted standards and also is covered under Delta's one million dollar liability insurance. Often institutions are most interested in the latter.

In addition to this national affiliation, the author also recommends becoming involved with a local animal-assisted therapy organization. The Delta Society can be helpful in locating such groups. The local organization, in turn, can be very useful in providing the chaplain/handler with a supportive network to keep animal-handling skills current. In addition, they help to ensure that the animals are treated well, rather than regarded merely as tools, and advocate for the therapeutic utilization of animals in new facilities.

References
3. Alan Beck and Aaron Katcher, Between Pets and People — The Importance of Animal Companionship (West Lafayette, IN: Purdue University Press, 1996), 94.
4. Ibid., 7.
5. Ibid., 14.
6. Ibid., 3-5.
8. Ibid., 169.

Additional Bibliography
The following two articles continue the exploration of the use of staff chaplains as educators and the delicate balance between maintaining excellence in chaplaincy training programs and providing quality pastoral care to patients, families, and staff.

The program at Virginia Commonwealth University, Richmond, Virginia, incorporates faculty and residents into a comprehensive program of pastoral care for the VCU Health System. At Memorial Sloan-Kettering Cancer Center, New York, New York, the Director and CPE Supervisor of The HealthCare Chaplaincy have forged a successful partnership with clearly delineated areas of responsibility.

Your comments and observations regarding these programs as well as the two which appeared in Chaplaincy Today 17.1 are welcomed.
One department’s evolutionary experience in the use of staff chaplains as educators in Clinical Pastoral Education is described. A comprehensive view of the dynamics inherent in this model also identifies its benefits and limitations. Input from ACPE supervisors, staff chaplains (clinical faculty), and CPE residents is included. Authors maintain that collaboration between supervisors and staff chaplains can enhance the learning experience of residents and contribute to an environment that promotes continual learning and challenges to supervisors and staff chaplains alike. They conclude that this model retains a healthy balance between education and service.

The program of pastoral care at Virginia Commonwealth University, which also encompasses Clinical Pastoral Education (CPE) is complex and somewhat unusual both structurally and educationally. Our department, the Program in Patient Counseling, is an academic unit within the School of Allied Health Professionals. Presently we have eight full-time faculty: three CPE supervisors, one of whom is also department chair and five clinical faculty/staff chaplains. A fourth CPE supervisor is a part-time staff member. Funding for these positions is supported through a combination of health system and university resources. The university provides educational space and academic resources. The health system authorit y provides clinical space and support. One position is grant-funded. In addition, the hospital funds seven stipend resident positions. All faculty and residents together serve as the health system’s Department of Pastoral Care. In that context, clinical faculty and residents provide the majority of direct patient care. Formal education of residents and interns remains primarily within the scope of responsibility of supervisors. The academic chair also provides administrative oversight, serving as the director of pastoral care. This arrangement is formalized through a clinical, educational, research, and service agreement.

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Within the university, the Program in Patient Counseling offers an Intern Certificate, a Graduate Certificate, and a Master of Science degree. The Intern Certificate program parallels the initial unit of CPE and teaches to Level I outcomes. The Graduate Certificate program parallels a three-unit CPE residency year and is focused on the outcomes of Level II CPE. Students in the M.S. program select either a chaplaincy certification/specialization track or a CPE supervision track. This degree teaches to the outcomes appropriate for the student's individual track. Clinical assignments are made within the Virginia Commonwealth University Health System (VCUHS). The CPE programs are accredited by the Association for Clinical Pastoral Education, Inc. (ACPE). Accreditation is held jointly by the university and the health system.

The Department of Pastoral Care provides 24-hour/7-day working coverage. Most chaplains work the day shift Monday through Friday. Two chaplains, one a clinical faculty member and one a rotating resident, work the evening shift. One chaplain, a clinical faculty member, works the night shift. Residents, in rotating 12-hour shifts, cover weekend and holiday hours. In addition, we have a defined backup system with residents serving as primary and faculty providing secondary backup. While they maintain designated clinical unit assignments, our use of CPE interns after hours is limited. All full-unit interns are required to complete eight 12-hour shifts. During the initial four shifts they are paired with either a faculty member or a resident. At that point, they are evaluated according to a clinical and knowledge-of-environment checklist. Once they have passed the checklist, interns are assigned to the remaining four 12-hour shifts in dyads with back-up coverage. On average, we have ten interns each summer and eight in each of the fall and spring academic semesters.

Faculty and residents share pastoral care coverage of the hospitals and clinics. Two of the clinical faculty serve in pediatrics. One is the primary chaplain for pediatrics, working predominantly in the intensive care inpatient arena. The second is dedicated to serving pediatric hematology/oncology patients primarily in the clinics. The fifth full-time clinical faculty member serves as the coordinator and team leader of our organ donation protocol providing concentrated pastoral services to families of neurologically devastated patients. One of the CPE supervisors serves two mornings per week as the chaplain to an off campus ambulatory site. The other supervisors provide pastoral care on an as needed basis. Clinical faculty, residents, and interns have defined clinical responsibilities either established by clinical service or shift. Supervisors do not.

In addition, the department provides considerable leadership in the health system. We provide primary staff support for the health system’s bereavement program. Departmental members are either chair or co-chair of the Ethics Committee, the Patient Rights and Organizational Ethics Committee, the Organ Donation Committee, and the Decedent Affairs Committee.

**Historical use**

It strikes us that, when viewed historically, the use of clinical faculty as educators with residents is a rather recent phenomenon. Nonetheless, we have some well-established practices that were consistently identified by supervisors, clinical faculty, and residents.

CPE has been present at the Medical College of Virginia since the late 1950s; the residency program was introduced soon after. For much of the his-
tory of the department, there has been a clear delineation between academic and clinical responsibility. The faculty (CPE supervisors) focused on education, while residents and interns performed clinical service.

Staff chaplains have been present since 1985 when the first pediatric oncology chaplain was hired. In 1990, a second chaplain was hired. It wasn't until 1993 that both were integrated into the department as clinical faculty. Until that time they worked rather independently of the education program. A third clinical faculty member was added in 1997 and two more in 1999. The intentional use of clinical faculty in the educational mission of our residents has evolved as the department has grown.

- Clinical faculty are always included in the interview process with prospective residents. Intentionally, their focus is to help assess pastoral competence and to identify personal characteristics appropriate for success in a high stress clinical environment.

- Clinical faculty are widely used during orientation for new residents and interns. Their knowledge of the clinical setting as well as the organizational protocols involving chaplains is a critical asset for both supervisors and CPE students. They remain available to residents as resources, providing information on the clinical environment throughout the program.

- Each clinical faculty member brings to the department proficiency related either to a clinical specialty or a theoretical expertise. As such, supervisors make regular use of clinical faculty for didactic presentations. Periodically, they are invited to join clinical seminars when residents present case material related to a specialty area.

- One of our clinical faculty teaches two semester-long academic courses for residents, one in clinical ethics and the other in professional ethics.

- Clinical faculty regularly serve as mentors for residents who are completing required projects. For example, clinical faculty are presently serving as mentors for residents specializing in trauma care and pediatrics. Two others are sharing mentorship of a resident who is facilitating the development of a new Interfaith Committee for the health system.

Viewed historically, clinical faculty were added to a department comprised predominantly of residents. We remain curious about the dynamics of other departments that have added CPE to a staff chaplain model. One interesting aspect of this is that the addition of clinical faculty was the direct result of the positive contribution of residents over the years. Quality resident care helped sell the value of pastoral services and the need for continuity of presence to hospital staff. On the other hand, the advent of clinical faculty impacted the CPE program by elevating the level of competence demanded by the clinical environment. It was this phenomenon that contributed to the decision to limit after-hours responsibility for interns.

**Surveys**

Evaluation of the use of clinical faculty in designed ways always has been a part of our program evaluation process. We began devoting more attention to the relationships in preparation for our recent ACPE site visit. Thus, the faculty eagerly voted to participate in the development of this article in collaboration with the residents who willingly agreed. The primary authors developed separate surveys for all three groups to prompt reflection and facilitate participation. Participants were free to focus on particular elements of the survey and to make additional comments as necessary. Two residents elected to focus on development of this article as their summer project for our class in pastoral care management and leadership. Three full-time supervisors, five clinical chaplains, and eight residents (two of whom recently graduated from the program) completed surveys. Shared primary authorship was offered to anyone who elected to write a significant portion. It was understood that everyone who participated would be acknowledged as a contributor to the article.

**Survey content**

The intentional use of clinical faculty in the training of residents, described in the previous section, was consistently identi-
fied in the survey results. The CPE residents who participated in the survey readily indicated that they received valuable clinical education and support from the clinical faculty at the VCUHS. These faculty members provide orientation to hospital units and protocols, offer mentorship for learning projects, and give guidance and consultation on pastoral care issues. The surveys identified additional dimensions of clinical faculty involvement in the education of residents.

- Residents are able to observe professional pastoral caregivers active in the clinical environment to which they can compare and contrast their clinical skills.

- Clinical faculty serve as spiritual role models. In particular, it was noted that the residents were able to witness first hand how these chaplains live out their faith through their work in the hospital.

- Clinical faculty are experienced as key members of the support system for the residents. It was repeatedly noted that their availability for debriefing and problem solving in difficult, critical incidents was invaluable.

- Residents identified the willingness of clinical faculty to share experience, theoretical understanding, and professional resources informally as a very important component in the education of the residents.

- Residents reported that they appreciated and enjoyed a spirit of collegiality with clinical faculty.

- Residents thought that because the clinical faculty were in the field, they could help with integrating the chaplain's position into the health care team and building interdisciplinary relationships, especially with physicians. This stands in contrast to the supervisors, whom the residents tend to see as the providers of the theory and technical skills of pastoral care.

- Residents appreciated the presence of clinical faculty in seminars, especially when they made themselves vulnerable by presenting their own clinical material.

The clinical faculty reported a similar list of contributions to the education of the CPE residents. It is of significance to this investigation that both groups saw the role of clinical faculty in much the same light. There were some noted differences however.

- Clinical faculty indicated a personal goal to provide more didactic experiences for the students. They felt that residents could indeed benefit from more theoretical and practical expertise in their areas of specialization. Time constraints and demanding workloads were identified as deterrents to accomplishing this goal.

- Clinical faculty noted that association with the education of residents has significantly enhanced their ministry skills as educators and mentors. As such, they have expanded their professional identity to include those dimensions. They expressed interest in furthering these skills through more formal teaching opportunities.

- Concerning their relationships with the CPE supervisors, clinical faculty concurred that the educational program would significantly benefit from more involvement of the supervisors in the clinical setting.

There were similar responses concerning the role of clinical faculty in the observations made by supervisors. The supervisors see these faculty members as mentors, valuable assistants to the debriefing process, and providers of clinical expertise and resources for specialized ministry. Theirs is a role that is complementary, collaborative, and supportive of the supervisors who offer technical theory and facilitate integration of personal and professional identity and functioning.

- In the opinion of the supervisors, clinical faculty provide a realistic glimpse of what it is like to be a chaplain in the health care system. They name the skills necessary for success in health care ministry. They become sounding boards for vocational discernment. They model styles of interdisciplinary functioning.

There are a few differing expectations of clinical faculty identified by supervisors:

- Clinical faculty explain their role as mentors, providers of clinical expertise and re-
sources, and assistants to any debriefing process. However, supervisors view the role of clinical faculty in an even more expansive way—as catalysts for resident growth, specifically around personal growing edges. This is particularly evident when clinical faculty are open with residents about their own vulnerabilities.

- Supervisors look to clinical faculty to model styles of leadership and to demonstrate creative opportunities for understanding the breadth and depth of pastoral care.

Primary limitations and benefits

Unclear role expectations and communication problems appear to contribute to the limitations noted by each group of participants. We have noted those most often identified.

- When supervisors and clinical faculty have different philosophies on student learning or standards of pastoral care, residents can get caught in the middle. Residents often utilize both sets of faculty for feedback and can feel conflicted when differing opinions on the resolution of clinical issues are received. The impact on education can be confusion, immobility, or taking the easier, and often more secure, path.

- Supervisory interventions with residents are not always within the purview of clinical faculty. Gaps in communication or respect for student privacy sometimes leave clinical faculty unaware of resident growing edges and the applicability of supervisory feedback on pastoral functioning.

- Mentorship provided by clinical faculty is inconsistent. Workload demands require clinical faculty to prioritize their commitments in favor of ministry to patients, families, and staff. In addition, service responsibilities by clinical faculty vary, with only two clinical faculty assigned to units also serviced by residents.

- Our department experiences tension between supervisors and clinical faculty over supervisors’ attention to and participation in the delivery of service. Residents can receive mixed messages regarding priorities and balancing of professional responsibilities.

- At times, residents feel constrained by clinical faculty. Premature interventions by clinical faculty can leave residents feeling undermined, threatening their autonomy and authority. In some areas, staff will bypass residents and go directly to faculty for assistance in problem resolution.

- Tension can exist for residents when they feel overshadowed by clinical faculty. A noted stressor for residents is the burden they place upon themselves to function at the same level of clinical competence as experienced chaplains.

- Within the clinical areas shared by faculty and residents, tension can result from unclear expectations and division of responsibilities.

- Clinical faculty can model poor self-care, creating tension within a resident’s own ability to value self-care. Residents experience a double message when this occurs, learn to care for yourself and place the needs of the organization above your own.

There tends to be, however, a greater degree of benefit experienced when clinical faculty are involved in the resident’s educational journey. In addition to aspects noted previously the following were highlighted.

- Generally, clinical faculty readily affirm the contributions by residents to the delivery of pastoral care service. Residents truly feel that support.

- Clinical faculty tend to be more sensitive to resident stressors displaying an awareness of the emotional impact of providing pastoral care in our environment. They provide the majority of debriefing for residents during stressful and/or critical events. In addition, they often will advocate for residents with supervisors.

- Clinical faculty offer their expertise as active pastoral care givers to which students are able to compare their own clinical skills.
The blended model of using clinical faculty and residents contributes to an atmosphere that promotes learning and professional development by all parties.

As noted in the surveys, the resident experience is enriched by the expertise in specific clinical areas, hospital protocol, and professional behavior modeling provided by clinical faculty. Much clinical insight is imparted through didactic presentations by clinical faculty, providing the opportunity for residents to practice their ministry more effectively.

Residents are encouraged to see a variety of theological perspectives and methods of applying theology to practice. They also get to witness the application of faith to practice through the shadowing of clinical faculty.

When supervisors and clinical faculty work well together, residents experience an integrated pastoral care team mutually beneficial to one another with respect and regard for one another's function in the teaching-learning clinical environment.

Since clinical faculty have more opportunity to observe residents within the clinical setting, they often provide valuable feedback for supervisors to incorporate into their teaching.

All agree that the collaborative efforts of clinical faculty and residents contribute to a high level of pastoral care from which the patients, their families, and the other hospital staff benefit tremendously. The educational program cannot help but benefit as the students get a firsthand opportunity to see good pastoral care in action and to implement these skills into their own ministry and pastoral identity. Clinical faculty cannot help but benefit from an environment that values learning, encourages risk and experimentation, and seeks to integrate theory and practice in ministry. Supervisors benefit from the challenge of clinical faculty to remain current with a changing health care environment that demands expanded knowledge and skill.

Analysis: themes and insights

Ambivalence

What have we learned? What can we carry forward? What challenges continue to present themselves? In reviewing the contribution of the three components of our program a number of themes stand out.

Peership

The department is faced with power and authority imbalances. It appears that residents seek and expect peership with clinical faculty but not so much with supervisors. Residents want to be treated as equals in the clinical environment. They tend to seek autonomy and want to establish their own authority. However, they can confuse being equal with having the same responsibility or doing the same thing. Curiously, when residents become stressed and the clinical demands are high, their hostility becomes directed at the clinical faculty. This occurs even though the clinical faculty cover the majority of the most critical patient care areas most of the time. Further, residents rarely get angry toward the supervisors who do little clinical coverage. Perhaps it feels safer. Residents are not alone in this. The parallel is that the clinical faculty share some of the same angry feelings toward the supervisors. The supervisors want to make use of clinical faculty effort to support their teaching but do not offer to share a comparable effort toward supporting patient care. Of course, all of this occurs dynamically even though position descriptions clearly delineate responsibilities.
Resident issues even as personal/professional learning issues arise in the clinical setting.

Production versus process

The tension within this theme appears to primarily affect the relationship between clinical faculty and supervisors. Clinical faculty tend to be more focused on work getting done, and supervisors on learning occurring. Supervisors have a tendency to treat failures or mistakes by residents less as problems and more as learning opportunities. Clinical faculty primarily focus on professional competence, whereas supervisors tend to focus foremost on professional identity and development. This tension is endemic to CPE, which by definition is an educational methodology charged with teaching clinical competence. While everyone would agree that these are both/and not either/or issues, the differences in philosophical emphasis do create tensions when it comes to resolving certain pastoral care dilemmas with residents. One clear example of this is a sense of urgency in getting problems addressed that tends to be greater for clinical faculty than for supervisors.

Accountability

To those of us who understand the dynamics associated with the clinical rhombus, tensions around accountability seem even more pressing in a model like ours. Clinical faculty accountability is focused primarily on the delivery of pastoral services and responsiveness to staff in the healthcare environment. Supervisors' accountability is focused primarily on the learning goals of students and the use of the clinical environment as a context conducive to resident professional and personal development. Residents often find themselves caught in the middle with shifting priorities, often torn by transitioning from providing clinical service to advocating for their own learning and the reflective time required to attend to it. Turning off all pagers during seminars has helped, but not eliminated, this dilemma. The program chair is charged with facilitating an environment with a creativity that promotes the "both/and" tension. Having dual lines of administrative accountability, the university and the health system, complicates this.

Communication

Our inquiry once again highlighted the fact that the successful incorporation of clinical faculty in the education of CPE residents is clear and consistent communication around expectations, roles, and boundaries. Gaps in communication create confusion, misunderstanding, and mistrust that jeopardize a positive learning environment. Communication between supervisors and clinical faculty helps preserve resident honesty and integrity in facing tough issues. The same communication offers residents a more comprehensive approach to resolving clinical dilemmas.

Postlude

Having summarized our collective thoughts and insights, did we still want to share them? Did we want to risk exposing our vulnerabilities and growing edges? After some discussion, we concluded that the answer had to be yes. Our commitment to process really drove us.

Will our use of clinical faculty in the educational process continue to evolve? This exercise has reinforced our commitment to make it so. The expectations for clinical competence in our environment demand it. Residents and future employers as consumers of our education programs will insist on it. Our hope is that this exercise will continue to focus and energize our department to improve what we have started and to seek new ways to utilize our composite expertise in educating CPE residents.

Authors' note

The following also contributed to this article: Faculty of Virginia Commonwealth University - Jim Bonomo, M.Div., Instructor and Chaplain; Marlyn Cain, Th.M., Assistant Professor and ACPE Supervisor; Ann Charles-Craft, M.Ed., M.Div., Instructor and Chaplain; Ken Faulkner, M.Div., M.A., Assistant Professor and Chaplain; Stephanie Hamilton, M.Div., Instructor and Chaplain; Alma Hassell, M.Div., Instructor and Chaplain; Robert A. Young, Jr., D.Min., Associate Professor and Assistant Chair, ACPE Supervisor; CPE Residents at VCU Health System – Roxanne Cherry, M.P.S., Stephen Coleman, M.Div., Tim Ford, M.A., Jennifer Steele, M.Div., and former CPE Residents Link Elmore M.Div., M.S. and Bambi Willis, M.T.S.
VUCHS Survey – Guidelines for Reflection

Supervisors
1. How do you use staff chaplains in your supervision?
2. What are expectations for the use of staff chaplains in the training of residents?
3. What are the assets and liabilities of using staff chaplains for chaplaincy training?
4. What are the specific benefits to the education of the residents?
5. How would you rate the overall delivery of pastoral care using both staff chaplains and chaplain residents vs. using one or the other?

Staff Chaplains
1. What academic assistance do you provide to the residents?
2. What clinical support do you provide to the residents?
3. What limits the overall effectiveness of your ministry while you are supporting the residents?
4. What strengths do you find in your own ministry by supporting the residents?
5. What are your particular concerns in working with the residents?
6. What model of didactic/clinical training do you incorporate in working with the residents?
7. What model of didactic/clinical training would you like to see incorporated in the learning of residents?
8. How would you describe the collaboration between yourself and the supervisors?
9. Is there anything else you would like to add to this inquiry?

Chaplain Residents
1. Do you receive academic and clinical support from staff chaplains? Yes__ No__
2. What academic and clinical support do you receive?
3. How has your ministry been strengthened through the support of staff chaplains?
4. How has your ministry been limited by the support of staff chaplains?
5. What model of didactic/clinical training would you like to see incorporated for use by staff chaplains to support your learning experience?
6. What has been the most profound contribution by a staff chaplain to your residency?
7. What growing edges do you see in the relationship of staff chaplains and chaplain residents?
8. Comment on your views concerning the contribution of the collaboration of the staff chaplains and supervisors to your education.
What a Pair!
Department Director and CPE Supervisor Collaborate at Memorial Sloan-Kettering

George Handzo • Margot Hover

Within this model of chaplaincy service-CPE program, department director and supervisor each have primary responsibility for certain aspects of the residency—comparable to the management of a parish where the pastor is accountable to the bishop and the parishioners and has administrative responsibility while the parish director of religious education supervises the education mission of the parish. This article explores the advantages (integration into the department and disadvantages (potential for triangulation) of this model and concludes that it is both viable and effective.

Supervising a year-long Clinical Pastoral Education (CPE) residency is a time consuming process that is both emotionally and physically demanding—on chaplaincy staff as well as on students. It is increasingly more difficult and complicated to attend fully to the learning needs of each student as well as to comply with the values, standards, regulations, and culture of the institution and accrediting organizations. Institutions have less and less tolerance for excusing noncompliance with institutional policy on everything from infection control to patient privacy merely because the offender is a student. At the same time, however, students inevitably make mistakes and, with support and supervision, learn from them. On the benefit side of this tension, residents who plan to go on to professional chaplaincy are better served if they have a chance to experience true professional accountability.

The setting

Memorial Sloan-Kettering Cancer Center (MSKCC) is a 480-bed hospital for the diagnosis and treatment of cancer. Its mission includes patient care, research, and education. In addition to the director and the CPE supervisor, the Chaplaincy Service includes one full-time rabbi, one Imam who is shared with several other area hospitals, one staff

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chaplain primarily for presurgery visits, and one part-time secretary, all of whom are provided by and report to The HealthCare Chaplaincy (HCC) under contract with MSKCC. Two Roman Catholic priests are provided by the diocese for full time ministry in the hospital, and others from their religious community respond to calls for a Catholic priest outside of the normal work day.

As with many other hospitals, calls for ministry specifically from Greek Orthodox, Buddhist, and other religious groups are relayed to appropriate area clergy. In general, hospital staff have come to rely heavily on CPE residents in the same way they do on staff chaplains, in contrast to the way in which staff traditionally view medical students. In other words, CPE residents are expected to attend and contribute to unit multi-disciplinary rounds as full-fledged members of each treatment team.

The program

For the past five years, the co-authors, as Chaplaincy Service director and CPE supervisor respectively, have worked closely with each other in the administration of the CPE residency program for HCC. For the first three years of this collaboration, the residents came to the program with at least one prior unit of CPE and usually rotated to one of the other medical centers in the HCC system for part of the residency year. At the conclusion of the residency, they entered either congregational or institutional ministerial positions.

In response to changes in applicant and employer needs, a Specialty Residency curriculum was designed to prepare residents with four prior units or a strong equivalency specifically for careers in health care ministry. One emphasis in this program was the presentation at year's end of a Ministry Specialty paper; a second emphasis was certification by the appropriate professional organization—Association of Professional Chaplains, National Association of Catholic Chaplains, or National Association of Jewish Chaplains.

The close collaboration between department director and CPE supervisor is emphatically not a cosupervisory relationship. It is, rather, two staff members exercising their related but different job responsibilities in relationship to students in the CPE residency program as well as in relationship to the institution. A parallel situation would be the management of a parish where the pastor (department director) is accountable to the bishop (CEO) and the parishioners (patients) and has administrative responsibility for parish life. The pastor facilitates but does not direct or implement the educational mission of the parish. That is the role of the parish director of religious education (CPE supervisor).

At MSKCC, the administration holds each department director responsible for the conduct of every member of that department's service. In the case of the Chaplaincy Service, this responsibility extends to all who have badges identifying them as part of this service—including adjunct community clergy and students. Any problems or complaints about student conduct are referred to the director even though the CPE supervisor is well known and respected. In this structure, it is necessary for the director to have some oversight of the residents in order to be fully accountable to hospital administration.

The basic operational premise of this model is that supervisor and director each have primary responsibility for certain aspects of the residency. However, each at least informs the other at every decision point and usually consults with the other. The supervisor is responsible for soliciting and screening applicants. Interviewing is generally done jointly. Decisions are by consensus with the supervisor's major concern being how the prospective student will use the educational process and fit into the emerging group, and the director's major concern being how the prospective student will function within the hospital and departmental culture. Probably no student would be accepted over either person's strenuous objection although this situation has never occurred. Generally, the supervisor's judgment takes precedence in borderline cases on the theory that she will have the larger problem to live with if an inappropriate student is accepted. The supervisor handles all communication with the prospective and accepted students.

The supervisor designs the curriculum and prepares the students' schedules. The director
may be consulted on possible didactic topics, potential faculty for didactics, and ideas about other hospital grand rounds or events that should be included.

The director also supplies a list of departmental events such as monthly staff meetings that the residents will be expected to attend as well as multidisciplinary rounds on the nursing units to which the residents will be assigned. The supervisor shares a copy of the students' schedules with the director for his information.

Following the basic operational premise as stated above, the supervisor is in charge of orienting students to the education program while the director has a larger role of providing orientation to hospital policies and procedures. The hospital's Training and Development Department runs a half-day orientation for the new residents covering all of the areas mandated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Since student clinical assignments need to take into account both the student's educational needs and the hospital's clinical and political realities, director and supervisor together meet with students after reaching consensus between themselves on which clinical assignments will be offered to which student.

In many ways, students function as staff chaplains. They participate fully in departmental staff meetings and program planning discussions. They share daily and on-call responsibilities with the permanent staff. They are encouraged to work directly with the director with respect to questions of how to relate to the hospital and to other chaplains in terms of clinical issues. For example, they deal directly with the Roman Catholic priest who covers their nursing units on clinical questions. Hopefully, it becomes natural for them to be accountable to the director just as permanent staff members would be.

At the same time, there is no question that their process with the supervisor and with each other is confidential and can in no way be shared with the director or other chaplains. It is made clear to them and repeatedly reinforced that issues that have to do with their educational process, their relationship with their supervisor, and their relationship with each other cannot be discussed outside the group. As students share one office with members of the permanent staff, they must keep issues between them literally in the group room or else they will be overheard.

The education process is run completely by the supervisor. The director might sit in on a didactic or verbatim at the student's invitation. The director would never sit in on supervision sessions, interpersonal relating seminars (IPRs), or evaluations. This separation helps to teach the students about boundaries.

For the most part, director and supervisor cover for each other when one is away, so the students become comfortable dealing with two different people in positions of authority. However, even when the supervisor is away, it is not assumed that the director will do individual or group supervision. In the MSKCC setting, the director as well as other staff chaplains and professionals often are invited to participate in pastoral work seminars and to present didactic seminars in their areas of expertise. Although supervisor and director share information about students' ongoing learning issues and how such issues impact their work, the supervisor deals with supervisory issues primarily in her peer supervision group with other supervisors.

This boundary is fairly easy to define in theory; when both supervisor and director have expertise and training in education and administration, they can be a valuable consultative resource to each other in both arenas. Along with the resulting richness, however, comes the responsibility for increased vigilance about what can or ought to be shared.

**Advantages to this structure**

Students have the advantage of being able to relate to two different authority figures in two different roles. With the supervisor, they relate primarily as student to teacher. With the director, they relate primarily as employee to manager. The students are able to practice being professional chaplains while they are still students. Sometimes it is easier for students to own some of their authority issues when it can be pointed out to them that they have the same issues with more than one authority figure.

Students tend to feel more fully integrated into the depart-
ment when they are allowed to relate directly to the director and staff chaplains. Again, they gain valuable experience in the role of professional chaplain while maintaining a supervisor and peer group to help them process issues that arise in this role. They learn to relate differently to people in authority depending on each person's given role.

Supervisor and director have the advantage of being able to administer the residency program as a team. While the supervisor does have a peer supervision group, having two pairs of eyes and two pairs of ears on site provides a great deal more feedback for students. Presenting a united front to students helps them to take responsibility for their own issues rather than deflecting them onto the supervisor.

Disadvantages

The sole major disadvantage is the potential for triangulation. Despite all attempts to avoid this problem, some students will seize on any perceived difference in presentation between director and supervisor and use it to claim that they are being treated differently by one than they are by the other.

Differences in personal style between the two can leave the same impression. In some cases, director and supervisor have different opinions of a student's performance, which are quite difficult to hide.

The only way of avoiding this problem is daily communication between director and supervisor. In this case, the director and supervisor both tend to arrive at work before the students and often take that opportunity to check in with each other.

Director and supervisor must have developed a strong enough relationship so that they can be open with each other about how each perceives the other's relationship with the students. It also must be strong enough that it would never be possible for one to have a stronger relationship with a student than they have with each other and strong enough to tolerate a student who likes one better than the other. Each must be able to tell the other when one believes the other's needs are taking precedence over the needs of the student or the needs of the clinical setting.

Maintaining the relationship and communication between director and supervisor takes time and must be a priority for both. It sometimes appears that it would be easier and more efficient to work alone than as a team; however, our experience with this program indicates that this is not uniformly true. Together, director and supervisor have been able to accomplish much more than either would have been able to accomplish alone—and more creatively as well.

From the standpoint of the department, the hospital was able to benefit from the chaplaincy and administrative skills of the CPE supervisor. From the vantage of the education of future health care chaplains, residents saw a variety of models of pastoral care, administration, and professional collaboration. Further, they had to practice working productively, even harmoniously, with all of them.

Conclusions

CPE supervisor/department director partnerships are a viable and effective model for CPE. The model is especially useful for advanced students who are seriously considering professional chaplaincy as a career. Like most CPE residency programs, this one offers the student an opportunity to practice working as a professional while maintaining the support and supervision that is part of being a student. Specific to this model is the challenge of learning to work with and report to multiple supervisors with differing responsibilities, who themselves have learned to work well together and productively within the larger institution. This program has demonstrated that it is fully possible to implement this model while abiding by the Association for Clinical Pastoral Education, Inc. (ACPE) standards and maintaining the integrity of the supervisor-student relationship.
God Does Not Give Me More Than I Can Handle

Georgia Gojmerac-Leiner

There is a certain look of beseeching, a look of longing and helplessness in the eyes of those who are ill and in the eyes of their loved ones. Usually illness is experienced as suffering, and the statement I hear most often from patients is, “God doesn’t give me more than I can handle.” What causes them to believe this? The way the word “God” is intoned makes it sound as if they have a special access to the Divine, as though they are on familiar terms. I hear a sense of exclusiveness to their suffering. They’ve been singled out for suffering because of their special strength.

The idea of strength of endurance implies that everyone in the hospital is being tested for endurance. Those who are strong enough will pull through, and those who are not will die. Implicit in their words, is the corollary, “What a shame it is to be weak and succumb to death.”

But surely God is not a will breaker. Surely, God does not go around hanging tent caterpillars on oak trees nor worms inside the ears of corn. Nature, which Saint Teresa of Avila, a doctor of the church, describes as the second Scripture, can teach us a lot.

Sometimes, if patients are well enough and seem open, or as Jack Shea might put it, “if they are in a developmental moment,” I offer to tell them the Scriptural source of this saying and then invite them to reflect on it. Such reflection often leads to a new understanding and to a new attitude towards illness.

Some respond with, “I never thought about it in this way,” others are skeptical about my interpretation. Though they don’t “buy” outright my suggestion that God may not actually be giving them the suffering, they may later accept this as a possibility.

“Are you sure God gave you this illness?” I ask. “Nothing happens without His knowing,” is the standard answer, “and I am sure He has something to do with this. There has to be a reason for what I am going through.”

They are saying three things, but it is the last one that reveals vulnerability. While I am amazed at the tightness of the logic, I am aware that I must remain sensitive to their need to make meaning out of life and especially out of their illnesses. It is possible for us to discover something new through our suffering, to gain a new perspective on life, but that does not explain the source of illness.

It seems that those who speak in these terms are convinced that there is a definite meaning to their illnesses that it...
has to be gained through suffering, and through the testing of their ability to survive. At the same time, they appear to believe that to accept illness is the equivalent of succumbing to weakness and see that as cowardly.

To some patients, accepting illness seems to be the equivalent of accepting that death is imminent and equal to admitting defeat in the fight against death. Poets, such as Dylan Thomas, defy death through their verse. John Donne, in his “167 Holy Sonnet,” writes angrily, “Death, thou shalt die.” But for Christians, Christ has already defeated death.

However, it is when we ponder the fact of death that we gain a new perspective on life. We learn that we are a part of bigger things, that we are a part of the eternity, where God holds us lovingly, like a child in her mother’s arms.

As Paul wrote in I Corinthians 10:13, 

No test has been sent you that does not come to all men [and women]. Besides, God keeps his promise. He will not let you be tested beyond your strength. Along with all the tests he will give you a way out of it so that you may be able to endure it (New American Bible, 1970).

Paul offers sentence four in particular as encouragement to his brethren as he prepares them for their faith in God to be tested. Might we say that illness is given us to test our faith? If so, then it is not our bodies we need to save, cure, or otherwise preserve or prolong but our sense of wholeness and connectedness to God.

These lines have a tone of hope and courage. They are packed with faith. The promise is that we will discover something about the strength of our faith through whatever form our individual tests take—illness, loss, despair, loneliness—and that we will grow spiritually as a result.

The first sentence states that there is no exclusivity to suffering. We all have a share. If we can be in solidarity with others, we won’t feel singled out. As long as we are not isolated by our suffering, it will be easier to bear and will have no stigma. That is one “way out” God gives to us.

A second is that suffering is an equalizer. It is not a special strength. There is no guarantee in this passage that the test will not end in physical death, but we are assured that through our faith we will be able to endure, whatever the result. Looking at it logically, since God does not give us more than we can handle, then if we can’t handle our problem, it is not from God since God gives us only what we can handle.

It rests upon those of us who are chaplains to help those to whom we minister to find the way to endure. Since illness has the power to transform consciousness, our work should not be difficult if our faith is secure. Trusting in God during suffering is necessary for healing. In that sense, suffering ceases to be an affliction we must bear passively and becomes a conduit for spiritual enlightenment.

We may die to this life, but in Christ we live forever. The testing is temporal, and what God gives is the means to pass through—to get out of—the test.

How do we endure suffering? Is it by saying, “God gave me this, and he’ll take care of it,” or by singing Psalm 90:

Seventy is the sum of our years, or eighty, if we are well. Teach us to number our days aright, that we may gain the wisdom of heart (NAB).

Ultimately, the only thing being tested is our faith in God: faith that God loves us and does not wish us to suffer, much less gives us the suffering. If we should suffer, it is the faith that God is with us in the suffering and that we have God’s strength of endurance, having been made in God’s very image that gets us through. Suffering may not have more than an existential meaning. It is a mixture of physical pain and spiritual pain, a struggle with biology and essence, an interplay between the perishable self and the spiritual self. What it offers is a confrontation with mortality, and we accept it according to our abilities. May we do so with grace.
19 y.o. white male, m.v.a.

so young, so much plumbing
pipes, wires, pumps and hoses
sugar, salt, medication going in
piss, pus and blood coming out
bleeping machines counting, tracking
his heartbeats, his breaths, his minutes
his losses, his advances, his chances
I voice the prayers of his sobbing mom,
his aunt, his uncle, his ten broken friends
telling God and them of love, grace, comfort
giving him up, giving them heart
nurses, docs, white clouds of them
swirling in/out, coming and going still trying
he will die but there seems so much to do

my kids would come home from school
tired, crabby and beaten, it was chemistry
low blood sugar; after macaroni and hot dogs
they would be flying again, talking and laughing
wrestling on the rug and giggling
life coursing again through their veins
they’re gone now
empty nested, I sit at the table
with their mother, my wife of a quarter century
sharing leftovers, she tells tales of her day
the drunken patient, the goofy resident, funny stuff
I tell of the 19 y.o. boy who died, it isn’t funny
it’s a conversation stopper, we fall silent
and clear the table
later I hear her on the phone with our daughter
laughing, new curtains, boys and gossip
I call my son, he got his first college B in English

William Shirk
Staff Chaplain
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The Journal of the Association of Professional Chaplains
One Too Many

She cried and cared
for sick and dying strangers.
Her heart could contain
no more sadness,
no more grief.
She'd been at the bedside of
one too many.

Comforted one too many:
screaming children,
grief stricken mamas,
stalwart men,
cliche-producing helpers denting the silence.

Watched one too many:
alcoholics literally dying for drink,
smokers gasping for air,
addicts manipulating;
etire families in denial.

Walked alongside one too many:
victims of neglect,
abandoned elderly
ex-vital bodies,
dying helplessly alone.

Witnessed one too many:
families leave,
while “everything” was done
in the name of love;
chests CPR bruised and broken.

Grieved with victim families of
gunshot wounds,
knife stabbings,
automobile accidents;
innocent bystanders caught in the crossfire.

She'd heard one too many
Whys with no answers,
especially for herself.

Her heart was full of
one too many
sadnesses for others,
leaving no room for her own.
She hugged compassion goodbye
for a time to refill her spirit.

Susan Simonds Yutzy
Staff Chaplain
St. John's Hospital
Springfield, IL
Reflections on “Font of Blessing”

Our purpose in writing to the Journal instead of solely to the author of the article, “Font of Blessing” (Aoife C. Lee, Chaplaincy Today 17.1) is to raise an important theological and pastoral case for broad discussion among the APC membership. The author is to be commended for her desire to respond pastorally to the needs of a difficult and heartrending experience for expectant parents. The article and its suggested procedures raised many questions for our staff and very likely for your general readership. Our staff is diverse in religious traditions and gender, including ordained and lay ministers with extensive experience in a tertiary care setting with a large neonatal and obstetrics/gynecological service. Given this context of experience and professional training, we found the article and its suggested practice raised serious questions both theological and pastoral.

The author writes in her introduction: “even when they are not alive at birth, I will baptize these children as pastoral care of the family. I also offer baptism in utero, especially when the mother can still feel that the baby is alive.” As a preface to discussion, it seems throughout the article that the concerns of the pastoral care provider are given priority over those of the patient. In the case presented, the parents were described as Roman Catholic and “anxious to have the baby baptized.” It is our experience that persons in crisis regularly phrase their needs in words most familiar to them, e.g., “last rites” or “baptism. It then becomes our task to respond to their needs compassionately and consonant with sound theological practice. What the parents are really asking for in this case does not seem to have been explored. In most instances of this sort, it is our experience that parents are looking for reassurance that their child is “acceptable” to God.

In the Roman Catholic and other Christian traditions, sacraments are not administered to those who have died or are yet unborn. Appropriate prayers and rituals are available which directly address the needs and pain of the parents, in the case of baptism, e.g., a naming ceremony with prayers and Sacred Scripture to comfort and assure parents in crisis. To offer baptism and a certificate of baptism is contrary to sound theological and pastoral understanding and practice.

In the case of “baptism in utero” questions also arise. For a female minister boundary issues seem strained at best. For a male minister, it would be totally inappropriate as described. Theologically, in all Christian traditions, baptism requires the pouring of the water and the saying of the words directly on the person to be baptized. By no stretch of the imagination would the “baptism in utero” be considered valid or appropriate. The explanation of the significance of the shell in religious tradition also is questionable. The additional rituals, as described, seem contrived and forced, clouded by the intensity of feeling and helplessness of the parents and family. Furthermore, when the grief is somewhat assuaged,
sometime later, and the experience comes up for discussion, someone may well say the “baptism” was well-meaning but totally contrary to tradition, throwing the parents into further confusion and renewed grief.

There are compassionate alternatives, e.g., memory boxes, pictures, memory books to which parents can contribute, as well as read for comfort from those who have had similar experiences. All of the above are consonant with sound theological understanding and pastoral practice. They also are respectful of parents and sensitive to their needs without being intrusive.

Throughout the article, the focus seems to be on the action and concerns of the caregiver and the pursuit of the “ritual.” In addition there is throughout a mixing of appropriate theological comment coupled with personal interpretation creating further possible confusion. Again, we do not question the sincerity of the caregiver but the soundness of her theological and pastoral practice.

We welcome further discussion and comment.

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Katherine N. Mitchell
Fran Hauck
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Editor’s comment:
There is ongoing disagreement both between and within Christian denominations as to the appropriateness of baptism when the child has died either in utero or during the birth process. Further, some parish clergy as well as chaplains do see provision of this sacrament in terms of pastoral care of parents/family of the child. As a professional journal, Chaplaincy Today is an appropriate medium for comment and debate on this issue.

Author Aoife C. Lee has elected not to respond at this time, preferring to leave such comment to the journal readership.

Rozann Allyn Shackleton
Editor, Chaplaincy Today
Betsy Anderson, Sue Steen. “Spiritual care: reflecting God’s love to children,” Journal of Christian Nursing 12, no. 2 (Spring 1995): 12-17, 47. • The authors are writing primarily for nurses, helping them to clarify how they might support the spirituality of their pediatric patients; however, their approach applies to pediatric chaplains too. They emphasize the primacy of establishing a relationship with the child before discussing assessment questions which can be used to determine the development and nature of a child’s beliefs and spiritual views. They illustrate the use of self in meeting spiritual needs as well as the use of touch. Also discussed are aspects of pastoral work which are more sensitive for nurses, e.g., use of prayer and scripture, whether or not the sharing of one’s personal faith is appropriate.

Lodovico Balducci, Russell Meyer. “Spirituality and medicine: a proposal,” Cancer Control 8, no. 4 (Jul/Aug 2001): 368-76. • This is a summary article, with a proposal. The authors—a physician and a parish minister—take the reader through the recent literature concerning spirituality and health, emphasizing the problems with defining spirituality and the question of how to understand the relationship between spirituality and psychology. In the first section a suggestion is made which is new to the medicine/spirituality dialogues. The proposal is “that the concept of sacrifice [be used] in medical investigations as a marker of defined spirituality perspectives.” They provide a rationale for this suggestion. They then turn to the matter of how to study spirituality. They claim there are four basic issues which need to be studied, though they offer no basis as to why these four specifically were chosen, especially the second, which seems rather arbitrary: 1) the relationship of spirituality and public health, 2) the efficacy of a spiritual perspective in overcoming addictive disorders, 3) the influence of a patient’s and practitioner’s spirituality on disease outcomes, and 4) the influence of spirituality on patient-physician communication. They point out that research has already been completed on aspects of these topics and highlight fifteen studies already published. They note the implications for the practice of medicine, for medical education, and for future research. This article will help the reader understand how a thoroughgoing scientist/physician may look at the question of spirituality and medicine. This is perhaps an added reason for reading the article, framing as it does, the spirituality/health dialogue in new and unexpected ways.

Janet Bodell, Kelly Rhoades. “Long-range prevention of complicated grief: an approach to the foundational experience with death and dying,” Healing Ministry 8, no. 2 (Mar/Apr 2001): 72-76. • The rather formidable title of this article also is somewhat misleading. The authors are concerned about ways in which young children can be helped to receive positive foundational experiences which will prepare them for later experiences with sickness, dying, and death. The information is intended for parents, teachers, and health care professionals. Bodell and Rhoades suggest that in order to help children, adults must be aware of their basic cognitive development processes, specifically those aspects which are related to memory and the short-term memory phenomenon of “chunking.” The authors describe chunking (a term first coined by George Miller in his major review article on short-term memory) as the formation of permanent sets of associative connections that then reside in long-term memory and are part of the process that create the basis for fluency in speaking. They proceed to describe how children can group and chunk information, which they do at a very early
(preverbal) age as they explore and attempt to make sense of what is happening around them. How this happens is described in a short theory section which is not technical in nature. The authors urge all who work with even the very young to keep in mind that children need to be educated about death and loss. The "preparation then must begin through a parent's conscious awareness of early memory formation from the time of an infant's very first life experiences (p. 74)." They describe some of the opportunities that parents, teachers, and health care professionals commonly have to provide such education. Their conclusion is that complicated grief is a "preventable condition."

Barbara L. Brush, Eileen M. McGee, Bonnie Cavanagh, Mary Woodward. "Forgiveness: a concept analysis," *Journal of Holistic Nursing* 19, no. 1 (Mar 2001): 27-41. • The authors provide an operational definition of forgiveness based on a study of the way it has been defined by others and of how it has been described in the nursing and theological literature. They summarize its antecedents, define its attributes, and identify some of the occurrences of forgiveness. Having done all that, they follow an approach devised by Walker and Avant (*Strategies for Theory Construction in Nursing* (1995) 3rd ed; Norwalk CT: Appleton and Lange) in order to illustrate the meaning of the concept of forgiveness. This involves using cases as examples of the concept; and this they do. Their theoretical definition of forgiveness is "a process whereby an individual and/or group acknowledges a past injury or injustice and its associated negative emotions and thoughts, becomes willing to relinquish and redirect negative energies, and derives freedom from the desire to retaliate and punish those responsible for the injury."

In addition to its value as an examination of an important construct in ministry, the paper is a useful example of the strategy devised by Walker and Avant to clarify elusive concepts.

**Eric J. Cassell.** "The Principles of the Belmont Report Revisited: how have respect for persons, beneficence, and justice been applied to clinical medicine?" *Hastings Center Report* 30, no. 4 (Jul/Aug 2000): 12-21. • Cassell vividly describes the change in the doctor-patient relationship over the past fifty years. In the mid-fifties, when the Belmont Report was written stating ethical principles to guide medical research, physicians functioned on the basis of benevolence (and skill of course) and provided care to the whole patient according to their best judgment as to what that involved. At century's end, care involves a series of treatment options, targeted not at the patient but at the systems or organs under the control of the patient (somewhat) and is viewed as an exchange of resources, which are limited by the resource allocation requirements of various interested parties, most usually insurance companies. It is difficult in a summary of a paper of this scope and elegance to capture Cassell's perceptiveness. Concerning truth telling, he writes, "From the destructiveness of complete lies (in the 1950s and 1960s) to the destructiveness of unmediated truth took less than three decades (p. 17)." Concerning our understanding of the physician's activity: "We no longer understand the medical act as that of an individual clinician caring for an individual patient within a relationship, but as a commodity or a resource within a marketplace." (p. 21) In his final section concerning making treatment decisions, as opposed to treating patients, he concludes with a sad story. I am taking the liberty of substituting a recent story of my own which illustrates his point. A woman was admitted to my hospital recently one Saturday morning. She was complaining of a burning sensation in her stomach when she ate. In fact, she had been unable to eat for several days. Over the weekend, she was worked up by means of the appropriate tests, and the results were to hand when the consultant made his rounds first thing Monday morning. He came into her room, noted to her that all her test results were within normal parameters, that she was now well hydrated, so he was going to discharge her. In passing, he noticed that she had eaten no breakfast from her tray. "You really should try to eat something," he urged. "But that is why I came to the hospital, doctor. I can't eat." It was only at her husband's insistence that she was not discharged. Cassell concludes his paper with an extended discussion of the nature of justice in health care ethics. He shows how the rise of managed care during the nineties has highlighted the distributive issues that arise when cost becomes the primary value by which services are measured and allocated. Like
all Cassell’s work, his paper is an easy, but troubling read.

Melanie Cooper-Effa, Wayne Blount, Nadine Kaslow, Richard Rothenberg, James Eckman. “Role of spirituality in patients with sickle cell disease,” Journal of American Board of Family Practice 14, no. 2 (2001): 116-22. • Sickle cell disease is a chronic and at times extremely painful disease. Historically it was also a dramatically life shortening disease, though improved medical care since the 1970s has helped this group of patients live longer. The median age of survival for men is now forty-two years, for women it is forty-eight years. It is most commonly found in African Americans. Patients have to find ways of coping with both the chronic pain and the acute, painful episodes for which they are often hospitalized. They do so in various ways: counseling, hypnosis, medication, and prayer. Spirituality is also a method of coping, and the authors of this study report how seventy-one patients in a sickle cell clinic cope with the pain and Ellison’s Spiritual Well-being Scale (SWBS) to investigate their degree of spirituality. The authors define spirituality as “the capacity to rise above life experiences, to celebrate life and to experience joy.” To study the ability to cope with pain, they used an established pain inventory questionnaire. The results showed an association of spiritual well-being with better perception of life control for this group.

With complications of sickle cell, what was not clear was the method through which spiritual well-being works its effects. The authors, who are circumspect in their claims to understand what they have found, will only say, “Spiritual well-being can help patients with sickle cell disease cope more effectively with the pain of the disease. This effect appears to be through a perception of more life control, measured in this study through the perception of social support. Considering oneself to be spiritual is correlated with perceiving oneself to have a supportive network. Spiritual well-being is not correlated with pain severity or life interference (p. 121).”

Edwin R. DuBose. “Preparing for death: linking medicine, spirituality and end-of-life care,” The Park Ridge Center Bulletin 21, (May-Jun 2001): 3-4. • There have been many changes in the care of the dying, with some interesting (and probably unexpected) consequences. For example, chaplains now know a great deal about pastoral care of the dying; community clergy do not. People are fearful of losing control of their lives as they are dying, and changes in health care delivery ensures that most of them do. Reformers have worked at improving communication between doctor and patient; but there is no evidence that doctors are less reluctant to talk about death and dying with their patients than they were a decade ago. The 1997 Gallup survey titled “Spiritual Beliefs and the Dying Process” also produced some surprising figures which DuBose quotes: Only 36 percent would look to clergy for spiritual support during their dying (no mention of chaplains); 30 percent would look to physicians, and 21 percent to nurses. For the majority, it would be to their family and friends that they would turn for their deeper spiritual needs as they were dying. Finally, DuBose turns to a paper by Bradshaw who has written about the “secularized spirituality” now to be found in health care. “The effort in health care to dissociate the spiritual dimension from religion produces a lowest common denominator that replaces the traditional notion of spirituality—the human being in relation to the transcendent—with a spirituality that is a personal and psychological search for meaning.” DuBose is concerned that this kind of spirituality can easily become a “silver bullet,” simply one particular kind of health benefit. “Even if spiritual care is important for dying people, does not the spiritual life need to be pursued in terms of its own goals—a deeper relationship with the transcendent—and not in terms of any beneficial effects?” This is a frustrating paper, with DuBose pointing out some important issues which are worthy of greater thought but which remain mostly undeveloped in this essay.

David C. Duncombe. “Prayer and fasting in the halls of Congress: a pastoral approach to lobbying,” Journal of Pastoral Care 55, no. 1 (Spring 2001): 7-16. • Over the years, David Duncombe has established his credibility as a pastor and chaplain with a social conscience, who sometimes acts on his beliefs in very public ways. In five earlier articles in the JPC he
has described those activities. In this paper he describes a ministry of prayer and fasting in Washington, DC in support of congressional legislation intended to permit debt relief for forty of the world’s most impoverished countries. Duncombe describes a “compelling parallel” between hospital visitation and lobbying. “The trust engendered by the pastoral process...becomes the foundation for whatever advice (or legislative recommendation) is later given (p. 14).” And the outcome? Duncombe seems reluctant to take much credit for himself, but he does report what others have called the “Wednesday night miracle” during which the House Appropriations Committee “resembled more of a revival meeting than a sleepy late night legislative session. Speaker after speaker rose to talk about the need for human compassion, human justice, and ‘doing what is right before God.’” The House eventually voted to more than triple debt relief, where the commonly held belief had been that the proposal would be lost. In a postscript written in October 2000, Duncombe reports that both houses had passed and the President had signed funding for debt forgiveness totaling $435 million, a figure far exceeding that originally hoped for and contrary to pundits’ expectations for the outcome of this legislation’s passage before Duncombe’s lobbying and prayer.

Garry Hamilton. “Dead man walking,” *New Scientist* 171, no. 2303 (11 Aug 2001): 31-33. • Seventeen years ago, Barry Marshall gave himself a cup of microbe-laced water. He was a trainee-doctor in Perth, Australia. A week or so later, over Easter, an examination of the lining of his stomach showed that he was developing gastritis, the first step toward a life threatening ulcer, or even stomach cancer. This was the first step in showing that gastric ulcers are not caused by spicy food or stress, but by a bacterium, *Helicobacter pylori*. The upshot has been that taking a course of antibiotics cures people of ulcers, whereas beforehand, they have had to take medication for life. Now, however, there are some doubts. It turns out that *H. pylori* may not be a total bad guy, after all. There is growing evidence that *H. pylori* may protect us from diarrhea, as well as a rare cancer now rising fast and mysteriously throughout the western world.

Laura Helmuth. “Moral reasoning relies on emotion,” *Science* 293, no. 5537 (14 Sept 2001): 1971-1972. • Helmuth discusses the findings in a study published in the same issue (J. D. Greene, R. Brian Somerville, et al., pp. 2105-07) which show that, in at least some situations, a person’s emotions are hard at work when faced with an ethical dilemma. The brain imaging study by Greene and his colleagues revealed that even when an ethical problem is stated in strictly rational terms, people’s emotions guide their solutions. Helmuth gives an illustration for the reader to use on themselves: you see a trolley with five frightened people heading for disaster. But you can save them if you throw a switch and send the trolley onto another track which will not take the trolley over the cliff, but where, tragically, another person is standing and who would be killed by the trolley. What would you do? Most people think they would throw the switch. However, what if there was not a second track or a switch, but a person standing in front of you whose bulk would stop the trolley if you pushed them into the trolley’s path. Would you push the person? Most people think it would be wrong to save the people by stopping the trolley that way. This paradox has been puzzling ethicists for a long time. Why is it sometimes O.K. to kill one person to save five whereas at other times it is not? Helmuth refers to philosopher Stephen Stich’s (Rutgers University) statement that the Greene results will not sit well with the majority of ethicists and moral philosophers who argue that moral decisions must be
based on pure reason alone. But it's an encouraging story for chaplains who know that emotions can never be removed from difficult ethical decisions, and yet another piece of research looking at different aspects of the biological substrate of faith and values.

E. Wayne Hill. "A collaborative pastoral care and counseling supervisory model," Journal of Pastoral Care 55, no. 1 (Spring 2001): 69-80. • Hill's purpose is to present a collaborative model of pastoral supervision that demonstrates a relational, educational, and theological construct and facilitates a therapeutic process in supervision. He also wishes to emphasize that supervision involves a process that is integrative and implies an unfolding and evolving process. "Integration in supervision is an unfolding intrapersonal and interpersonal learning process (p.71)." He lays the groundwork for the model by discussing such issues as cognition, learning theory, and anxiety. He grounds his understanding of the supervisory relationship in the attachment theory of John Bowlby. He comments on a number of attachment styles that can be identified in the supervisory process. Finally, he discusses the supervisory implications of his understanding of attachment theory, describing them in five stages, which he says he has identified from his observations of the supervisory process. Hill concludes with a theological reflection based on Luke 15:11-32, the parable of the prodigal son. He draws attention to the theological significance and relevance of attachment theory in this parable.

Douglas MacDonald. "Hope and Hanukkah," Healing Ministry 8, no. 2 (Mar/Apr 2001): 57-59. • An exploration of the theme of hope, "as it stubbornly manifests itself in seemingly hopeless situations." It is written by a hospice social worker who is on the admissions team of a hospice in New York state. He and a nurse have the task of "enrolling" a man for hospice care. His wife is not ready for that step. MacDonald tells the story of their involvement.

Kenneth Pargament, Harold G. Koenig, Nalini Tarakeshwar, June Hahn. "Religious struggle as a predictor of mortality among medically ill elderly patients: a two-year longitudinal study," Archives of Internal Medicine 161, no. 15 (13–27 Aug 2001): 1881-85. • There have been many studies published showing that frequent church attendance is associated with increased life span (though many of these same studies have been dismissed for their lack of sophistication.) In some ways, this study reports the opposite effect. Pargament and his colleagues show in this research that religious struggle as the result of an illness increases the risk of dying. This is the first empirical study to identify religious variables that increase, rather than decrease the risk of dying. They studied 596 patients over a two-year period and examined their mortality rate. Mortality during the study period was higher in those persons who said they were feeling abandoned or punished by God, those who questioned God's love for them, those who felt abandoned by their church, those who believed that the devil was at work in their illness, and those who questioned the power of God. The mortality risk increased by 6 percent for every point scored on a 0 to 21 point negative religious coping scale. The revelation of the significant impact of these negative beliefs suggests an important area of ministry which chaplains will need to address in a more systematic way.

David Paulk. "Munchausen syndrome by proxy: tall tales and real hurts," Clinician Reviews 11, no. 8 (2001): 51-56. • Children tortured by their parents. We would like to think that this only happens in other countries. Paulk shows that it does not as he describes a form of child abuse in which a parent or a caretaker, usually the mother, systematically fabricates information about a child's health, or intentionally makes the child ill, in order to assume the sick person's role, by proxy. By forcing the sick role onto the child, the perpetrator gains gratification through the surrogate patient, i.e., by proxy. Munchausen syndrome by proxy (MSBP) or "factitious disorder by proxy" was first described in 1977. It is a formal psychiatric disorder. It is hard to spot. Lying to cover up physical abuse is not MSBP. There is no "personality profile" that can be used to identify the perpetrators; the family environment usually gives no clues. Paulk describes some objective characteristics of the victim, the victim's siblings, and the perpetrator, which can serve as warning signs of MSBP. There is an important ethical issue related to this problem. Covert video surveillance (CVS) is a recommended tool.
when MSBP is a strong consideration. Most hospitals do not have a CVS policy, and so when the issue arises, there are often two problems to deal with simultaneously, both of which are emotionally charged. Chaplains can be of substantial help by being aware of this syndrome and of the need for the creation of a policy if the institution does not already have one.

Stephen G. Post. "Tube feeding and advanced dementia," Hastings Center Report 31, no. 1 (Jan/Feb 2001): 36-42. • In the late 1970s, Michael Gauderer developed the concept and use of the PEG, the percutaneous endoscopic gastrostomy, which allows long-term tube feeding. The number of persons being provided nutrition and hydration by this method has risen dramatically, to the point where Gauderer himself has called for greater attention to the ethics of the use of PEGs. The problem is not its use when a person is likely to recover from an acute health crisis. The issue is when, and for how long, should a feeding tube be used when a person is certainly but slowly dying. To move toward an answer to this question, Post analyzes the benefits and burdens of the use of tube feeding from the patient’s perspective. He looks at the burdens of such feeding, which in Post’s mind have always been minimized and overlooked. There are six issues to be considered, which he does in turn. The desire to give food and water to any living person has deep emotional roots for all who work around patients. For either care-givers or family members to stop providing them is often exceedingly difficult. Such situations call for the presence of a chaplain, both to address the ethical issues and to provide good pastoral care.

Julia D. Quiring-Emblen. “When pills won’t work—one couple’s struggle for health through homeopathy,” Journal of Christian Nursing 18, no. 4 (Fall 2001): 4-7. • In a personal story, Quiring-Emblen, herself chair of nursing at a university in British Columbia Canada, describes the medical history of her husband, their friendship and marriage when he was in his mid-thirties. Her husband John had been raised in a family which used homeopathic medicine when they became sick, and which he used to treat his severe rheumatoid arthritis. Quiring-Emblen, whose background had always been around conventional (allopathic) medicine helps us understand how she struggled to be supportive of the beliefs of her husband about treatment, and what she thought were its limitations. Eventually her husband died after their thirteen-month marriage, and Quiring-Emblen has concluded that homeopathy should only be used for less serious conditions, and that when a problem becomes more acute, conventional medicine’s help should be sought. This article is the first in an entire issue of JCN which has been designed to help Christian nurses make informed judgments about complementary and alternative medicines (CAM). There are articles on touch healing, homeopathy, energy medicine, and herbal remedies.

Michele Le D. Sakurai. “Regulations impacting spiritual care in health care,” Vision 11, no. 9 (Oct 2001): 4. • There has been a significant amount of misinformation with accompanying anxiety in chaplains who have heard recently about the new HIPAA (Health Insurance Portability and Accountability Act of 1996). Sakurai, who is chair of JCAPS, sets the record straight. The issue has been privacy, but it is not true that chaplains need a patient’s permission before they enter that person’s room, a claim that some ill-informed hospital administrators have been making. Chaplains who are employed by a health care entity may function as they always have with regard to access to information about patients. What has changed is the disclosure of information to community clergy. Community clergy are treated differently than members of the general public. Clergy may now be given a patient’s name and general condition (as long as it does not contain specific information), the person’s location in a facility, and the person’s religious affiliation. It is referred to as “directory information.” Additional information about this legislation can be found at: <http://www.hhs.gov/ocr/hipaa> Sakurai states, “The final rule distinguishes between staff in the health care entity and those who operate outside the walls of the entity.” Inside-the-walls staff definitely includes chaplains.

Susan A. Salladay. “Tristam Englehardt’s Christian Bioethics—a physician-philosopher confronts health care in the light of faith,” Journal of Christian Nursing 18, no. 4 (Fall 2001): 28-30. • Tristam Englehardt’s name is well known in medical ethics circles. He has published twenty-five books on
bioethics, and more than 250 articles over the past twenty-five years. He was trained as a physician, and he has a doctorate in philosophy. Until 1991, his work in bioethics had been secular in character and often very critical of religious belief. Then he became a Christian, being baptized into the Greek Orthodox tradition. He began a new journal, Christian Bioethics, and in 1999 published his book The Foundations of Christian Bioethics. He says that the book "attempts to clarify what it is to be a Christian in today's world, a world that is post-Christian, post-traditional, and postmodern. These 'posts' mark a fundamental rupture in culture. We have moved from a Christian to a neo-pagan moral context." Salladay interviews him about how his thinking has changed since his religious conversion, and as you may have guessed from the tone of the above quote, he is highly critical of much of what passes for religion and spirituality in health care today.

Carl E. Schneider. "Gang aft agley," Hastings Center Report 31, no. 1 (Jan/Feb 2001): 27-28. • Schneider begins with a quote from columnist Walter Lippman (from A Preface to Morals): "the amount of law is relatively small which a written legislature can successfully impose." Schneider proceeds to examine how the law requiring advance directives has been so successfully unsuccessful in the United States, in spite of determined efforts in hospitals to implement systems to encourage their completion and use. He describes the chain of circumstances necessary for a living will to be used. He identifies five, and failure at any step means total failure. He concludes, "In sum, failures confound every step along the path toward a successful regime of advance directives and show how challenging it can be for the law to affect behavior even in apparently simple and desirable ways."

Marna L. Skinner. "Confrontational communication," The 2001 Annual: Consulting 2, (2001): 167-71. • As chaplains, we regularly encounter and minister to persons who are angry for any number of different reasons. Skinner's brief article describes the dynamics of such encounters and provides us with a framework within which we can function effectively. Skinner is writing for managers in business; however, her four-step process is immediately applicable to ministry situations. The four steps: inquire, empathize, ask permission, and explain or offer choices. She gives examples.

Sandie Soldwisch. "Building confidence in spiritual care – strategies and outcomes," Journal of Christian Nursing 18, no. 4 (Fall 2001): 24-27. • A nurse educator describes the development of her school's curriculum to ensure that spirituality can be adequately addressed by all students in their nursing practices. Central to the essay is her description of one student's work in planning the care of a patient, with the assessment and care plan presented in detail both before and after the course. There is a marked difference between the two plans and, as a chaplain, I would like to have nurses around me who can do such thorough assessments.

Anastasia Toufexis. "A pioneer in the battle to avert needless suffering," New York Times (6 Nov 2001): D5. • This story features the work of Dr. Kathleen Foley, a neurologist at Sloan-Kettering Cancer Center in New York since 1974, and the founder (in 1981) of the first pain service in a cancer center. However, since 1983 she has been the director of the Open Society Institute's Project on Death in America. The work of the project is to alter the culture of dying in American society through initiatives and research. In this interview she describes what palliative care is, what it tries to accomplish, and the problems it still faces. Inserted in the story is a reference to a report which chaplains might be aware of. Published in June 2001, it is a "stunning indictment of the care offered to cancer patients... at the end of life....Many of the 550,000 patients who die of cancer each year spend their last days in distress, suffering, from pain, nausea, fatigue, and depression." According to the authors, much of this distress easily can be avoided. The report can be found at <www.aim.edu> and is titled "Improving Palliative Care for Cancer." It was published by the National Cancer Policy Board of the Institute of Medicine and National Research Council. The entire report can be printed, though navigating the site takes a little effort. There is nothing in the report that chaplains can act on, except to be aware of the existence and political importance of this document at a time when cancer care in general is still provided so poorly.
Larry VandeCreek, Karolyann Siegel, Eileen Gorey, Sharon Brown, Rhoda Toperez. “How many chaplains per 100 inpatients? Benchmarks of health care chaplaincy departments,” Journal of Pastoral Care 55, no. 3 (Fall 2001): 289-301. • What is the ratio of chaplains to patients needed to provide good pastoral care in a hospital? This is a question which is regularly asked, and for which there are a variety of answers. This paper reports the results of a research project which, while it does not answer the above question, does reflect the current practices in a large number of hospitals across the United States. A questionnaire survey was sent to 500 pastoral care department directors, and responses were received from 370. They were drawn from the Association of Professional Chaplains, the National Association of Catholic Chaplains, and the Association of Mental Health Clergy. Questions asked included the following: How many chaplains do you have per one hundred inpatients? What is the relationship between the number of employed chaplains and your CPE program if you have one? How much outpatient ministry do you provide? What percentage of your pastoral effort is provided by volunteer chaplains? The results from the study, and there are many, are detailed, reflecting the customary attention to detail paid by VandeCreek, the lead author. The results provide chaplains with reliable information that will assist them in their strategic planning processes.

Melissa G. West. “Building a playground for your spirit,” Spirituality & Health 4, no.3 (Fall 2001): 54-55. • Labyrinths, ancient devices found in medieval cathedrals and remote hilltops around Europe can now be found in many modern places, including hospitals. West describes how wooden finger labyrinths can be used by hospital patients. Finger labyrinths, also known as “Troy Stones” were used in Cornwall, England at least five hundred years ago. Etched in slate, they were considered sacred, and either handed on to following generations or destroyed upon the owner’s death. West describes their use by hospital patients, tells where they can be purchased, and provides a template for those who wish to make their own. This issue of Spirituality and Health also contains photos and comments on over a dozen full-sized labyrinths, in addition to those in West’s article.
A Prayer for Chaplains

O Holy One
We come again to you, our Center  
  Ground us
We come to confess our weariness  
  Hold us
We come to seek your face  
  Smile on us
We come to be made whole  
  Heal us
We come to open our hearts  
  Fill us
We come to open our minds  
  Teach us
We come to open our spirits  
  Breathe into us
We come to live and to die in you  
  Give us your peace

Amen

Dick Millspaugh
President
Association of Professional Chaplains

This prayer was composed following the tragedies of September 11, 2001.